THE MUNRO REVIEW OF CHILD PROTECTION

Progress report: Moving towards a child centred system

Professor Eileen Munro

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Executive Summary

My review made recommendations that will, together, help to create a work environment that will better support professionals in giving children and young people the help they need. This report considers how well implementation of these recommendations has progressed in the year since the review's publication, and how the child protection landscape as a whole is changing.

The overall conclusion of this report is that progress is moving in the right direction but that it needs to move faster. There are promising signs that some reforms are encouraging new ways of thinking and working and so improving services for children. There are, however, a number of reforms that still require implementation; as this happens over the next 12 months, the pace of change should be hastened further.

One fundamental change that is needed is for all to have realistic expectations of how well professionals can protect children and young people. The work involves uncertainty: we cannot know for sure what is going on in the privacy of family life, nor can we predict with certainty what will happen. Too often, expectations have become unrealistic, demanding that professionals 'ensure' children's safety, strengthening a belief that if something bad happens 'some professional must be to blame'. This has contributed to the development of a defensive culture that focuses on compliance with targets and rules instead of whether services are providing effective help. Having realistic expectations of professionals will make it easier for them to have the confidence to use judgment instead of applying rules that do not match a specific child's needs, and the humility to reflect on weaknesses in their practice so that they can learn.

Increasing local and professional flexibility

Chapter 2 looks at progress in reducing statutory guidance so that there is more scope for professional and local autonomy. There has been some understandable delay in implementing these changes, caused by the need for proper public consultation.

A key issue is the removal of fixed assessment timescales. The experience of the trial authorities who were granted exemptions from these statutory timescales has been positive. They report that the additional flexibility has encouraged better, more thoughtful working practices, and better and clearer consideration of priorities.

Many practitioners previously felt that the inspection process had become unduly fixated on compliance with regulation rather than good practice. Particularly welcome is Ofsted's revised child protection inspection framework, which focuses on the impact and effectiveness of help and protection for children, young people and their families, in addition to a more rigorous examination of the quality of professional practice. Crucial to driving change across services will be the introduction of the multiagency inspection framework in 2013.

Redesigning services around children and families' needs

Chapter 3 deals with changes in the many services that play a part in supporting families and improving children's safety and wellbeing before they require attention by child protection agencies. The improved provision of 'early help' through better interagency working was a key feature of the original report. This report has found many encouraging examples of services working together and with social services to provide better understanding of children's needs. Some existing statutory guidance is, however, still hampering co-working and joint assessment – once the Government has removed this, all services should be better placed to work together to offer improved early help.

There are many other reforms taking place in parallel to those in child protection, most notably in health and policing. Because these new working environments are still evolving, I emphasise that it is extremely important that the Government should continue to facilitate and encourage understanding between services.

Children's Social Care and social work

Chapter 4 focuses on children's social work, on developments in social work expertise arising partly from my review but also from the work of the Social Work Reform Board and the new College of Social Work. Important improvements are already being made to initial education, in selecting the right people to train, and in meeting the needs of those aspiring to be the next generation of social workers. These reforms are absolutely vital to ensure that the profession is equipped to make the best decisions for children.

A key concern of the review was that the views of frontline practitioners should be properly represented to managers and budget keepers at central and local level so that they can understand the impact their decisions might have on work with children and families. Consequently, it has been encouraging to see the Government has taken steps to appoint a Chief Social Worker and that local authorities are starting to recruit Principal Social Workers to their teams.

What is particularly encouraging is that some local authorities are already developing innovative ways of working that are enhancing the quality of help received by families; this chapter gives some examples of good work already underway.

Learning how we are doing

Chapter 5 looks at improvements in learning how well we are helping children. One of the reasons for creating greater flexibility is so that professionals can learn from experiences and feedback and adapt their practices accordingly. The review noted that an inhibitor of good practice has been an over reliance of performance indicators and targets, the attainment of which had become an end in themselves rather than a spur to better work with children. The Government has responded by producing new data requirements that are expressed as performance information not as indicators or targets. The challenge for all professionals involved is that they use this data as the starting point for analysis rather than as its conclusion.

The chapter also discusses how learning can be (and is being) encouraged at local level through peer review, at case level through case management analysis, and by better consultation and conversation with children. Finally, it discusses the capacity building, methodological refinement and cultural change necessary to fully implement a Serious Case Review process focused on whole system improvement.

Conclusion

Chapter 6 emphasises the importance of implementing all the proposed reforms in concert. In order to create a new culture within child protection it is necessary to increase the flexibility to respond to needs on the ground both within and across services, to have the skills and experience to take advantage of this flexibility, and to be able to assess, learn and respond to how well we are helping children. Addressing individual parts of the system will only succeed in pushing problems elsewhere, leaving child protection as weak, or weaker, than it was before. Implementing these reforms as a whole will give professionals the scope and skills they require to better protect children and to continue to improve their methods and means.

Chapter 1: Introduction

1.1 Now, a year after my final report was submitted, is a good time to reflect on the progress being made in implementing my recommendations. The Government will shortly be publishing radically revised statutory guidance for consultation. I have seen only draft versions and the comments in this report are based on these but the versions that are published may differ in some respects. A new inspection framework also comes into operation in May. These fundamental changes will make a significant contribution to helping the system re-orientate itself from checking compliance to learning how well children and young people are being helped, and having sufficient flexibility to respond to these lessons. This is the time when local services and professionals need to seize the opportunity to move towards a child-centred system. My conclusion is that things are moving in the right direction but need to move faster.

1.2 My report last year sought a culture change in the way that children and young people are protected from harm. They need professionals who are able to understand and help them. This requires intelligence and good skills in getting on with family members, in coping with the strong emotions that are stirred up, in helping people solve problems, and in making decisions about what, on balance, is in the child or young person's best interests. Such important and complex work needs good guidance, good management, and good records. However, as my review concluded, the system had become unbalanced so that there was an undue emphasis on recording and compliance with targets and procedures. Consequently, professionals had too little time with families and too little scope to use their expertise and make judgments.

1.3 The positive response to my review shows how many agree with this analysis. There is real enthusiasm for change. But it is not easy to shake off the compliance culture. At heart, this work involves uncertainty: we cannot know for sure what is going in the privacy of family life; we cannot predict with certainty what will happen to children; we can only make judgments and decisions that, on the evidence available, look the best. Yet, too often, expectations have become unrealistic. Government and local documents are peppered with the word 'ensure' on matters where no-one can realistically do so. Public horror when tragedies occur has strengthened the belief that if something bad happens 'someone must be to blame'.

1.4 The compliance culture is an understandable response to this impossible expectation. The need to avoid and deflect blame ripples through the system encouraging people to simplify the work. Targets that were introduced as proxy measures for good practice become the goal themselves. Guidance that was intended to inform professional judgment is treated as a set of rules. Recording takes on undue importance as the source of evidence of your actions. As a result, the reality of what is happening to children and young people shifts into the background.

1.5 Oversimplifying the work protects adults from anxiety but it does not protect children or young people from harm. Moving from a compliance culture to one that is child centred requires us to grapple with the complexity and uncertainty, supporting and valuing professionals for what they can realistically attain. With hindsight, we can all be wise so it is tempting to criticise professionals:

for not seeing the handwriting on the wall – forgetting that it was written in invisible ink that became legible only afterward. Actions that seemed prudent in foresight can look irresponsibly negligent in hindsight (Kahnemann, p.203.)

1.6 Recent comments from the Government have been helpful in encouraging a move from a blame to a just culture. In responding to the Serious Case Review on the case of the J Children in Edlington, Michael Gove, the Secretary of State for Education, wrote:

People working in these circumstances need to have the confidence that they will be backed by their managers when they take difficult decisions with good intent and sound judgment, whatever the outcome (2012).

1.7 Tim Loughton, the Parliamentary Under Secretary of State for Children and Families, has sought feasible goals, for example, ending an introduction to new guidance on tackling sexual exploitation with the ambition to make children 'safer' rather than 'safe' (Department for Education, 2012). Although it may seem a small difference from 'ensuring that all children are safe', it is an example of what I hope will be a more realistic culture of expectation.

1.8 The Government has accepted all the recommendations from my review, with some provisos. Appendix A lists the actions taken in response to each recommendation but, within this report, I want to look at how they are interacting. Until the major changes in statutory guidance and inspection are implemented, local agencies are limited in their freedom to re-design their work practices. However, there are many examples to report of significant developments both planned and already underway.

1.9 There are also other major changes going on that are having, or will have, a major impact on child protection. In the reforms I discuss in this report, it is difficult to separate out the impact that my review has had from several other influences.

1.10 The cuts in public sector funding are clearly significant. This means that services are attempting to implement my recommendations along with other changes needed to live within their budgets. There is a rise in referrals to Children's Social Care that may be linked to cuts in support services for families. The financial problems and welfare reforms also affect families with estimates of increasing child poverty (Bradshaw, 2011, Browne, 2012). Although parents on low incomes can provide excellent care, it is well established that poverty correlates with neglect in particular and so there might be an increase in referrals because of this.

1.11 Radical changes are also taking place in public sector services - in health, police, the court system, and education. These all play a major part in safeguarding children and young people; the good mechanisms that have been established for working together and with Children's Social Care that have been established need to be preserved amongst all the change. Therefore it is vital that the Government gives a clear message about the priority of safeguarding vulnerable children and young people so that their needs are not obscured or overlooked in the midst of unprecedented change.

1.12 In preparing this report, I have been helped by many discussions about my review at seminars, conferences and meetings with multi-agency and multi-professional groups. I have visited a number of local authorities, undertaken a survey of Local Safeguarding Children Boards (LSCB) Chairs, received extensive written and verbal feedback, and

been sent many examples of reforms. The survey of LSCB Chairs provided valuable information on how people were implementing my recommendations but the response rate was only 39% so it may not be representative of the whole country. The Children's Improvement Board (CIB) has provided useful data on what local areas are doing. The Centre for Excellence and Outcomes in Children and Young People's Services (C4EO) has been collecting examples of successful innovations in family support that illustrate the range of activities going on. The information gathered from all these sources provides insights into what aspects look feasible and what is worrying people. It also conveys a welcome sense of enthusiasm for the changes.

1.13 This report provides an overview of progress on the set of recommendations that will together help create a work environment where professionals have increasing confidence and competence, and where the primary focus is on whether or not children have been helped. The next chapter looks at the Government's actions in reducing statutory guidance so that there is more scope for professional and local autonomy. Changes here allow changes in the inspection process which many have seen as a prime driver of the compliance culture and the new inspection framework could also be a prime driver in encouraging a learning culture. Chapter Three deals with the changes in the many services that play a part in supporting families and improving children's safety and wellbeing. The extent of policy reform and funding cuts make change unavoidable and many areas are re-designing their services to improve families' access to the right help in a timely manner. They are, however, hampered by the continued presence of the statutory guidance and by the inspection process. Children's Social Care figures in this chapter in terms of how it works with other services but Chapter Four is specifically on it and on developments in social work expertise arising partly from my review but also from the Social Work Task Force. Changes are needed in the way the different services monitor themselves and define 'good practice'. Chapter Five looks at progress in ways of learning how well we are doing in helping children. Finally, (Chapter Six) I offer an assessment of progress.

1.14 These reforms are only the start of an ongoing process by which the child protection system can better serve children; taken together they should create work environments in which better practice is likely to flourish. There is very much further to go but, one year on from the publication of my review I am delighted to be able to report that the journey has begun.

Chapter 2: Increasing local and professional flexibility

Introduction

2.1 There has been considerable progress in planning to revise statutory guidance. Radical changes to this guidance and to inspection were recommended in my review because they had, over time, been absorbed into a defensive culture and been given undue prominence. This was seen to distract attention from children's safety and welfare by becoming the focus. Data such as timescales that began life as intelligent indirect measures of the quality of help children received became the direct goal of practice. The guidance also proliferated over the years with the original prescription of goals being increasingly augmented with prescription of how to achieve them, thereby creating increasing obstacles to flexibility and reform at the local level.

2.2 The Government accepted my recommendations on this but has not yet published revised statutory guidance for consultation. This delay, albeit for good reasons, has caused some problems, with some hesitating to start reforms in case the Government changes its mind and others feeling frustrated because they can only partly implement reforms until the guidance allows them more freedom. The reform of the inspection process is further ahead with a revised framework having been published for consultation in July 2011, piloted in five local authorities, and coming into force in May this year.

2.3 Moving responsibility for deciding how to meet the statutory duties to local and professional control requires change in how professionals work together. There are many examples of formal and informal mechanisms being developed, and we can draw on the evidence from the local authorities who were granted exemptions during my review (see below) to become more focused on the quality of help children are receiving.

2.4 In moving from a compliance to a learning culture, professionals need more space to exercise judgment and respond to the variety of needs of children and families. However, those feeding back on my review have asked me to clarify when rules are still essential.

More judgment, fewer rules

2.5 Why should there be more judgment? As discussed in the final report of my review (paras 3.1 – 3.5), rules and procedures are, of course, essential for some aspects of the work. It is the Government's responsibility to set out the duties and principles of the services, as is done in the document *Working Together to Safeguard Children* (2010). These should not be expressed just in terms of individual services. The importance of working together is a lesson that has been painfully learned - individually, professionals have only a partial picture of the child's life and the full extent of the danger and needs can be hidden until they share their knowledge. It is therefore essential for the Government to set out basic rules about roles and tasks for working together. A clear understanding of each other's role is necessary to enable professionals to work together efficiently and know what part each will play. This is especially so when it is not an established team but a group who have come together on a particular occasion, as is often the case when carrying out a child protection enquiry into an allegation of child abuse or neglect. The culture of working together

that has been embedded in England is impressive not just in relation to concerns about abuse or neglect but also in supporting families who are receiving help from more than one service.

2.6 Rules are also desirable when dealing with simple actions where there is a 'right' way to do things, e.g. in some aspects of preparing a court application. But some degree of professional judgment is needed when dealing with complicated tasks, for example when deciding whether a referral requires an urgent response. Guidance may offer suggestions of factors to consider but, ultimately, the competent professional exercises judgment in determining how to respond.

2.7 Over the years, the increase in statutory guidance and of locally created rules has meant that the scope for judgment has been eroded with complicated tasks being treated as simple. As a consequence, professionals' ability to be child-centred, to make decisions that take account of the specific circumstances of the child, has diminished. The fixed timescale for assessments, for instance, has for many become the overriding concern so that an assessment is concluded because the deadline has been reached not because the worker thinks they have acquired a good enough understanding of the child's needs to make a sound decision about what to do.

Revisions to statutory guidance

2.8 The Government felt it was necessary to consult widely before making such radical changes. At the time of writing, revised versions of *Working Together to Safeguard Children* and *Framework for the Assessment of Need of Children and their Families* should shortly be published for formal, public consultation. This set of documents contain a radically reduced amount of central prescription, with Government retaining the responsibility to set out the duties, roles, and principles while providing more local and professional control of the way that these were implemented. This major reduction in Government control has strong endorsement from Ministers and indicates a confidence in the sector to take more responsibility.

2.9 It is important that this guidance leaves no one in any doubt about their responsibilities to safeguard and promote the welfare of children. It must make it very clear what must be done. However, it should free professionals from the degree of prescription on how to meet their responsibilities that takes away space for innovation, judgment, and the flexibility to meet the specific needs of individual children and young people.

Taking more responsibility – sharing and learning

2.10 In the survey of LSCB Chairs, the majority (86%) of Chairs who responded agreed that greater local autonomy and reduced central prescription were to be welcomed, with strong endorsements for removing the statutory distinction between initial and core assessments (76%), and removal of statutory timescales (64%). However, there are also many concerns about altering the status quo and the Government has taken the time to listen and discuss in order to get things right.

2.11 There are concerns about 'removing guidance' but it is more accurate to say that the revisions are 'moving some guidance' - from the statutory to professional and local control. The changes do not require any radical immediate action by LSCBs. With some exceptions, their existing local procedure manuals will continue to be functional since the duties and powers remain the same. However, they have scope for adapting them

in line with the ways that they choose to redesign the way local services work together.

2.12 I have heard some concern that local autonomy will lead to a proliferation of assessment forms and procedures that will complicate life for services that work with many different areas. In relation to assessment forms, these are not currently centrally prescribed and so the changes in statutory guidance that I recommended make no difference. The Common Assessment Framework has never been statutory and has been modified in many places. Children's Social Care have been free to change the assessment forms used by social workers since June 2009 when the limitations of the forms in ICS were recognised and, acting on the advice of the Social Work Taskforce, the Government agreed that ICT systems should be locally owned and locally implemented. In relation to procedures, variation will be limited by the fact that they refer to implementing the same duties. Some degree of flexibility, however, is desirable. There are many examples, discussed in the following chapter, of major reforms to the way that services work together in engaging and supporting families and, currently, there are unintended restrictions arising from statutory guidance. In areas adopting the Signs of Safety approach, for example, they currently have to duplicate documentation instead of just using the forms designed for the approach.

2.13 Standardisation has value when we know how to do something to a high standard but, in safeguarding children, we still have much to learn and so it is premature to create a detailed nationally prescribed way of working. It is important to have the flexibility to allow learning and improvement. The experience of the ICS software in Children's Social Care has been a lesson in the negative impact of poorly designed tools on professional practice.

2.14 There are also concerns that the reduced guidance in *Working Together to Safeguard Children* happening at the same time as the radical reform of the health service may lead to a loss of attention being paid to safeguarding children in the health sector. This is discussed in the next chapter.

2.15 There is considerable evidence of progress in preparing to exercise this greater responsibility and of services developing mechanisms for working together to learn and improve. It is not the case that each LSCB or service has to act alone.

2.16 The Children's Improvement Board plays a significant part in supporting reform. It has set out its proposed activity as follows:

> *Local implementation, if it is to be effective and sustained over time, needs to be collectively driven by the sector, not just by individual Councils. CIB will play a key role in this at both national and regional levels through:*
>
> - *sector-led improvement cycle activity around peer challenge, peer review, improvement support and self-assessment*
> - *Developing more sector specialists in safeguarding and on the analysis of performance information*
> - *promoting evidence-based improvement to identify and share good practice and innovation including regional development sites*
> - *developing relevant data profiles that enable more effective peer challenge and support (CIB, 2012).*

2.17 The training in leadership for Directors of Children's Services (DCSs), formerly provided at the National College for Leadership of Schools, is being continued but is now provided by the Virtual Staff College. This provides on-going support to DCSs and training to aspirant DCSs.

2.18 The College of Social Work is now in operation and is developing services that support professional development in line with the recommendations of the Social Work Task Force and my review. The other professional colleges continue to help their members understand and meet their responsibilities in relation to safeguarding children, providing training and guidance for their members.

2.19 While there is great value in professional groups being able to adapt guidance to suit the specific tasks and contexts in which their members work (and indeed many of them do this to some degree already), there is also a need to keep a check on whether this variation leads to incompatibilities in the guidance being given to the different groups. I suggest that the Chief Social Worker takes on a lead role in co-ordinating a group of representatives from the professions involved to facilitate discussion of any emerging problems in the *Working Together* guidance and suggest revisions as needed in the future.

2.20 As well as the more formal mechanisms for support, I have been given many examples of services getting together to help each other. The following is by no means a comprehensive list but indicative of the type of activities going on. Many of these groups are regional, using the groupings of the former Government Offices for the Regions. They have been meeting and discussing plans, with some making plans for joint development work. The London Safeguarding Councils group continues to co-ordinate services across London. I have attended regional workshops for LSCBs in the North East, North West , and the East Midlands where discussions highlighted the challenges and opportunities plus ways they could work together to encourage reform, with some of them using the CIB as a forum in which this collaboration can be maintained. The East Midlands (2011), for example, are planning /implementing a scheme of Unannounced Safeguarding Assurance Visits designed

- *to provide support and challenge to each local authority in the leadership and management of their safeguarding practice.*
- *to support the regional aspiration to develop a stronger culture of reflective safeguarding*

2.21 The NSPCC organised a series of free multi-agency events to provide opportunities for consideration of the workforce challenges arising from the Munro review. The feedback reported:

> *There was general agreement that the review provided renewed drivers for good practice including: multi- agency working; re-focus on workforce development; more visible leadership; supervision focus on relationship; emphasis on early intervention/prevention; 3rd sector involvement (NSPCC, 2012).*

2.22 The above covers only a small amount of what is going on but I hope it illustrates how the different services and agencies involved in working with children and their parents have a number of resources, some established and some being developed, to support them in the task of exercising more responsibility for deciding how to help, monitoring for emerging problems, and responding constructively when problems appear. It is clearly not the case that, as the Government re-draws the boundaries of responsibilities, i*ndividual* services or *individual* professionals will carry the additional responsibility alone.

Evidence from the trial authorities

2.23 Another concern has been that replacing the statutory guidance on timescales with a judgment of quality and timeliness for the child will lead to drift. This is a major issue and evidence of drift was the original reason for introducing guidance on average timescales. However, there is some evidence to counter this concern. During my review, I was able to obtain permission for some local authorities to be granted exemptions from some rules. The experiences of these trial authorities provide good evidence of the positive effects of increasing local autonomy and should help to allay some anxiety.

2.24 The exemptions granted to each local authority by the Department entailed the setting aside of the following requirements of *Working Together to Safeguard Children* (HM Government, 2010):

(i) the requirement that there be a two stage process of assessment, an initial assessment followed where appropriate by a core assessment (8 LAs);

(ii) The time scales for completing initial and core assessments (10 and 35 working days respectively) (6 LAs);

(iii) Removal of the 15 working day timing from date of last strategy discussion to the initial child protection conference (1 LA):

(iv) The 10 working day timescale between an initial child protection conference and first core group meeting (2 LAs).

2.25 One clear lesson from these authorities is that change is not simply a question of taking away intrusive rules and allowing good practice to flourish. One authority commented on the initial slowness of change though this subsequently altered:

> *There was evidence that first line managers are still prescribing a strict timescale for assessment, with reference in four cases to, for example, 'complete complex assessment within 35 days'. This was disappointing but not unexpected. It suggests that, despite briefings for all staff, the traditional culture of front line duty services is solidly entrenched and will take some time to dispel. Suggests that our briefing and rationale for the change was not communicated clearly enough.*
>
> *Some social workers stated in their audit interviews that there was limited feel of significant change in the way they felt they were assigned assessments with a plan of work by managers – they felt that their managers remain preoccupied with timescales, as opposed to timeliness and quality. (Wandsworth)*

2.26 The changes also make more demands on professional skill, and emphasise that professional judgment is not just an individual matter but that the organization shares responsibility for achieving high quality practice. It is important to be clear that removing timescales does not imply 'anything goes'. There is a need to monitor both timeliness and quality and the managerial task is more challenging:

> *It is our view that the increased flexibilities have brought with them both the awareness of the importance of 1st line managers (and their oversight and scrutiny of case work to ensure there is no delay in the provision of help to a child and their family and all decisions are made in a timely fashion) and the clear need for social work practitioners to be skilled and confident in exercising their judgment (Knowsley).*

Islington reported:

Workers report key improvements in their practice as:
** More time to consider the historical factors in the case. i.e. reading past files and compiling chronologies.*
** More time to plan how to conduct the assessment and reflect on the information gathered.*
** "Everything didn't need to be done on only one visit" Less pressure to visit the family, conduct checks and write a report in the 10 day IA timescale. This practice previously led to pressurising the family to comply with these timescales and make decisions sometimes based on limited information from one visit and/or without all the standard information checks. Workers report specifically the conflation of IA & CA and the redefinition of the 10 day timescale means they are able to spend the first visit doing basic safety checks and building a rapport with the family, which they believe leads to a better working relationship and better outcomes.*

But they also warn:

It is highly improbable the relaxation of assessment timescales alone will significantly improve the quality of assessing and planning, it is one part of a jigsaw (Islington).

2.27 One painful lesson that some have reported is that they found timescales had been operating as a smokescreen and, once removed, they looked beyond them to the quality of work being done and focused on improving it. This is, of course, a desirable lesson since it led them to focus on enhancing skill. Looking at quality also draws attention to the purpose of assessments: to provide the basis for making a decision, a fact that seems to have been forgotten by some to whom completing forms within the specified time had become the task itself rather than a means to an end.

2.28 In having the statutory basis for timescales removed, the authorities have not abandoned them but returned to using them as originally intended – not as a fixed time for all children and young people but as indicative of the time within which *most* assessments should have been completed, some should be done more urgently, others need longer to be good enough to form a sound basis for decision-making. Managers monitor the overall time and examine why some take significantly longer. This may or may not cause concern depending on the reasons. It is important to keep families informed of what is happening and when they may expect a decision or to explain the reasons for delay.

Revised inspection framework

2.29 Over the past decade, regulation has been increasingly used as both a lever to secure compliance and a performance monitoring mechanism for a range of national indicators and targets. The predominance of central prescription and extensive statutory guidance has contributed to a widely held view that the inspection of children's services has been unduly concerned with evidence of compliance. As set out in my review's final report (Munro, 2011), this perception is not shared by inspectors themselves but the prevalence of the belief among professionals means that it acts as a major influence on practice so that the importance of compliance outweighs being child-centred. Since the publication of my final report, Ofsted (2012) has radically

revised the framework for inspection of the local arrangements for the protection of children. These new inspections begin in May 2012.

2.30 The framework has been the subject of development, consultation, piloting and revision during the past twelve months. Central to the change is a very clear intention on the part of Ofsted to focus on both the impact and effectiveness of help and protection for children, young people and their families, in addition to a more rigorous examination of the quality of professional practice. Inspectors will be examining closely how well children and young people are protected from significant harm but also how effectively those at risk of, or those suffering, harm are identified and helped. Ofsted have made clear that early identification and early help are firmly within the scope of the new inspections and that the degree to which agencies work together to construct an effective local system are significant aspects of the new approach.

2.31 New elements of the inspection methodology include direct observation of practice and case tracking and sampling, which involve an examination of the quality of management oversight and case supervision. Inspectors also attend child protection planning, review and core group meetings where this is possible. The new framework describes an inspection focused on the child's journey from needing to receiving help. Critically their experiences on that journey are reviewed (including whether they feel they have been helped) and the difference that is made by the professionals helping and protecting them and their families is to be evaluated.

2.32 The pilot inspections in support of the new framework provided encouraging feedback. The new and stronger emphasis on the effectiveness of help and protection and the quality of professional practice did secure the basis for judgments about impact, children and young people's direct experiences, and the change that was being effected in families through the arrangements to help and protect them. Local authorities taking part confirmed that the examination of practice at the front line was refreshing though demanding. The decision to involve Directors of Children's Services in the 'judgment-building meeting' at the end of the inspection was particularly valued and confirmed the advantages of a transparent mechanism to evaluate observed professional practice as part of these inspections. (Previously DCSs were only presented with agreed inspection feedback, rather than being able to hear the nature and use of evidence in reaching judgments.) Tracking and sampling the cases of children and young people was well supported, particularly as a means of judging the quality of professional practice. Inspectors involved in these early pilot inspections also said that their increased closeness to practice brought them closer to evidence about the difference that professional interventions were making. The link between plans for children, management oversight and the quality of supervision was reported to be clearer and easier to assess. The extent to which professional judgment was allowed to flourish and the confidence and competence of practitioners was more obvious. Key elements of the framework and supporting schedule were reported to encourage inspectors to consider the extent to which children and young people were being effectively protected, the effectiveness of help at the point where concerns were first identified, the activities undertaken by managers and leaders to examine their impact, the knowledge used in local areas to plan and deliver services based on the needs of local families, and the integration of feedback from children and young people into help focused on their needs and experiences.

2.33 Other, more direct learning from the pilots, required Ofsted to be clear about the weighing of evidence across both statutory child protection and early help services, providing clarity about what is and is not in scope. The new framework clearly states

that these new inspections are concerned with child protection and not wider safeguarding. Creating an inspection experience that is not based on a deficit model and that identifies good practice and improvement is also a challenge that Ofsted have committed to continue to evaluate during the first year. They have also confirmed their intention in the new framework to focus on what makes the biggest difference to the lives of children, young people and families. This first cycle will be significant in establishing that expectations are not too high but are realistic and ambitious about the protection of children and young people. Ofsted's role in describing and sharing emergent and strong practice will be important in a new system that is beginning to establish strong local arrangements in the absence of nationally prescribed rules. Weaker authorities will need to learn from those performing strongly and making more impact. Regular evaluation and shared learning of these developments is a rich resource that Ofsted will want to make available in support of children's services taking the lead in their own improvement.

2.34 Whilst my final report recommended that the new inspections should consider the contribution of all professionals, I note that the new framework is a single inspectorate framework only. I am pleased that when Ofsted published details about the new arrangements in January of this year, they also announced the development over the coming twelve months of a new shared inspectorate framework due for implementation in 2013. This will be an important extension of the significant new foundations that I believe these first inspections this year will establish. Ofsted, the Care Quality Commission, HMI Probation, HMI Constabulary and HMI Prisons, have all publicly confirmed their intention to develop and be part of a multi-agency inspection programme with practice, effectiveness, and children and young people's experiences at its heart. It would also be desirable for these inspections to focus on the effectiveness of the LSCB and the contribution of all partners to it. Inspection that is focused on the effectiveness of practice, the development of professional judgment and a deep reflection on the difference that this is making for children, young people and their families is significant progress and a considerable lever in the system changes that must continue to develop and improve.

Conclusion

2.35 The recommendations relating to changes in statutory guidance and the inspection process are important components of the cultural change needed. There has been considerable work done on all of these though substantive changes have not yet come into force. This delay has obviously limited services' ability to review their ways of working, revise documentation, and improve their software (and the impact will be discussed in more detail in chapters 4 and 5). It has created anxiety in that greater freedom means greater responsibility. Nevertheless many promising strategies are being developed that allow that responsibility to be shared at a local and professional level. Once these changes come into force, however, there will be much increased opportunity for local services to create a better environment for encouraging and supporting professional expertise in helping children, young people and families.

Chapter 3: Redesigning services around children, young people and families' needs

Introduction

3.1 In my review, I used the concept of the child's journey to look at service provision from the viewpoint of the child or young person rather than the provider. This draws attention to the number of different services who may be in contact with family members and have an influence, direct or indirect, on children and young people's experiences as they grow up. The reactive child protection services deal with only a small percentage of the problems that children and young people experience; most formal help is provided by universal services or targeted services. That help, besides improving their well-being in general, also significantly reduces the incidence and severity of abuse and neglect. Services to adults who are parents are as important as those directly working with children and young people since they can improve the quality of parenting that the child experiences.

3.2 The importance of working together has long been appreciated in England and good progress has been made in recent years. In relation to early help, although there has been less statutory prescription than in child protection, my review highlighted that increased flexibility is still needed to allow them to find better ways of working constructively together and with child protection services. By creating the space for services to work together and by encouraging that work through LSCBs, Health and Well-Being Boards, and multi-agency inspections it should be possible to improve the quality of early help for vulnerable children and young people

Early Help and Flexibility

3.3 'Early' help is given as soon as a problem emerges and is intended to prevent escalation. It creates two challenges (a) deciding what level of skill is needed to help the family – the visible problem may be low level but be due to complex causes that are hard to change - and (b) whether the concerns are evidence of actual or potential abuse or neglect and warrant referral to Children's Social Care.

3.4 The Government's policies on Community Budgets, Family Intervention Projects, and Troubled Families have been developed in response to evidence of families who have numerous contacts with services but show little benefit. The Department for Communities and Local Government provides the following case study to illustrate how expensive ineffective services can be:

> *A large and complex family was made up of mum and two different fathers who between them had seven children.*
>
> *The family was causing significant problems in the community and was constantly at risk of sanctions. As a result of their behaviour they were drawing in considerable local resources relating to child protection, domestic violence, truanting, offending problems and as a result were costing around £160,000 a year. The vast majority of the money (80 per cent) was on reactive spend and not addressing the underlying causes of the behaviour (Department for Communities and Local Government, 2012).*

3.5 Research on neglectful families produces similar findings of ineffective responses, often linked to inadequate assessments of the degree of harm that the children were suffering.

> *It is the chronic nature of neglect that is known to be particularly corrosive to child development. However, protective systems, like those across the UK, have developed around a forensic core, and are notoriously clumsy when it comes to dealing with sustained problems rather than one-off events. 'Neglect' as defined by the official system has become overly complicated and process-bound. A distance has developed between common-sense empathy with the unhappiness of hungry, tired, un-kempt and distressed children and an overly bureaucratic and anxiety-ridden system for reaching out to help them. There seem to be many delays and barriers to children receiving a swift and coordinated response …*
>
> *Some respondents identified the problem that children and families can be bombarded with services that appear to have little appreciable impact on the quality of the child's day-to-day life (Action for Children, 2011, p.20-21).*

3.6 The Serious Case Review on Family Z (Haringey LSCB, 2012) provides a classic example of repeated reports of concern about the children and young people's care and well-being failing to trigger an adequate assessment of the harm they were suffering until they had had prolonged exposure to neglect.

3.7 Therefore, the greater flexibility arising from the revision of statutory guidance may lead to better ways of responding to concerns about neglect and, in particular, to tackling the problem that the current child protection guidance is better designed for responding to incidents of abuse than to chronic patterns of parenting that harm the child's development. In writing of my review in relation to improving early help, Matt Dunkley DCS of East Sussex said '*importantly, it offers an opportunity to do things differently*' (East Sussex County Council, 2011).

3.8 The many examples of reforms I have received show how areas and services are grappling with the complexity of children and young people's needs and are already working through ways of getting the right help to the right families as quickly as possible and of helping those working with families outside child protection to monitor and manage risk to children and young people.

3.9 For example, in Suffolk, the 'Integrated Access Team' that is co-located with police was implanted county-wide by July 2011. The team is now diverting 70% of initial contacts that would previously have been dealt with by Social Care Teams towards other, more proportionate responses. It is estimated that the new way of working has saved £7million for the Children and Young People's Directorate (see C4EO website for details).

3.10 The greater focus on monitoring outcomes that should be encouraged by my set of recommendations should help services to identify when they are not making progress with a family and need to re-think what to do.

The importance of working together

3.11 A recent summary of messages from research (Davies & Ward, 2012) has a wealth of valuable material and endorses the soundness of the preventive agenda, key messages include:

> *Programmes that prevent the occurrence of abuse are likely to be more effective than those that address its consequences.*

and

> *A population-based approach to prevention is non-stigmatizing, more likely to reach families early and prevent escalation of abuse, and more likely to reach those children whose maltreatment tends to pass unnoticed* (p.71).

3.12 The Every Child Matters policy of the last Government did much of the groundwork in establishing the value of services working better together. Davies & Ward's review of research on progress, includes the observations that:

- *Important advances have been made in recent years at the practice level through innovative approaches to service delivery such as mixed disciplinary teams and co-location of workers.*
- *There are also slow but important advances in a shared sense of responsibility between agencies and reductions in the silo mentality to working. It is important to build on these gains.*
- *Local Safeguarding Children Boards have played an important part in building stronger relationships through providing high-quality interagency training and building networking arrangements between and across disciplinary groups* (2012 p.137).

3.13 They also warn: 'There are risks that these advances could be lost as a result of radical restructuring of services'. It will be important that services are mindful of these risks as the restructuring beds in.

3.14 There is similar risk from the other major driver of reform at present: funding cuts to all services. Local authorities, for example, are having to accommodate to 28% reduction in their funding on average, but estimates of the cuts in children's services vary (ADCS, 2012). The evidence so far is that areas are making significant attempts to protect early and preventive children's services but do not think this can be maintained in the coming financial year because of the level of cuts (PricewaterhouseCooper, 2011).

3.15 The Coalition Government endorses the need for services to work together to provide help most efficiently and effectively but have removed the requirement for local authorities to set up a Children's Trust Board. Many areas have continued these boards by choice because they find them a helpful way of co-ordinating services locally. In a time of budgetary cuts, there is a fear that co-operation will reduce and that preventive work might seem less important. To reduce this risk, I recommended that 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 10) and that guidance to LSCBs should include an

assessment of the effectiveness of the help being provided to children, young people and families (including the effectiveness and value for money of early help services, including early years provision) (recommendation 6).

3.16 The Government has concluded that a new duty is not necessary because the existing duty on local strategic bodies to co-operate (Section 10 of the Children Act 2004) meets the need already. In their response in December (Department for Education, 2011), they said:

> *The Government has been working with partners to consider the best route to secure Professor Munro's vision of a transparent and co-ordinated offer of early help for children and families. We have engaged with partners in ADCS, health, police and education and have concluded that we do not need a new statutory duty to deliver early help and that there is sufficient existing legislation to realise Professor Munro's recommendation. We will continue to work with partners to clarify existing legislation to emphasise the importance of early help. In the meantime we encourage local areas to continue to work to provide early help for the compelling arguments that Professor Munro articulated*.

3.17 Continued commitment to working together will also be promoted by the implementation of another of my recommendations (recommendation 2) that 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 and young people. This has been accepted by the relevant inspectorates but, because of the diversity in their ways of operating, work is needed to create a shared approach and this is planned to come into operation in June 2013.

Related policies

3.18 There are several related policies that make a valuable contribution to effective safeguarding. The Government's appreciation of the importance of early help led them to set up a review headed by Graham Allen of early intervention delivery. This reported in 2011 (Allen, 2011). The primary recommendation arising from these reports was the establishment of an Early Intervention Foundation. Graham Allen outlined the purpose of the independent Foundation as:

- *Be a strong voice to promote and foster the impact of early intervention work and add value to those who already work in the field.*
- *Evaluate and validate the evidence based programmes and practises in the early intervention and prevention field to establish a rigorous, independent evidence base on what works in early intervention in the UK.*
- *Create and foster a new market of social investment;*
- *Provide high quality advice and guidance to councils, private capital, philanthropy and third sector to create new localised, impact and outcome driven services built on the principles of Early Intervention.*

3.19 To coincide with the launch of the new Social Justice Strategy, the Secretary of State for Work and Pensions, Iain Duncan-Smith MP, announced a procurement exercise to create an independent Early Intervention Foundation (EIF) or an organisation to deliver implementation and guidance services on early intervention programmes.

3.20 Recognition of the importance of collaboration between services is also evident in the Government's continuation of the Family Improvement Projects (FIPs) and the introduction of the Community Budgets and Troubled Families scheme. Evidence from the monitoring of FIPs (Department for Education, 2011a) has already shown encouraging results in improving children and young people's care.

3.21 The new Troubled Families policy builds on the thinking behind FIPs and also seeks to harness the efforts of the many services that can be involved with one family to create a more constructive collaborative effort. It is innovative in that it will:

> *run primarily on a payment-by-results basis to incentivise local authorities and other partners to take action to turn around the lives of troubled families in their area by 2015. The Government will offer to pay up to 40 per cent of local authorities' costs of dealing with these families (Payment by Results Model) payable only when they and their partners achieve success with families.*
>
> *The Government will also fund a national network of troubled family 'trouble-shooters' in each (upper-tier) local council. The trouble-shooters will operate at a senior level to oversee the programme of action in their area (Dept for Communities and Local Government, 2012).*

3.22 Another related aspect of government policy is health reform. Health services make a major contribution to the health and well being of children, young people and their families, and their reform will have a significant effect on safeguarding. It will be extremely important that LSCBs, Health and Well-Being Boards, and professional bodies cooperate to ensure that safeguarding does not get lost in the mix.

3.23 Current health policies contain many developments that will directly contribute to improving the quality of safeguarding. The Marmot Review (2010) highlighted the inequalities in health outcomes and the importance of taking a life course approach to planning services that emphasises the value of prevention and early help. The Healthy Child Programme 0-19 has ambitious goals to improve all children's development. The planned increase of 4,200 additional health visitors by 2015 (Department of Health, 2011a) will significantly improve their ability to support families. The expansion of the Family Nurse Partnership (2012) will help some of the most vulnerable parents through pregnancy and the early years. Mental health policy is also of relevance, both for children, young people and their parents (Department of Health, 2011b). The relevance of the NHS outcomes framework is discussed in Chapter 5 when looking at feedback on how effective services are being.

3.24 Another major provision in The Health and Social Care Act 2012 is the requirement to establish a Health and Wellbeing Board for every upper tier local authority. This takes effect from April 2013. This will make a substantial contribution to the safeguarding agenda. Through Health and Wellbeing Boards, NHS and local authority commissioners along with other partners, will work with communities to collect and analyse evidence about health and care needs. This will result in a shared understanding of what communities' needs are, formulated in Joint Strategic Needs Assessment (JSNA), and identify where there are inequalities in outcomes within communities. Health and Wellbeing Boards will consider what resources they have available to meet those needs, including what communities themselves can contribute. Based on this, Health and Wellbeing Boards will develop and agree with

partners and communities shared priorities for action. The priorities should reflect the issues that matter most to communities and where the greatest impact can be made on health and wellbeing outcomes.

3.25 The Joint Health and Wellbeing Strategies (JHWS) will set out how the NHS, local government, wider partners and communities will address the priorities, and improve both services and health and wellbeing outcomes. This will include plans for how they can work together, for example using shared budgets and joint commissioning to integrate services, as well as the contribution individual partners can make. It would also be best practice to include action to address wider factors that impact on health and care outcomes, such as housing, education, the economy, or crime.

3.26 However the radical scale of change in the organisation of the health service that is now in progress is also causing concern. Fear has been expressed that the embedded mechanisms for keeping a clear focus on safeguarding children and young people may get lost or reduced in the process of change. The Royal College of Paediatrics and Child Health is concerned about how safeguarding standards will be maintained and improved in the reformed health service and recommended that NICE should develop a quality standard for safeguarding to drive service improvement (RCPCH, 2012). This would be a valuable means of helping the new system keep a clear focus on safeguarding as the radical reforms are implemented and I endorse their recommendation.

3.27 The new health system gives weight to users' views but giving children and young people a meaningful voice is a distinct challenge. Unlike adults, they do not have any leverage through the voting system; they have little voice in the usual channels of communication. On many issues, one can expect their parents to represent their needs and views but this clearly does not apply when the issue is child protection since parents are unlikely to complain that their abusive behaviour is going undetected. Therefore it is essential that the considerable expertise on safeguarding in the health service is maintained and it should be readily available as the new entities come into operation. The system of named and designated doctors and nurses will be maintained but there should be formal arrangements for linking them into the new system so that they inform managerial decision-making.

3.28 In my report I recommended:

> *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 on the ability to provide effective help for children and young people who are suffering, or likely to suffer, significant harm.*

In response, the Government has committed to Department of Health and Department for Education, local government and other partners working together to agree a work programme to ensure effective arrangements to safeguard children are central to the reforms. A new accountabilities framework has been worked out, showing the roles of the new entities in meeting the duties set out in Working together to safeguard Children, i.e. the NHS Commissioning Board, the clinical commissioning groups, the regulators, health service providers, and public health. At

the time of writing this report, it was still unclear where this framework will be published.

Examples of local reforms

3.29 Partly as on-going implementation of the last Government's policy and partly in response to the Allen review and mine, there are numerous examples of local authorities and partner agencies seeking to improve the ways they decide what level of help is needed and to improve the amount of help offered to families who have significant problems but which do not meet the criteria for a service from specialist services, including child protection. I can only give a sample of the reform here. Many more can be found on the C4EO website since they called for examples of local practice around early help and these are now being published as they are received. (http://www.c4eo.org.uk/themes/earlyintervention/default.aspx?themeid=12&accesstypeid=1)

3.30 Co-locating services is a common strategy and these multidisciplinary groups seem better able to answer the question 'what help does this family need and who is best able to provide it?' rather than the more individual question 'should my service accept this referral?' There are many examples of new ways of discussing concerns and managing referrals that seem to be improving the speed with which families are getting to the right help and reducing the number of referrals to services that result in no offer of help.

3.31 The police-led initiative Multi-Agency Safeguarding Hub (MASH) that I mentioned in my final report has now been evaluated by the National Foundation for Educational Research (Golden et al, 2011). The team, comprising people from police, health and Children's Social Care, works in a 'sealed intelligence hub', meaning that they can share information within the team but there are agreed rules in place covering the release of information to staff in the rest of the organizations involved. The team provides advice and information on safeguarding matters. It makes an initial assessment of risk before deciding on appropriate action and allocating cases accordingly. The evaluation is clear that the work is still in its early stages but initial findings are promising.

3.32 Police have also been innovative in developing a service to help children and young people who are the victims of domestic violence. Operation Encompass, developed in Devon and Cornwall, has trained 'key adults' in schools to support children and young people who witness domestic violence. When police are aware of an incident of violence affecting a child, they inform the relevant key adult who offers support dependent on the wishes and needs of the child (Carney-Haworth, 2012).

3.33 Milton Keynes have replaced their Children's Trust with a Children and Young People partnership, signed up to by three elected members representing each party, as well as representatives from health, education, police, probation, and social care. It is linked to the LSCB because the chair of the partnership sits on the LSCB and the chair of the LSCB sits on the board of the CYP partnership. They have created Children and Families Practices, multidisciplinary, locality-based teams to respond to problems that are below the threshold for specialist services but still of considerable concern. Milton Keynes also has an active voluntary sector and Community Action MK seeks to mobilise communities' resources.

3.34 While the Common Assessment Framework policy remains, many areas have made modifications to the original form to suit local needs (56 per cent in the LSCB questionnaire) and, in some cases, to improve compatibility with the Children's Social Care software, ICS. Some have also altered the focus from the individual child to the family so the CAF has become a FAF (Family Assessment Framework) and the TAC (Team around the Child) has become the TAF (Team around the Family).

3.35 Hertfordshire provides an evaluated example of improving access to services. This report is taken from the C4EO website (downloaded on 25.4.12):

The Right Response, by the Right Service at the Right Time, Hertfordshire

Background and drivers for change

The 'Right Response' project was set up in July 2009 to develop and embed multi-agency arrangements which best support how children and families receive services and where revised arrangements could make best use of available resources. The driver was high social care referral rates and some families were not receiving a prompt response (where the needs were for family support, as opposed to safeguarding). Findings supported the view that some referrals could have been better addressed in other ways, including the use of the Common Assessment Framework (CAF) and this would also support social care colleagues in providing an improved service to the most vulnerable children.

The overarching focus was to ensure a multi-agency approach to achieving the best outcomes for a child or young person, without delay, and where their needs are met at the lowest possible tier of service (wherever safe to do so) and for all practitioners to take full responsibility for ensuring that everything possible is done to prevent unnecessary escalation of issues or needs. A threshold document was developed to ensure that thresholds of need for children and families were matched to the level of service required. This Targeted Advice Service (TAS) was introduced in February 2010.

Achievements so far

The changes in arrangements for managing contacts and referrals fully, took effect in February 2010. Since this date, the key achievements have been to reduce the referrals into social care; to improve the communication and support for referring practitioners; as well as providing a more effective service for children and

families including an increase in CAF activity, where this provides co-ordinated multi-agency support to families.
There had also been an increase in CAF activity since the introduction of the Targeted Advice Service. There were 451 CAFs recorded in the first quarter of 2010, compared with 171 in the first quarter of 2009. The number of CAFs started in March 2011 was the highest to date, at 188. The work of TAS has been considered a significant contributing factor to this increase.
From a sample audit of 22 cases received and progressed by TAS, the findings were that

- *In 17 cases (77%), the young person and family had received the required support and their needs were being addressed or have been met;*
- *In three cases (14%), needs were not addressed due to family refusal to engage and practitioners agreed to monitor the needs of the child/young person;*
- *In two cases (9.1%), additional information was gathered and the needs for the child considered to be particularly complex and of concern, requiring a referral to social care.*

The audit included feedback from referrers about the service they received from the Targeted Advice Service. Of the 22 cases audited, 95.5% of referrers felt that they received good advice and support (referrers were: 59% health, 13.6% police, 13.6% family, 9% schools and 9% Voluntary & Community Sector).
In addition, the stigma felt by families being referred to social care should not be under-estimated and the changes made in managing contacts and referrals means only those cases meeting threshold are referred to social care.

3.36 Attention is paid to children and young people across the life course, not just in the early years. In Walsall, there is an interesting example of a multi-agency service for children and young people at risk of sexual exploitation, an issue that has received greater attention in recent years. Since 2000, Walsall have had a Multi agency panel that responds to concerns about Young People at risk of Sexual Exploitation, recognising the links between Runaways, Trafficked Young People and those at Risk of Sexual Exploitation. It is known locally as CARE (Children at Risk of Exploitation) panel. Underpinning the work of the CARE Panel has been the contractual relationship dating back to 1999 that Childrens Services have with Walsall Street Teams (WST), a third sector charitable agency who provide direct specialist intervention and prevention work to young people at risk of or being sexually exploited, and training, consultation and advice to professionals and carers to assist with safeguarding them appropriately. They have two projects which work specifically with young people at risk of sexual exploitation, 'Jigsaw' working with girls and young women and 'Mars', the boys and

young men's project. With the child/young person as their focus, they listen to them and work alongside them to recognise and understand what is happening to them, and the impact that exploitation in the widest sense has on their lives.

Conclusion

3.37 Child abuse and neglect needs to be seen within the wider context of how society supports families. Children's Social Care is just one of many services that work with one or more family members. Many of the policy developments at present seek to integrate the efforts of different services better since there is considerable inefficiency in each working separately and possibly duplicating efforts in some cases while other families receive nothing. There are also efforts to offer help at an early (or earlier) stage. However, this does not necessarily mean that problems need lower levels of skill to solve. It is necessary to have good quality assessments and monitoring to identify which problems are hard to deal with and need a more skilled response. The greater focus on outcomes should make this easier to achieve. Another problem is to identify which children and young people are suffering abuse or neglect and need a referral to Children's Social Child Care because of this (referrals may be made for other reasons too). Creative innovations are producing new multi-agency ways of dealing with this challenging judgment.

3.38 There are many examples of good progress and creative innovation so that families receive help in a more joined-up way. As these new methods of working together are developed, it is important that Children's Social Care can adapt and fit in, reducing the problems that are currently often reported of departments being overly bureaucratic and remote in their relationships with other services. Therefore, the increased local control allowed in the revised statutory guidance should be of great benefit here.

3.39 The multi-inspection process and the LSCBs' proposed role in monitoring the effectiveness of early help should encourage these developments and the planned Health and Well-Being Boards will make a significant contribution to prioritising and co-ordinating preventive services.

3.40 The future of early help lies very much in the hands of services that work with young people and families, the authorities who commission them and the professional bodies who represent and regulate them. All must co-operate with each other, and with social services in order to help children and young people receive help that might prevent serious concerns from escalating to child protection issues.

Chapter 4: Children's social care and social work

Introduction

4.1 The compliance culture that had become so widespread had made many social workers feel that they were no longer able to do 'real' social work. The organisational priorities were so focused on complying with targets and performance indicators that front line workers often felt they were not supported enough by their managers in keeping a prime focus on children and young people's best interests. The data entry demands, too, had taken so much time that they severely hampered their ability to form constructive working relationships with family members. Efforts to improve the quality of practice had placed undue weight on the contribution of guidance manuals and this in combination with the performance management regime had led to the core skills and knowledge in the individual worker being undervalued.

4.2 Freeing up social workers from bureaucracy is necessary but not sufficient to produce high quality practice. As the many examples I have been given illustrate, managers in Children's Social Care recognise that social workers need to be given on-going training, coaching, and supervision to exercise professional judgment well. The need for more robust training and on-going development was at the heart of the Social Work Task Force (2009) recommendations as well as my own.

4.3 Progress is being made on strengthening the profession as a whole, creating a career structure that rewards those who choose to focus on increasing their expertise, and on redesigning children's social care services so that they reflect this greater priority being given to the organisation's ability to help children, young people and families effectively. This chapter looks at progress on both issues, beginning with professional developments.

Professional developments

Social Work Training

4.4 The changes advocated by the Social Work Task Force rely for their successful implementation on the practical frameworks and tools developed by the Social Work Reform Board which can strengthen the social work profession and develop a better quality of practice. These include improvements to initial education, in selecting the right people to train, and in meeting the needs of those aspiring to be the next generation of social workers and their employers, keeping up-to-date with emerging problems such as our increased awareness of the extent of sexual exploitation and trafficking of children and young people. From this September, there will be an Assessed and Supported Year in Employment (ASYE) for newly qualified social workers in their first year of work. This builds on the Newly Qualified Social Worker programme that it replaces and, while it does not move the point of formal qualification to the end of this ASYE as the Task Force had envisaged, it represents a much stronger base for building a professional career in social work.

4.5 Improvements to the training and development of social workers will start to impact from September 2012, and will come fully into effect from September 2013. Advice is already available on improving recruitment processes, as are topic guides intended to

allow both lecturers and course leads to review content. New standards for practice placements have also been developed.

4.6 The Social Work Reform Board is nearing its end and will be publishing a report which will give full details of progress and continue the momentum of reform. Future progress will depend on local authorities and other employers, higher education institutes, and the profession using the frameworks to drive improvements, which will take 5 -10 years to embed.

4.7 The College of Social Work has taken ownership of a number of frameworks developed by the Reform Board with the sector. Key aspects that will improve training are:

- A professional capabilities framework (PCF) which establishes shared expectations of social workers at each stage of their careers. These expectations will underpin the social work degree, a social worker's first year of employment, and their continuing professional development;
- Partnership working so that Higher Education Institutes (HEIs) and employers share the responsibility for degree courses, including the practice learning in which students spend almost half their time.

Social work regulation changes

4.8 On 1st August 2012, the Health Professions Council (HPC) will become the new regulator for social workers, including registration of social workers and approval of social work degree programmes.

4.9 As part of meeting HCPC standards, education providers must reflect the philosophy, core values, skills and knowledge base articulated in any relevant curriculum guidance. Social work education providers can use the Professional Capabilities Framework and education recommendations from the Social Work Reform Board and College of Social Work to inform the development of their programme to meet HCPC standards. In addition to HCPC approval, the College of Social Work is planning to offer an endorsement scheme for education provision, which will provide a kitemark of quality in professional standards.

College of Social Work

4.10 Establishing a College of Social Work was a recommendation of the Social Work Task Force:

> *We are recommending the establishment of an independent national college of social work. This will articulate and promote the interests of good social work. It will give the profession itself, strong independent leadership; a clear voice in public debate, policy development and policy delivery and strong ownership of the standards to be upheld. (Social Work Task Force, 2009).*

4.11 The College began admitting members in January this year and, at the time of writing, had a prospective membership of approximately ten thousand. It is operating with a Transition Board and Transitional Professional Assembly for the first year and then members will elect people to take College positions. The Board and Assembly are supported by three College Faculties and a Policy Development Group.

4.12 The three Faculties are for Child and Family Social Work, Adults, and Mental Health. They will focus on encouraging social workers throughout the country to become involved in the work of The College. They will bring together the wisdom and expertise of social workers to develop their professional specialisms, discuss and resolve problems, produce guidance, and influence changes in law, policy and practice. I have accepted the role of Transitional Chair of the Faculty for Child and Families Social Work for the first year and, to date, we have created one Community of Practice around the Signs of Safety approach, providing a mechanism for the many authorities working with this approach to form a network to share learning. More Communities of Practice will be developed as members generate ideas.

4.13 The College will monitor the implementation of the reform agenda set out by the Social Work Reform Board. This will act alongside the HPC's regulatory processes.

Chief Social Worker

4.14 My recommendation to create the post of Chief Social Worker has been accepted and the post advertised. He or she will be an adviser to the Government on adult and child social work issues and the development of relevant policies, and will provide authoritative external leadership and challenge on the professional development of the social work profession. The post will report jointly to the Director General of Children, Young People and Families in DfE and the Director General for Social Care, Local Government and Care Partnerships in the Department of Health.

4.15 Key responsibilities will include:

- advising the Secretaries of State for Education and Health and wider Government on social work practice and policy development;
- promoting values and standards of professional practice;
- encouraging the use of research and evidence to improve social work practice;
- performing a challenge role to the sector on raising standards, and informing the improvement agenda;
- raising public awareness and understanding of social work;
- working with disciplines beyond social work to encourage effective inter-agency practice; and
- advising the Government on strengthening the social work role in supporting and safeguarding those in vulnerable circumstances.

Principal Child and Family Social Worker

4.16 My recommendation on encouraging local authorities to have a role of Principal Child and Family Social Worker (PCFSW) sought to resolve two issues. Firstly the emerging disconnection between the front line experience and organisational decision making; and secondly, the need to discover different ways of extending the practice career pathway through to senior salaried roles, reinforcing the Social Work Task Force's recommendation on this. At present, the salary structure in most authorities assigns greater value to become expert at managing than to becoming expert in helping children and young people. Like the Task Force, I consider that the development of a strong knowledge and skills base for the profession requires a career option that values those who choose to develop their social work expertise. No detailed specification was given about how some component of direct work was included in the post, to allow for local flexibility.

4.17 I have learned from feedback that it is generally agreed that professional knowledge about social work and child protection needs to be an integral part of the senior management team. Effective decisions - about families through to service policy, to structural change, to resource management - need to be based on senior professional social work advice so that both the positive and negative consequences on practice are fully understood, and proper public accountability for decision making is held. This is generally addressed at present through the appointment of a senior officer who is a qualified social worker and who has responsibility for communicating the realities of front line practice in decision making. This is most often an Assistant Director/Head of Service/Deputy Director whose portfolio includes child & family social work services. Many consider that this arrangement is adequate but my recommendation was inspired by the findings in other fields that once people have stopped engaging in front line practice then the vivid reality of it starts to fade and priorities start to shift to the management agenda. I did not recommend that they carried a caseload but that they continued to do some direct work and I have heard of examples that show some do this at present. One Director, for example, does a half day on duty a month. Assistant Directors sometimes help with the more challenging families. Therefore, the recommendation on appointing a PCFSW may not be novel in some authorities.

4.18 It is reasonable to assume that the first issue is already addressed where local authorities already have a designated senior officer role whose primary focus is on effective child & family social work practice, who is significantly involved in casework as part of their day to day role, and who has a designated duty and authority to apply their knowledge about the conditions in which effective social work can flourish in all significant organizational decisions.

4.19 The role of PCFSW should, however, also be used to address the second issue i.e. the need to create extended practice career pathways. This will make most sense where there is a complete review of career and role structures. In some of the more fundamental redesigns of service that I shall report on later in this chapter, this role is more readily included.

4.20 Currently, there are rarely practice-based opportunities which extend beyond the senior/advanced practitioner roles. For talented practitioners to remain in practice throughout their careers, opportunities which attract increasing financial reward need to be created. Within the health service there are already effective working models where clinical (practice based) careers are common-place. In senior clinical roles, significant amounts of time may be spent on case supervision, research and teaching, service developments etc but, critically, the person always continues to practice. People in these roles are powerful and influential within the health system and are often well respected advocates whose expertise and opinion is sought on all significant changes. It is this type of clinical career structure which I want to promote through my review. One where the most experienced and skilled social workers can remain involved in practice as they progress to the most senior officer grades, and provide a well regarded contribution to the decision making in organisations reflective of the realities of the front line.

4.21 One example of how the role has been developed comes from Cornwall:

They have developed a role of Principal Child and Family Social Worker (PCFSW) at senior level and a Principal Social Worker (PSW) role – one for each team – as an

advanced practitioner role and together they create a virtual team that works to the PC&FSW. The PSW is on the same grade as a team manager. This is part of an organisation-wide move to enhance the expertise in the workforce.

The PCFSW leads on the redesign of social work in Cornwall, promotes a learning culture within operational services and reports the views and experiences of the front line to all levels of management and members. The PCFSW is responsible for making leading edge research in practice, policy and guidance readily available to all social workers, promoting the use of a web-based resource library to underpin evidence based practice. The post holder also leads on the formulation and delivery of an annual children's social work conference.

The role of the Principal Social Worker, under the leadership and management of the Team Manager, is to:

- *provide a statutory social work service, particularly in the most complex of cases;*
- *provide a key role in developing, supporting and monitoring the competency and confidence of front line social work staff through developing, maintaining and championing expertise in specific areas of social work practice*
- *drive excellent practice based on research evidence and professional experience;*
- *support the achievement of improved outcomes for vulnerable children and young people, including safe, stable and permanent care;*
- *provide supervision, mentoring and support to less experienced team members including practice teaching for student social workers.*

Developments in Children's Social Care

4.22 Children's Social Care departments are implementing a number of reforms. Some are making major changes to enhance the quality of help received by families while others are moving more cautiously. The LSCB questionnaire (Munro & Lushey, 2012, p.9) reports on what is going on in the 57 areas that responded and I have added some examples for illustration.

Promoting reflective practice- the most frequently cited activity was promotion of, and enhanced training in, reflective supervision practices. In the South West Region, for example, training in 'mindful practice' has been provided for front line managers and social workers with an evaluation reporting improvements in sound analysis and decision making (Jones, 2011).

Changes to supervision systems and processes-primarily to support reflective practice.
The Tavistock Clinic (2012), for instance, has a core model 'that integrates a view of organisations as open systems, with close attention to the emotional dimensions of the work, to working relationships, and to their connection with the wider policy environment'. It runs 'complexity forums' in several local authorities where professionals bring complex cases where an impasse has been reached, and a 'whole systems' intervention to provide reflective supervision groups.

Use of motivational interviewing (MI) (a way of working with people around behaviour change that involves building a relationship, helping the individual resolve ambivalence about change and then making and supporting plans for change. There is a strong evidence base for its effectiveness across a range of problem behaviours

(particularly alcohol and drug use). It is particularly focussed on understanding and reducing client resistance and how to challenge effectively and therefore seems likely to be useful in child protection settings) - eight LSCBs indicated that motivational interviewing techniques were used within their area. Islington, for example, are training all their Children in Need social workers in MI as part of a proposed randomised controlled trial (Forrester, 2012a).

Evidence based interventions -thirty five LSCBs reported they had implemented evidence based interventions. The most commonly cited was the Triple P-Positive Parenting Programme followed by multi-systemic therapy. One LSCB reported they had developed a resource bank of evidence based approaches to promote purposeful effective intervention and inform training needs analysis.

Improving feedback to professionals making referrals to children's social care - thirty three LSCBs said they had taken action to improve feedback to professionals making referrals to children's social care.

Implementing changes to reduce the number of changes of social worker experienced by children and families- thirty two LSCBs reported they had or were taking measures which were intended to reduce the number of changes of social worker experienced by children, young people and families. Mechanisms to do this included: redesigning services to minimise 'system led' change; and strategies to maximise recruitment and retention of social workers.

Redesigning the Common Assessment Framework (CAF) to meet local needs- thirty two LSCBs reported they were reviewing the design of the CAF or had already implemented changes to meet local needs. Developments included introducing a local form of eCAF, redesigning the forms and/or simplifying procedures.

Developing systems to obtain better feedback from children, young people and families in relation to their experiences of services- thirty nine LSCBs reported systems were being developed to obtain better feedback from children, young people and families in relation to their experiences of services. The following developments and feedback mechanisms were identified:

- Redesigning feedback forms.
- Conducting surveys (for example, a survey of parental experiences of child protection conferences to inform strategies to improve parents' experiences and engagement).
- Interviews and/or focus groups (for example, interviews with children and young people who are or have been the subject of a child protection plan and their families to obtain their views of the services they have received or are receiving).
- Introduction of a Participation Strategy.
- Engagement in academic research.
- Use of Viewpoint software to obtain the views of children and young people on their experiences.
- Feedback from Children in Care Councils and other groups.

Data collection and analysis to inform plans- forty LSCBs stated data collection and analysis had been undertaken to inform developments in response to recommendations from the Munro Review. The actions they reported were

predominately concerned with reviewing data requirements (and generally expanding data sets) or redesigning performance frameworks. A small number of LSCB Chairs specifically acknowledged the increasing sophistication of reporting mechanisms and/or the importance of analysing both qualitative and quantitative data to monitor performance.

4.23 In the responses, mention was also made of using the Signs of Safety approach (Turnell, 2012) and the Reclaiming Social Work approach developed in Hackney (Goodman & Trowler, 2011). These are both whole system redesigns and being adopted by several authorities so merit more detail.

Reclaiming social work

Submission to Munro Progress Report, from Morning Lane Associates.

Reclaiming Social Work is an operations systems/systemic methodology for statutory child and family social work (details of the full model can be found at www.morninglane.org). At the time of this report, the model has been rolled out in full in one authority and has shown very promising results in keeping children and young people safely at home (Cross, Hubbard & Munro, 2010 and Forrester, D. 2012b).

Since then many authorities have adapted the model to suit local circumstances and are already seeing very positive changes. As part of this group an extensive network of authorities have banded together to form the National Redesign Network, all focused on embracing a different journey for child & family social work and the families they work with, and through a process of exchange of ideas and expertise, challenge and debate with each other, and within their own local areas, have developed some progressive and creative programmes of change.

Derbyshire has been piloting the use of systemic based clinical supervision in addition to that provided by the team manager as a way of introducing more reflective opportunities to think through child protection concerns and how best to positively engage the family and progress safety plans. Starting with just 2 social workers, the approach is being rolled out across the county to over 80 social workers.

'She is really transparent - she doesn't stab you in the back at case conferences - all the others did. She understands what we are going through - doesn't dwell on the past - she shows us lots of respect. She is genuinely trying to help us - not trip us up. I really think we are going to be alright now - things are getting better '
(A mother whose children have child protection plans)

The use of systemic theory with a pilot group of families within Derbyshire has begun to affect real change for those children, young people and parents involved; reducing risk and improving potential outcomes. The workers involved have a renewed enthusiasm for Social Work having experienced the positive difference made by an alternative method of engagement. The focus on relationship dynamics

and strengths in families rather than their deficiencies has proved inspiring for the practitioners.(District Manager:)

Cambridgeshire is in the process of implementing 'Working for Families' – a whole systems change which aims to keep children and young people safely with families through enhanced evidence based skills development and a structure which supports collaborative working amongst professionals and with families (more details are available on the Munro Review website, in Progress Submissions).

'I continue to be enthusiastic and energised about this way of working in a way that I do not remember in all my years as a social worker. There are clear differences in our practice already. The responsibility is shared between a small group (unit) of staff, who pool their respective ideas and skills in a coordinated and much more active way than before. Each and every child is discussed every week and plans are made about a range of interventions. The work is strengths based….much more hands on, with workers helping families to build skills to enable them to problem solve much more effectively for themselves. Developing a shared knowledge base through systems and social learning theory, while still using other research such as attachment theory, has been invaluable. The inclusion of a specialist clinician has been especially exciting, particularly in families where there are entrenched drink or drug addictions or mental health issues. This is so much better for the families than before…..it is such a rewarding way to do social work without the heavy burden of responsibility on any one set of shoulders. What is fantastic is that we are continuing to learn – this is only the beginning' (Group Manager, Cambridgeshire)

Cornwall Child & Family Social Work Services has created a network of new roles across the operational system: Principal Social Workers in every team who are advanced practitioners with a small caseload and who have responsibility for supervision, mentoring and support to other social workers; and Consultant Social Workers who have a full caseload but crucially, both posts are paid the same as team managers but with no line management or budget responsibility. This is significant because it gives a very strong message that practice skills have equal status to management skills.

Cornwall is the first authority to invest in exploring the potential to apply the principles underpinning Reclaiming Social Work to an adult social care context. This is a creative response to the pressures facing these services where practitioners and senior management want to find ways to increase direct contact time with service users as well as ensure the nuts and bolts of care management are done most effectively. Other authorities are now at the beginning stages of thinking through these possibilities.

Harrow is a good example of an authority taking a whole systems approach to both early help and targeted services. Their new model prioritises parenting skills, family support and responses to young people on the cusp of exclusion, crime or care. Critical though is the strong strategic approach to changing practice through the introduction of a limited set of evidence based methodologies across the children's workforce as well as providing on the job coaching and modelling.

Islington have a comprehensive redesign programme in place, which focuses on the whole system of child & family social work. Within the wide range of initiatives, they have introduced a time and motion methodology which other authorities have now adopted, which shows the detail of what social workers spend their time doing, what proportion of time is sent on direct work and reveals what needs to shift in order to increase that proportion. A much more strategic approach to skills development has also been launched where resources are targeted towards long term evidence based skills development underpinned by rigorous academic evaluation provided through the Tilda Goldberg Foundation under the leadership of Professor Donald Forrester.

Worcestershire found the timing of the Munro Review exactly right as they had identified significant workforce issues following an OFSTED inspection and, as a result, received significant additional financial investment to improve capacity at the front line. This was in addition to a time limited Senior Manager post – Programme Manager Social Care Workforce Reform which currently incorporates the role of Principal Social Worker. This has supported the development of a comprehensive Workforce Strategy with a work plan that specifically evidences the Social Work Reform Board and Munro recommendations and which uses, as its framework, the Employer Standards. They have embraced the ideal 'More Professional Accountability, Less Bureaucracy' which is enabling them to look at every aspect of our policy, procedures, systems practices and ask 'Is this the spirit of Munro?' As a consequence this is enabling them to challenge some corporate agendas (reduction of admin) and to enable their staff to have a clear framework within which to challenge the Senior Management Team.

The Munro recommendations are changing the culture of the organisation and recent OFSTED Inspection (March 2012) has highlighted positive impact of the Workforce Strategy on the moral and changing professional practice. Has given real opportunity to return to 'real' social work and we all want to wave goodbye to the 'tick box' culture. The challenge is still how easy it is for us all to let go?

4.24 In his interim evaluation report, Forrester (2012b) ends with two very thought-provoking paragraphs:

This evaluation began with a sceptical interest in the Hackney model. It appeared promising, but experience suggested that it was unlikely to be as impressive as its proponents believed. In this respect our findings suggested we were perhaps overly

sceptical. The approach to work in Hackney is exceptional. This is perhaps best captured by a comment made by one of our researchers (herself an experienced social worker) during analysis: 'if we were starting child protection from scratch and comparing the Hackney approach and traditional children's services there is no question that you would opt for the Hackney model.' As outlined above, there are several reasons for this but at the heart of it is joint allocation of children to small teams. This necessitates far more discussion and shared input for work, which when properly supported and informed by theory, creates a far higher quality and consistency in practice.

In contrast, the traditional hierarchical model operates in a linear way, like a chain of command from senior management to worker. This can work when each link is strong and well supported, but it is essentially a 'brittle' system; any weak links caused by personality or circumstance are likely to lead to breakdowns in assessment and work. Such a system may appear easier to manage, but it is particularly vulnerable to systemic failure – ironically the very thing which children's services seek to avoid as it can have such disastrous consequences. It is possible that such an approach worked when it was created in the 1960s and 1970s, but our study suggests serious questions about whether it is appropriate for the very high levels of need and risk found in almost all families worked with in contemporary social work.

Signs of Safety

Submission to Munro Progress Report from Viv Hogg and Andrew Turnell, Signs of Safety. (More details are available on the Munro Review website in Progress Report Submissions).

The Signs of Safety is an approach developed in Western Australia by Andrew Turnell & Steve Edwards based on practitioner wisdom about what actually works with families. The approach expands the investigation of risk to encompass strengths and signs of safety that can be built upon to stabilise and strengthen the child & family's situation. The approach requires practitioners to develop skills around critical thinking and questioning and it provides them with a framework for guidance and recording focused around 4 key domains:-

What are we worried about – past harm, current and future danger
What's working well – strengths, existing and future safety
Judgment – current safety of the child
What needs to happen – required outcome and next steps

Essential to the Signs of Safety approach is the attention to building engagement with the family and partnership with other professionals in order to develop everyday safety plans.

'We really understand this and know what we are all doing. I don't agree with your worries but I will work with them in the safety plan'.(Great Grandmother from Leics, following a Planning Meeting)

'It is a really useful method of intervention in helping families get the value and importance of future safety planning regardless of whether there is ownership of past events or abuse. It moves the focus from admission of guilt

to planning for a better and safer future for the child'. (Independent Reviewing Officer from Leics.)

Many UK boroughs have already received training in the Signs of Safety and twenty-four local authorities have expressed a strong interest in using the approach as a means of relocating partnership with families at the centre of their children's services. In 2012, 12 boroughs will begin multi-year implementations of the Signs of Safety approach with more to follow in 2013. These boroughs, along with key partners will be lead by Viv Hogg and Andrew Turnell and will collaborate closely to share learning and act as critical friends to support and deepen the implementation process.

Evaluation data of the Signs of Safety approach from implementing jurisdictions around the world consistently shows practitioners welcome the approach and shows increased practitioner morale and pride in their work, and evidence of reductions in statutory intervention such as children and young people taken into care and families to court (DCP, 2011; Skrypek et.al., 2010; Skrypek et.al., 2012; Turnell, 2012; Wheeler and Hogg, 2011).

Making Systemic Change - the introduction of 'systems thinking' into Children's Services in Cumbria

4.25 Cumbria offers another, interesting way of using systems thinking, drawing on lean management theory, to start to reform their response to referrals, with plans to roll out the approach to other aspects of work. I was sent the following submission:

Changes to the system in Cumbria are being informed directly from practitioners based on their understanding of what is 'value work' and 'waste work'; the former being that activity valued by children and families, the latter being everything else i.e. the activity that gets in the way of doing the value work.

This new perspective on activity is more than re-engineering a process – it is the beginnings of a change in service and organisational culture where practitioners are empowered to challenge the status quo to continuously redesign the system in which they operate around the value work (i.e. Listening, Understanding, Identifying Need/Desired Outcome, Meeting Needs/Desired Outcomes).

'Working on the work flows has made all the difference, I realised how much system work I did previously that had no impact on the outcomes for children' Social Worker

The mechanism being used to facilitate this change is a 'blockage board' - a whiteboard set up in the team room to encourage practitioners to write down issues and challenges that take up significant time and prevent time spent doing value work with children and families. It is reviewed each week by the team in 'de-brief' – a structured feedback session where practitioners and

managers can discuss cases as a group to learn and inform change. By their own account the presence of a Blockage Board and the response to it by managers, has improved morale and staff have said they feel like they have been listened to, can see things changing and feel that they are being taken seriously. It is a visual tool that helps to maintain a de-personalised focus on the system and informs the activity of managers whose new role is to act on the system.

Specifically, the new emerging role for management is to:

- support and empower the professional judgement of practitioners
- observe and support practitioners in reflective practice
- uphold and reinforce the Operating Principles to develop a change in thinking and actions across teams, individuals, partner agencies and the organisation
- solve and remove blockages within the system as identified by measures and staff
- facilitate needs led outcome focussed work
- identify more clearly when resolution of issues is beyond their remit and access the appropriate expertise

The two leading measures established are: 'Right first time' and 'End-to-end time '. Development of these measures in terms of data capture is at an early stage but most importantly they are currently driving behaviour and being used by the service to learn and improve.

> *'getting it right first time is really important – if I can see the child's story from the starting point to the end point then I know that everything is real. 'Better for Children' has changed that, we get it more right more times' Social Worker*

The Needs Led Outcome Focussed single assessment has been designed around what matters to children and families. This single proportionate assessment has had comprehensive endorsement by practitioners, seeing it as a tool that provides a better and more understandable assessment process for children, families and practitioners. There is an improved understanding of seriousness and risk and a similar clarity of what is required, by whom, and by when, to minimise risk.

> *'it was when the families got it, like one couple did. The dad was in prison and the mum a teenager, she was terrified of getting us involved, because of the dad, but when we put things in a needs led way, like 'the baby needs us to do this", she got it, he got it and it was OK'*
>
> Social Work in Early Intervention

'one of my mums had involvement throughout her child's life and a number of initial assessments were completed, when she read the `seriousness` she said she finally got how things were and what needed to happen to meet her child's needs.' Social Worker Triage

'one mum commented that she could see her child's story more throughout the assessment' Social Worker Triage

Reports from Children's Centres have been extremely positive and indeed the local Barnado's provider has adopted the needs lead outcome focus assessment as part of their own referral process.

Feedback to date indicates that staff are practising from a more children and family perspective and are less process driven by ICS. They are observed to be more reflective and will challenge each other and systems more readily in a safe and productive way.

A major change away from the tick box mentality that is encouraged by ICS is being consolidated in Carlisle and Eden, and will be taken forward in county roll out.

'I think the old system took away our analytical thinking because there were too many boxes to tick, it became mechanical' Social Worker Triage

Partnerships with universities

4.26 In feedback from seminars, many saw an increased importance of using the resources of universities as they sought to embed higher aspirations for standards of social work practice and use of research in social work. There are an increasing number of examples of places strengthening the relationship between the universities and employers in different regions to embed a learning culture in social work agencies. To mention one as an example, Birmingham Social Work Academy - it opened in October 2011 for all social workers and managers in Birmingham City Council, with the following purposes:

To ensure that social work staff in Birmingham are able to access the best possible learning and development opportunities; to ensure the service is characterised by high standards of academic and intellectual ability; to ensure BCC develops as a learning organisation; to ensure that new entrants into the profession are of the highest calibre and given the best opportunities and generally to promote and value the social work profession in the City Birmingham Social Work Academy (2012).

ICS reforms

Submission to Munro Progress Report from Professor Sue White, Birmingham University

> Progress with any substantial reforms to the ICS remains rather slow. The enthusiasm for redesign in many authorities is high, but is hampered by a number of factors:

- **Demands of data entry**

The performance management system and workflow requirements needed to comply with inspection (e.g. time scales) are as yet unchanged [although will be soon] except for some limited concessions in trial authorities. Working Together is currently under review and it is likely that it will be radically simplified which will be helpful. However, critical, honest and imaginative attention to the relevance and amount of data gathered and whether it is really useful locally or centrally is also necessary.

- **Contracting Arrangements**

There remain restrictions and disincentives for Local Authorities to innovate, or to change suppliers which result from the conditions of current contracts. Most local authorities are making do with minor changes to their ICS because they are tied into contracts, or because the problems of data migration to new systems untested locally are too risky or too costly, or do not interface well with systems in adult services or elsewhere. This is exacerbated by the point made above. Why would one risk a major shift if the regime is substantially unchanged?

- **Procurement**

There are specific problems with EU rules on procurement which are inhibiting the processes of user-centred design in some authorities working with both new and old suppliers. Any work ongoing between a supplier and authority , such as user centred design workshops and collaborative, iterative piloting, must cease when a contract goes out to tender. Thus work is short-circuited just as it may start to produce really useable products. This needs urgent attention.

More generally, the landscape of suppliers appears to be shifting with fewer of the established providers tendering and one or two new suppliers entering the market with specially designed products. This must be a positive development as it suggests that some established suppliers are committed to providing products for children's social care and may well be able to introduce more flexibility as the regime (hopefully) changes. However, even the newer 'ICS' type systems remain very much recording and data entry focused, which is not surprising given that this remains a pressing priority if local authorities are to negotiate the range of performance measures in place.

However, in the future a more resolute focus on reading and sense making from the system is essential and needs a new design orientation, which keeps the document management functions, but streamlines recording, for example, using voice recognition systems, photographs, video and displays documents in an intuitive way. I have yet to see anything that looks like a system for the post ICS world. There is a compelling case for an open source project for children's and indeed adult social care. We need to harness the design expertise of the sector and produce a sustainable adaptable, iterative system with potential to increase creative capacity and technological expertise in the sector. The

current government are rightly championing 'open source' technology. The Cabinet Office have recently published an open source tool-kit intended to dispel some of the prejudices against open source solutions and also made helpful changes to procurement rules.

We recommend that actions be taken to instigate an open source project to provide a successor to ICS. Like other open source projects, this will, in due course, produce a community version free to all agencies, as well as other implementation options with different levels of commercial support. It will also increase competitiveness in commercial suppliers as cost of ownership in whatever form will be much cheaper with open source product.

Beyond ICS: Using Social Media to Support Practice
Whilst it will always be necessary to have systems for storing documents, recording events and decisions and gather data, it is important that the use of technology does not become reduced to these important but rather static functions. There is growing evidence of smaller scale, pilot design projects. It would be useful to illustrate this with an exemplar:

> *Brighton and Hove are piloting the use of Patchwork. Patchwork was developed with funding from NESTA, the Nominet Trust and Staffordshire County Council, led by FutureGov who work to make public services better through innovative technologies.*
>
> *Patchwork works to 'glue together' professionals around children in a lightweight way requiring very little data entry. Brighton and Hove are now developing a programme to sit alongside Patchwork, to address the families agenda. Patchwork will be co-designed and developed with front line practitioners. The next steps are expected to include:*
>
> - *widening the user base into sensitive services and out to CVS, hospitals, GPs, schools etc*
> - *implementing the simple tool to support multi-agency working with adult clients*
> - *building on this, developing the tool to create family networks and expose the wider group of professionals engaged with different members of the family*
> - *undertaking ethnography with families to understand how they experience services and how they can be involved in service design*
> - *tactical projects to free up social workers, such as streamlining assessment, removing inflexibility etc in the current ICS*
>
> *Paul Brewer, Head of Performance for Children's Services at Brighton and Hove says of the next steps:*

'This is an open, iterative process that will deliver practical benefit on the ground quickly while starting to examine more deeply how services work with families, including social care. We think innovating with technology can help enable change and that these new tools will help relationships to develop between professionals and with families to achieve better outcomes' Brighton and Hove and Patchwork

Open source solutions would work well with this kind of incremental user-centred approach as specific modules can be added from different sources to build a bespoke solution.

Conclusion

4.27 Social work can and should be a highly skilled job where social workers are capable of using relationship and therapeutic skills to help families overcome their problems. These skills must be built through high quality training and then fostered by a stimulating and supportive work environment. The examples in this chapter illustrate how many are enthusiastically taking the challenge to improve the way they seek to help children and young people.

4.28 The work of the Social Work Reform Board has led to some very good progress on social work training over the past few years. However, there is also an ongoing need to strengthen the existing workforce and to provide good learning opportunities for newly qualified so that they can continue to develop expertise.

4.29 The creation of Principal Child and Family Social Workers and a Chief Social Worker over the next year should help to improve the working environment for frontline practitioners. Both roles should help to keep other parts of the system (Government Ministers, councillors, senior managers etc.) informed of social workers' experiences and needs. This dialogue should help refresh local procedures, remove barriers to the exercise of professional judgment and encourage more stimulating and effective working. Improved working environments should increase staff retention and so give greater opportunities for sustained professional development, as well as allowing continuity of contact with children and families.

4.30 The rejuvenation of social work is a process that will take many years and although the process is now well under way, it is vital that the opportunities created by the changes in statutory guidance are capitalised on.

Chapter 5: Learning how we are doing

Introduction

5.1 The reason for creating more flexibility in the system is so that people can learn from feedback, reflect on how well they are doing, and adapt their practices if necessary. Services have become so measured by inputs and bureaucratic processes that too little is learned about whether children are being adequately helped. Becoming better at learning what impact services are having on the lives of children and families is key to driving improvement but it is also a major challenge. Outcomes are much harder to measure than service outputs. For instance, it is easier to count how many children were taken off child protection plans within two years than it is to ascertain whether the decision to remove them from the plan was in their best interest and whether that decision subsequently led to good outcomes for the children. Nor can all problems be solved quickly – some families need prolonged help to change entrenched difficulties. It is also important to find out whether improvements are sustained; progress made while services are actively engaged with families can sometimes fade once the families are on their own.

5.2 The Convention on the Rights of the Child provides a useful framework of what children need in order to flourish. It is also vital, in evaluating human services, to remember that 'good' refers to morally good as well as technically effective. Professionals have professional codes of ethics that inform their practice and what is acceptable or unacceptable.

5.3 There are some good examples of progress being made, with developments in peer review showing a willingness to be self-critical. However, more improvement on monitoring the impact of services is needed because it is such a major element in becoming better at learning and adapting to improve services.

5.4 Feedback is obtained through a number of mechanisms. In this chapter, I look at what is happening at the national level in terms of collecting performance information, what is happening at service levels, and what is happening in individual cases. Progress being made on the implementation of my recommendation on changing the way we learn from serious incidents is also covered.

Performance information, not indicators

5.5 In order to move from a culture of compliance to a learning culture that is child-centred, feedback is needed on how well services are achieving their goals, both in individual cases and overall. In my review, I criticised the system of targets and performance indicators as having introduced perverse incentives and led to too much focus on achieving targets rather than children's needs. A compliance culture results in too little evidence about how well children have been helped or, indeed, whether they have been harmed by the intervention in their lives.

5.6 The Government has responded by producing new data requirements that are expressed as information not indicators. Performance indicators are interpreted as straightforward measures of good practice but, as has been

shown in every service where they operate, they can be produced by a number of routes, only some of which achieve good outcomes for the child. A reduced set of performance information will be published shortly, with some to be collected by central Government and another set for local use.

5.7 There are two broad types of performance information. The first is population information which relates to trends within society or parts of society, which are multi dimensional and can only be improved or changed through the contributions of many different partners. Examples of this might be obesity, unemployment or teenage pregnancy. In safeguarding, it is vital that LSCBs and their partners have population information on such issues such as neglect, bullying and trafficking so that they can put in place preventive strategies to reduce the trends. Service information, on the other hand, will enable the LSCB and their partners, individually and collectively, to monitor whether their services are making any difference to improving the safety of the children and families they are working with. The focus of the service information will be on outcomes not process.

5.8 When considering performance information, it is important that it is viewed from the perspective of the quality of practice and conditions behind it. If the numbers of children with CP plans has increased significantly, is this a good thing or a bad thing? It depends. The answers will lie in the examination of the quality of the work being delivered, illustrated by outcomes, not measured solely by process. This interrogation of data should be encouraged by central and local Government in order to prevent data being treated as targets and simple indicators. For example, it is important that the new adoption performance information does not become a series of blunt targets or naïve judgments about practice.

5.9 A framework seeking to measure the effectiveness of the safeguarding system might have in the past included the speed of the initial assessment and the turnover rate of staff. Whilst this is useful information about the efficiency of the department it tells us nothing about the quality or effectiveness of the service. To gauge this, an LSCB needs to know whether there have been repeated reports of abuse, whether the parents say their parenting skills have improved as a result of the support being offered, or that children say they are feeling safer from abuse/ bullying.

5.10 Information about children is also collected by the health sector and the NHS outcomes frameworks have considerable overlap with social care outcomes so it is important for those in other services to be aware of them and use them constructively. In the public health policy framework, the following indicators that relate to children and young people clearly have relevance to safeguarding:

Domain 1: Improving the wider determinants of health
Children in poverty
School readiness (placeholder)
Pupil absence
First time entrants to the youth justice system

16-18 year olds not in education, employment or training

Domain 2: Health improvement
Low birth weight of term babies
Breastfeeding
Smoking status at time of delivery
Under 18 conceptions
Child development at 2 – 2.5 years (Placeholder)
Excess weight in 4-5 and 10-11 year olds
Hospital admissions caused by unintentional and deliberate injuries in under 18s
Emotional well-being of looked after children (Placeholder)
Smoking prevalence – 15 year olds (Placeholder)

Domain 3: Health protection
Chlamydia diagnoses (15-24 year olds)

Domain 4: Healthcare public health and preventing premature mortality
Infant mortality
Tooth decay in children aged 5

5.11 It is important that health and social care performance information is well co-ordinated to reduce duplication and maximise learning.

Peer review

5.12 Earlier in this report, I discussed the major changes about to take place in the inspection process and this clearly plays a major role in encouraging services to learn more about how services are doing. The sector is also taking a lead on improving practice. The Local Government Association (LGA) and the Children's Improvement Board (CIB) are developing additional strategies for local authorities to review one another and reflect on how well they are doing through peer review. This fits well with the need to analyse and interpret in order to understand whether the data they examine indicates good practice. Peer review has progressed very well over the past couple of years and regularly involves police and health people on the review team.

5.13 The peer review programme became fully operational in January 2010. An evaluation (Martin & Jeffes, 2011) has found that:

there were three main rationales for seeking a peer review: authentic and real-world reflective practice and improvement; specific service or process improvement; preparation and planning for inspections. Impacts resulting from a peer review include:

- *increased commitment and drive to make improvements in safeguarding*
- *development of ideas, plans and actions*
- *promotion of learning and reflective practice*
- *revision of policies, processes and systems*
- *improvement in staff morale and relations*
- *affirmation and enhancement of the quality of partnership working.*

5.14 LGA continues to build on and evolve the tried, tested and trusted peer review model. The aim is to help councils strengthen local accountability and tackle the way they evaluate and improve services. The LGA has offered every authority the opportunity to have a peer challenge between 2011 and 2014.

> *'Peer challenges are managed and delivered by the sector for the sector. They are improvement focused; the scope will be agreed with the council and tailored to reflect their local needs and specific requirements. The peer team will involve peers from across the sector and beyond. Their ambition is to help your council respond to its local priorities and issues in its own way to greatest effect'(LGA, 2011).*

Evaluating progress in case management

5.15 Learning about effectiveness is equally important at the individual case level. Outcomes arise from the interaction of many aspects of a family's life so it is not straightforward to identify what causal part, if any, a single service provided. However, professionals can find out whether their intended goals have been achieved even if factors other than the service input helped to bring them about.

5.16 There is very variable practice in clarity and specificity of objectives in working with a family. As the wider system becomes more focused on effectiveness, this will hopefully influence practitioners to do the same. Clearer goals allow professionals to notice when they are failing to make progress and need to rethink the help they are offering. At the case level, goals are usually co-produced with the child and family so it is important to have the flexibility to allow their views and preferences to be included in monitoring practice.

5.17 Standardised instruments such as the Strengths and Difficulties Questionnaire and Parenting Daily Hassles Questionnaire (Dept. of Health, 2000) are being used in some places to provide a baseline measurement of the problems and allow workers and family members together see whether progress is being made.

5.18 The Signs of Safety approach includes creating a safety plan with the family that sets out the goals and details very precisely, in language the family can readily understand, what is working well, what people are worried about, and what needs to happen to allay those worries, Examples of such plans are available at http://www.education.gov.uk/munroreview

5.19 In the latest version of the NHS outcomes framework, the Government has made an explicit commitment to seek the views of children and young people about their experience of health care by conducting a survey. How this will be linked to local information gathering is yet to be seen but it will make some contribution to local services' understanding of how services are impacting on children and young people.

5.20 Roger Morgan, the Children's Rights Commissioner carried out interviews with a sample of children and young people in the trial authorities. This illustrates how their feedback adds another valuable dimension to making an overall judgment about the quality of services. Their answers in these interviews also demonstrates that they are able to keep their focus on the *process* of being involved in the child protection system, not getting distracted into discussing the content of the protection issues themselves.

5.21 Their feedback is informative. The individual social worker is of great significance to them. Many had had several social workers so were able to compare them and this revealed how varied the quality of practice was, with some workers being highly praised and others criticised. Feeling listened to and understood is important, with several mentioning the importance of being able to discuss some matters confidentially. When asked if they trusted their social worker, those who said 'yes' made comments such as *'she listened', 'she got to know me', 'he's got the right approach – he really understands me', 'I can tell him everything and trust that he won't go to other people and chat', 'she's done what she said she was going to do'*. Those who did not trust their social worker said *'he didn't keep anything confidential', 'she keeps cancelling appointments', 'she was scary', 'she didn't listen to anything I said or wanted'.*

5.22 Some of the answers show that, when not given enough information, the children and young people make assumptions about what rules are operating. One, for example, who was puzzled that the social worker inspected his bedroom, said he had not asked her because 'I thought they would say I couldn't ask anything'. This illustrates the importance of helping them understand what is going on.

5.23 The Children's Commissioner (2012) provides additional information, having consulted children and young people with the aim of finding out how they might contribute to the evaluation of services at a local level and how their feedback might assist those running local child protection services to learn whether they were making a difference. The findings are summarised as:

'There are some important starting points:

- *to build a listening culture in order to establish what are the issues that matter to individual children and to all children and young people in a particular area; and*
- *to help professionals to communicate well with children about their intentions and plans.*

Both will help to make the gathering of feedback a routine part of practice and respect for their views a meaningful right for children and young people.

On the first point, much is already known about what matters to children about those who work with them, from research and young people's messages from a range of consultations both local and national. Consistent messages have been given about the need for sustained relationships; for more contact with social workers and greater continuity of worker; for ways to be consulted, engaged and informed. Local areas can establish ways of finding out what matters for the children and the families they serve, alongside gathering feedback on ongoing experience. The ideas above will assist in guiding this work so that outcome measures can be developed within the listening culture which children want'….

'One of the suggestions above is that existing approaches for engaging with looked after children could also be developed with and for those in need and in need of protection. Those practices would need to be built upon in order to make it possible to draw on them for performance purposes. Another overall message is that effective feedback relies on good practice in communication with children and so perhaps one of the ways forward is to build the requested conversations into basic good practice in the context of the relationships young people have with those working with and

caring for them. This would bring in other aspects of the agenda for change following the Munro Review – concerning quality of training and professional support.'

Learning from serious incidents

5.24 The Government has accepted my recommendation for systems methodology for learning to be adopted and appropriate revisions to Chapter 8 of Working Together are currently being considered. This follows the health sector's example of using the systems approach to underpin the patient safety agenda.

5.25 However my recommendation cannot be implemented instantly nation wide. Firstly, capacity building is required to provide reviewers with a good understanding of systems methodology and adequate competence in its application. There is also a need for further work in refining the existing Learning Together (Fish, Munro & Bairstow 2008) model and developing new models for use in child welfare. Finally, the implementation of this recommendation requires progress against the other recommendations to minimise obstacles. Perhaps most pressing is the kind of leadership required to enable an open, learning culture to flourish. Unless people feel that they are in a just culture, they are reluctant to discuss weaknesses in their practice, an essential prerequisite for learning.

5.26 Feedback on my report has identified a need to clarify what is meant by a 'systems' methodology for case reviews and SCRs. In response I have produced a short paper (Munro, 2012) outlining the features that must be present to justify the name a 'systems approach'. The full paper is on the website but the four key features are:

- *a focus on the person in context, seeing performance as arising from the interaction of the context and what the individual brings to it.*
- *the aim of understanding why someone acted as they did, not just describing what they did. In a systems approach, the aim is to avoid the hindsight bias that grossly distorts our retrospective analysis of a case and seek to understand how things were perceived and the rationale for decisions, actions, or inactions at the time.*
- *the aim of finding out whether the problems revealed are specific to that case or more widespread, seeking to find patterns of weak performance, i.e. the individual case is taken as 'a window on the system' (Vincent, 2006). This enables the enquiry to extrapolate from the individual instance to general lessons.*
- *the use of research methods to maximise the reliability and validity of the findings. This of course is relevant whatever approach is being taken.*

The 'Learning together' model

Submission to the Munro Progress Report from Dr Sheila Fish, Social Care Institute for Excellence.

> Considerable progress has been made in developing and using the systems model 'Learning together to safeguard children' (Fish, Munro, & Bairstow, 2008), often called the 'SCIE model' – fuller details are in the report (Fish, 2012) on the review website. The Children's Improvement Board reports strong support from the sector for the use of a systems methodology for SCRs and other cases, using the 'Learning together' model (Fish, Munro, & Bairstow, 2008). The North West, the first region

to pilot the approach, has now made use of the systems approach a regional priority. The approach is also gaining recognition internationally in child welfare with training in the 'Learning together' model having taken place in Germany, and in planning for Netherlands, Scotland.

One training course is being run by SCIE, latterly with funding from the Department for Education, with 43 people having taken it to date. The course and assessment process for accreditation have now been assured by the Institute of Leadership and Management (ILM). The process of assessing trainees toward accreditation is in process. There are also currently three pilot SCRs being conducted using this model by Coventry, Lancashire and Devon. This was facilitated by the Parliamentary Under Secretary of State for Children and Families allowing LSCBs to apply for dispensation from various aspects of the statutory guidance. The Department for Education has commissioned an independent evaluation of these experiences, by researchers at Loughborough University. This aims to focus on capturing learning about particular difficulties raised by use of the approach.. It is due to report later this year.

> *Making the analytical move away from the case specific - what happened in a particular case and why - to what that might then tell you about weaknesses in local systems more generally, is deceptively difficult to do. It demands a conscious move away from the familiar – and is tiring and hard on the brain. (London trainee reviewer)*

LSCBs who have commissioned case reviews using the Learning Together model are positive about the learning that flows from it. They tend to distinguish two different forms of learning and impact:

1) learning attained in the process for those taking part, and
2) learning about how the system is functioning, presented as considerations for the LSCB.

The practitioner engagement in the case review process that the Learning Together model encourages and facilitates receives unanimous praise. Feedback highlights the different quality of debate that is generated by bringing staff together to discuss what happened and explore why it happened, without recourse to hindsight bias.

> *I got a lot from it: the main thing was just being able to take a step outside regular day to day, talk openly, talk about why decisions were made, good reflective practice. I also liked the tunnel idea because it felt like we were learning IN the process and not just THROUGH the process. It felt very active rather than reactive. The value of the group discussion and how we interpret what we say to each other.... really helped to clarify things. I will be supporting this with those I line manage. (case group member, South West project)*

In terms of the formal findings, feedback from the lead reviewers is also indicating that the systems approach is beginning to produce findings of a qualitatively different nature to those often produced though SCRs to-date. This raises more difficult issues for LSCBs and member agencies and poses more of a challenge to them in terms of response.

> *"This was much more of a challenge to the Local Safeguarding Children Board because this process highlighted those areas that are much harder to deal with. That is good. (Colin Green, South West event)"*

The cost of SCRs has long been a concern but SCIE has recently introduced flexibility to the application of the Learning Together model, in response to concerns that the approach was too resource-intensive. A sliding scale of options means that the burden can be proportionate to the particular learning needs of the particular time, place and case. See http://www.scie.org.uk/children/learningtogether/index.asp.

Interest is being shown in extending the systems approach to regular auditing work. Devon, Hackney and East Cheshire are three LSCBs currently working with SCIE to develop a systems approach to routine audit to replace the desk-top, file audits that they have been running to-date.

5.27 Besides the 'Learning together' model, there is progress in developing other models and methods. People in the health sector are looking at how Root Cause Analysis (RCA), the systems approach in health, would need to be adapted for use in child welfare. NHS London is in discussions with SCIE about conducting systems training in RCA as well as the Learning Together model, for health leads in safeguarding.

5.28 There is interesting work in progress developing other systems approaches from the engineering sector, such as Failure Mode Effect Analysis (FMEA). Rather than using a single case review as the learning mechanism, FMEA maps a particular process and, uses a particular analytic method, to gauge high risk areas and design flaws in the process. Researchers at Warwick University and NSPCC are working together to pilot use of this approach in children's services.

5.29 SCIE reports that some LSCBs are expressing an interest in identifying others facing similar difficulties so they can share the responses that they have tried respectively. It is important to find mechanisms for sharing learning at a national level since many of the weaknesses in practice that are identified in a systems review are not specific to that locality nor are the solutions necessarily local but may require change at a higher level of policy or further research to identify solutions. It would help learning at a national level if a basic typology for reporting findings was set out in statutory guidance so that recurrent issues could be readily identified. This way of collating findings about professional practice is, of course, not the same as the work done through the Child Death Overview Panel, which collates epidemiological data that aims to identify trends in the children who die, and risk factors in their environments.

Conclusion

5.30 In a child-centred system, it is vital to know how well children are being helped. This applies at all levels, nationally, locally and in individual cases. The change in the inspection processes will be a significant driver as services are asked to provide evidence about their effectiveness. When the multi-inspection process begins next year, the different services will need to find ways of coordinating and discussing their data.

5.31 The move from measuring practice by targets and performance indicators to a more interrogative appraisal of the data will promote a better focus on quality and reduce the risk of proxies for good practice becoming goals in themselves.

5.32 The new systems approach to Serious Case Reviews follows the example set by the health sector, and offers opportunities for deeper learning of why practice problems occur and for national learning of weaknesses in practice. At present, the *Learning Together* model is the most developed but the Government is clear that other models can be developed.

5.33 The only sensible measure of how well the system is performing is the measure of how effectively it is helping children, young people and their families. When this becomes the primary goal then it encourages all levels in the system to become clearer about what their contribution is meant to achieve and to use feedback on effectiveness to drive learning and improvement. Learning how to improve our measurement of effectiveness is an on-going challenge but it will require using data from several sources, from individual cases, feedback from children and families, service level data on outcomes, and population data. Only by doing this can we reconfigure the system so that it is constantly alert to children's needs and how they are being served.

Chapter 6: Conclusion

Systemic and cultural change

6.1 In my final report, I warned that there should be no cherry-picking of my recommendations; all are needed to dislodge the defensive compliance culture and lead to a system that is better able to monitor its effectiveness and adapt as it seeks to promote children's safety and wellbeing. That system needs to offer the space for sound professional judgments, the skills, support and experience to make those judgments, and the ability to assess and learn from the effectiveness of the help provided as a result of those judgments. Culture change takes effort to initiate and time to embed but, from the individual child's point of view, the need to create a more child-centred system is urgent. It is very pleasing to be able to report that that culture change has begun.

6.2 The radical reforms that I have seen in the draft revised statutory guidance and the new inspection framework make this a watershed moment. Services can respond within the spirit of my recommendations or recreate at a local level the defensive, rule-bound culture that has been so problematic. From the examples I have been sent and the many discussions I have had, I believe that there are many with the confidence and motivation to shift the focus away from compliance with prescription and towards learning about outcomes and improving the skills needed to provide effective help. However, there are also many who are uncertain how to do this; I hope the examples of good practice that I have included in this report and on the website may inspire them.

6.3 The quality of leadership is supremely important in trying to achieve a culture change. Leaders at all levels from – from social work to politics – will need to be resourceful, innovative, and brave in order to face up to the challenges of system change. Hearteningly, as the evidence submitted to this report has shown, many are already rising to the challenge.

6.4 There are a number of factors that may slow progress down, yet these issues are far from insurmountable.

6.5 The number and scale of changes in the different services that work together to safeguard children create a risk of losing some of the embedded culture and wisdom that has developed over the years. The reform of the health service in particular is so fundamental that many have stressed the urgency of making it clear what the accountabilities are in the new structure and how they will be monitored. The relationship between LSCBs and the new Health and Well-Being Boards needs to be clarified because their interests are closely connected. On the plus side, the preventive agenda in the health service will reinforce the focus on early help and prevention in policies for children, young people and families. The national outcomes framework is also to be welcomed

including, as it does, so many variables that relate to children's safety and wellbeing.

6.6 There is also potential danger of fragmentation because a number of other policy changes that affect services to families are pulling in conflicting directions. The Troubled Families Programme is led by the Department for Communities and Local Government yet clearly deals with families where there are concerns about the quality of parenting so it needs to be integrated with other services. The adoption inspection criteria and the reforms in the court system both introduce timescales and targets which are at variance with my review's aim of reducing them because of the perverse effects they have produced. For those responsible for managing children's services, this creates a confusing narrative. Yet the political will to consider and address these problems creates opportunities to settle this confusion.

6.7 The reductions in public sector funding combined with the rise in referrals to Children's Social Care and in applications for Care Orders create a tough environment. They also make change more urgent. With less money, it is even more important that professionals' time is better balanced between supporting families and keeping records; it is even more urgent to improve the expertise of social workers and others in helping families resolve problems and create a home that is safe and nurturing enough for children to stay there; it is even more wasteful to go on providing support services that are not improving the children's care and safety.

6.8 There is also a risk that giving local services more freedom and responsibility while the media continue to judge them against unrealistic standards may inhibit reforms that reduce defensiveness. There will be tragedies in the future too but there is a developing acceptance that uncertainty and risk are inherent aspects of child protection. I shall repeat the comment made by the Secretary of State for Education that I quoted in the Introduction with the hope that it will set the standard of the response:

> *'People working in these circumstances need to have the confidence that they will be backed by their managers when they take difficult decisions with good intent and sound judgement, whatever the outcome.'*
> *Michael Gove, Secretary of State for Education, March 2012*

6.9 How great the dangers I have just discussed turn out to be is hard to predict. But this emphasises the need for all the services together and individually to improve their monitoring of the impact they are having on children, young people and families so that emerging problems can be detected promptly and efforts made to solve them. The increased flexibility that they will shortly have will give them more scope for doing so. It may seem depressing to comment on new problems but, in the complex set of services that support families and safeguard children, it would be negligent to pretend that they would not arise.

Children and young people's safety and well-being will be best protected by services that expect problems and seek to find them and respond quickly.

6.10 In view of the many major changes that are going on at present, I recommend the Government consider on-going oversight of the whole system so that progress is maintained and encouraged. The people I have met throughout the past year have impressed me with their commitment and determination to improve the help they provide to children, young people and their families, despite the hard economic circumstances. It is crucial that improvements in services are furthered developed and sustained. For children, young people and their families, improvements are urgent. Conducting this review of progress has been a valuable opportunity to reflect on what is happening and highlight examples of good progress and where further action is needed. Some form of oversight needs to continue in order to maintain momentum and identify emerging areas of concern.

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Appendix

Table updating on current status of recommendations listed in Government response to Munro Review as at 22 May 2012

No	Recommendation	Position
1.	The Government should revise Working Together to Safeguard Children and The Framework for the Assessment of Children in Need and their Families.	The Government accepted this recommendation and is committed to a radical revision of the statutory guidance. Revised drafts of the statutory guidance Working Together to Safeguard Children and the Framework for Assessment of Children in Need and their Families will be issued shortly for consultation and revised guidance will be published in the autumn. To inform the new guidance, the Government is working with eight local authorities (Cumbria, Knowsley, Hackney, Westminster, Wandsworth, Islington, Hammersmith and Fulham and Kensington and Chelsea) to trial more flexible approaches to assessment. These trials will be independently evaluated. This evaluation and the formal consultation will inform the Government's final decision about national assessment timescales. Decommissioning of National eCAF: In December 2011, following a targeted consultation and a market sounding exercise, the Government announced its decision to decommission National eCAF. The Government is working with the current users of the system to ensure a smooth transition.
2.	The inspection framework should examine the effectiveness of the contributions of all local services including health, education, police, probation and the justice system.	Over the summer, Ofsted consulted on new local authority child protection inspection arrangements that reflected Professor Munro's recommendations. In January they published the new inspection framework that will begin in May 2012. Joint Inspection: The inspectorates have produced a detailed project plan and will be implementing the new joint framework during 2013-14.
3.	The new inspection framework should examine the child's journey and examine how the feelings and experiences of children and young people inform and shape the	

	provision of services.	
4.	Local authorities and their partners should use a combination of nationally collected and locally published performance information on the Department's website.	The Government issued a public consultation on 23 January 2012 which ran until April, seeking views on what information should be collected nationally. 60 responses were received. Locally recommended performance information was agreed with the sector and published in December. This local information has been revised as part of the full public consultation on the wider framework which will be published shortly along with the Governments' consultation response.
5.	Statutory requirements for each Local Safeguarding Children Board (LSCB) to publish an annual report should be amended, to require its submission to the Chief Executive and Leader of the Council.	The Government will be implementing this through amending statutory guidance.
6.	Working Together to Safeguard Children should be amended to state that when monitoring and evaluating local arrangements, LSCBs should include an assessment of the effectiveness of the help being provided.	This will be included as part of the forthcoming consultation on *Working Together*.
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.	The Government has consulted on new guidance for DCSs and Lead Members to improve clarity about their roles. Revised guidance was published on 3 April 2012.

8.	The Government should work collaboratively with others to research the impact of health reorganisation on effective partnership arrangements.	Work is ongoing with the Department of Health, following publication of a co-produced work programme at the end of October 2011, *Safeguarding Children in the reformed NHS*. Phase one has now been completed and work is progressing between the two departments and phase two work has begun. This looks at the role health professionals have in delivering early help.
9.	The Government should require LSCBs to use systems methodology when undertaking Serious Case Reviews (SCRs), In the meantime, Ofsted's evaluation of SCRs should end.	As part of the consultation on *Working Together* and the *Framework for the Assessment of Children in Need and their Families,* the Government will consult on revised statutory guidance for Serious Case Reviews and Child Death Overview Panels. Coventry, Devon and Lancashire LSCBs are piloting the Social Care Institute for Excellence's (SCIE) "Learning Together" model on Serious Case Reviews as part of the drive to improve learning from serious incidents. Iindependent evaluations of the pilots have been commissioned The Government is continuing to look at other sectors, and the Welsh Government's proposals to identify ways of ensuring effective learning from serious incidents resulting in sustained improvements in practice. In January 2012, Ofsted introduced more streamlined evaluations of SCRs with a greater focus on identifying and embedding learning in order to support improvements in professional practice.
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.	On 13 December 2011 Tim Loughton MP announced that there is sufficient legislation to realise Professor Munro's vision of a transparent and coordinated offer of early help. The Government is continuing to work with sector partners to reinforce the existing legislation and to understand how progress on early help can be made. It is also consulting on performance measures that could be adopted locally on early help. Ofsted will be inspecting provision of early help through their inspection of child protection services.
11.	The Social Work Reform Board's Professional Capabilities Framework (PCF) should incorporate capabilities necessary for child and family social work and should inform social work	The PCF has been completed to advanced level, including ensuring capabilities for child and family social work. Work is underway to develop capabilities for the Principal Social Worker role – expected June. The new Continuous Professional Development (CPD) framework now incorporates the importance of learning through a range of activities and in developing professional decision making, judgement and responsibility. The Employer standards which support appropriate supervision and support for CPD are being adopted across the country.

	training.	

12.	Employers and higher education institutions (HEIs) should work together so that social work students are prepared for child protection work and practice placements are of high quality.	HEIs will introduce revised arrangements for practice placement and skills delivery alongside a revised and more relevant curriculum for initial education from September 2013.
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.	CWDC/The College of Social Work have held a series of events with local authorities on system redesign including designating a Principal Child and Family Social Worker in every local area.
14.	Local authorities should designate a Principal Child and Family Social Worker, who is a senior manager who is still actively involved in frontline practice.	A number of areas have activities in place to establish the Principal Child and Family Social Worker; others are still determining whether they will retain senior managers in front line practice.
15.	A Chief Social Worker should be created in Government, whose duties should include advising the Government on social work practice.	The post of Chief Social Worker was advertised nationally in April 2012, starting the recruitment process for this important role. It is envisaged that the CSW will be in post in later this year.