The Munro Review of Child Protection:

Final Report

A child-centred system

Professor Eileen Munro

Reliable
Supportive
Informed
Consistent
Experienced
Trustworthy
Accessible
Relationships
Honest
Kind
Empathetic
Respectful
Approachable
Knowledgeable
Hearing
Rights
Enthusiastic
Involving
Dedicated
Listening
Helpful
Continuity
Protection
Open

Department for Education

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Contents

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Preface

In June 2010, the Secretary of State for Education, the Right Honourable Michael Gove MP, asked me to conduct an independent review of child protection in England. This is my third and final report in which I set out recommendations that I believe will, taken together, help to reform the child protection system from being over-bureaucratised and concerned with compliance to one that keeps a focus on children, checking whether they are being effectively helped, and adapting when problems are identified.

A move from a compliance to a learning culture will require those working in child protection to be given more scope to exercise professional judgment in deciding how best to help children and their families. It will require more determined and robust management at the front line to support the development of professional confidence. The considerable interest in the review and the feedback I have received makes me confident that there are many in the sector who are capable and eager to take on this responsibility.

The call for evidence and later consultations with those working in the sector received a large number of responses that were thoughtful and of great value to me. A survey run by *Community Care* and also distributed by the British Association of Social Workers received around 550 responses in total. The responses were subjected to thematic analysis by the Childhood Wellbeing Research Centre.

I have been consulting closely with a number of local authorities and learning from local leaders, managers, and frontline practitioners who have made innovations to improve professional practice and who are creating a learning culture. Their receptiveness to regular feedback from the front line and from children and families is helping to create an adaptive environment with greater opportunity to reflect on the difference they are making and to exercise appropriate professional judgement.

The review has worked closely with the Office of the Children's Rights Director and the Office of the Children's Commissioner to collect and consider children's views and experiences of the child protection system. This has reinforced my belief in the need for change and my ambition to see the child protection system become child-centred.

Professor Eileen Munro
London School of Economics and Political Science

Executive Summary

1   When the Secretary of State for Education commissioned this review of child protection in June 2010, a central question was 'what helps professionals make the best judgments they can to protect a vulnerable child?'. This final report sets out proposals for reform which, taken together, are intended to create the conditions that enable professionals to make the best judgments about the help to give to children, young people and families. This involves moving from a system that has become over-bureaucratised and focused on compliance to one that values and develops professional expertise and is focused on the safety and welfare of children and young people.

2   The review began by using 'systems' theory to examine how the current conditions had evolved. The review's first report in October 2010 described the child protection system in recent times as one that has been shaped by four key driving forces:

   ● the importance of the safety and welfare of children and young people and the understandable strong reaction when a child is killed or seriously harmed;
   ● a commonly held belief that the complexity and associated uncertainty of child protection work can be eradicated;
   ● a readiness, in high profile public inquiries into the death of a child, to focus on professional error without looking deeply enough into its causes; and
   ● the undue importance given to performance indicators and targets which provide only part of the picture of practice, and which have skewed attention to process over the quality and effectiveness of help given.

3   These forces have come together to create a defensive system that puts so much emphasis on procedures and recording that insufficient attention is given to developing and supporting the expertise to work effectively with children, young people and families.

4   The review's second report, in February this year, considered the child's journey through the child protection system – from needing to receiving help – to show how the system could be improved. It concluded that instead of "doing things right" (i.e. following procedures) the system needed to be focused on doing the right thing (i.e. checking whether children and young people are being helped). Extensive consultation on the reform areas set out in that report contributed to the development of this final report.

A system that values professional expertise

5   Practitioners and their managers told the review that statutory guidance, targets and local rules have become so extensive that they limit their ability to stay child-centred. The demands of bureaucracy have reduced their capacity to work directly with children, young people and families. Services have become so standardised that they do not provide the required range of responses to the variety of need that is presented. This review recommends a radical reduction in the amount of

central prescription to help professionals move from a compliance culture to a learning culture, where they have more freedom to use their expertise in assessing need and providing the right help.

6   The review is recommending that the Government revise statutory, multi-agency guidance to remove unnecessary or unhelpful prescription and focus only on essential rules for effective multi-agency working and on the principles that underpin good practice. For example, the prescribed timescales for social work assessments should be removed, since they distort practice. The underlying principle of timeliness is important and should be applied to the whole process of helping a child or young person, not just the early stage of assessment.

7   Inspection is a key influence on priorities in frontline practice so needs to support the change from a compliance to a learning culture. The review has worked closely with Ofsted to look at how inspection can focus on and measure what really matters – whether children have been helped. The review is confirming the recommendation made in its second report, that inspection should be conducted on an unannounced basis in order to minimise the bureaucratic burden. It also recommends that the inspection framework examines the effectiveness of the contributions of all local services, including health, education, police, probation and the justice system, putting the experiences of children, young people and their families at the heart of the inspection system.

Sharing responsibility for the provision of early help

8   Like the reviews led by Graham Allen MP, Dame Clare Tickell, and Rt Hon Frank Field MP, this review has noted the growing body of evidence of the effectiveness of early intervention with children and families and shares their view on the importance of providing such help. Preventative services can do more to reduce abuse and neglect than reactive services. Many services and professions help children and families so co-ordinating their work is important to reduce inefficiencies and omissions. The review is recommending the Government place a duty on local authorities and their statutory partners to secure the sufficient provision of local early help services for children, young and people and families. This should lead to the identification of the early help that is needed by a particular child and their family and to the provision of an offer of help where their needs do not match the criteria for receiving children's social care services.

9   Within preventative and other services good mechanisms are needed to help identify those children and young people who are suffering, or likely to suffer, harm from abuse or neglect and who need referral to children's social care. The association between child abuse and neglect and parental problems, such as poor mental health, domestic violence and substance misuse, is well established. It is not easy to identify abuse and neglect. Signs and symptoms are often ambiguous and so it is important that those working with children, young people and adults have ready access to social work expertise to discuss concerns and decide whether a referral to children's social care is needed.

Developing social work expertise

10   The level of increased prescription for social workers, while intended to improve the quality of practice, has created an imbalance. Complying with prescription and

keeping records to demonstrate compliance has become too dominant. The centrality of forming relationships with children and families to understand and help them has become obscured. The review is making recommendations to enable social workers to exercise more professional judgment but is also concerned to improve their expertise. Building on the work of the Social Work Task Force (SWTF) and the Social Work Reform Board (SWRB), this review makes the case for radically improving the knowledge and skills of social workers from initial training through to continuing professional development. The review highlights the importance of social workers' use of research evidence to help them reach the most appropriate decisions.

11   The review has concluded that the high levels of prescription have also hampered the profession's ability to take responsibility for developing its own knowledge and skills. The SWTF and SWRB have laid the foundations for improving skills and have developed a generic Professional Capabilities Framework. For child and family social work, this review gives more detail of the capabilities relating to knowledge, critical reflection and analysis, and intervention and skills. The review recommends that these capabilities explicitly inform initial social work training, continuing professional development, performance appraisal and career structures.

12   Reform of the social work profession should significantly improve outcomes for children and young people by making best use of available evidence about what helps to resolve the problems in children's lives. Increasing the expertise of the workforce requires investment, but in areas where local reforms have upgraded the knowledge and skill of their workforce, savings have been seen overall. Skilled help can enable more children and young people to stay safely with their families, bringing significant savings. Initially resources will be required to develop the additional expertise and training necessary to set the profession off on a new path and this is an area that the review considers to be a priority for investment.

The organisational context: supporting effective social work practice

13   With the reduction of prescription, leaders in local authorities will have more autonomy but also more responsibility for helping their staff to operate with a high level of knowledge and skills. The review asks local authorities to take more responsibility for deciding the range of services they will offer, defining the knowledge and skills needed and helping the workers develop them. For example, a local authority wishing to implement a particular evidence-based way of working with children and families needs to consider what changes might be needed in the training, supervision, IT support and monitoring to enable this to be carried out effectively. To keep the focus on the quality of help being given to children and young people, they need to pay close attention to the views and experiences of those receiving services and the professionals who help them.

14   The review shares the view of the SWTF that the current career structure hampers the development of expertise, both in the individual and in the profession in general, because promotion leads too quickly to leaving direct work with children and families. A more varied career path and a stronger voice for practitioners in management is needed. The review recommends the designation, in each local authority, of a Principal Child and Family Social Worker, who is still doing direct

work, to advise on enhancing practice skills. This role would take responsibility for relating the views of social workers to those whose decisions affect their work.

15   The College of Social Work, which is being created on the recommendation of the SWTF, will play a major role in helping the profession build its knowledge and expertise. The review also considers that social work must have greater visibility and voice within Government. It is recommending the establishment of a Chief Social Worker, whose duties should include advising Government on social work practice and the effectiveness of help offered to children and young people.

Clarifying accountabilities and creating a learning system

16   A major challenge in building a more responsive child protection system is helping a wide range of professions to work together well in order to build an accurate understanding of what is happening in the child or young person's life, so the right help can be provided. Clear lines of accountability, and roles such as the Director of Children's Services and designated and named persons, are vitally important.

17   This review recommends that there continues to be clear lines of accountability as the Coalition Government's plans for reform in the public services are implemented. In particular, the review recommends that local authorities give due consideration to protecting the discrete roles and responsibilities of a Director of Children's Services and Lead Member for Children's Services before allocating any additional functions to individuals occupying such roles, asking whether alternative approaches allow sufficient focus and attention to be paid to the nation's most vulnerable children.

18   In moving to a system that promotes the exercise of professional judgment, local multi-agency systems will need to be better at monitoring, learning and adapting their practice. This review recommends regular review of cases becomes the norm and that the 'systems approach' used in the health sector is adopted and applied, in particular, to Serious Case Reviews. This will enable deeper learning to overcome obstacles to good practice.

19   Data on performance are an essential source of information for both managers and inspectors. The review sets out how local government and their partners should use a combination of nationally and locally collected performance information to help benchmark performance, facilitate improvement and promote accountability. Performance information should not be treated as a straightforward measure of good or bad practice but interrogated to see what lies behind it. A low number of children being removed from their birth families, for example, can arise from skilled help making the children safe or from a poor quality assessment of risk.

Implementation

20   In responding to this review, the Government should provide clarity around roles, responsibilities and accountabilities, and set out what goals the system should aim for, leaving professionals to judge how best to meet those goals. In the past, problems have too often led to more central prescription, culminating in the current over-proceduralised system. This review proposes an alternative view: that the system is complex and it is not possible to predict or control it with precision.

Feedback is the important mechanism for monitoring how the system is working, so that problems are seen early and efforts are made to resolve them.

21   The recommendations in this review are geared towards creating a better balance between essential rules, principles, and professional expertise. Helping children is a human process. When the bureaucratic aspects of work become too dominant, the heart of the work is lost. The recommendations are to be considered *together*, and the review cautions strongly against cherry picking some of the reforms to implement. Reducing prescription without creating a learning system will not secure the desired improvements in the system. On the other hand, delaying the reduction of prescription until services show they can take responsibility prevents them from demonstrating it. The review also cautions against taking a short-term approach to reform – the depth of change recommended in this report means it will take time for the necessary knowledge and skills to be developed and for experiences of new ways of working to accumulate to the point where they can be fully effective. Taken together, these reforms will redress the balance between prescription and the exercise of judgment so that those working in child protection are able to stay child-centred.

Summary of recommendations

Chapter three: A system that values professional expertise

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

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

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

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

Recommendation 4: Local authorities and their partners should use a combination of nationally collected and locally published performance information to help benchmark performance, facilitate improvement and promote accountability. It is crucial that performance information is not treated as an unambiguous measure of good or bad performance as performance indicators tend to be.

Chapter four: Clarifying accountabilities and improving learning

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

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

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

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

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

- provide accredited, skilled and independent reviewers to jointly work with LSCBs on each SCR;
- promote the development of a variety of systems-based methodologies to learn from practice;
- initiate the development of a typology of the problems that contribute to adverse outcomes to facilitate national learning; and
- disseminate learning nationally to improve practice and inform the work of the Chief Social Worker (see chapter seven).

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

Chapter 5: Sharing responsibility for the provision of early help

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

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

Chapter 6: Developing social work expertise

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

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

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

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

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

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

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

Chapter one: Introduction

1.1 Determining how to improve the child protection system is a difficult task as the system is inherently complex. The problems faced by children are complicated and the cost of failure high. Abuse and neglect can present in ambiguous ways and concerns about a child's safety or development can arise from myriad signs and symptoms. Future predictions about abusive behaviours are necessarily fallible. The number of professions and agencies who have some role in identifying and responding to abuse and neglect means the coordination and communication between them is crucial to success.

1.2 This complexity has influenced the way the review has been conducted. The first report, *Part One: A Systems Analysi*s[1], sought to analyse and understand why previous reforms had failed to achieve their goals and had, in some ways, contributed to the creation of new problems. The second, *Part Two: The Child's Journey*[2], aimed to set out the characteristics of an effective child protection system. This third report presents recommendations for reform. It is written to be free-standing. It includes key points from the earlier reports though, where appropriate, the reader will be referred to those reports for a more detailed account of specific topics.

1.3 This introductory chapter summarises the factors that have contributed to the current problems in practice. Chapter two describes the principles that should underpin an effective child protection system that keeps children's best interests at its heart. Chapter three makes recommendations on revising statutory guidance to give professionals more scope for exercising their expertise and to enable inspection of children's services to concentrate on the effectiveness of help being provided, rather than compliance with procedures. Chapter four details the leadership and accountability framework currently in place to promote interagency working and whole-system learning. It uses evidence collected by the review to propose changes to current arrangements in order to build a system better able to learn and adapt.

1.4 The second half of the report focuses on service provision and the quality of the help children and families receive. Support services play a crucial role in the child protection system in offering help to children and families either before problems develop or when there are low level problems, thereby reducing the risk of escalation. Chapter five draws on research and other current reviews and argues that these support services can do more to prevent abuse and neglect or reduce its severity than services provided only when abuse and/or neglect has become severe. Therefore a decisive step is now needed to develop the provision of

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1 Munro, E. (2010), *Part One: A System's Analysis*, London, Department for Education (available online at http://www.education.gov.uk/munroreview/)

2 Munro, E. (2011), *The Munro Review of Child Protection Interim Report: The Child's Journey*, London, Department for Education (available online at (http://www.education.gov.uk/munroreview/)

support services in each locality. Chapter six focuses on social work practice and builds on the work of the Social Work Task Force and Social Work Reform Board, setting out plans to improve radically the expertise of social workers. The organisational and national support needed to help social workers develop their knowledge and skills, make critical use of research, and monitor the effectiveness of help is outlined in chapter seven.

1.5   There have been determined efforts to improve the child protection system over many decades. The reforms made have been well-informed and substantial progress has been made. Despite this, the problems revealed in inquiries and Serious Case Reviews (SCRs) into child deaths and serious injuries are of a repetitive nature[3]. The cumulative impact of reforms has contributed to a heavily bureaucratised, process-driven system that frontline professionals experience as creating obstacles to the timely and effective provision of help to children and families[4,5]. To understand better why reforms have not always had the intended effect, the review has undertaken a systems analysis[6]. Before making further recommendations for reform, systems thinking has helped the review form a deeper understanding not only of *what* has been going wrong but *why* the system has evolved this way.

1.6   The review has also drawn on the lessons learned from other high risk areas of work such as healthcare and aviation[7]. These sectors share a similar history to child protection of mistakes and tragic outcomes leading to reform efforts that not only produced a disappointing level of improvement but also created new complications. By looking at the wider context in which professionals work, these industries have developed new methods of understanding what contributes to the quality of performance. These lessons are now leading to more effective reforms that raise the quality of work.

1.7   The review's first report identified four major drivers of developments in child protection in recent times:

- the importance that members of the public attach to children and young people's safety and welfare and, consequently, the strength of reaction when a child is killed or suffers serious harm;
- the sometimes limited understanding amongst the public and policy makers of the unavoidable degree of uncertainty involved in making child protection decisions, and the impossibility of eradicating that uncertainty;

3   Department of Health & Social Security, (1982), *Child Abuse: A Study of Inquiry Reports,* London, HMSO; Reder, P. & Duncan, S. (1999), *Lost Innocents; A follow-up study of fatal child abuse*, London, Routledge; Brandon, M., et al. (2010), *Building on the learning from Serious Case Reviews: a two year analysis of child protection database notifications 2007 – 2009*, London, Department for Education (available online at https://www.education.gov.uk/publications/standard/publicationdetail/page1/DFE-RR040)

4   The Social Work Task Force, (2010), *Building a safe, confident future – The final report of the Social Work Task Force*, London, Department for Education. (available online at https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-01114-2009)

5   The Lord Laming, (2009), *The Protection of Children in England: A Progress Report*, London, The Stationery Office. (available online at https://www.education.gov.uk/publications/standard/publicationdetail/page1/HC%20330).

6   Forrester, J.W. (1968), *Principles of Systems*, Cambridge, Mass Wright-Allen Press.

7   Woods, D. et al. (2010), *Behind Human Error*, 2nd Edition, Farnham, Ashgate; Vincent, C. (2006), *Patient Safety*. Edinburgh, Elsevier.

- the tendency of the analyses of inquiries into child abuse deaths to invoke human error too readily, rather than taking a broader view when drawing lessons. This has led to recommendations that focus on prescribing what professionals should do without examining well enough the obstacles to doing so; and
- the demands of the audit and inspection system for transparency and accountability that has contributed to undue weight being given to readily measured aspects of practice.

These four drivers have led to reforms and developments in the system that have some value but have had the unintended, cumulative effect of creating obstacles to good practice.

1.8 The first major driver, the importance of children and young people's safety and welfare, is manifested in the development of a human rights instrument specifically for children and young people, and its ratification by all but two of the United Nations' member states. The United Nations Convention on the Rights of the Child (CRC) provides a child-centred framework within which services to children are located. It spells out the basic human rights that all children have, including '*the right to survival; to develop to the fullest; to protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life*'[8]. The four core principles of the Convention are: non-discrimination; devotion to the best interests of the child; the right to life, survival and development; and respect for the views of the child. The Children's Rights Director has reported that children themselves rank protection from abuse first among all children's rights[9]. The vision of children implicit in the CRC and in the Children Act 1989 is that they are neither the property of their parents nor are they helpless objects of charity. Children are individuals, members of a family and a community, with rights and responsibilities appropriate to their age and stage of development. This point was expressed very vividly by Baroness Butler-Sloss: '*the child is a person not an object of concern*'[10].

1.9 In England, the responsibility to care for and protect children and young people rests primarily with their parents. However, there is a recognised need for State involvement to protect children and young people from all forms of abuse or neglect and to support them where necessary. This involvement should not be limited to just reactive responses; as the CRC makes clear, the child's right to protection from maltreatment places a duty on the State not just to react to incidents of maltreatment but to put in place measures to reduce their incidence in the first place. Article 19 of the CRC [11] sets out that:

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8 The United Nations, (1989), *The United Nations Convention on the Rights of the Child* (available online at http://www2.ohchr.org/english/law/crc.htm)
9 Children's Rights Director, (2010), *Children on Rights and Responsibilities,* London, Ofsted.
10 Cm 412, (1988), *Report of the Inquiry into Child Abuse in Cleveland 1987,* London, HMSO.
11 For more detail see General Comment No. 13, (2011), *Article 19: The right of the child to freedom from all forms of violence*, New York, United Nations (available online at http://www2.ohchr.org/english/bodies/crc/docs/CRC.C.GC.13_en.pdf)

'1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

'2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.'

1.10 The importance of children and young people's safety and welfare to the public is apparent in the strength of the protective feelings most adults have, as evidenced by the intensity of their reactions when a child dies. These protective feelings strengthen society's motivation to provide a good child protection service, so that children get the help they need. However, these protective feelings are a double-edged sword. Whilst child protection almost always attracts the general public's attention following a high profile serious incident, the intensity of that reaction places enormous pressure on Government and professionals to act and act quickly in order to improve practice. This has meant that the majority of reform to the child protection system over the past forty years has taken place in the midst of a clamour for change. This review is unusual in that it is being conducted in a less emotionally charged atmosphere.

1.11 Mistakes in assessing risk can be either of under-estimating (false negative) or over-estimating (false positive) the danger to the child. With hindsight, it can be deemed that the child was left in an unsafe home or was removed without sufficient cause. The former kind of mistake is more easily seen so there is more pressure in general to avoid false negatives than false positives. However, there seems a predictable rhythm to society's pressure. Fluctuations in public attitudes to removing children from their birth families are linked to major media coverage of mistakes. As discussed in detail in the first report, data confirm that a shift in public attitudes influences the anxiety that child protection professionals experience when trying to avoid false negatives when dealing with a difficult case[12]. However, people also react strongly when they see families being broken up by what they see as over-zealous professionals. Whenever it is perceived that large numbers of children are being removed from their birth parents, anxiety grows that too many families are being torn apart and professionals are getting too powerful, leading to push in the other direction.

1.12 This links to the second major driver of change: trying to manage the uncertainty inherent in the work. Child protection work is intrinsically difficult because uncertainty occurs in two main stages of work. First, abuse and neglect often occur (although not exclusively) in the privacy of the family home so they are not readily identified. In most circumstances, parents are trusted to act in their children's best interests. The State plays a major role in providing services that help them to raise

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12   Stanley, N. & Manthorpe, J. (eds.) (2004), *The age of inquiry: learning and blaming in health and social care*, London, Routledge; Lonne, B., Parton, N., Thomson, J. & Harries, M. (2009), *Reforming Child Protection*, London, Routledge.

their children well, for example, health, education, housing, and income maintenance. A high value is attached to the autonomy and privacy of family life; the 'nanny State' is a derogatory term. Monitoring of children's safety and development, especially in the early years, is therefore largely reliant on the cooperation of parents in, for example, attending health check-ups. This means that when a child is suffering or likely to suffer abuse or neglect in the home, it can be concealed. Even if the symptoms of abuse and neglect are visible, these may not always be identified as such by those who see the child, whether family, neighbours or professionals, because the signs and symptoms are often ambiguous and a benign explanation is possible.

1.13   The second stage at which uncertainty arises is when making predictions about children's future safety. The big problem for society (and consequently for professionals) is establishing a realistic expectation of professionals' ability to predict the future and manage risk of harm to children and young people. Even when it is ascertained that abuse or neglect has occurred, there are difficult decisions to make about whether the parents can be helped to keep children safe from harm or whether the child needs to be removed. Such decisions involve making predictions about likely future harm and so are fallible. It may be judged highly unlikely that the child will be re-abused but low probability events happen. This does not in itself indicate flaws in the professional reasoning. The ideal would be if risk management could eradicate risk but this is not possible; it can only try to reduce the probability of harm.

1.14   It is important to be aware how much hindsight distorts our judgment about the predictability of an adverse outcome. Once we know that the outcome was tragic, we look backwards from it and it seems clear which assessments or actions were critical in leading to that outcome. It is then easy to say in amazement 'how could they not have seen x?' or 'how could they not have realised that x would lead to y?' Even when we know the evidence on the hindsight bias, it is difficult to shift it; we still look back and over-estimate how visible the signs of danger were. The hindsight bias:

> *'oversimplifies or trivialises the situation confronting the practitioners and masks the processes affecting practitioner behaviour before-the-fact. Hindsight bias blocks our ability to see the deeper story of systematic factors that predictably shape human performance'* [13].

1.15   The hindsight bias problem relates to the third driver of system change: the tendency of inquiries to consider human error as a good enough explanation. Hindsight bias has influenced the authors of many of the SCRs conducted when children, known to services, die or are seriously injured. The most frequent conclusions are that the faulty practice is due to human error: with hindsight it looks as if, for example, the teacher or social worker 'should have' been able to see the danger to the child and ought to have acted differently. In this respect, child protection has followed the pattern of other inquiries in high risk areas of work in concluding that human error was the problem. There is, indeed, a common pattern

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13   Woods, D. et al. (2010), *Behind Human Error*, 2nd Edition, pp15, Farnham, Ashgate.

across different areas of work of about 70–80 per cent of inquiries concluding that human error was a significant cause[14].

1.16   When it is concluded that human error is a significant causal factor, the customary, and understandable, solution has been to find ways of controlling people so that they do not make these mistakes. The three main mechanisms are: psychological pressure on professionals to try harder; reducing the scope for individual judgment by adding procedures and rules; and increasing the level of monitoring to ensure compliance with them. This has been the repeated response in child protection. Each inquiry adds a few more rules to the book, increases the pressure on staff to comply with procedures, and strengthens the mechanisms for monitoring and inspecting practice so that non-compliance can be detected[15]. Over the years, a combination of national and local reforms and initiatives has led to the heavily-bureaucratised system that was analysed in the first report of this review. Each addition *in isolation* makes sense but the cumulative effect is to create a work environment full of obstacles to keeping a clear focus on meeting the needs of children.

1.17   In the alternative systems approach now being developed in healthcare, when human error is found it is treated as the starting point, not the conclusion of inquiry. There is recognition of the need to gain a better understanding of the nature of practice to inform recommendations for reform and identify:

> *'How systematic features of people's environment can reasonably (and predictably) trigger particular actions; actions that make sense given the situation that helped bring them forth … When you go behind the label 'human error', you see people and organizations trying to cope with complexity, continually adapting, evolving along with the changing nature of risk in their operations. Such coping with complexity is not easy to see when we make only brief forays into intricate worlds of practice'*[16].

1.18   The fourth driver of reform in child protection has been the increased demand for transparency and accountability required by the new managerialist approach to public services, introduced in the 1980s[17]. This sought to bring the efficiencies of the market system into the public sector by introducing a number of strategies including targets, performance indicators and a purchaser-provider split.

1.19   The original form of audit was face-to-face; the auditor listened to an account of how work had been done. But pressures of cost and time have led to audit now being primarily an indirect check, focusing on scrutinising organisations' internal systems of control rather than making a direct examination of practice itself[18].

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14   Boeing Product Safety Organization, (1993), *Statistical summary of commercial jet aircraft accidents; worldwide operations, 1959–1992*, Seattle, WA7 Boeing Commercial Airplanes; Cooper, J., Newbower, R., et al. (1984), 'An analysis of major errors and equipment failures in anesthesia management: Conditions for prevention and detection*', Anasthesiology*, 60, pp42– 43; Wright, D., Mackenzie, S., et al. (1991), 'Critical incidents in the intensive therapy unit', *Lancet*, 388, pp676– 678; Munro, E. (1999), 'Common errors of reasoning in child protection work', *Child Abuse and Neglect*, 23, pp745–58.

15   Rose, W. & Barnes, J. (2008), *Improving safeguarding practice. Study of serious case reviews 2001–2003,* London, Department for Children, Schools and Families (available online at https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-RR022)

16   Woods, D. et al. (2010), *Behind Human Error*, ppxix, Farnham, Ashgate.

17   Power, M. (1997), *The Audit Society: Rituals of Verification*, Oxford, Oxford University Press.

18   Power, M. (1997), *The Audit Society: Rituals of Verification,* Oxford, Oxford University Press.

Consequently, records of work have acquired a new dominance. The approach to management has assumed that the process can be divided into a series of tasks that can be sequentially completed and recorded[19]. Hence, in child protection work, flowcharts now map out the ideal management of a case. However, such an approach provides an incomplete account of the intricacies of working with children and families for the many professions involved in child protection. It undervalues the fact that the work is done *in a relationship* with children and family members so that the importance of continuity in human relationships is overlooked, causing considerable distress to children and parents. The assumption that records provide an adequate account of a helping profession has led to a distortion of the priorities of practice. The emotional dimensions and intellectual nuances of reasoning are undervalued in comparison with simple data about service processes such as time to complete a form.

1.20   A central tenet of managerialism is that workers are self-seeking and, in absence of the profit motive, this suggests that artificial incentives must be created to drive up attainment. Targets, performance indicators and assessments have therefore been constructed to motivate the workforce, failing to appreciate that, for most who work in the helping professions, altruism is a strong motive[20].

1.21   These four drivers have interacted in ways that lead to further problems. Concern with managing uncertainty has been affected by the level of public outcry when mistakes are made, so that there has been a shift towards defensive practice where a concern with protecting oneself or one's agency has competed, and sometimes overridden, a concern with protecting children. In this respect, the focus on process and recording needed by the audit system has offered a tempting solution. As identified in the first review report, if it is generally agreed that 'good' practice equals following procedures and keeping records well, then these are all tasks within the control of managers. From a management perspective, a concentration on auditing increasingly prescribed procedures offers a way of defending the organisation and fending off criticism. But the availability of the 'correct procedures were followed' defence is a siren call[21]. It seems to hold out security but actually creates a feedback loop that reinforces the defensive routine based on a procedural perspective which hampers professional learning[22]. From the perspective of the front line, this has contributed to many feeling that they are working in a compliance culture where meeting performance management demands becomes the dominant focus rather than meeting the needs of children and their families. When these conflict, even the most dedicated child-centred professionals can feel pressured to prioritise the performance demand over the child's needs.

19   Ayre, P. & Preston-Shoot, M. (eds.) (2010), *Children's Services at the Crossroads: A Critical Evaluation of Contemporary Policy for Practice,* Lyme Regis, Russell House Publishing.

20   Chard, A. & Ayre, P. (2010), 'Managerialism – At the Tipping Point?', in *Children's Services at the Crossroads: A Critical Evaluation of Contemporary Policy for Practice*, eds. Ayre, P. & Preston-Shoot, M., pp95–107, Lyme Regis, Russell House Publishing.

21   Munro, E. (2010), *Part One: A Systems Analysis*, London, Department for Education, Appendix 2 (available online at http://www.education.gov.uk/munroreview/)

22   Argyris, C. & Schön, D. (1978), *Organizational Learning: A theory of action perspective*, Reading, MA, Addison-Wesley.

1.22 It is important to remember that causation is complex. The factors identified here push but do not compel organisations to move in a particular direction. The comments above on how the system has altered apply at a general level. At a local level, there is considerable variation in the ways in which agencies have responded to external messages, with some developing strategies that counter some of the pressure. However, many have commented on how this is despite, not because of, the wider system.

1.23 The review has a particular remit to make recommendations to strengthen the social work profession. The current priorities in practice have come together to create work conditions that are not conducive to developing the profession's knowledge and skills in helping children. Some of the immediate and/or proximal effects of increased prescription of child and family social work activity have undoubtedly been beneficial. However, as part of the review, systems analysis was used to consider the 'ripple effects' of these policies as they diffused through the system via longer, more complex chains of causality. This analysis explored the unintended consequences of increased proceduralisation leading to reduced time with children and families, less job satisfaction, and higher turnover of staff (see Appendix A for a full account).

1.24 The influences on the system identified here are individually understandable and reasonable elements in any child protection system. We should expect the public to be upset by children's suffering; it is valid to have some rules and procedures; and it is reasonable to expect public services to show how well they are using public money. The problem lies in how they interact to drive practice in the wrong direction. This has occurred over a long period, with small, incremental changes that have slowly moved the primary focus away from helping children. For example, in 2009, the public were amazed to hear that some social workers were spending up to 80 per cent of their time on paperwork but this had developed gradually making it hard for those involved to notice[23].

1.25 This review aims to recommend reforms that will modify each factor so that the cumulative impact will be to set the system moving in a more constructive direction. This review makes an assumption about the nature of causality that differs from the assumption that appears to have underpinned many previous reforms. It is assumed that the causal links are complex so that as a directive from central Government is transmitted, it interacts, often in surprising ways, with local factors so that the end result may be far from what was intended. Previous reforms have tended to assume that the unintended consequences mean that the system needs more control and central directives and this has contributed to the over-bureaucratised system we now have. The alternative view is to recognise that this will happen and the need is to monitor and notice emerging problems. A secondary aim of the review, based on the assumption that unintended consequences will arise from any new reforms, is therefore to establish better monitoring of how the system is working so that emerging problems can be more readily identified and dealt with in future.

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23   White, S., Wastell, D., Broadhurst, K. & Hall, C. (2010), 'When policy o'erleaps itself: The 'tragic tale' of the Integrated Children's System', *Critical Social Policy*, 30, pp405–429.

1.26   The complexity of causality also underpins the review's conclusions that the Government should, for the most part, establish the goals the system should aim at, providing clarity around roles, responsibilities, values and accountabilities, but allowing professionals greater flexibility and autonomy to judge *how* best to achieve these goals and protect children and young people.

1.27   This resonates with the Coalition Government's policy on localism. The State's responsibility to protect children and young people means the Government must continue to provide a clear legal and regulatory framework and set out what vulnerable children and young people and their families should expect from the collective efforts of local agencies. There is a need to strip away much of the top-down bureaucracy that previous reforms have put in the way of frontline services. Giving professionals greater opportunity for responsible innovation and space for professional judgment is fundamental if the child protection system is to realise the improvements that have been lacking following previous reforms.

1.28   The protection of children presents unique challenges for Government. All children are vulnerable to some extent by virtue of their age, immaturity and dependence on adults. The voices of adults are often heard over those of children as they make known their views to professionals. Children, unlike adults, cannot influence policy via the ballot box. In most circumstances, their parents can be relied on to speak for them if necessary but this does not apply when the parents are the source of the child's problems. It is important a statutory framework remains in place for making what can be unparalleled life-changing decisions about children's safety and removal from their birth families.

1.29   The recommendations in this report will not solve all the complex problems inherent to child protection. Neither will all the changes and improvements it recommends take effect immediately. The Government and the sector will need to work together to realise the opportunities set out in this report. It will also be important that the Government commissions a research programme to examine the extent to which the changes are being implemented, any barriers to implementation and whether the reforms are having the desired impact on improving outcomes for children and on the workforce.

1.30   It must not be forgotten that the English child protection system has made enormous strides over the past couple of decades, in terms of our knowledge of effective interventions and in embedding the framework for multi-agency working. Far from dwelling on the negative aspects of the current system, this report applauds the good and innovative practice taking place in some areas of the country. It seeks to harness and build upon these advances in the ways outlined above to provide children and young people with the best help and protection possible.

Chapter two: The principles of an effective child protection system

It is important to explain the principles of a good child protection system that underpin the review's recommendations for reform.

1. **The system should be child-centred:** everyone involved in child protection should pursue child-centred working and recognise children and young people as individuals with rights, including their right to participation in decisions about them in line with their age and maturity.

2. **The family is usually the best place for bringing up children and young people**, but difficult judgments are sometimes needed in balancing the right of a child to be with their birth family with their right to protection from abuse and neglect.

3. **Helping children and families involves working with them** and therefore the quality of the relationship between the child and family and professionals directly impacts on the effectiveness of help given.

4. **Early help is better for children:** it minimises the period of adverse experiences and improves outcomes for children.

5. **Children's needs and circumstances are varied so the system needs to offer equal variety in its response.**

6. **Good professional practice is informed by knowledge of the latest theory and research.**

7. **Uncertainty and risk are features of child protection work:** risk management can only reduce risks, not eliminate them.

8. **The measure of the success of child protection systems, both local and national, is whether children are receiving effective help.**

The system should be child-centred

2.1   The child protection system should be child-centred[24], recognising children and young people as individuals with rights, including their right to participate in major decisions about them in line with their age and maturity. Although a focus of work is often on helping parents with their problems, it is important to keep assessing whether this is leading to sufficient improvement in the capacity of the parents to respond to each of their children's needs. This, at times, requires difficult judgments about whether the parents can change quickly enough to meet the child's developmental needs.[25]

Communication with children

2.2   The UK Government's ratification of the United Nations Convention on the Rights of the Child (CRC) in 1991 recognised children's rights to expression and to receiving information. In relation to all children's right to express and have their views given due weight, Article 12 of the Convention grants that:

> *'(1) States parties shall assure to the child who is capable of forming his or her own views, the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with age and maturity of the child.'*

2.3   This right is reinforced by Article 10 of the Human Rights Act 1998 and the Children Act 1989, which requires a local authority to ascertain the 'wishes and feelings' of children and give due consideration (with regard to the child's age and understanding) to these when determining what services to provide, or what action to take.

2.4   Evidence provided by children to this review gives a mixed picture of what they experience in practice, but it also conveys how much positive impact professionals can have when they find time to spend with the children they are helping and keeping a clear focus on their needs. The cover of this report displays the key qualities that children and young people involved with this review said they wanted in the professionals who entered their lives. They emphasise the importance of reliability, honesty, and continuity.

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24   See also paragraph 5.5, first bullet point of HM Government, (2010), *Working Together to Safeguard Children,* London, Department for Children, Schools and Families and paragraphs 1.34 – 1.35 of the Department of Health, Department for Education and Employment and the Home Office, (2000) *Framework for the Assessment of Children in Need and their Families*, London, The Stationery Office.

25   Farmer, E. & Lutman, E. (2009), *Case Management and Outcomes for Neglected Children Returned to their Parents: a five year follow up study,* London, Department of Children, Schools and Families, Research Report (available online at https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-RB214); Wade, J., Biehal, N., Farrelly, N. & Sinclair, I. (2010), *Maltreated Children In The Looked After System: A Comparison Of Outcomes For Those Who Go Home And Those Who Do Not,* London, Department for Education, Research Report (available online at: https://www.education.gov.uk/publications/standard/publicationDetail/Page1/DFE-RBX-10-06); Ward, H., Brown, R., Westlake, D. & Munro, E.R. (2010), *Infants Suffering, or Likely to Suffer, Significant Harm: a prospective longitudinal study,* London, Department for Education, Research Report (available online at https://www.education.gov.uk/publications/RSG/AllPublications/Page1/DFE-RB053)

2.5 Children and young people are a key source of information about their lives and the impact any problems are having on them in the specific culture and values of their family.[26] It is therefore puzzling that the evidence shows that children are not being adequately included in child protection work. A persistent criticism in reports of inquiries and reviews into child deaths is that people did not speak to the children enough. A recent report by Ofsted[27] on the themes and lessons to be learned from Serious Case Reviews between 1 April and 30 September 2010, highlights five main messages with respect to the participation of children:

- the child was not seen frequently enough by the professionals involved, or was not asked about their views and feelings;
- agencies did not listen to adults who tried to speak on behalf of the child and who had important information to contribute;
- parents and carers prevented professionals from seeing and listening to the child;
- practitioners focused too much on the needs of the parents, especially on vulnerable parents, and overlooked the implications for the child; and
- agencies did not interpret their findings well enough to protect the child.

2.6 Many of these findings confirm the views children have expressed in research papers and the review's consultation events. They have said they value an ongoing relationship with their worker, that their needs and rights to protection should be at the heart of practice, that they should have a voice, and be listened to.

2.7 Participation can be empowering if undertaken well. However, practitioners may feel ill-equipped to communicate with children and involve them at every stage of the child protection process. Jones[28] lists the core skills required for effective communication with children. These include listening, being able to convey genuine interest, empathic concern, understanding, emotional warmth, respect for the child, and the capacity to reflect and to manage emotions. He stresses the importance of these skills in seeking to communicate with children who have suffered adverse experiences:

26 Willow, C. (2009), 'Putting Children and Their Rights at the Heart of the Safeguarding Process', in *Safeguarding Children. A Shared Responsibility,* Cleaver, H., Cawson P, Gorin S, et al., pp13–37, Chichester, Wiley -Blackwell; Jones, D.P.H. (2003), *Communicating with Vulnerable Children. A Guide for Practitioners, London,* Gaskell; Aldgate, J. & Seden, J. (2006), 'Direct Work with Children' in *The Developing World of the Child,* (eds.) Aldgate, J., Jones, D., Rose W,, et al., pp229–242, London, Jessica Kingsley Publishers; Cleaver, H., Unell, I. & Aldgate, J. (in press), *Children's Needs – Parenting Capacity. Child Abuse: Parental Mental Illness, Learning Disability, Substance Misuse, and Domestic Violence* (2nd edition), London, The Stationery Office; Hicks, L. & Stein, M. (2010), *Neglect Matters: a Multi-agency Guide for professionals working together on behalf of teenagers,* London, Department for Children, Schools and Families (available online at https://www.education.gov.uk/publications/standard/Integratedworking/Page1/DCSF-00247-2010)

27 Ofsted, (2010), *The voice of the child: learning lessons from Serious Case Reviews. A thematic report of Ofsted's evaluation of Serious Case Reviews from 1 April to 30 September 2010* (available online at: http://www.ofsted.gov.uk/content/download/12180/141321/file/The%20voice%20of%20the%20child.pdf)

28 Jones, D.P.H. (2003), *Communicating with Vulnerable Children. A Guide for Practitioners London,* Gaskell; Oates R. K., Jones D. P. H., Denson D., et al. (2000) 'Erroneous concerns about child sexual abuse', *Child Abuse and Neglect*, 24, pp149–157.

> *'…good communication skills on the part of the professional are desperately needed by children who have been victimised, in order to allow them to impart any information or express their concerns. Equally the potential consequences of poorly developed professional skills are serious for such children, as they can lead to erroneous accounts and distortions of children's memories (Oates et al 2000). Inadequate skill levels are liable to produce not only errors of commission (false positives of abuse or maltreatment of children) but also errors of omission (in which a compromised child may be left unheard and unprotected). The consequences can be serious, psychologically, emotionally and legally.'*

2.8   Research[29] has shown that practitioners have strong personal views about the age at which children should be consulted and as a result there is evidence of polarised attitudes which resonate with Trinder's[30] 1997 findings on children and divorce:

> *'What is remarkable, and frustrating, is how the adult constructions had become ensnared in … a simple …dichotomy, where children are classified as either subjects or objects, competent or incompetent, reliable or unreliable, harmed by decision-making or harmed by exclusion, wanting to participate or not wanting to participate. Practice then becomes founded upon certainties, the perfected (single) procedure, based on the single conception of the child.'*

She continues:

> *'… some children had very rational reasons for wanting to influence decisions, but others made a rational decision that they were better off acting like children by not participating in an adult decision, or choosing non-participation.'*

2.9   Messages from children on their experience of the child protection system were submitted to the review by the Office of the Children's Commissioner[31]. Children voiced the importance of being heard separately from their parents and being listened to. They expressed how confusing they had found the process of being helped, which, in their eyes, was far from transparent. They made a plea for better information, honesty, and emotional support throughout the process. Elements of frontline practice that children and young people particularly valued were: access to consistent help from the same worker; respectful treatment; and services which do not get withdrawn as soon as the crisis is passed. They also spoke very highly of the support provided by voluntary sector advocacy services which they describe as critical in helping them to disclose abuse and harm.

29   Shemmings, D. (2000), 'Professionals' attitudes to children's participation in decision making: dichotomous accounts and doctrinal contests', *Child and Family Social Work*, 5, pp235–243.

30   Trinder, L. (1997), 'Competing constructions of childhood: children's rights and wishes in divorce', *Journal of Social Welfare and Family Law*, 19, pp291–305.

31   Submission by the Office of the Children's Commissioner (2011) to the review.

2.10 Research by the Children's Rights Director for England gives valuable insight into the views and experiences of 50 children and young people who had recently come into care[32,33]. The overwhelming majority of children thought that, in retrospect, coming into care was the right thing for them and their lives were generally better than before. Their comments included:

> *'Being in care has given me a life': 'I have had a better life than I ever would have got at home with my family.'*

2.11 However, on the day children came into care they felt scared, sad and upset. The main thing that would have made the first day in care easier was a better understanding of what was happening to them and not being separated from their siblings. More than half the children had not known they were coming into care until it actually happened.

> *'Someone could have explained things so I could understand what was happening.'*

2.12 A quarter of the children expected to return home when things improved.

2.13 But one of the key messages from the children to the government was:

> *'Being in care can be OK, even a good experience if you have the right placement and a good social worker. I think the care system's main priority should be making sure both those things are OK.'*

2.14 Much of the research on children's experiences looks specifically at their contact with social workers. Recent research[34] commissioned by the Office of the Children's Commissioner continues to report that significant proportions of children are not seen alone by their social worker, have minimal relationships with them, rarely see or discuss their reports or assessments and do not know why critical decisions are taken about their future care.

2.15 The charts below are from a study conducted during a meeting with 150 children and young people, arranged by the Child Rights Director in support of this review[35]. The review heard about their contact with social workers and interactive voting technology was used to capture their views. The results to four of the questions can be seen below.
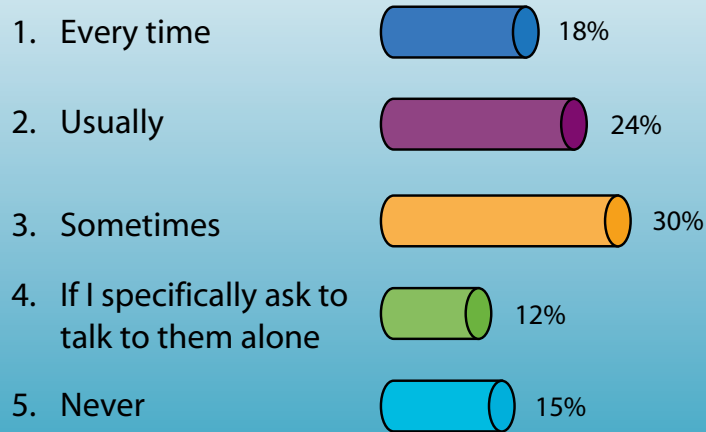
32 Ofsted, (2010), *Before Care – a report of children's views on entering care by the Children's Rights Director for England* (available online at http://www.ofsted.gov.uk/Ofsted-home/Publications-and-research/Browse-all-by/Care/Children-s-rights/Before-care

33 The review is using the colloquial but familiar term 'in care' rather than the statutory term 'looked after child'.

34 The Office of the Children's Commissioner, (2011), *Don't make assumptions – Children and young people's views of the child protection system and messages for change* (available online at http://www.childrenscommissioner.gov.uk/force_download.php?fp=%2Fclient_assets%2Fcp%2Fpublication%2F486%2FChildrens_and_young_peoples_views_of_the_child_protection_system_.pdf)

35 Office of the Children's Rights Director, (March 2011), *Consultation with children event.*

Does your social worker or caseworker talk with you alone, without anyone else listening to what you are saying?

1. Every time — 18%
2. Usually — 24%
3. Sometimes — 30%
4. If I specifically ask to talk to them alone — 12%
5. Never — 15%

How good is your social worker, or caseworker, at giving you information you need from them?

1. Very good — 16%
2. Fairly good — 16%
3. It varies — 19%
4. Fairly bad — 14%
5. Very bad — 35%
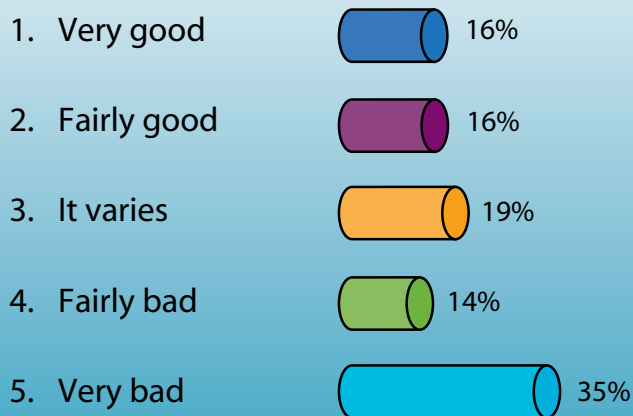
Does your social worker or caseworker take notice of your wishes and feelings?

1. Always — 14%
2. Nearly always — 10%
3. Sometimes — 27%
4. Not usually — 17%
5. Never — 33%
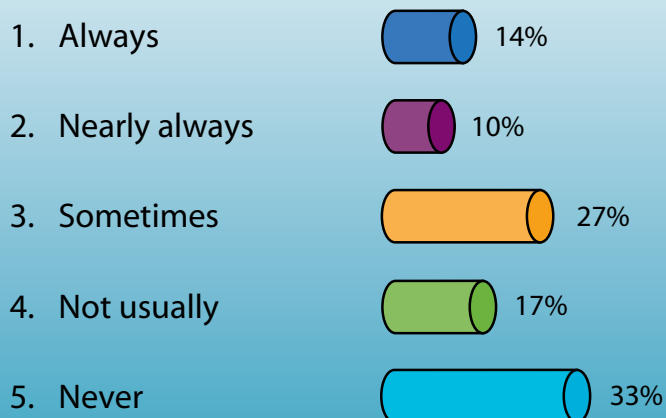
What would be good ways for professionals to find out your wishes and feelings?

You can press more than one button to answer this question. It is OK not to vote for any of them!

|		
1.	By asking you on the phone	40%
2.	By texting	40%
3.	By asking you to show your feelings by doing a drawing	19%
4.	By email	34%
5.	By meeting you face to face on your own	78%
6.	By meeting you face to face with someone else there to support you	38%
7.	By asking you to show your feelings through drama or acting	22%
8.	By asking you to write them down on paper	35%
9.	By asking you in a group of other children or young people	22%
10.	Some other way	20%

2.16 The responses to the final question shows how highly children value face-to-face contact with their social workers.

2.17 The following case study submitted to the review[36] shows one way of helping children communicate and also illustrates how getting close to children's experiences has a significant emotional impact on the worker as the children discuss deeply painful material.

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36   Submission by Andrew Turnell, Signs of Safety and Resolutions Consultancy, Australia to the review.

The Three Houses

The Three Houses tool for interviewing children was first created by Nicki Weld and colleagues in New Zealand[37] and further refined and developed through the efforts of many international practitioners[38]. This tool focuses on interviewing children through their own words and drawings focused on a 'house of worries', 'house of good things' and 'house of dreams'.

House of Worries   House of Good Things   House of Dreams
The Three Houses
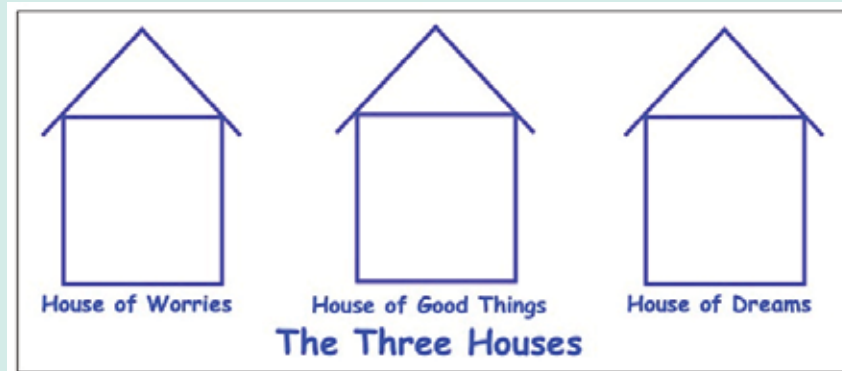
Example

A child protection worker had to investigate a domestic violence case involving a mother, her boyfriend and children 'Ramon' (10 years) and 'Stephanie' (7 years). The children had been interviewed twice previously but were very withdrawn, giving very little information. Knowing she needed to do something different, the worker conducted the third interview using the three houses tool.

After the children drew house outlines on three separate blank sheets, she gave the children the choice of which house they would start with. They began by together drawing cold and drafty stables where the boyfriend would often lock them at night together with his aggressive black dog. As the children drew, the worker would write their exact explanations alongside the drawings.

Next the children drew the following in the house of worries:

- Ramon kicking and yelling at the boyfriend – this had never actually happened but it was obvious to the worker that it was important to let Ramon draw this picture;
- on the roof Stephanie drew her mother crying in distress;

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37   Weld, N. (2008). 'The three houses tool: building safety and positive change' in *Contemporary risk assessment in safeguarding children,* (ed.) Calder, M., Lyme Regis, Russell House Publishing.

38   Turnell, A. (2009), *Of houses, wizards and fairies: involving children in child protection casework*, Perth, Resolutions Consultancy.

- in the roof space Ramon drew his bedroom which he said he hated including a broken window that made the room cold. Stephanie described that she didn't have a bedroom since the boyfriend moved in but had her bed in a corridor;
  - a picture of the boyfriend yelling at the children for not finishing a meal; and
  - a fork, which he used to stab them if they did not eat their meals. (Ramon showed the worker healing scars on his hand consistent with the tines of a fork.)

The children then went on to create their house of good things drawing their experience of visiting their father, and then on separate sheets of paper drew separate houses of dreams. Though Stephanie's house of dreams was more colourful both showed them living with their mother, the boyfriend gone, each house protected by strong doors and guard dogs and them having good food, nice clothes and activities and their own rooms.

With the children's permission, the worker showed the mother the children's drawings, which led the mother for the first time to admit the problems at home. The mother made commitments to leave the boyfriend but unfortunately was not able to and the children were brought into care. Nine months later when the mother was able to separate she came immediately back to the worker to work to get her children back.

Relationships with children

2.18 A clear message from children (and their parents) is that they value continuity in their relationships[39]. To talk openly about personal and often painful problems requires a degree of trust in the professional and changes of worker mean that that trust has to be re-developed with someone new. This reinforces the point made in the review's first report that helping children and families to change requires working *with* them not doing things to them.

2.19 For some children, there is also a problem of the bewilderingly large number of people who get involved in their case. The following case study from the independent organisation Triangle highlights this and illustrates how, if the child's point of view is given more attention, radical changes in the way services are provided might be needed.

Case Study

Lianne was accommodated by her local authority at the age of four, because of severe neglect. She was initially described as passive and unresponsive, and her development was very delayed but then she began to show sexualised behaviour and her behaviour became increasingly challenging and disturbing. Lianne's needs were assessed by many different people, most of whom began from zero and repeated a number of the same assessment processes. Children like Lianne, whose ability to relate to others is already disrupted, often have to meet many people in unpredictable, unboundaried, uncoordinated ways.

Children who have not been able to develop a healthy early attachment with an adult are now known to be at high risk of a range of damaging neurological effects. Lianne was often hyper-aroused, which meant she was switched permanently to 'danger' mode, unable to regulate her own nervous system. This was contributing to her challenging behaviour and broken relationships. The discontinuity within the child protection system was adding to Lianne's difficulties.

New adults that Lianne met in her first six months in the care system:

Day to day involvement

1. Foster carer (first placement)
2. Foster carer (first placement)
3. Nursery teacher
4. Nursery assistant
5. Learning support assistant
6. Foster carer (second placement)
7. Foster carer (second placement)
8. Nursery teacher (second nursery)
9. Nursery assistant
10. Teacher (first infants school)

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39   Sadly, this message is not new. See for example Butler, I. & Williamson, H. (1994), *Children Speak: Children, Trauma and Social Work,* Essex, Longman; Schofield, G. & Thoburn, J. (1996), *Child Protection: The Voice of the Child in Decision-Making,* London, Institute for Public Policy Research.

11. Individual needs assistant
12. Second individual needs assistant given intensity of needs
13. Clinical psychology assistant looking at behaviour management
14. Lunchtime supervisor
15. Lunchtime supervisor
16. Special educational needs coordinator
17. Taxi driver
18. Taxi driver
19. Taxi escort
20. Replacement taxi escort as first one on long term sick leave
21. Contact supervisor
22. Contact supervisor
23. Additional contact supervisor

Ongoing involvement
24. Local authority social worker
25. Changed, reallocated social worker (reorganisation)
26. Fostering agency social worker
27. CAFCASS guardian now on maternity leave so
28. new CAFCASS guardian
29. Health visitor
30. GP
31. School liaison nurse
32. Consultant community paediatrician
33. Specialist paediatric neurologist
34. Consultant child and adolescent psychiatrist
35. Clinical psychologist
36. Mental health nurse
37. Looked-after children nurse
38. Independent reviewing officer
39. Speech and language therapist
40. Occupational therapist
41. Educational psychologist

Involvement during police investigation
42. Police officer in case
43. Interviewing police officer
44. Interviewing social worker (main social worker not ABE trained)
45. Registered intermediary
46. Monitoring police officer

2.20 As mentioned in the Preface, the review is working with a number of local authorities that are demonstrating the type of systemic learning and adaptation that the review wishes to encourage. They have identified problems in the existing way of working and, drawing on theory and research, have formulated ways of improving practice. The following case studies are examples from two of these 'journey authorities' of how they have redesigned their work to improve the continuity of relationship with children and families. These innovations are too new to produce evidence of impact yet.

Redesigning systems in Cumbria

Cumbria is aiming to deliver children's services in a radically different way through its 'Better for Children Project'. A review team, using a systems thinking approach, has analysed current systems and processes and their effectiveness in meeting the needs of children, young people and families.

In trying to centre any offer of help on the child, young person and family involved, they have developed some key questions that they ask, for every request for help. These include:

- did we get it right from the child and family's perspective first time?
- what was the length of time from first contact with the child or family to their actually receiving a service to help them?
- what was the number of professionals involved in the case?
- how often was the child or family passed from one professional or part of the system to another?

Bath and North East Somerset 'lean review'

In 2010 Bath and North East Somerset's (BANES) children's social care department embarked on a review of their social care system, including safeguarding services aimed at improving outcomes for children and young people.

At the start of the review, they developed these questions to focus on the child/young person's experience:

- how/where do I make the first contact?
- how easy will it be to make that first contact and how will I be received?
- will I be able to get across all the information I need to?
- what will happen next and how will I be informed and involved? (this question runs throughout the examination of all processes.)
- will somebody see me as a part of this?
- will I be given somebody's name and contact details?
- how and when will the help I need be provided?
- will I have a clear understanding of this? Will it be explained to me?

The family is usually the best place for bringing up children and young people

2.21 The CRC and the Children Act 1989 endorse the principle that the family is the best place for bringing up children and young people wherever possible and that the family is the prime source of protection. Indeed, while much abuse and neglect occurs in the family setting, children are also exposed to harm in the wider community, with school bullying being a major source of concern.

> *'The CRC requires the State to fully respect and support families. But families can be dangerous places for children and in particular for babies and young children … The CRC claims, on the one hand, children's right to individuality and to have their views on all matters which affect them taken seriously; and on the other, in the light of their developmental state and vulnerability, rights to special care and protection. The CRC makes clear that wherever possible children should be raised within their family; and where the family is unable to care for and protect them adequately, an alternative family-type environment should be provided. Therefore the CRC uncompromisingly asserts that the family is the primary site for children's healthy, loving and safe upbringing. However, this role must be fully underpinned and supported by the State, including by stepping over the family threshold to intervene when necessary, in the best interests of the child'*[40].

2.22   In a recent consultation held by the Children's Rights Director, children under-12 and living in care or away from home in residential education still put 'family' top of their list of the best things in life[41].

2.23   Family members may be in contact with a number of different agencies and professions and so effective working between them is critical. The association of parental problems, such as poor mental health, domestic violence, substance misuse, and learning disabilities with child abuse and neglect is well-established[42]. Adult services are therefore vital in recognising the possible impact that such problems may be having on children.

Helping children and families involves working with them

2.24   Relatively few children are removed permanently from their birth families and the main part of child protection work is helping parents provide better care. The work is informed by professional ethics, which include respect for culture, and a difficult combination of skills: being able to be authoritative and ask challenging questions about family life as well as engaging with parents in order to work with them to resolve their problems and improve their parenting capacity. Professionals can struggle with this. Some are so focused on supporting parents that they are insufficiently challenging of problematic parenting; others are so focused on checking that the child is safe that they enter an adversarial relationship with the parents. Sometimes the latter is unavoidable, however skilled the professional, but overall, successful engagement with the parents is a key contributor to effective helping[43].

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40 United Nations, (2006), *Study on Violence Against Children* (available online at http://www.unviolencestudy.org/)

41 Ofsted, (2011), *Younger children's views: A report of children's views by the Children's Rights Director for England* (available online at: https://www.rights4me.org/content/beheardreports/453/REPORT_Younger_children's_views.pdf)

42 Cleaver, H., Unell, I. & Aldgate, J. (in press), *Children's needs– parenting capacity: the impact of parental mental illness, learning disability, substance misuse and domestic violence on child abuse (*2nd edition*).* London, The Stationery Office.

43 Department of Health, (1995), *Child Protection: Messages from Research*, London, HMSO; Davies C. & Ward H. (in press), *Safeguarding Children Across Services: Messages from research on identifying and responding to child maltreatment,* London, Jessica Kingsley Publishers.

2.25   People sometimes raise the question of whether the 'right' number of children are being removed from their families but this cannot be answered without considering the effectiveness of help available to children and families. There is no one 'right' number but the more effective the help that can be given, the more likely it will be that children can stay safely with their birth family.

2.26   In relation to early help, both in the sense of early years and early in the emergence of problems, services are offered on a voluntary basis so children and families who use the services have some motivation to engage but it is more difficult when the problems are more serious and a child protection enquiry is required. The Family Rights Group submitted evidence[44] to the review that identifies many of the obstacles to engaging families:

- *'they are often unclear about the totality of the concerns and the reasons for them – they may be given information in a series of different conversations and/ or local authority social workers are often unclear themselves about the nature of the underlying problems that need to be addressed and at times may give contradictory views. This has been a particular difficulty in the climate of targets and time pressures, described so well in 'A Child's Journey';*
- *they are frightened, angry and confused which prevents them from hearing what is being said by the local authority, and they often don't know where to turn for advice;*
- *they often don't understand the processes and are overwhelmed by continuous assessments and meetings in which they are under the spot light of a large numbers of professionals;*
- *the fear that the child may be removed by the local authority makes it hard for them to trust and to work openly with social workers, to reach agreement about how their child should be kept safe; and*
- *the system doesn't support families to take responsibility; instead parents often feel decisions and actions are done 'to' rather than 'with' them, thus encouraging a sense of dependency and resentment. Practitioners need to be managed, supported and equipped to work with families in ways that are high in support and high in challenge.'*

Early help is better for children

2.27   The child protection system could be taken to refer specifically to the reactive service of identifying incidents of maltreatment and preventing their recurrence. However, as the CRC makes clear, the child's right to protection from maltreatment places a duty on the State not just to react to incidents of maltreatment but to provide support to children and families to reduce the incidence.

2.28   From a child or young person's point of view, the earlier help is received the better. Research on children's development emphasises the importance of the early years on their long-term outcomes so preventative services to help parents are a key strategy. Early help, however, is needed not just in the early years but throughout childhood as problems develop.

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44   Submission by the Family Rights Group to the review.

Children's needs and circumstances are varied so the system needs to offer equal variety in its response

2.29   As discussed in the review's first report, a system needs 'requisite variety' [45] to respond to the varied needs of children and young people. Evidence submitted to the review has made clear that many professionals describe themselves as working in an over-standardised framework that makes it difficult for them to tailor their responses to the specific circumstances of individual children. Yet children's needs and circumstances are very varied and this is not an area of work that can be reduced to a set response. Consequently, professional judgment needs to be exercised in determining how or whether to follow procedures and guidance in any specific case. This requires professionals to understand the rationale for procedures and guidance in order to use them intelligently.

2.30   Many examples were submitted to the review of how particular groups were not receiving services adequately adapted to their needs. For example, the case was made that timeliness of response had a different value when dealing with babies because the early years are so crucial for brain development and forming secure attachments[46]. Babies and young children are particularly vulnerable, and they are at increased risk of being maltreated when they are growing up in families affected by parental substance misuse, domestic violence and mental ill health[47]. Similarly, issues specific to adolescents and young people, such as self-harm, involvement with, or fear of, gang related violence, and sexual exploitation require appropriate consideration and tailored interventions[48] . The submission from the National Deaf Children's Society drew attention to the special communication needs of deaf children, referencing their guidance for social care practitioners[49]. The Fatherhood Institute pointed to the evidence on failure to engage fathers adequately[50].

45   Munro, E. (2010), *Part One: A System's Analysis*, London, Department for Education; Munro, E. (2011), *The Munro Review of Child Protection Interim Report: The Child's Journey*, London, Department for Education (available online at http://www.education.gov.uk/munroreview/); Ashby, R. (1956), *An Introduction to Cybernetics,* London, Chapman & Hall.

46   Glaser, D. (2000), 'Child Abuse and Neglect and the Brain – a review', *Journal of Child Psychology and Psychiatry*, 41:1, 97- 11; Perry, B. (2006), 'Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children. The Neurosequential Model of Therapeutics', in *Working with Traumatized Youth in Child Welfare, (ed)* Webb, N. New York, The Guilford Press (see www.childtrauma.org); Davies, C. and Ward, H. (2011), *Safeguarding Children Across Services: Messages from Research on identifying and responding to child maltreatment. Executive Summary*. London, Department for Education. Research Report.

47   Cleaver, H., Unell, I. & Aldgate, J. (1999), *Children's Needs: Parenting Capacity. The impact of parental mental illness, problem alcohol and drug use, and domestic violence on children's development*. London: The Stationery Office; Cleaver, H., Unell, I. and Aldgate, J. (in press) *Children's Needs – Parenting Capacity. Child Abuse: Parental mental illness, learning disability, substance misuse and domestic violence.* 2nd Edition*,* London, The Stationery Office.

48   Joint submission by the Children's Commissioner for England, Deputy Children's Commissioner for England, The Children's Society, Kids Company, Voice, Young Minds, University of East Anglia & University of Central Lancashire to the review; Hicks, L. & Stein, M. (2010), *Neglect Matters: a Multi-Agency Guide for professionals working together on behalf of teenagers,* London, Department for Children, Schools and Families (available online at https://www.education.gov.uk/publications/standard/Integratedworking/Page1/DCSF-00247-2010)

49   National Deaf Children's Society, (2011), *Social care for deaf children and young people: A guide to assessment and child protection investigations for social care practitioners (*available online at http://www.ndcs.org.uk/document.rm?id=5771)

50   Family Rights Group, (2011), *Working with risky fathers*, London, Family Rights Group.

Good professional practice is informed by knowledge of the latest theory and research

2.31 For all the professional groups involved in child protection, continuing professional development is important so that children and families can benefit from the use of best evidence. Therefore the system should be flexible enough to enable professionals to incorporate new learning into their practice.

Uncertainty and risk are features of child protection work

2.32 Uncertainty pervades the work of child protection. Many of the imbalances in the current system arise from efforts to deal with that uncertainty by assessing and managing risk. Risk management cannot eradicate risk; it can only try to reduce the probability of harm. The big problem for society (and consequently for professionals) is working out a realistic expectation of professionals' ability to predict the future and manage risk of harm to children and young people.

2.33 As the first report of this review discussed in detail, risk assessments are fallible and can err by over-estimating or under-estimating the danger the child is in. A well thought out assessment may conclude that the probability of a child suffering significant harm in the birth family is low. However, low probability events happen and sometimes the child left in the birth family is a victim of extreme violence and dies or is seriously injured. Professionals, in particular social workers, currently face the possibility of censure whatever they do: they are 'damned if they do and damned if they don't.' It is therefore important to convey a more accurate picture of the work and an understanding that the death or serious injury of a child may follow even when the quality of professional practice is high.

The measure of the success of child protection systems, both local and national, is whether children are receiving effective help

2.34 The services involved with helping children and families need to monitor what impact they are having. Agencies can only improve if they have a good understanding (through, for example, collecting feedback from children and families) of what contribution, if any, they are making to children's safety and welfare. This is particularly important in terms of checking whether services are having a negative impact on children and families.

2.35 In such a complex system as child protection, it is inevitable that any innovations have unexpected consequences as they are put into operation and interact with other parts of the system. Good feedback is needed to notice emerging problems so that imbalances are amended. Attention is paid throughout this report to how better feedback can be obtained at all levels in the system, from workers getting feedback from children, young people and families to central Government getting feedback from local services.

Chapter three: A system that values professional expertise

The review's analysis of current problems identified that some of the constraints experienced by practitioners and their managers were attributed to statutory guidance and the inspection culture. Many complain that practice has become focused on compliance with guidance and performance management criteria, rather than on using these as a framework to guide the provision of effective help to children. The review has concluded that statutory guidance needs to be revised and the inspection process modified so that they enable and encourage professionals to keep a clearer focus on children's needs and to exercise their judgment on how to provide services to children and families.

Removing barriers to professional judgment

3.1   A significant part of the review's remit is to remove '*unnecessary bureaucracy and guidance*'[51]. In considering how to do this, the review has looked at studies in other areas of work to understand better the strengths and weaknesses of rules and procedures[52]. Procedures play a crucial role when people have to work together, enabling them to predict what each other will do, setting out basic rules about roles and tasks. This is even more important when it is not an established team but a group who come together for a particular purpose, as is often the case when carrying out a child protection enquiry into an allegation of child abuse or neglect.

3.2   In professional practice procedures are an effective way of formulating best practice in carrying out a task so that the wisdom of experienced staff is readily disseminated throughout the organisation and variation in the quality and type of service received is reduced. Procedures are also good as training tools, helping novices get started in learning a task, giving them simple rules to follow without going through the longer process of understanding why those rules are sensible. For experienced workers, they are valuable as a checklist to use when reviewing their work, and are particularly helpful if they are interrupted and have to leave the task for a while.

3.3   Procedures, however, have a number of weaknesses. The strength mentioned above that newcomers can quickly learn to follow procedures even when they do not understand them is also a weakness. It can lead to people *just* following procedures and not seeking to understand them or trying to become more effective in their complex tasks:

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51   Letter from Secretary of State for Education to Professor Eileen Munro, 10 June 2010 (available online at: http://www.education.gov.uk/news/news/~/media/Files/lacuna/news/munro-review/michaelgovetoeileenmunro.ashx)

52   Woods, D., et al. (2010), *Behind Human Error*, 2nd Edition, Farnham, Ashgate; Dekker, S. (2005), *Ten Questions about Human Error*, pp136, London, Lawrence Erlbaum Associates.

> *'procedures can lull people into a passive mindset of just following the steps, and not really thinking about what they are doing. When we become passive, we don't try to improve our skills. Why bother, if all we are doing is following the procedures? So the checklists and procedural guides can reduce our motivation to become highly skilled at a job'*[53].

3.4   Another weakness is that procedures are always incomplete and require skill and the use of judgment to implement them[54]. Key skills in child protection work are to engage, communicate with others, and make complex interpretations of the information about a child or young person's needs and circumstances. When the organisation does not pay sufficient attention to these skills, then procedures may be followed in a way that is technically correct but is so inexpert that the desired result is not achieved.

3.5   These two weaknesses are interwoven: procedures can deal well with typical scenarios but not with unusual ones, and an organisational culture where procedural compliance is dominant can stifle the development of expertise. In child protection, the needs and circumstances of children and young people are so varied that procedures cannot fully encompass that variety. Efforts to make procedures cover more variety quickly lead to the proliferation of procedural manuals that, because of their size, become harder to use in daily practice. The inquiry into the death of Victoria Climbié[55] found that there were 13 documents containing policies, procedures, and guidance to staff in relation to children's services. Dealing with the variety of need is better achieved by professionals understanding the underlying principles of good practice and developing the expertise to apply them, taking account of the specifics of a child's or young person's circumstances.

Revising the statutory guidance on assessment and multi-agency working

3.6   The statutory guidance on assessment is set out in *The Framework for Assessment of Children in Need and their Families* (2000). This provides a conceptual framework for practitioners that takes a developmental/ecological approach to assessing the child's needs, including the need for protection. It was developed in response to the finding that professionals had become so focused on investigating alleged incidents of abuse or neglect that they were paying too little attention to the overall quality of care that the child was receiving. While the majority of child protection enquiries concluded that the alleged incident did not warrant further action, many of the parents were experiencing problems, such as domestic violence or mental ill health, which were having an impact on their standard of care but they were not offered any help[56].

53   Klein, G. (2009), *Streetlights and Shadows: Searching for the Keys to Adaptive Decision Making*, pp22, Cambridge, Mass, MIT Press.

54   Dekker, S. (2005), *Ten Questions about Human Error*, pp136, London, Lawrence Erlbaum Associates.

55   Cm 5730, (2003), *The Victoria Climbié Inquiry Report of an Inquiry by Lord Laming*, paragraph 1.60 (available online at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008654).

56   Department of Health, (1995), *Child Protection: Messages from Research*, London, HMSO.

3.7   The Assessment Framework includes ten underpinning principles:

Assessments:

- are child-centred;
- are rooted in child development;
- are ecological in their approach;
- ensure equality of opportunity;
- involve working with children and families;
- build on strengths as well as identify difficulties;
- are inter-agency in their approach to assessment and the provision of services;
- are a continuing process, not a single event;
- are carried out in parallel with other action and providing services; and
- are grounded in evidence based knowledge.

3.8   While the review endorses these excellent principles, it has become clear that they have become linked with specific theories, recording forms and processes. These have subsequently become the subject of performance targets so that, in combination, they are driving practice in dysfunctional ways and limiting professionals' ability to take responsibility for determining *how* to implement the principles in their practice. For example, evidence to the review has clearly indicated that professionals too often feel they must complete a form before a child is eligible to receive support, instead of responding to obvious or urgent needs while carrying out the assessment process. The problems this combination of factors has created came to a head with the design of the IT system, the Integrated Children's System (ICS) which is discussed in chapter seven. The division between initial and core assessments seems to have resulted in a distinct division of the assessment process in many authorities. Different social workers often undertake each assessment and the second one frequently starts the whole process again rather than building on a common assessment submitted by another agency or the initial assessment.

3.9   The importance of making a proportionate assessment seems to be neglected. For some children, a brief assessment is all that is required prior to offering services and for others the assessment needs to be more in-depth, broader in scope, and take longer in order to get a sufficiently accurate understanding of the child's needs and circumstances to inform effective planning. A decision about the depth and breadth of an assessment should be made at a local level rather than having to follow a centrally prescribed formula. The rationale for undertaking these assessments – getting help to children and families quickly and proportionately – at present seems to be overshadowed by process demands.

3.10   As part of the review, four local authorities – Cumbria, Knowsley and the London Boroughs of Hackney and Westminster – have been granted some exemptions from aspects of statutory guidance to trial a more flexible approach. Removing the requirement to adhere to statutory timescales for assessments has been the most common request for exemptions by these authorities. In Westminster and Knowsley, for example, exemption from these timescales is allowing more flexibility so that social workers and their managers can exercise their professional judgment in balancing timeliness with accuracy. These trials illustrate how greater

freedom can be responsibly exercised by implementing well thought out redesigns of practice and monitoring their impact.

3.11   As the local authority has a statutory duty to safeguard and promote the welfare of children, guidance on undertaking assessments of children in need should remain on a statutory footing. However, the approach that has been taken in *The Framework for Assessment of Children in Need and their families* (2000) needs to be revised and re-issued to present the ten underpinning principles only, but give professionals the responsibility for deciding how they can be implemented in practice.

3.12   *Working Together to Safeguard Children* (2010) sets out how organisations and individuals should work together to safeguard and promote the welfare of children and young people in accordance with the Children Act 1989 and the Children Act 2004. As the statutory guidance says, it is important that '*all practitioners working together to safeguard children and young people understand fully their responsibilities and duties as set out in primary legislation and associated regulations and guidance*'[57]. The review convened a working group of representatives from the major professional organisations that work in child protection in order to consider how professional advice to Government could be given for future editions of *Working Together* . The unanimous view of this group was that it is important to continue to have a single set of rules that all organisations, including professional bodies, voluntary and private sector providers and government departments, follow and are clear on their respective roles and responsibilities for protecting children from harm. As mentioned earlier, such rules are crucial when people have to work together on a task so that they have reasonable expectations of each other.

3.13   However, the review has observed that as *Working Together* has grown, so it has become more prescriptive and less useful. As was highlighted in the first report, it is now 55 times longer than it was in 1974[58]. Submissions to the review have strongly suggested that the current guidance has become too long to be practically useful. This can be dangerous: research has shown that thick manuals of procedures can be paralysing because they are hard to use and can prevent workers from moving quickly enough to seize opportunities[59].

3.14   The main reason why statutory guidance has grown is because advice on good practice has been added to the guidance. There is a risk that this approach has actually contributed to the deprofessionalisation of child protection, as those working in the field feel increasingly obliged to do things 'by the book' rather than use their professional judgment about children's needs.

3.15   The review considers that *Working Together* should be revised to distinguish more clearly between rules and professional guidance. Some rules are essential to enable different professionals to work together constructively, by establishing the

57   HM Government, (2010), *Working Together to Safeguard Children.* London, Department for Children, Schools and Families (available online at
     https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010)

58   Munro, E. (2010), The Munro Review of Child Protection Part One: A Systems Analysis, pp11, (available online at http://www.education.gov.uk/munroreview/); Parton, N. (2011), *The increasing length and complexity of central government guidance about child abuse in England: 1974–2010*. Discussion Paper. University of Huddersfield, (Unpublished) available online at http://eprints.hud.ac.uk/9906/

59   Eisenhardt, K. M. & Sull, D. N. (2001), *Strategy as simple rules*, Harvard Business Review.

roles and responsibilities of the different agencies and organisations involved in child protection. In future, professional guidance should be best formulated as principles that professionals apply intelligently in particular cases.

3.16 Subsequent revisions of *Working Together* should be made drawing on the advice of a group of experienced professionals from across the relevant disciplines. The review envisages that the Chief Social Worker would consult with this group (see chapter seven). The working group advising the review concluded that it would be useful to lay out the principles which should inform all child protection work. The principles presented in chapter two of this report offer a starting point for this.

3.17 These principles included the observation that the system and the wider public need to acknowledge the uncertainty and risk that inevitably surrounds child protection. In this, it is similar to the task faced by the military. As Charles Haddon-Cave wrote in his review of military aviation following the 2006 Nimrod loss in Afghanistan:

> *'The MOD has the responsibility for delivering a certain military capability and balancing risk with task. A military organisation must be '**risk sensible**' but not too '**risk averse**'. The [Military Airworthiness Authority] must understand and appreciate operational relevance and, importantly, be seen by military operators to understand and appreciate this, if it is to enjoy their confidence*[60].

3.18 Those involved in child protection must be 'risk sensible'. There is no option of being risk averse since there is no absolutely safe option. In reality, risk averse practice usually entails *displacing* the risk onto someone else. Even if every child who was considered or suspected to be suffering harm was removed from their birth family, that would only incur different risks. The Association of Chief Police Officers (ACPO) has recently grappled with this issue and drawn up a list of organisational 'Risk Principles' to inform officers' thinking. These have been adapted by the review to refer to all those who work in child protection:

Principle 1:
The willingness to make decisions in conditions of uncertainty (i.e. risk taking) is a core professional requirement for all those working in child protection.

Principle 2:
Maintaining or achieving the safety, security and wellbeing of individuals and communities is a primary consideration in risk decision making.

Principle 3:
Risk taking involves judgment and balance, with decision makers required to consider the value and likelihood of the possible benefits of a particular decision against the seriousness and likelihood of the possible harms.

Principle 4:
Harm can never be totally prevented. Risk decisions should, therefore, be judged by the quality of the decision making, not by the outcome.

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60 Haddon-Cave, C. (2009), *An Independent Review into the Broader Issues Surrounding the Loss of RAF Nimrod MR2 Aircraft XV230 in Afghanistan in 2006* (available online at http://www.official-documents.gov.uk/document/hc0809/hc10/1025/1025.pdf)

Principle 5:
Taking risk decisions, and reviewing others' risk decision making, is difficult so account should be taken of whether they involved dilemmas, emergencies, were part of a sequence of decisions or might appropriately be taken by other agencies. If the decision is shared, then the risk is shared too and the risk of error reduced.

Principle 6:
The standard expected and required of those working in child protection is that their risk decisions should be consistent with those that would have been made in the same circumstances by professionals of similar specialism or experience.

Principle 7:
Whether to record a decision is a risk decision in itself which should, to a large extent, be left to professional judgment. The decision whether or not to make a record, however, and the extent of that record, should be made after considering the likelihood of harm occurring and its seriousness.

Principle 8:
To reduce risk aversion and improve decision making, child protection needs a culture that learns from successes as well as failures. Good risk taking should be identified, celebrated and shared in a regular review of significant events.

Principle 9:
Since good risk taking depends upon quality information, those working in child protection should work with partner agencies and others to share relevant information about people who pose a risk of harm to others or people who are vulnerable to the risk of being harmed.

Principle 10:
Those working in child protection who make decisions consistent with these principles should receive the encouragement, approval and support of their organisation.

Recommendation

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

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

Reforming inspection

> *'Not everything that can be counted counts, and not everything that counts can be counted'* [61].

3.19 In the helping professions, an inspection system that places considerable weight on indirect measures of performance is seriously hampered in reaching reliable judgments about the quality of the service. This is because the measures exclude important factors that are not easily counted. In critiquing the current inspection system, the review is concerned with the culture that has developed around inspection that is only partly due to the formal inspection processes themselves. It is important to remember that people's behaviour is influenced not just by how they are judged but how they believe they are judged. There is a perception that inspectors focus too much on adherence to processes, timescales and guidance and not enough on the things that really matter; outcomes for children and young people. This belief then influences priorities. Moreover, even if such easily measured factors are only part of the inspection, they are likely to be a major focus for senior managers because they can be more readily controlled.

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61   Cameron, W. B. (1963), *Informal sociology: a casual introduction to sociological thinking,* New York, Random House.

3.20 Evidence to this review from frontline workers shows that their experience is of process issues being dominant[62]. This reflects a misunderstanding of inspectors' intentions: Ofsted's published guidance is explicit that inspection will focus on the quality of assessment and whether, in the circumstances of the individual child, the response was timely and appropriate. It is therefore important that the new inspection framework dispels such perceptions, and the best way of doing this is to show that the focus is clearly on children and young people and the effectiveness of the help provided to them and their families.

3.21 A new inspection system should:

- drive child-centred practice and improved outcomes for children;
- examine children's experiences and their journey through the system;
- focus on the quality of frontline practice and the capabilities of staff in exercising professional judgment and providing help;
- indicate how improvements in services might best be achieved, including highlighting where good practice exists;
- inspect the effectiveness of help offered to children and families, not just in responding to cases of abuse or neglect, but in providing early help to improve the wellbeing of children (as described in chapter five);
- look at the breadth and range of available provision when compared to known local need;
- examine the extent to which key partners work together to protect and help children; and
- identify whether local authorities and partners are learning, adapting and improving the help provided, including drawing on the lessons from Serious Case Reviews and other types of case reviews more widely.

3.22 In line with the recommendations included in the second report, in future, inspection should be broad, covering the contribution of all children's services to the protection of children, and be conducted on an unannounced basis in order to minimise the bureaucratic burden of the inspection.

3.23 While there will continue to be a place for individual inspectorates to examine the individual contributions of particular agencies or organisations to the protection of children, the review considers that child protection is a complex area of multi-agency working and, in future, inspectorates should work more closely together. The review has looked at a number of options for how inspection should best reflect the principles set out above. The 'ideal' solution might be multi-inspectorate teams where inspectors from the relevant inspectorates (Ofsted, Care Quality Commission, Her Majesty's Inspectorate of Constabulary, and Her Majesty's Inspectorate of Probation) would jointly inspect the various aspects of safeguarding and child protection in each locality. However, in a world where resources are limited, such a solution might not be possible. Should it prove the case that a truly multi-inspectorate model is not possible in any future reforms, it may be that the next best solution would be for Ofsted to conduct a local authority based inspection of children's services which looks at the input of other agencies into the child protection system from the perspective of the child.

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62 Munro, E. R. (2011), *Professional perspectives on reducing bureaucracy, performance and accountability, and early help and support to inform Munro's review of child protection*, Loughborough University, Childhood Wellbeing Research Centre.

3.24   The review recognises that in this model there may be issues to address concerning Ofsted's powers to inspect and make judgments on certain aspects of children's services. Whilst case-based analysis could, for example, offer the opportunity for some shared judgments about the local effectiveness of help for children and young people, creative mechanisms will need to be considered to enable some monitoring of the whole children's system. Within a system such as this, inspectorates should work together to share information and feedback about performance, the experiences of children and young people needing help and the effectiveness of that help. It will be critical that inspectors have the necessary skills to access expertise to make such a system work effectively in practice. To this end, Ofsted should consider the opportunities for inspection with seconded practitioners from local authorities, health, probation and police services as well as mechanisms to enable skilled staff from other inspectorates to participate in appropriate elements of the inspection process. This would build on the progress Ofsted has already made in recruiting and training senior local authority staff to become members of inspection teams.

3.25   In addition to recommending broader unannounced inspections, the second report also outlined the concept of 'deep dive' inspections, which could be used where data or information from past inspection or peer review indicate that there may be particular cause for concern about parts of practice in a given local area. Such 'deep dive' inspections should be tailored to suit local concerns and circumstances, but they would not be necessary as a matter of course. They might be most appropriate where there is an indication that identified issues are not being adequately addressed. They might even be triggered at the request of the Secretary of State, following concerns about performance or by local areas themselves. As such, 'deep dive' inspections are likely to be exceptions to the broad principle that inspection should be unannounced and, depending on the particular issue, it might be appropriate for these to involve inspectors from two or more inspectorates.

> ### Recommendation
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> **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.**

3.26   It is important to be clear that inspection does not, and should not, stand by itself. The inspection system is a key component of an overall system of performance improvement – which also includes local authority self evaluation as its foundation, supported by sector-based peer review and challenge and improvement support – which should operate on an ongoing cycle, elements of which should be conducted annually.

3.27   As the second report made clear, a sector-based improvement model including a systematic process of peer review and challenge, should play a key role in the performance architecture as capacity is built up in the sector. Over the last few months, local government has been developing such a system with the Department for Education. The two-way learning that is facilitated through peer review and challenge , in particular, is a major strength of this approach over

external inspection. For such an approach to work effectively, local areas need to be open and honest with each other about their strengths and weaknesses. In doing so, local areas will be able to learn from each other, improve and adapt.

3.28   Sector-based approaches should not be seen as a replacement for inspection and it is crucial that inspection continues to provide external scrutiny of the system. It is important that inspection places as little burden on the services inspected as possible and is more proportionate, but this does not mean that inspection should be 'light touch'. In designing a new framework for inspection, inspectorates will need to balance carefully the twin pressures of taking the criteria outlined in paragraph 3.21 into account, and setting the inspection cycle sufficiently frequent to provide regular external challenge and scrutiny to the system. As sector based improvement approaches become more established and generate sufficient capacity, it is possible that the inspection system could become less intensive. But until that time, and until the overall child protection system begins to embed the necessary changes, it is important that external inspection continues to be as rigorous as possible. The interface between sector-led improvement and inspection should be kept under review.

3.29   The most important measure of how well children's social care services are operating is whether children and young people are effectively helped and kept safe from harm. It is imperative, therefore, that the new inspection framework reflects how well this is happening in local areas. As part of this, the inspection system should be able to examine the journey of children through the child protection system from needing to receiving help. This includes assessing not only the role that agencies such as health and the police have played in bringing them to the attention of children's social care, but also their ongoing role in working in collaboration with children's social care, and how quickly and effectively children's social care services responded to and progressed cases.

3.30   The inspection system should make use of the 'twin core' of data (national and local, described in paragraph 3.36), supplemented by any additional locally available information which sits outside of this, to inform their judgments. This should include specifically interrogating local survey data to understand how well the children and young people engaged with children's social care services think that those services are helping them and how well those services are learning and adapting by addressing the concerns raised by children and young people. It is important to stress, though, that inspectors should not interpret data and performance information as absolute indicators of performance. The data should be treated as information that needs to be carefully and intelligently interrogated in order to understand the particular circumstances and pattern of provision in each area.

3.31   When examining the journey of children and young people through the system, from needing to receiving help, the focus should not just be on timeliness, although this is important, but also the quality and effectiveness of the services provided. Crucially, inspectors should also continue to examine case files to form an opinion of the journey that children and young people have taken through the system, but they should also, as they do in school inspections, observe direct practice to assess how well help is being provided and the quality of that practice. This might include talking directly to children about their concerns, experiences,

perceptions and proposals for improvement (supplementing data collected by local authorities through their own surveys), or observing initial child protection conferences or social worker visits to children and families. It is critical that inspectors have the skills and expertise to be able to make informed judgments on what they are observing.

3.32 As part of its focus on the effectiveness of the services provided to children and young people, the inspection system should also specifically consider how well the local authority is fulfilling its statutory duty under section 17 of the Children Act 1989 (as amended) to ascertain and give due consideration (with regard to the child's age and understanding) to the wishes and feelings of children, before deciding what services to provide or action to take.

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

Performance information

3.33 Data on performance are an essential source of information for both managers and inspectors but the current set collected is problematic. The first report of this review presented clear evidence which suggested that:

> *'the focus of performance indicators and targets on specific aspects of process as opposed to practice, has skewed and misdirected local priorities'.*

3.34 The second report, drawing on research from Tilbury[63], Broadhurst[64] and Sanger[65], built on this analysis highlighting the strong influence that performance indicators and targets have in social work and, in particular, on the way that social workers practise and how their managers allocate resources and judge whether practice is good or bad.

3.35 Nevertheless, as the second report emphasised, performance data are crucially important in managing the provision of effective services but should not be treated as unambiguous indicators of performance. This is perfectly acceptable in some areas of service provision but not suitable in child protection where the vast majority of the information available on performance is more nuanced (the information that would best serve as an indicator is the rate of abuse and neglect locally, but this is hard to collect accurately).

3.36 The second report introduced the concept of a 'twin core' of data made up of information collected nationally and standardised data published locally. The

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63 Tilbury, C. (2006), 'Accountability via performance measurement: The case of child protection services', *Australian Journal of Public Administration Volume 65, Issue 3, pp48–61.*

64 Broadhurst, K. et al. (2009), 'Performing Initial Assessment: Identifying the Latent Conditions for Error at the Front-Door of Local Authority Children's Services', *British Journal of Social Work, 40 (2), 352–370.*

65 Sanger, M. B. (2008), 'From Measurement to Management: Breaking through the Barriers to State and Local Performance', *Public Administration Review*, 68, special issue, S70–S85.

latter should be developed by the sector, based on the local element of the 'twin core', as outlined in Appendix B. The 'twin core' idea is consistent with the concept of requisite variety where complex systems must be monitored using a corresponding variety of signals otherwise their interpretation may lead to misleading and dysfunctional guidance for policy and practice[66]. This draft 'twin core' of data – using a combination of timeliness data, quality of service information, outcomes measures and management information – should be used to provide the context for discussions about the health of child protection services in local areas[67]. Local authorities and their partners should take a holistic view of the 'twin core' set outlined at Appendix B, drawing on both the national and draft local elements of the set, to paint a picture of the provision of services in each local authority area. This should include understanding the child's journey through the system, as part of their self evaluation activity. Peer reviewers and inspectors can use this performance information in a similar manner to get under the skin of the pattern, and effectiveness, of service provision in each local area.

3.37 This 'twin-core' of data should seek to:

- create a better balance between the use of data for the purposes of external accountability (measurement) and shared learning (feedback). Currently, the balance is towards the former at the expense of the latter;
- move away from reporting systems that encourage a linear cause and effect view of events towards an approach that encourages a systems-based perspective;
- give professionals freedom to operate, with performance evaluated against population outcomes and service quality; and
- provide higher level outcome and service quality information to central Government, and standardised management information for use by local authorities.

3.38 The draft set of measures and data for systems monitoring set out in Appendix B can be categorised as follows:

a) *Outcomes*: information which sits at partnership level in terms of accountability. These measures relate to the safety of all children and young people within the area that the partnership has jurisdiction for and are the collective responsibility of all partner agencies;

b) *Service level information* to help partners assess the quality of the experience across a number of areas for example accessibility; responsiveness; cultural competence; timeliness; quality of settings/buildings; communication; involvement and so on; and

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66   Lane, D. C., Monefeldt, C. & Rosenhead, J. V. (2000), 'Looking in the wrong place for healthcare improvements: A system dynamics study of an accident and emergency department', *Journal of the Operational Research Society,* 51, pp518–531.

67   See Pinnock, M. (forthcoming) for further work on lead indicators commissioned by the Department for Education.

c) *Management information* with standardised definitions that includes the data required to provide an audit trail of (a) and (b) above, and data to be used by local authorities and central Government to provide intelligence around service management, development and improvement. Data on the workforce have been included here because research indicates that sickness absence, vacancy and turnover rates are lower when workers feel they are doing a good job and helping children (see Appendix B).

Further work will be necessary when developing the future data requirements for local authorities and their statutory partners, as well as for national collections. In addition to the draft set at Appendix B, consideration should be given to data on the provision of early help as well as improving the quality of data on outcomes for children and young people.

3.39 When constructing this performance information set, the review has been conscious of the need to minimise, as far as is possible, the reporting requirements on local authorities and their partners. The Children in Need Census has been criticised for being too burdensome on local authorities, and was subject to its own review recently. This is why the 'twin core' set is made up of both national *and* local elements. It highlights six areas for national reporting and monitoring, namely outcomes, workforce, timeliness, plans, flow and activity. There is scope for some debate over the balance between the national and local elements, but in the view of the review the split in Appendix B sets the right tone. Some items should definitely be local including, most importantly, the feedback from children and young people involved in the children's social care system. The annual Children's Care Monitor produced by the Children's Rights Director, could also be used to provide data for benchmarking purposes. Some data should definitely be national, for example, the recommended new data collection on the children's social care workforce.

Recommendation

Local authorities and their partners should use a combination of nationally collected and locally published performance information to help benchmark performance, facilitate improvement and promote accountability. It is crucial that performance information is not treated as an unambiguous measure of good or bad performance as performance indicators tend to be.

Chapter four: Clarifying accountabilities and improving learning

The number of agencies and professions required to work together well in order to build an accurate understanding of what is happening in the child's life and to provide help is part of the inherent challenge in building an effective child protection system. Clear lines of accountability, and roles such as the Director of Children's Services and designated and named persons, are very important. This chapter recommends that the integrity of lines of accountability and roles are preserved as the Coalition Government's plans for reform in the public services are implemented. The previous chapter argued the case to move from a compliance culture to a system that promotes the exercise of professional judgment. To do so local multi-agency systems will need to be better at monitoring, learning and adapting their practice. This chapter recommends regular review of cases becomes the norm and that the child protection system adopts the 'systems approach' that is being developed in the health sector. The review recommends adopting a 'systems approach' to Serious Case Reviews in particular, carried out when a child dies or is seriously injured and abuse or neglect are thought to be a factor. This will enable deeper learning to overcome obstacles to good practice.

The importance of accountability

4.1   As Lord Laming outlined in *The Victoria Climbié Inquiry Report*[68]:

> *'What is needed most of all is a structure in which there is no ambiguity about the decision-making process for the quality of services to children and families.'*

4.2   One of the strengths in the English child protection system is the extent to which the many agencies and professions work together to coordinate their work with children and families. Formal procedures for agencies and professionals working together have been in place since the 1950s[69], but as institutions, organisations, boards, and partnerships evolve, responsibilities and lines of accountabilities change with them. Given the current wave of radical reform in each of the major public services, it is important that the formal mechanisms for working together
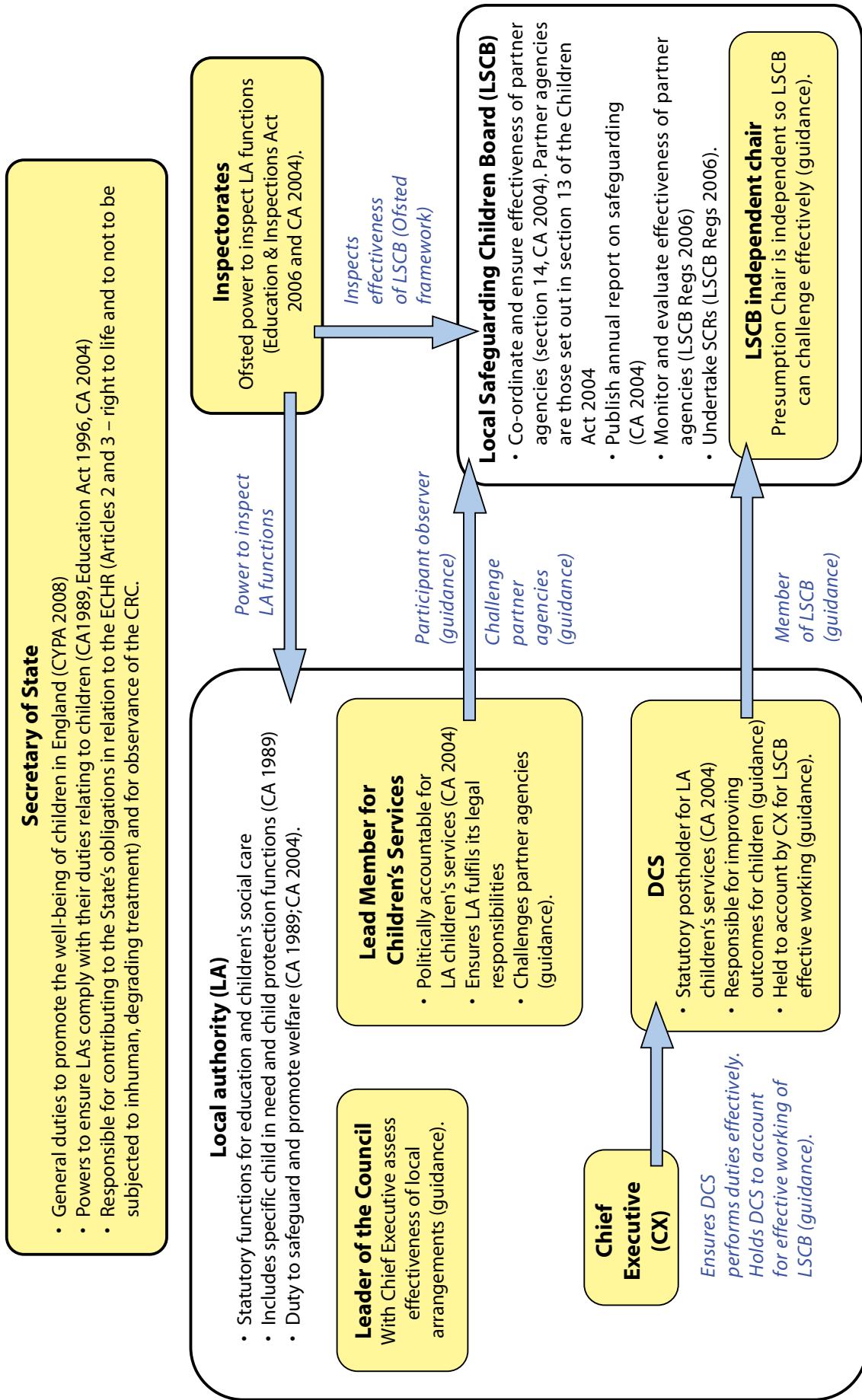
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68   Cm 5730, (2003), *The Victoria Climbié Inquiry Report of an Inquiry by Lord Laming* (available online at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_110711.pdf)
69   Home Office, Ministry of Health & the Ministry of Education, (1950), *Joint circular from the Home Office, Ministry of Health and Ministry of Education. Children neglected or ill-treated in their homes*. London, Home Office.

to safeguard and promote the welfare of children, and the lines of accountability within and between different organisations, are as clear and unambiguous as possible.

4.3   The current accountability architecture for child protection in local areas was prescribed in the Children Act 2004 with the statutory positions of Director of Children's Services (DCS) and Lead Member for Children's Services as the respective key points of professional and political accountability within the local authority. Around these key positions, which are discussed in more detail later in this chapter, other services, such as the police and health, play key roles through local partnership structures, i.e. the Children's Trust Board and the Local Safeguarding Children Board (LSCB). The current accountabilities framework is described in the diagram below.

4.4   The Coalition Government plans to remove the statutory requirement for local authorities to establish Children's Trust Boards. There will continue to be a need, in some form (see discussion below on planned reforms), for local partners to check that local services are coordinated and commissioned to meet their duty to improve the wellbeing of children and young people. LSCBs are primarily scrutiny bodies, which monitor whether local partners, through the Children's Trust Board, are effectively safeguarding and promoting the welfare of children and young people in their local area. Like the Children's Trust Board, the LSCB is a statutory body. As part of their scrutiny function each LSCB produces and publishes an annual report about safeguarding and promoting the welfare of children in its local area, and submits a copy of this report to the Children's Trust Board. The majority of LSCBs are independently chaired, meaning that they are in a better position to provide scrutiny and challenge to the local authority and its Children's Trust Board partners.

4.5   Though the LSCB coordinates the effectiveness of arrangements to safeguard and promote the welfare of children in that locality, the LSCB is not accountable for the operational work of the Board's partners. Each Board partner retains their own existing lines of accountability.

Current statutory accountabilities for safeguarding and promoting the welfare of children and young people

Secretary of State

- General duties to promote the well-being of children in England (CYPA 2008)
- Powers to ensure LAs comply with their duties relating to children (CA1989, Education Act 1996, CA 2004)
- Responsible for contributing to the State's obligations in relation to the ECHR (Articles 2 and 3 – right to life and to not to be subjected to inhuman, degrading treatment) and for observance of the CRC.

Inspectorates

Ofsted power to inspect LA functions (Education & Inspections Act 2006 and CA 2004).

Inspects effectiveness of LSCB (Ofsted framework)

Power to inspect LA functions

Local authority (LA)

- Statutory functions for education and children's social care
- Includes specific child in need and child protection functions (CA 1989)
- Duty to safeguard and promote welfare (CA 1989; CA 2004).

Lead Member for Children's Services

- Politically accountable for LA children's services (CA 2004)
- Ensures LA fulfils its legal responsibilities
- Challenges partner agencies (guidance).

Participant observer (guidance)

Challenge partner agencies (guidance)

DCS

- Statutory postholder for LA children's services (CA 2004)
- Responsible for improving outcomes for children (guidance)
- Held to account by CX for LSCB effective working (guidance).

Leader of the Council

With Chief Executive assess effectiveness of local arrangements (guidance).

Chief Executive (CX)

Ensures DCS performs duties effectively. Holds DCS to account for effective working of LSCB (guidance).

Local Safeguarding Children Board (LSCB)

- Co-ordinate and ensure effectiveness of partner agencies (section 14, CA 2004). Partner agencies are those set out in section 13 of the Children Act 2004
- Publish annual report on safeguarding (CA 2004)
- Monitor and evaluate effectiveness of partner agencies (LSCB Regs 2006)
- Undertake SCRs (LSCB Regs 2006).

LSCB independent chair

Presumption Chair is independent so LSCB can challenge effectively (guidance).

Member of LSCB (guidance)

Planned reforms in public services

4.6   The Coalition Government has embarked upon a programme of radical reform in the major public services of health, education, and the police, set against the backdrop of a tighter funding settlement across the public sector. Within this changing landscape, it is even more important to be clear about accountabilities so that the range of agencies involved in child protection continue to work together effectively to safeguard and promote the welfare of children. The Coalition Government has already stated its intention to repeal the legislation requiring local areas to have a Children's Trust Board, although some areas may choose to retain these Boards when the legislative requirement to do so has been removed. With, subject to the will of Parliament, the emergence of new statutory health and wellbeing boards, the local accountability architecture will vary as local areas design different structures taking account of the effectiveness of their existing arrangements.

4.7   In relation to child protection and safeguarding, health and wellbeing boards may well in practice be expected to fulfil a similar role to Children's Trust Boards. The LSCB will, in accountability terms, continue to scrutinise the work of local partners in ensuring that services safeguard and promote the welfare of children and young people. LSCBs play an extremely valuable role and will remain uniquely positioned within the local accountability architecture to monitor how professionals and services are working together to safeguard and promote the welfare of children. They are also well placed to identify emerging problems through learning from practice and to oversee efforts to improve services in response.

4.8   The review endorses the principle that LSCBs should be independently chaired. Feedback from localities indicates that 134 out of 148 LSCBs have independent chairs. Having an independent chair increases the likelihood that the LSCB will be in a position to challenge and scrutinise effectively the work of local partners in protecting children and young people from harm. However, the review does not wish to prescribe this model of operation beyond endorsing the principle that having an independent chair is generally preferable. The review is aware that a handful of boards are chaired effectively by DCSs or other Board partners.

4.9   Whether the LSCB is chaired independently or not, it is important that the LSCB Chair manages an open channel of communication through the DCS and Chief Executive to the Lead Member and Leader of the Council so that they are all made fully aware of any areas of concern that the LSCB may have.

4.10   It is critical that DCSs continue to be members of LSCBs and play a full and active role in the work of the Board, as set out in statutory guidance[70]. It is equally important that the role of Lead Members for Children's Services as 'participant observers' on LSCBs remains unchanged. This means that Lead Members should routinely attend Board meetings and receive any and all written reports, but the word 'participant' is important; Lead Members should play a full role in discussions, including asking questions and seeking clarity where needed, with the only difference in their role being that they do not take part in any decision-making

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70   Department for Children, Schools and Families, (2009), *The Roles and Responsibilities of the Lead Member for Children's Services and the Director of Children's Services* (available online at: http://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00686-2009)

processes. This unique role allows the Lead Member to retain a degree of independence enabling them to challenge, when necessary, from a well-informed position.

4.11 Police and Crime Commissioners are a key part of the Government's programme of decentralisation. It will be important that the local authority, through both the Leader of the Council and the Chief Executive, liaise with this Commissioner on a regular basis. This will take place through various arrangements including Community Safety Partnerships. In relation to the protection of children, the review considers it will be important for the Chair of the LSCB to work closely with the police and Crime Commissioner to keep the welfare of children in the local area high on the Commissioner's agenda.

4.12 In education, despite changes in the provision of schools, section 175 of the Education Act 2002 will continue to place a duty on local authorities, maintained (state) schools and further education institutions, including sixth-form colleges, to exercise their functions with a view to safeguarding and promoting the welfare of children: children who are pupils, and students under 18 years of age in the case of schools and colleges. The same duty is placed on independent schools, including academies, by the Independent School Standards regulations made under section 157 of that Act.

4.13 It is essential that, however accountability structures change in the future, the requirement for LSCBs to produce and publish an annual report under section 14a of the Children Act 2004 (as amended) is further amended to reflect these changes. Such amendments should provide for the LSCB annual report to be seen by the people who have influence over the various services: Director of Children's Services; Lead Member; Chief Executive; and the Leader of the Council; and in future, and subject to the passage of legislation, the local police and Crime Commissioner, the Director of Public Health, and the Chair of the health and wellbeing boards.

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

Responsibilities of LSCBs

4.14 Chapter five considers the argument for the Government to require local authorities and statutory partners to secure the provision of effective early help services and set out their arrangements to develop and implement local early help for children, young people and families in order to respond quickly when children develop problems. In parallel, it will be important that the remit of LSCBs explicitly monitor the effectiveness of such services in reducing the incidence of maltreatment (see chapter one).

4.15 LSCBs already play an important role in encouraging the provision of that multi-agency training on safeguarding and promoting the welfare of children. Research[71] has shown that multi agency training is effective in helping professionals understand their respective roles and responsibilities, the procedures of each agency involved in safeguarding and promoting the welfare of children, and in developing a shared understanding of assessment and decision-making practices. Further, the opportunity to learn together is greatly valued: participants report increased confidence in working with colleagues from other agencies and greater mutual respect. However, participation in such training is often variable, with low take up from, for example, doctors and adult services staff. As highlighted in the 2005–07 Biennial Analysis of Serious Case Reviews[72]:

> *'The tendency towards 'silo practice' that we found, where professionals preferred to work within the comfort zone of their own specialism, underlines the importance of joint child protection training. This should continue to be offered not just for those working with children but also to the adult workforce and any groups of workers coming into contact with children and families.'*

4.16 At a time when financial resources are coming under increasing pressure, inter-agency training is coming under threat, with a number of specialist posts being eroded and subsumed into wider learning and development posts in local authorities. There is a very real risk that the expertise, independence and the distinctive skills necessary to train an inter-agency audience could be lost. It would be regrettable if the strong platform of inter-disciplinary training built up in recent years was now eroded. It is therefore important that LSCBs continue to make multi-agency training available, and draw on the partnership nature of the Board itself to encourage participation. Following on from this, it is also important that LSCBs evaluate such training.

Recommendation

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

4.17 As the second report made clear, the review considers it important that, in local authorities, the role of the DCS continues as the key point of professional accountability for child protection services within the local authority and that this is not diluted or weakened. When the role of DCS was created through the Children Act 2004, the aim was to bring together all local authority education and

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71 Carpenter, J., Hackett, S., Patsios, D. & Szilassy, E. (2009), *Organisation, outcomes and costs of inter-agency training for safeguarding and promoting the welfare of children*, London, Department for Children, Schools and Families, Research Report. (available online at
http://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-RBX-09-13)

72 Brandon, M., Bailey, S., et al. (2009), *Understanding Serious Case Reviews and their Impact – A Biennial Analysis of Serious Case Reviews 2005–2007* (available online at: http://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-RR129)

children's social care functions under the leadership of a single statutory chief officer. This was intended to help overcome the historical communication difficulties between education and social care services and provide a single point of professional accountability for children on the local authority senior management team. These aims and objectives remain important, and the review sees it as crucial that, given the fiscal climate and the pressures on local budgets, local authorities follow both the letter and the spirit of section 18 of the Children Act 2004.

4.18   The review has become aware that some authorities are restructuring their senior management teams in ways that are inconsistent with the aims and objectives of this legislation. Examples include re-creating the split between education and children's social care services (thereby confusing accountabilities) or combining children's and adult's services, with a single 'Director of People' holding both statutory roles of DCS and Director of Adult Social Services. While local authorities are, of course, generally in the best position to determine their own management structures in light of their particular local circumstances, the review questions whether such structures would allow sufficient focus and attention to be paid to the most vulnerable children.

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

4.19   The importance of the named and designated safeguarding children professionals for health and the designated lead for safeguarding in schools was highlighted in the second report. *Working Together* is clear about the roles that these named and designated individuals play in recognising and responding to the possible abuse and neglect of a child and young person. These roles facilitate effective engagement and dialogue for teachers, school support staff and health professionals as well as providing a single, senior point of contact for local partners. They are critical for the identification and delivery of help to children, young people and families.

4.20   It will be important that changes associated within the health reforms do not jeopardise the role of the named and designated safeguarding professionals**.** There is already evidence showing that local relationships established to enable strategic thinking about safeguarding have become eroded and that children's services and health services are growing further apart in their strategic priorities for

children and young people. There remains a critical role for a senior paediatrician and a senior nurse to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children within the local area. This role includes the provision of expert advice on commissioning across the whole health economy and to the LSCB, and the provision of overall leadership and direction.

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

4.21   This review welcomes the recommendations from Dame Clare Tickell[73] to improve the clarity of the welfare requirement of the Early Years Foundation Stage (EYFS) and to rename it the 'safeguarding and welfare requirements'. The review endorses Dame Clare's recommendation that the EYFS should clearly set out the content of the child protection training that lead safeguarding practitioners in early years settings are required to attend. It will be important that any re-write of the EYFS continues to require that there is a practitioner who is designated and takes a lead responsibility for safeguarding within all early years settings.

4.22   In order to build capacity for the delivery of early help described in chapter five, the review recommends that all agencies which deliver these services to children, young people and families should have a designated lead for safeguarding.

4.23   In addition to the original terms of reference, Ministers asked that the review also look at the issue of and need for a national signposting service to consider the potential value of having a national means of providing a quick and reliable way of identifying whether a child or young person is, or has been, the subject of a child protection plan or whether they are, or have been, looked after. The review's findings are set out in Appendix C.

Serious Case Reviews and learning

4.24   The remit of this review included a specific request to consider how Serious Case Reviews (SCRs) could be improved. There has been considerable criticism of the current SCR methods and evidence from professionals report that:

> *'There is an overwhelming sense that there is too much emphasis on getting the process right, rather than on improving outcomes for children, of the process being driven by fear of getting it wrong, of practitioners and managers feeling more criticised than supported by the process, and that the Ofsted evaluations do not support learning'*[74].

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73   Tickell, C. (2011), *The Early Years: Foundations for life, health and learning* (available online at: http://www.education.gov.uk/tickellreview)

74   Sidebotham, P. et al. (2010), *Learning from SCRs. Report of a research study on the methods of learning lessons nationally from SCRs,* London, Department for Education (available online at http://www.education.gov.uk/publications/standard/publicationDetail/Page1/DFE-RR037)

Ofsted has noted:

> *'Serious Case Reviews were generally successful at identifying what had happened to the children concerned, but were less effective at addressing why'*[75].

4.25   Without being able to explain why professionals acted or failed to act as they did, SCR recommendations tend to take the form of admonishments to professionals of what they 'should', 'need' or 'must' do in specific situations in the future. This, as the review has identified, has ended up reinforcing a prescriptive approach toward practice, corroborated by the conclusions of a biennial review of SCRs:

> *'What was marked was the emphasis in the recommendations on reviewing or strengthening existing procedures or developing new procedures. This was supported by the views of some of the respondents that the systems were adequate but the problem was one of staff compliance. There was less emphasis than might have been expected on issues of management, supervision, staffing resources and staff knowledge, skills and experience. The organisational context, which in some agencies at the time was undergoing major change, resulting in disruption and discontinuity in staffing, also rarely featured in issues to be addressed'*[76].

4.26   The prescriptive approach continues in LSCBs' response to SCR recommendations. A recent study noted that LSCBs often focus:

> *'on implementing action plans that only address superficial aspects of procedures, rather than taking time to reflect on and learn from deeper issues in the systems, attitudes and practices of the organisation and individuals within it'*[77].

The problem with such a prescriptive approach is that without sufficient understanding of what is making it difficult for staff to comply to certain standards or procedures in the first place, renewing and revising those procedures or reminding professionals of their existence, is unlikely to be effective in securing or sustaining the desired change.

4.27   The review, therefore, recommends a fundamental rethink of how to learn about professional practice through the SCR process. The engineering sector has led the way in developing knowledge about how to learn from incidents and accidents, and how best to develop reliable organisations which can operate at a high level of safety. The health sector followed the engineering sector's example using a systems approach to improving patient safety when the National Patient Safety Agency (NPSA) was set up by the Department of Health. Over a decade ago, an

75   Ofsted, (2008), *Learning lessons, taking action: Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008* (available online at http://www.ofsted.gov.uk/Ofsted-home/Publications-and-research/Browse-all-by/Documents-by-type/Thematic-reports/Learning-lessons-taking-action-Ofsted-s-evaluations-of-serious-case-reviews-1-April-2007-to-31-March-2008)

76   Rose, W. & Barnes, J. (2008), *Improving Safeguarding Practice: Study of Serious Case Reviews 2001–2003*, London, Department for Children, Schools and Families, Research Report, pp88. (available online at https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-RR022)

77   Sidebotham, P. et al. (2010), *Learning from SCRs. Report of a research study on the methods of learning lessons nationally from SCRs, London,* Department for Education, Research Report (available online at https://www.education.gov.uk/publications/RSG/AllRsgPublications/Page9/DFE-RR037)

expert group chaired by the Chief Medical Officer, described the NHS as having an 'old fashioned' approach to organisational learning. Healthcare was seen as needing to 'catch up' with other 'high risk' or 'safety critical' industries, such as civil aviation, in methods of reducing incidents of avoidable harm to patients from errors or mistakes.

> *'In the 1990s it was increasingly realised that most harm was not done deliberately, negligently or through serious incompetence but through normally competent clinicians working in inadequate systems'*[78].

4.28 *An organisation with a memory*[79]*,* summarises this change of direction. It is now judged to be a seminal document and, since its publication, the NHS has become a world pioneer in the field of patient safety. It has initiated the establishment of a World Health Organisation (WHO) patient safety programme[80]. *'To err is human'*[81], a parallel US publication, neatly captures the essence of this revolution that took place in the field of patient safety on both sides of the Atlantic. It argued cogently that the issue of medical errors was '*not a 'bad apple' problem*' and that '*mistakes can best be prevented by designing the health system at all levels to make it safer – make it harder for people to do something wrong and easier for them to do it right*'.

4.29 Safety management moved to the view that blaming individuals for errors and mistakes is rarely helpful or productive. It produces inadequate learning and, in some cases, creates new obstacles to improving performance. Instead errors and mistakes should be accepted as to some degree inevitable and to be expected, given the complexity of the task and work environment. In place of a blame culture, where people try to conceal difficulties, it is better for people to discuss problems so that they can be managed or minimised. This approach explicitly focuses on understanding professional practice in context. It draws on human factors research which aims to design and re-design processes and procedures that are based on realistic conceptions of human strengths and weaknesses, so that broader compatibility can be achieved between people, technology, and work environments.

4.30 The review recommends an equivalent move in the child welfare sector and considers that the child protection system has much to gain from copying these developments. The systems approach can address the problems with the current methods of SCRs. Critically, it explicitly focuses on a deeper understanding of *why* professionals have acted in the way they have, so that any resulting changes are grounded in practice realities. It provides a clear theoretical framework for understanding professional practice in context. The merit in the approach is that it counters the tendency of the current SCR methods to reinforce prescriptive approaches to practice, focusing instead on professional learning and increasing professional capacity and expertise. The review opts to call this a 'systems

78   House of Commons Health Committee (2009), Patient Safety, Sixth Report of Session 2008–09, page 11 (available online from http://www.publications.parliament.uk/pa/cm200809/cmselect/cmhealth/151/151i.pdf)

79   Department of Health (2000) *An organisation with a memory. Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer* (available on line from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4065083)

80   World Health Organization, (2004), *World Health Organization Patient Safety Programme* (available online at http://www.who.int/patientsafety/en/)

81   Institute of Medicine, (1999), *To Err is Human: Building A Safer Health System,* National Academy of Sciences, paragraph 121.

approach', rather than use the term 'Root Cause Analysis' which is common in the health sector, in order to highlight that study of the particular incident creates the opportunity to study the whole system, enabling learning not just of flaws but also about what is working well[82].

4.31 The review has presented the case for moving from a compliance to a learning culture. The complexity of the multi-agency child protection system heightens the need for continual and reliable feedback about how the system is performing. This is in order that organisations can learn about what is working well and identify emerging problems and so adapt accordingly. Such a learning culture is needed both within and between agencies. It needs to include people at all levels in organisations, from the frontline workers engaging with families, to the most senior managers in hierarchies. Mechanisms for generating organisational learning are therefore also valuable forms of multi-agency training. These provide opportunities for people to better understand their relative roles and areas of expertise across agencies and how they can best work together and support each other in their common goal of helping children and families. The review has therefore been considering how these opportunities can be strengthened.

4.32 The review noted in the second report that it is important multi-agency training and learning mechanisms include, but are not restricted to, SCRs which have played a disproportionate role to date. Such tragic cases are not representative of the majority of professional work and therefore, while remaining important, it is unwise to premise the majority of organisational development on them. Therefore the review is recommending that a larger repertoire of learning options be developed.

4.33 Case reviews can usefully be initiated for a variety of reasons. The review distinguishes between 'Serious Case Reviews' and 'case reviews' of other kinds. The review is aware that many LSCBs already conduct such case reviews, for example, selecting a case because it represents a particular family scenario or practice area about which there are concerns and a need to better understand what is helping and hindering professionals in their work. There is also increasing interest in putting cases of good practice under the case review spotlight, in order to better understand the mechanisms underpinning effective help given to children and families.

4.34 When undertaking a SCR in accordance with chapter eight of *Working Together*, a LSCB is not required to gain consent of the family in order to share information held by professionals about the child who is the subject of a SCR. In reviews of cases other than SCRs this is not necessarily the case. The review considers that in the majority of cases, families will consent to a review of how professionals endeavoured to help them in the past, if it is for the explicit purpose of trying to learn and improve the effectiveness of this help giving. Obtaining the consent of the child's family should, therefore, always be the first option to be considered by LSCBs wishing to carry out case reviews that are not SCRs. If, for some reason, it is not possible or appropriate to seek consent from families, then LSCBs will need to consider, on a case-by-case basis whether the review should and can lawfully be carried out without such consent. They will need to consider the purposes of the

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82   Vincent, C. (2006), *Patient Safety*, Edinburgh, Elsevier.

review, their powers for undertaking a case review and the Data Protection Act requirements to ensure that any sharing of information in such circumstances (i.e. without consent and for the purposes of a case review) is lawful and is appropriate.

4.35   Case reviews and SCRs have their limitations, including cost, as current practice with SCRs has demonstrated. It is important therefore that a wider range of learning mechanisms are developed. The Metropolitan Police, for example, have developed a multi-agency training programme called Multi-Agency Critical Incident Experience (MACIE) that contains the key elements of a systems approach to case reviews, albeit using a simulated, not a real, case.

Multi-agency training (MACIE case study)

The course runs in the 'Hydra simulator', an immersive learning tool, providing delegates with the information in the right format and within realistic timescales. The LSCB delegates are divided into five groups, Social Care/Education/Health/police and a Diamond group of higher level strategic leaders. The learning outcomes from the training are:

- a clear understanding that protection of children is a ***shared responsibility*** between agencies and professionals;
- recognition that all workers in all agencies need to be ***supported by strong leadership*** making ***decisions*** underpinned ***by full and unambiguous rationale;***
- the development and examination of decision-making processes in full partnership with each other;
- the value of sharing ***potential indicators*** of abuse or neglect and sharing such observations at the earliest stage;
- ***regularly reviewing*** the outcomes of actions or information with partners as part of the shared responsibility;
- debating the role, language and behaviours of the various agencies with a view to ***developing a 'common language'*** and a consistency of best practice; and
- increased confidence of staff and managers to ***challenge with partner professionals.***

4.36   Other learning mechanisms could include the development of a three level process for undertaking case reviews along the lines that the Welsh Assembly Government has developed[83]. Others may be unconnected to incidents or cases at all. Failure Mode Effects Analysis (FMEA), for example, is another learning mechanism developed in engineering and taken up more recently in health. Its potential application to multi-agency child protection work is being tested by the NSPCC, in collaboration with the Social Care Institute for Excellence (SCIE).

4.37   The critical issue will be that all these efforts have a common theoretical framework that helps individuals and organisations move beyond apportioning blame to learning together about what is helping and what is hindering efforts to help

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83   Welsh Assembly Government, (2011), *Plenary statement on progress in developing a new framework to replace the existing Serious Case Review process* (available online at http://wales.gov.uk/publications/accessinfo/drnewhomepage/healthdrs/2011/scrnewprossessstsmnt/?lang=en)

children, young people and families. Such learning will provide the basis for developing a common typology of factors influencing practice in helpful or unhelpful ways, to support national learning of trends and themes.

A systems methodology for case reviews and SCRs

4.38   Whatever the reason for conducting a case review, the principles of how to study professional practice using a systems approach remain the same. In the child protection field, SCIE has taken a lead in adopting and adapting this approach to learning. The SCIE Learning Together model[84] has been designed specifically to apply to cases involving multi-agency work and can also be applied to any example of professional practice. Feedback from participants of case reviews completed using this model in the North West of England and underway in the West Midlands and London using this model has been very positive about process and outcomes[85]. There is therefore a workable model for use in reviewing multi-agency child protection and safeguarding work. It contains the key theoretical assumptions so the review recommends that this is taken as an illustration for future developments. Given how new the use of this approach is in the child protection field, it will necessarily be augmented over time. The explicit focus on ongoing research and development activity that SCIE has initiated, conducted in close collaboration with the sector, should continue.

4.39   The SCIE model makes clear that the focus of a case review using a systems approach is on multi-agency professional practice, not the particular child(ren) and family. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the 'deeper', underlying issues that are influencing practice more generally. This involves exploring, among other factors, the local rationality of those involved. It is these generic patterns that count as 'findings' or 'lessons' from a case and changing them will contribute to improving practice more widely. Prioritising which underlying issues to focus on always requires judgment, and local knowledge of strategic and operational managers is useful. That underlies the need for a 'review team', as it is called in the SCIE Learning Together model. National learning will be facilitated if findings are presented using a consistent typology. However a typology should not be created in a vacuum and imposed, but formulated as learning increases. The SCIE model contains a simple typology that could usefully form the basis for a more detailed one.

4.40   Using a systems approach for studying a system in which people and the context interact requires the use of qualitative research methods to improve transparency and rigour. The key tasks are data collection and analysis. The authority and reliability of the process comes from the methods themselves and the lead reviewers' application of these methods, rather than from the Author or Chair's 'independence'. The importance of understanding local rationality – of learning how people saw things at the time and exploring with them ways in which aspects

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84   Fish, S., Munro, E. and Bairstow, S. (2008), *Learning together to safeguard children: developing a multi-agency systems approach for case reviews,* London, SCIE (available online at http://www.scie.org.uk/publications/reports/report19.pdf)

85   Fish, S., Munro, E. & Bairstow, S. (2010). *Piloting the SCIE 'systems' model for case reviews: learning from the North West of England,* London, Social Care Institute for Excellence (available online at http://www.scie.org.uk/publications/learningtogether/files/NWPilotsReport.pdf)

of the context were influencing their work – requires those involved in a case to play a major part in the review in analysing how and why practice unfolded the way it did and the broader organisational relevance. The approach is highly collaborative and findings from the SCIE pilots, like findings from the NPSA[86], show this approach secures timely and sustainable practice for those professionals involved, long before the findings are formally disseminated.

4.41   The current statutory guidance on SCRs gives agencies responsibility for collecting and analysing data within their own organisation and writing this up as an individual management review (IMR). An overview author is then commissioned to collate and analyse the set of reports and write an overview report. In a systems approach such a division is unhelpful and in place of an overview author a lead reviewer, trained in systems methodology, works with local professionals, to collect and analyse data. Adopting a systems approach will therefore require revising statutory guidance to remove the requirement for IMRs.

4.42   The new statutory requirement to publish not just the executive summary but the overview reports of SCRs has heightened concerns among professionals about how to anonymise successfully information about the child and family concerned, as well as the professionals involved. These are important issues. The failure to protect the privacy and welfare of the individuals involved may have serious implications and the Government has set out that '*overview reports should be published together with the executive summaries unless there are compelling reasons relating to the welfare of any children directly concerned in the case for this not to happen*'[87]. The systems approach focus on professional practice allows a report to foreground understanding of the practice issues, with minimal detail of the child and family concerned, and therefore reduces the risk of identification or distress.

4.43   When a child has died or been seriously injured and abuse or neglect issues are involved, there is necessarily a high chance that other proceedings, particularly criminal proceedings, will run in parallel to the SCR process or that negligence or employment tribunal proceedings will ensue. Participants in the SCR may therefore be called as witnesses. In circumstances such as this, it is vital that the SCR process endeavours not to contaminate evidence, by allowing potential witnesses access to information about the case they would not otherwise have had access to. As well as individuals potentially being summoned as witnesses, all the data generated as part of the case review process is potentially admissible in the court process and the LSCB would be legally required to disclose it if ordered to do so by a court. In the current SCR process, depending on the type of proceedings in question, this could include transcripts from interviews with staff, IMR reports, SCR Panel meeting minutes and the overview report. Taking a systems approach does not change this situation significantly.

4.44   The review understands that there is great anxiety on this matter, particularly because the systems approach asks staff to be open and honest about their work environments and how different aspects of context influence their work for better

86   Nicolini, D., Waring, J. & Mengis, J. (2011). 'The challenges of undertaking root cause analysis in health care: a qualitative study', *Journal of Health Services Research and Policy*, 16, pp34–41.

87   Letter from Parliamentary Under Secretary of State for Children and Families to LSCB Chairs and DCSs, 10 June 2010 (available on line at http://www.education.gov.uk/Childrenandyoungpeople/strategy/laupdates/a0071132/publication-of-serious-case-review-overview-reports-and-munro-review-of-child-protection)

or worse. However, the review does not consider that the kind of information garnered via a systems focused interview would be hugely relevant in criminal proceedings. To date, under the current process, the review understands that it is extremely rare, if ever, that anything beyond the overview report has been requested by the judiciary. It may be, therefore, that the fear associated with this scenario is more hypothetical than real. To test that, it will be important that instances and outcomes of disclosure requests are regularly monitored.

4.45   The review has heard a great deal of dissatisfaction from LSCBs and member agencies, about the unintended consequences of Ofsted's evaluations of SCRs. Many feel this has resulted in prioritising compliance with statutory guidance over and above the attainment of useful learning. As stated in the review's second report, and consistent with the move to reduce the bureaucratic burden of inspection, the review recommends that evaluations of SCRs should end.

4.46   Efforts to apply the systems approach to the multi-agency child protection system are still very new relative to other sectors. So it will be vital for Government to work with relevant agencies to give national leadership to the development of this approach. The health sector in England had a very senior public face fronting their move to a safety culture that focuses on learning, even when things have gone very wrong. There is no equivalent for the multi-agency child protection system and senior cross agency endorsement will be vital. The review considers that the Chief Social Worker proposed in chapter seven will need to play a central role.

4.47   The move to a systems approach to learning will require a radical reconceptualisation of the task and readjustment of the required skills. The extent of the change should not be underestimated. Here the experience of the recent SCIE pilots is useful. People fed back that 'getting your head around' the approach can be more difficult than expected:

> *'The challenge of escaping our deeply entrenched ways of thinking about and understanding front-line practice should not be underestimated. As we all tend to interpret new material in terms of familiar ideas and concepts, it is easy to misunderstand the fundamental nature of the change in moving to a systems approach and, therefore, to misapply the model'*[88].

4.48   Part of the function of developing expertise will need to include the provision of national training and accreditation programmes for lead reviewers of SCRs and other case reviews. Unlike the courses provided nationally to date, this will need to focus specifically on investigation theory and practice methods using a systems approach. The experience of the NPSA suggests that a one-off taught course is insufficient for this purpose. In response, SCIE is developing a practice-based learning model, whereby trainees conduct a supervised and supported case review thereby learning 'on the job'. The review suggests that previous experiences in health and social care are drawn on when developing future approaches to training and accreditation.

4.49   The review suggests that accredited lead reviewers become part of an active network, with obligations to provide methodological quality assurance of each other's case reviews and SCRs, on a peer support and challenge model. This

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88   Submission by Sheila Fish, SCIE, to the review.

function will need to be developed over time, as experience increases and is held by a wider group of people It will not remove accountability and responsibility for SCRs from LSCBs. LSCBs will still be responsible for initiating and signing off the final SCR report.

4.50   The review also suggests that the network of accredited reviewers is given obligations to document and reflect on the process of case reviews and SCRs they conduct. This would provide invaluable data on which to premise ongoing methodological development and updates to the training courses as required. The work and progress of this network might usefully be shared at an annual conference on systems methodology for conducting case reviews and SCRs.

4.51   As noted earlier, national learning will be facilitated by the development of a consistent typology with which to organise and present findings from training and learning activities. This reporting function should be linked to the national analysis and dissemination of lessons learnt from the Child Death Overview Panels (CDOP). As was noted in the second report, while there is evidence of good local learning from these CDOP reviews, there is currently no national mechanism in place for systematically analysing, collating, and disseminating that local learning.

4.52   To date, these kinds of expertise and functions to allow the development of systems approaches to reviews in the sector have not existed at a national level. SCR authors and chairs have not been expected to have particular expertise in review or other equivalent learning methods, such as those held by accident investigators in other fields. They have also tended to work very much in isolation, with no sense of being a professional community, in contrast with patient safety experts. This has limited any systematic collation of experience and consolidation or sharing of knowledge and expertise. There has been no cultivation of ongoing cycles of learning *about learning*. This needs to be rectified and the reviewing community supported to stay creative, in order that the sector can get cumulatively more effective at this vital task. In addition, the collation and dissemination at a national level of lessons learnt has been hindered by the lack of a consistent typology for the organisation and presentation of findings from individual SCRs.

4.53   At the second report stage the review was considering whether these functions would best be carried out by a national body equivalent to the NPSA. Given the extent of the tasks as described above, the review does consider that some kind of body will be necessary to lead and coordinate these roles. However, the review has decided to leave the questions of form to Government and set out the required functions and how they are related. Learning from discussions with the NPSA, the review also strongly suggests that the training and accreditation functions not be separated from the other functions, in order to allow for timely methodological adaptation on an ongoing basis.

Recommendation

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

- provide accredited, skilled and independent reviewers to jointly work with LSCBs on each SCR;
- promote the development of a variety of systems-based methodologies to learn from practice;
- initiate the development of a typology of the problems that contribute to adverse outcomes to facilitate national learning; and
- disseminate learning nationally to improve practice and inform the work of the Chief Social Worker (see chapter seven).

In the meantime, Ofsted's evaluation of Serious Case Reviews should end.

Chapter five: Sharing responsibility for the provision of early help

The case for preventative services is clear, both in the sense of offering help to children and families before any problems are apparent and in providing help when low level problems emerge. From the perspective of a child or young person, it is clearly best if they receive help before they have any, or have only minor, adverse experiences. Evaluative research provides the same message, showing that there are a number of helping methods that have a good record of reducing the later incidence of adverse outcomes for children and young people but that, in comparison, services offered once problems become severe have a much lower effectiveness rate. The reviews conducted by Graham Allen MP, Rt Hon Frank Field MP and Dame Clare Tickell share this review's belief in the importance of providing help early.

From this review's point of view the three key messages are that:

- preventative services will do more to reduce abuse and neglect than reactive services;
- coordination of services is important to maximise efficiency; and
- within preventative services, there need to be good mechanisms for helping people identify those children and young people who are suffering or likely to suffer harm from abuse or neglect and who need referral to children's social care.

The argument for early help

5.1   Services offering early help are not aimed just at preventing abuse or neglect but at improving the life chances of children and young people in general. 'Early help' is an ambiguous term, referring both to help in the early years of a child or young person's life and early in the emergence of a problem at any stage in their lives. Both meanings are relevant in the review. Children and young people's problems arise from many factors other than poor or dangerous parental care, but it is the latter cause that is most relevant to this review.

5.2   The arguments for early help are three-fold. First there is the moral argument for minimising adverse experiences for children and young people. This is endorsed by the United Nations Convention on the Rights of the Child (CRC) and the Children Act 1989. Secondly, there is the argument of 'now or never' arising from the evidence of how difficult it is to reverse damage to children and young people's development. The third argument is that it is cost-effective when current expenditure is compared with estimated expenditure if serious problems develop later.

5.3   From a child or young person's point of view, the earlier any necessary help is offered the better, since it minimises his or her experience of difficulties. There are also good arguments from research findings to endorse this. The evidence demonstrates how deficiencies in early years experiences have an enduring impact on the child or young person's subsequent development and opportunities in life[89]. The evidence from evaluative research shows that we have more ability to prevent or resolve maltreatment problems when they are at an early stage than when serious abuse or neglect has occurred[90].

5.4   It is known from research that certain features of family life are associated with adverse outcomes for children and young people. These include having parents with mental health needs or substance misuse issues, living in a home where domestic violence occurs[91], and living in poverty. However, it is also known that many children and young people affected by these factors nonetheless thrive. This is important because it indicates that these circumstances do not make harm inevitable. Studies of siblings who have suffered maltreatment, for example, reveal how varied their life course may be[92]. Conversely, children and young people in families without these risk factors may suffer adverse outcomes.

5.5   As detailed in the review's second report, there are national statistics available about the actual or potentially harmful circumstances in which children and young people are living and local areas have the task (and statutory duty in the case of the Joint Strategic Needs Assessment) of building up a profile of their own local need. This profile (underpinning the strategies of the planned health and wellbeing boards) should help strategic leaders, local politicians, and professionals to understand the potential variety of responses that may be required in their area and to commission appropriate and relevant services.

5.6   The provision of early help also plays a critical part in child protection, in supporting the State to fulfil its duties under Article 19 of the CRC. This Article particularly requires action to prevent the abuse or neglect of children and young people as well as to deal with its incidence. In March 2011, a 'General Comment' on this article was made by the Committee supporting the CRC. One observation underpinning the Article is that responsibility for the primary prevention of violence against children and young people lies with public health, education, social and other services[93]. In the 'General Comment', violence is defined as all forms of harm to children and young people, including physical and mental violence, injury or abuse, neglect or negligent treatment or exploitation, including sexual abuse.

5.7   The 'now or never' argument cites the compelling evidence on the enduring damage done to babies by unresponsive and neglectful adults. Later in life, their

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89   National Research Council (2000), *From Neurons to Neighbourhoods: The Science of Early Childhood Development*, Washington D.C. (available online at http://www.nap.edu/openbook.php?isbn=0309069882)

90   Macmillan, H. et al. (2009), 'Interventions to prevent child maltreatment and associated impairment', *The Lancet*, Volume 373, pp250–266.

91   Cleaver, H., Unell, I., & Aldgate, J. (in press), *Children's Needs – Parenting Capacity. Child Abuse: parental mental illness, learning disability, substance misuse and domestic violence.* 2nd edition, London, Jessica Kingsley Publishers.

92   Bifulco, A. (2008), 'Risk and resilience in young Londoners' in *Treating traumatised children: Risk, resilience and recovery* (eds.) Brom, D., Pat-Horenczyk, R., and Ford, J. London, Routledge.

93   See General Comment No. 13 (2011), *Article 19: The right of the child to freedom from all forms of violence*, New York, United Nations (available online at http://www2.ohchr.org/english/bodies/crc/docs/CRC.C.GC.13_en.pdf)

abilities to develop social and emotional capabilities are at serious risk. Babies reach out from birth naturally to create emotional bonds. Such bonds develop at their best when caring adults respond warmly and consistently.

> *'This secure attachment with those close to them leads to the development of empathy, trust and wellbeing. In contrast, an impoverished, neglectful or abusive environment often results in a child who doesn't develop empathy, learn how to regulate their emotions or develop social skills, and this can lead to an increased risk of mental health problems, relationship difficulties, anti-social behaviour and aggression … some forms of insecure attachment are associated with significantly elevated levels of perpetrating domestic violence, higher levels of alcohol and substance misuse …'* [94].

5.8   Neuroscience also offers lessons on the importance of the early years. A recent paper by the Royal Society[95] on the implications of neuroscience for education policy, highlights that there are changes in the brain taking place throughout life, but the number decreases with age. The worst and deepest brain damage occurs before birth and in the first 18 months of life when the emotional circuits are forming.

5.9   The third argument on the cost-effectiveness of early help has a growing body of evidence to support it. This is addressed in the interim report of the Allen Review[96] and also in a recent publication[97] that analysed the costs and economic pay-offs of a range of interventions in the area of mental health prevention, promotion, and early intervention. The report identified potential savings over the following six years, for every one pound of expenditure including:

- parenting interventions to prevent persistent conduct disorders in their children, savings of £7.89;
- school-based social and emotional learning programmes, savings of £83.73; and
- GP screening for alcohol misuse, savings of £11.75.

5.10 The report summarises the lessons to draw from their work. The results of these economic models suggest some general conclusions:

- ***value for money.*** *Even though the economic modelling is based on conservative assumptions, many interventions are seen to be outstandingly good value for money;*
- ***self-financing*** *A number of interventions are self-financing over time, even from the narrow perspective of the NHS alone. However, the scope for 'quick wins', in the sense of very short payback periods for the NHS, is relatively limited;*

94   Allen, G. (2011), *Early Intervention: the next steps* (available online at http://media.education.gov.uk/assets/files/pdf/g/graham%20allens%20review%20of%20early%20intervention.pdf)

95   The Royal Society, (2011), *Brain Waves Module 2: Neuroscience implications for education and lifelong learning* (available online at http://royalsociety.org/uploadedFiles/Royal_Society/Policy_and_Influence/Module_2_Neuroscience_Education_Full_Report.pdf)

96   Allen, G. (2011), *Early Intervention: the next steps* (available online at http://media.education.gov.uk/assets/files/pdf/g/graham%20allens%20review%20of%20early%20intervention.pdf).

97   Knapp, M., Parsonage M. & McDaid, D. (eds.) (2011), *Mental Health Promotion and Mental Illness Prevention: The Economic Case,* London, Department of Health (available online at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_126085)

- ● ***range of impacts*** *Many interventions have a broad range of pay-offs, both within the public sector and more widely (such as through better educational performance, improved employment/earnings and reduced crime;)*

- ● ***timescales*** *In some cases the pay-offs are spread over many years. Most obviously this is the case for programmes dealing with childhood mental health problems, which in the absence of intervention have a strong tendency to persist throughout childhood and adolescence into adult life. However, the overall scale of economic pay-offs from these interventions is generally such that their costs are fully recovered within a relatively short period of time;*

- ● ***low cost*** *Many interventions are very low cost. A small shift in the balance of expenditure from treatment to prevention/promotion should generate efficiency gains;*

- ● ***range of interventions*** *The interventions included in the analysis cover a wide range, from the prevention of childhood conduct disorder to early intervention for psychosis, practical measures to reduce the number of suicides and wellbeing programmes provided in the workplace. Many of these interventions are an NHS responsibility, but the analysis also highlights opportunities for the NHS to work closely in partnerships with other organisations and in jointly funded programmes;*

- ● ***programme design and implementation*** *In many cases the modelling of economic impacts reveals the importance of key elements of programme design and implementation such as targeting, take-up and drop-out, although we have not reported details here. One consequence is that for some interventions the most cost-effective action when refining a programme may be to increase take-up among high-risk groups or to improve completion rates, rather than to broaden coverage of the intervention; and*

- ● ***evidence-based*** *Finally, it should be emphasised once again that each of the modelled interventions is evidence-based, in the sense of having been shown to be effective in improving mental health. The economic analyses summarised in this report show that, over and above these gains in health and quality of life, the interventions also generate very significant economic benefits including savings in public expenditure*[98].

Associated reviews

5.11   Three other reviews concerned with aspects of early help have been commissioned by the Coalition Government. They have all independently reached the same conclusions as this review on the importance of providing help early in order to improve outcomes for children and young people, with concerns that range from preventing abuse and neglect to helping parents achieve the aspirations they hold for their children.

5.12   The independent review by the Rt Hon Frank Field MP[99] looked specifically at child poverty and life chances for those born into the most disadvantaged circumstances. The findings were clear that very early interventions are essential if

98   Knapp, M., Parsonage, M. & McDaid, D. (eds.) (2011), *Mental Health Promotion and Mental Illness Prevention: The Economic Case,* London, Department of Health (available online at http://www.dh.gov.uk/en/ Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_126085).

99   Field, F. (2010), *The Foundation Years: preventing poor children becoming poor adults* (available online at http://webarchive.nationalarchives.gov.uk/20110120090128/http://povertyreview.independent.gov.uk/ media/20254/poverty-report.pdf).

children and young people are to overcome their disadvantage and go on to experience good outcomes. The review was equally clear that these interventions are most effective in the form of excellent services in the early years, rather than cash transfers or remedial action later in life. A further recommendation advised that excellent services should also be provided for those children and young people who need them when they are older.

5.13 This emphasis on effective intervention in the early years is echoed in Graham Allen's independent review[100]. The Allen review is seeking to break the intergenerational cycle of disadvantage by analysing and disseminating what works in terms of early intervention. It considered how models of best practice could best be disseminated as well as how they could be supported through innovative funding models, including non-Government funding. The review focused on those early interventions that have clear evidence of effectiveness in improving outcomes for their target group in a cost effective way, taking account of savings on costly interventions in later life. The review published its first report on 19 January. A final report on funding will be produced by May 2011.

5.14 The third review, chaired by Dame Clare Tickell[101], looked at the Early Years Foundation Stage (EYFS), which includes safeguarding requirements for early years settings. Dame Clare Tickell makes recommendations for improvements in how settings keep children safe, making clear that this is an element of the EYFS which cannot be compromised, and this is a view which has the overwhelming support of the sector. There is a recommendation that the welfare section of the EYFS is renamed the 'safeguarding and welfare requirements', and that the welfare requirements are re-drafted to improve their clarity. The review also calls for a greater emphasis on identifying inappropriate behaviours, in both children and adults, which may indicate maltreatment. Dame Clare Tickell recommended that practitioners be expected to have the necessary knowledge and expertise to make clear and appropriate judgments so that concerns are either effectively addressed or passed to the most appropriate local agencies.

5.15 The Marmot review[102] of health care, commissioned by the previous Government, also described the importance of provision for families in children's early years and for an integrated policy framework for early child development, including the prenatal period and infancy. The planning and commissioning of maternity, infant and early years family support services should, the review argues, be part of a wider multi-agency approach to commissioning children and family services[103].

Current policies

5.16 The previous and current governments have acknowledged the importance of early help in improving outcomes for children and young people. The previous Government developed the National Service Framework for Children, Young

100 Allen, G. (2011), *Early Intervention: the next steps* (available online at http://media.education.gov.uk/assets/files/pdf/g/graham%20allens%20review%20of%20early%20intervention.pdf)

101 Tickell, C. (2010), *The Early Years: Foundations for life, health and learning* (available online at: http://www.education.gov.uk/tickellreview)

102 Marmot, M. (2010), *Fair Society, Healthy Lives – A Strategic Review of Health Inequalities in England* (available online at http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf)

103 Ibid, pp102

People and Maternity Services[104], the Every Child Matters: Change for Children programme, the Children Act 2004 and the Childcare Act 2006 came into force.

5.17   The current Government has continued to emphasise the importance of multi-agency working and early intervention:

- the Early Intervention Grant (EIG) worth £2,222 million (2011–12) and £2,307 million (2012–13) is being allocated to local authorities in England to fund universal programmes and activities available to all children, young people and families as well as specialist services where intensive support is needed;
- the Social Mobility Strategy, *Opening Doors, Breaking Barriers*[105] aims for everyone to have a fair opportunity to fulfil their potential, regardless of the circumstances of their birth with specific measures to improve social mobility from the Foundation Years to school and adulthood;
- the child poverty strategy, *Tackling the causes of disadvantage and transforming families lives*[106] sets out how the Government intends to transform people's lives by breaking the vicious cycle of deprivation and a new Social Mobility and Child Poverty Commission has been established; and
- the commitment to double the number of places on the Family Nurse Partnership programme for new mothers that has been shown to improve parenting and can help families where there is a risk of abuse or neglect.

5.18   The review endorses the initiatives described above in addition to the Government's intentions to improve family support services in communities through the Sure Start Children's Centre programme and the Health Visitor programme (the Government has committed to have an extra 4,200 health visitors by 2015 – an increase of some 50 per cent). Sure Start Children's Centres are well placed to provide early help to children and families. The Government has committed to retaining a network of children's centres, accessible to all families but focused on those in greatest need. There remains a duty for local authorities to ensure that there is sufficient provision of children's centres to meet local need, as outlined in the Childcare Act 2006.

5.19   Many families are already familiar with the range of services delivered from Sure Start Children's Centres including Health Visitors and wider therapeutic services. The best Sure Start Children's Centres know their communities well and already work holistically with the whole family, acting as hubs for multi-agency teams with access to social work expertise that allows conversations around the types of help and interventions that are needed to support children, young people and families. According to *The Sure Start Journey: A Summary of evidence*[107] which summarises the headlines from the National Evaluation of Sure Start (NESS) research reports:

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104 Department of Health and Department for Education and Skills (2004), *National Service Framework for Children, Young People and Maternity Services,* London, Department of Health (available online at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089101)

105 HM Government (2011), *Opening Doors, Breaking Barriers: A Strategy for Social Mobility (*available online at http://download.cabinetoffice.gov.uk/social-mobility/opening-doors-breaking-barriers.pdf)

106 HM Government (2011), *A New Approach to Child Poverty: Tackling the Causes of Disadvantage and Transforming Families' Lives* (available online at: http://www.education.gov.uk/publications/eOrderingDownload/CM-8061.pdf).

107 Department for Children, Schools and Families (2008), *The Sure Start Journey: A Summary of Evidence* (available online at http://www.education.gov.uk/publications/standard/Surestart/Page1/DCSF-00220-2008)

'the nature of multi-agency working in programmes allowed services to be offered in good time to prevent difficulties developing, especially where children had additional needs and in safeguarding cases.'

5.20 The following case study illustrates the extensive role children's centres can play in providing services to children and families.

Case Study

Merton's 0–12 yrs, Supporting Families Service (0–12 SFS)

The London Borough of Merton's 0–12 SFS has been operational since October 2008. The service provides a single point of access for targeted child and family support services and gives a coordinated response to children from pre-birth up to the age of 12 and their families.

The service provides the borough wide Children's Centre targeted provision, which complements the core delivery of the eleven Children's Centres across the borough. This includes support to address the wide-ranging needs of disadvantaged children and families and to help establish the best outcomes for them.

It operates as an early help service which is integral to Merton's child well being model. Requests for services are made by parents or professionals and are considered by a multi-agency panel, overseen by a manager who is a qualified social worker. Professionals associated with panel decisions about early help for families include, the manager from the Access and Assessment service, the Designated Lead for Child Protection from the Child Health Service, the manager of the school based social work team, a Lead Officer for the special educational needs and Disabilities Integrated Service, a shared Child and Adolescent Mental Health worker and jointly commissioned voluntary sector agencies that provide targeted family support. Of the six services commissioned to provide targeted family support, three are managed by social work qualified staff, one is a well established national organisation and two are long standing local organisations with well qualified staff.

Recent evaluations have concluded that the 0–12 SFS provides an appropriate and timely response to addressing children's needs.

5.21 Organisations such as Home Start UK and Community Service Volunteers (CSV) demonstrate the value of volunteers in communicating models of good parenting too. Evidence submitted to the review indicates that their services are well received by parents that are struggling, because specific attention is devoted to those children with complex needs and the support is shaped to reflect the needs of children and families[108]. Volunteers working with children and families require regular and skilled supervision. CSV volunteers are provided with formal supervision on a six-weekly basis, which is supplemented by informal telephone and email conversations with project coordinators. Project coordinators are recruited from a range of backgrounds, but all are familiar with child protection

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108 Tunstill, J. (2007), *Volunteers in Child Protection: A study and evaluation of CSV's pilot projects in Sunderland and Bromley – Executive Summary,* Community Service Volunteers (available online at http://www.csv.org.uk/sites/default/files/ViCP%20Research%20-%20Executive%20Summary.pdf)

procedures and have experience of working with vulnerable children, young people and families. Volunteers should be confident to discuss any concerns about a child's safety and welfare with the lead professional or a social worker and know when to refer a child or young person to children's social care.

Coordination of service provision

5.22   When the cost-effectiveness of early help provision is considered, comparison should be made of the expenditure in providing the service and the predicted savings on provision of other services later on. The problem is that this later provision is often provided by a different agency so, at an individual service level, the cost-effectiveness argument is not always strong. Outcomes for children, young people and families at a later point are usually also worse because difficulties have existed for longer. This has led the current Government to develop the Families with Multiple Problems Programme:

- families with multiple problems require a range of different help and support which needs to be provided in a focused and targeted way if it is to be effective and yet evidence has shown that these children and families can be targeted by up to 20 professionals. Such an approach is both disruptive for the child and family as well as costly. Cost data provided by local authorities identified that local areas already spend in excess of £4bn each year in supporting and dealing with the problems faced by these children and families. Intensive coordinated interventions with such children and families can deliver substantial savings in public expenditure but the savings do not necessarily accrue to the organisations that need to invest in the intervention. Independent monitoring of 'key worker' type family interventions show sustained 30–50 per cent reductions in problems associated with family functioning, crime, health and education within 12 months through operating in a coordinated and joined up way[109];

- government funding streams and funding restrictions have prevented local areas from redesigning services, have created unnecessary duplication and have prevented services from focusing on family needs. This has led the Coalition Government to introduce community budgets to enable local areas to overcome this complexity by allowing services to pool resources and share the savings. It is recognised that local areas may need to invest in service redesign before being able to realise savings in future years. This approach fits well with that taken by this review, of creating space for innovation, working collaboratively across services to create a joined up approach dedicated to tackling family problems and investing in service redesign to meet the specific needs of children, young people and families. From April 2011 there are 16 community budget areas piloting this approach and the review team has been working with a number of them on flexibilities relating to assessment and timescales.

5.23   During the course of this review, there has been concerning evidence that early support and preventative services are the target for cuts and efficiencies in this financial year because of the constrained financial situation at the present time. In December 2010 the Local Government Association indicated that the non-

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109 Department for Education (2010), *Monitoring and evaluation of Family Intervention Projects to March 2010* (available online at http://www.education.gov.uk/rsgateway/DB/STR/d000956/index.shtml)

schools budget will decrease by 12 per cent in real terms with no indication of the impact on non-schools spending covering areas such as child protection and prevention[110]. The *Counting the Cuts* survey questioned 72 *Children England* member organisations. Seventy-one per cent said they would experience some kind of cut in income for 2011/12 with more than a quarter experiencing cuts of more than 25 per cent[111].

5.24 Since preventative services do more to reduce abuse and neglect than reactive services, this review considers attention to coordinating services, such as is being attempted through community budgets, as essential. This is both to maximise the efficient use of resources and to effectively safeguard and promote the welfare of local children and young people. With significant reforms underway in all the main public services, there is a further risk of inefficiencies if reforms do not take account of the repercussions for other services. Coordination of preventative services can be achieved locally through responsible innovation and improved professional judgment by local partners and need not be prescribed nationally. However the State's responsibility to protect children and young people means Government must provide a clear legal framework to set out what vulnerable children and young people and their families should expect from the collective efforts of local agencies. The review is therefore recommending that the Government require local authorities and statutory partners to secure sufficient provision for early help and to set out their arrangements to develop and implement this locally for children, young and people and families.

5.25 With so many providers involved, often working with members of the same family, coordination of help is important to reduce confusion, inefficiency and ineffectiveness in service provision. Evidence to the review indicates that many working with children, young people and families are unclear about how to manage and share information, how to make decisions about what early help to offer, or how to safely identify those children and young people who may be suffering or likely to suffer harm. The boundary between what is safe for a child or young person in a family and what has become too dangerous and harmful is never clear. This is one key reason for local policies about early help to be shared, clearly understood by those working in them, and for social work expertise to be available.

5.26 Confusingly, the phrase 'the Common Assessment Framework' is used to describe both the policy of encouraging integrated professional work to provide early help, and the form that has been developed by Government. Whilst the review does not disagree with the policy (though its non-mandatory status creates a confusing message about the importance of early and shared responsibility for helping children and families), there is conflicting evidence on whether the form is contributing to improved practice or not. In line with other recommendations on reducing prescription about how professionals carry out their duties, the review considers that local areas should have the flexibility to make local decisions on revising the form to suit local needs. In doing so, they should work closely with other professionals involved with children and families and agree both the

110 Local Government Group, (2010), *LGA briefing for Opposition Day Debate: Impact of cuts to local government funding* (available online at http://www.lga.gov.uk/lga/core/page.do?pageId=15383240)

111 CYP Now, (5 April 2011), *Preventive work hardest hit by cuts by Janaki Mahadevan* (available online at http://www.cypnow.co.uk/Joint_working/article/1064067/Preventive-work-hardest-hit-cuts/)

evidence and theoretical basis for their offer of early help. Nationally prescribed sets of forms and software specifications can unintentionally influence and limit local practice, making it difficult for local authorities to innovate in response to new evidence or respond to particular problems in their area. Local arrangements should take account of the cross-boundary work of health and police services. Arrangements should also make it clear whether a child or their parents have consented to sharing personal and sensitive information with other services and always take account of the child or young persons' perceptions of their circumstances and their wishes and feelings in line with their evolving capacities.

5.27   In developing local and shared arrangements to identify and record the early help needed by children, young people and families, it is the *provision* of an early help offer, where their needs do not meet the threshold for children's social care services, which will continue to matter and make the most difference to them.

Recommendation

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

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

5.28   The health reforms being planned at the time of this review offer the potential to support emerging strategies concerning early help to children, young people and families. The planned health and wellbeing boards are likely, as a minimum, to bring together elected councillors, representatives of local people and patients through local health watch organisations, and the lead commissioners for health, social care and children's services. Their members are likely to develop shared strategies for how they can best work together to improve the health and wellbeing of local people and communities, including children, young people and families.

Identifying abuse and neglect

5.29 That there is a strong case for providing early help is relatively easy to understand. More difficultly is introduced when considerations about abuse and neglect are added. It is easy to offer a definition of which families or problems can be helped through a range of preventative services, but in practice, there are many difficulties in assigning children and families to appropriate services that meet their needs. However, making decisions about when a child is or may be suffering harm and needs a child protection response is, in many cases, complex.

5.30 Levels of prevention can be categorised as:

- *universal primary prevention* – addressing the entire population and aiming to reduce the later incidence of problems, for example, the universal services of health, education, income support;
- *selective primary prevention* – focusing on groups which research has indicated are at higher than average risk of developing problems. Many of the interventions recommended in Graham Allen's review fall into this category, for example, offering additional support services to teenage mothers;
- *secondary prevention* – aiming to respond quickly when low level problems arise in order to prevent them getting worse. This area of multi-agency work has been the focus of policy development since the last Conservative Government's 're-focusing' policy in 1995 and the Labour Government's policy of 'Every Child Matters';
- *tertiary help/prevention* – involving a response when the problem has become serious, for example, child protection, hospital care, criminal justice; and
- *quarternary help/prevention* – providing therapy to victims so that they do not suffer long term harm, for example, therapy for victims of sexual abuse or therapeutic help for looked after children.

5.31 However, the link between the levels of services is not clear cut. There are particular challenges involved in assessing whether children and young people are suffering, or are likely to suffer, significant harm. Statutory guidance tells those working with children and families to refer such children to children's social care but making this decision is not straightforward. Abuse and neglect rarely present with a clear, unequivocal picture. It is often the totality of information, the overall pattern of the child's story, that raises suspicions of possible abuse or neglect.

5.32 Secondary preventative services seek to identify children and families with first signs of problems, but they may fit several categories and it is not easy for workers to know which is which. The presenting signs may be in the child or the parents' behaviour. A teacher may become concerned because a parent appears intoxicated when collecting a young child from school or because a child starts to behave in a problematic way in the classroom. The level of impact on the child from problematic parenting does not correlate with the severity of the adult's problems. A child may be showing only low level signs of disturbance that appear to be linked to having a drug-abusing mother but dealing with the mother's drug addiction is not a low level problem. It is important that assessments of a child's

circumstances include some assessment of the level of expertise needed to deal with the problems in a family that are contributing to poor outcomes for the child.

5.33 However, the most problematic group are those where the first signs look low level but are really the tip of an iceberg and the child is actually being seriously harmed. To give a real example, a support worker may visit a home and be told that one child is visiting his grandmother. She can see that his brother and sister are well cared for. Being told that a child is visiting a grandparent does not, on its own, ring alarm bells. If that child continues to be out of sight on future visits as well, then there comes a point when the support worker should become suspicious, though this requires judgment. There is no simple rule. In one form of maltreatment, parents scapegoat a particular child and take good care of the others. In this case, the absent child was, in fact, locked in a bedroom starving.

5.34 This last possibility that the presenting problem, though low level in itself, may be the surface evidence of a deeper problem receives more attention when there has been a major child death story in the media. Workers often then make more referrals to children's social care in case, on further investigation, the child is found to be suffering significant harm. Over the past three years, referrals to children's social care have risen steadily. 547,000 children were referred to children's social care in 2008/09. There has been a 10 per cent rise to 603,500 in 2009/10. The figures for 2009/10 also show 13 and 14 per cent rises in initial and core assessments respectively from 2008/09. In both years six per cent of children referred to children's social care became or continued to be the subject of child protection plans. The overwhelming majority of referrals concerned children who were subsequently judged not to be suffering, or likely to be suffer, significant harm. The looked after children population rose by six per cent from 60,900 in 2008/09 to 64,400 in 2009/10. This level of demand for responding to referrals diminishes the ability of children's social care to provide effective protection to those children who are suffering, or likely to suffer, harm.

5.35 There is a tension in providing support to parents. For most, the right approach is to offer services to children and families where they are able to make a voluntary choice to receive them. There are parents whose capacity to meet their children's needs raises some concerns and the relevant services can make more strenuous efforts to make them aware of the help available and to gain their cooperation. There are also parents whose capacity to parent their children raises serious concerns, and it may be necessary to take a more coercive approach. It is the problem of deciding when to escalate the level of professional involvement that is the major challenge in practice. The risks to, and potential harm that can come to, children who are being supported in community services when they are in fact being neglected and hurt and should be the referred to statutory child protection services is the dilemma professionals face. Equally, there is a cost to having a low threshold of referral to children's social care. In many cases, suspected abuse or neglect will not be substantiated but the children and families may have been subject to a child protection enquiry which is an unpleasant, and sometimes traumatic, experience. A complicating factor is that parents who voluntarily engage with support services tend to make more progress, while a more coercive approach can deteriorate into an adversarial relationship which blocks progress. Therefore, moving up the scale of intrusiveness carries both gains and losses and so creates a complex decision.

5.36   Designated and named leads working in early years, education and health have an important role to play in responding to the challenges involved in assessing whether children's presenting needs means they are suffering, or are likely to suffer, significant harm. *Working Together* is clear about the significance of the roles that these named individuals have in recognising and responding to the indicators of possible abuse and neglect of a child and young person at an early stage. These roles facilitate effective engagement and dialogue between professionals and provide a single point of contact for local partners.

5.37   Schools are particularly well placed to notice children and young people in need of help and also to notice those where there are more serious concerns about their safety. Supporting children so that they get the very best education is only possible when they are safe and well cared for. Evidence to the review from Head Teachers was that they often have difficulty in accessing help for children and young people about whom they have concerns. High local thresholds may mean that social care services cannot help and yet there is still a need and possibly some distress for the child or young person about their circumstances. A lack of feedback from some children's social care services means that teachers and Head Teachers are not able to learn how to select cases for referral more accurately. Further, the process for accessing other services may not be clear, if indeed the services exist. This further emphasises the need for the review's recommendation to secure early help services set out earlier in this chapter. It will be important that services are available to support the needs of vulnerable children and young people who are not in need of protection but who clearly need help. The availability of social work expertise in these cases is important in helping school staff to think through best next steps and to take more urgent action if that is deemed necessary.

5.38   The police play a crucial part in the identification and support of children, young people and families. Safeguarding is not only the duty of the specialist child protection officers but is a fundamental duty of all police officers and staff. Patrol officers and Safer Neighbourhood policing sfaff, are regularly involved in instances of domestic abuse, parent and carer substance misuse and mental health issues. This places them in a key position to identify and children or young people living in these households who may be in need of early help or protection.

5.39   Because of the complexity of assessing why a child has problems or how serious they are, many areas are developing some form of multi-agency team for responding to referrals and deciding which type of help, if any, is needed. Evidence to the review is that many welcome the opportunity to consult such a team and access social work expertise to discuss how best to help children. Around the country a number of areas are developing co-located social work led multi-agency teams, which in some areas are called 'locality teams'. Within these teams, police have safer neighbourhood policing staff, school liaison officers, youth offending teams, and regular interaction with the specialist child abuse officers.

5.40   These multi-agency teams are relatively new and are taking a number of forms so it will be valuable to look at evidence about their relative effectiveness as it is collected. One example is given in the case study below.

> **Case Study**
>
> **Multi Agency Safeguarding Hubs (MASH)**
>
> In 2008, Devon and Cornwall police and Devon County Council worked with other safeguarding partners to establish a more robust and secure system for sharing information across different agencies and partners. This coincided with Devon Safeguarding Children Board commissioning a multi-agency audit of safeguarding cases which had provided evidence that key pieces of information were not being shared between agencies and as a result outcomes for children and young people were being jeopardised.
>
> The MASH comprises a multi-agency team of people who continue to be employed by their individual agencies (local authority, police and health services) but who are co-located in one office. It operates on the basis of a 'sealed' intelligence hub where protocols govern how and what information can be released in support of helping and protecting children and young people. Co-location was considered essential in order for the process to work, being the most effective means of building relationships, trust and understanding between agencies in order to enhance confidence in sharing information.
>
> Notifications to the MASH are triaged by a social work manager who categorises them by making an initial judgment as to the level of risk to the child. The category determines the timescale for a decision to be made, ranging from a few hours (four hours in urgent cases) to a few days. Information is shared securely within the hub and is gathered from teachers, GPs, health visitors, school nurses, police officers and others who are contacted by their professional lead who sits within the hub. Once this information has been gathered together, a social work manager makes a decision as to what further action is required.
>
> An evaluative study commissioned by Devon County Council is showing early indications of improvements in decision making and outcomes for children and young people as a result of agencies being co-located. Better information is also leading to better responses to referrals. This has however also meant that workloads for the early help teams have increased and there is now a clear acknowledgement across statutory partners, that a better range of services is needed at this preventative tier if many of the children are to be helped early.

5.41   There is also some evidence that such multi-agency teams are proving more efficient than previous arrangements. The Integrated pathway and support team in Tower Hamlets manages the 'front door' for children's social care. It is an integrated team managed by an experienced social worker. Conversations about referrals from other agencies form a major part of the work for the team. Despite a significant increase in contacts over the past two years, there has been a 50 per cent reduction in those that progress to referral – that is moving forward into the statutory social care service – by being appropriately directed elsewhere. The efficiencies gained in not pursuing contacts that can and should be better managed outside of social care should be noted.

5.42 A final note of caution is that however expert are the multi-agency team who assess a referral, they cannot guarantee making the right judgments. Some cases of abuse and neglect are well concealed and the surface problems within a family look benign. There is a limit to how thoroughly family life can be scrutinised.

Chapter six: Developing social work expertise

Many of the previous reforms that have increased prescription and bureaucratic processes in child and family social work were intended to improve the quality of practice. The review considers that the balance between following rules and exercising professional expertise has become skewed so that insufficient attention has been given to how to help frontline workers work effectively with children and families. Building on the work of the Social Work Task Force and the Social Work Reform Board, this chapter makes the case for radically improving the knowledge and skills of social workers from initial training through to continuing professional development. Social work involves forming relationships with children and families to understand them and help them change. This has implications for how they are managed and supervised to minimise bias, help them articulate their reasoning, draw on research evidence, and manage their emotions to reduce the risk of distorted reasoning. Analysis of current practice, in the light of evidence about how people reason and develop knowledge and skills, concludes that the development of expertise, both in the individual and in the profession in general, has been hampered by a career structure that fails to encourage and reward growing expertise.

The case for change

6.1   The review was asked to consider how to reduce bureaucracy in social work and increase the space for professional judgment. Whilst sound professional judgment requires time, it also requires social workers to be in possession of the right knowledge and be capable of clear reasoning. Children need and deserve a high level of expertise from their social workers who make such crucial decisions about what is in their best interests. This expertise should include being skilled in relationships where care and control often need to be combined, able to make critical use of best evidence from research to inform the complex judgments and decisions needed and to help children and families to solve problems and to change.

6.2   Social workers can make a significant contribution to improving the lives of children and their families[112]. Some practice is already excellent but the review is concerned to create the context in which that high level of expertise can become the norm. The aim of this chapter is to set out what knowledge and skills are needed. However, the individual social worker cannot achieve expertise without the right institutional structures and support. It is the conclusion of this review

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112 Mullen, E. & Shuluk, J. (2010), 'Outcomes of social work intervention in the context of evidence-based practice', *Journal of Social Work*, 11, pp49–63; Lindsey, D. & Shlonsky, A. (2008), *Child Welfare Research*, Oxford, Oxford University Press.

that the current career pathways and conditions of employment are not conducive to developing the level of expertise that is potentially available to help children and their families and this is discussed in chapter seven.

6.3   Efforts to improve the profession's expertise have a long history – often with limited success. Most recently, the work of the Social Work Task Force (SWTF) being implemented by the Social Work Reform Board (SWRB) has yet to take full effect. This review warmly endorses these reforms and is keen to build on their efforts and momentum.

6.4   The path to today's commitment to a highly trained workforce has been long and marked by dispute about what knowledge or skills were needed. The profession of social work began as several distinct occupations, which had very different assumptions about the nature of their expertise and the importance of training. There were, for example, two occupations working with people with mental illness: psychiatric social workers based in hospitals were required to have undertaken university-based training while the Poor Law Receiving Officers, working in the community, had no formal training. Child Care Officers, created by the 1948 Children Act, and Medical Social Workers (formerly almoners) undertook university training but few Welfare Officers in local authorities did so[113].

6.5   In 1972, following the Seebohm Report[114], most of these different groups were brought together in the newly-formed Social Services Departments and most people were employed as 'generic' social workers, considered competent to work with the full range of human problems that fall within the remit of social work[115]. The fact that it was considered possible to amalgamate people in this way, bringing together those with graduate education and those without any formal training, illustrates a lack of conviction that training and specialist knowledge was really important. The mixed range of abilities in the workforce was reflected in a subsequent split in training between the university-based Certificate of Qualification in Social Work and the lower educational level Certificate of Social Services until the 1990s when the two qualifications were amalgamated into a single qualification, the Diploma in Social Work (DipSW), which could be obtained via a range of different educational routes.

6.6   In 2001 the Government announced the introduction of the social work Honours degree as the minimum standard for social work training. In the 2003/4 academic year, the Honours degree replaced the DipSW as the main entry route into social work. Prospective social workers are also able to undertake the social work Masters degree. Just under two-thirds of social work students are studying on undergraduate courses and a third are studying on Masters courses[116]. In its final report[117], the SWTF encouraged the expansion of Masters-level provision. Alongside the degree, the Government introduced the social work bursary.

113 Parsloe, P. & Stevenson, O. (eds). (1978), *Social Service Teams: The Practitioner's View*, London, HMSO.

114 Cmnd. 3703 (1968), *Report of The Committee on Local Authority and Allied Personal Social Services,* London, HMSO.

115 Cmnd. 3703 (1968) *Report of The Committee on Local Authority and Allied Personal Social Services,* London, HMSO.

116 General Social Care Council (2010), *A Report on Social Work Education in England 2009–2010: a summary* (available online at http://www.gscc.org.uk/cmsFiles/Education%20and%20Training/A%20Report%20on%20 Social%20Work%20Education%20in%20England%202009-10.pdf)

117 The Social Work Task Force (2009), *Building a safe, confident future – The final report of the Social Work Task Force*, pp22, London, Department for Education (available online at http://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-01114-2009)

Together, these steps appear to have been extremely successful in attracting people to train as social workers[118]. In 2009, however, the SWTF said that:

> '[We] heard from many sources that initial education and training is not yet reliable enough in meeting its primary objective, which must be to prepare students for the demands of frontline practice…
>
> 'There are, of course, many strong, respected courses that other providers can learn from. Reform needs to build on such successes – and ensure that the whole system reaches new levels of consistency in providing high quality education and training'[119].

The SWTF went on to identify a number of areas for reform in social work education, which are set out later in this chapter.

6.7   The reforms that have, over many years, created today's work environment have been introduced with the aim of improving the quality of service received by children and families. The evidence[120] on current standards of practice indicates that good practice is not sufficiently widespread. The review considers that two central problems have contributed to this. Firstly, there is a lack of consensus within the profession about the nature of social work expertise. One view considers that the primary driver of change is through the relationship formed with children and families. The other, as the SWTF and this review believe, considers that social workers *also* need formal training and high intelligence to achieve the level of critical reasoning needed to make sound judgments and decisions on the complex family problems they confront. Secondly, and importantly, there has been an inappropriate model of practice underpinning much of the reform. The professional account of social work practice 'in which relationships play a central role' appears to have been gradually stifled and replaced by a managerialist account that is fundamentally different. The managerialist approach has been called a 'rational-technical approach', where the emphasis has been on the conscious, cognitive elements of the task of working with children and families, on collecting information, and making plans. This focus has led to '*a curious absence from a great deal of social work and child protection literature, policy and discussions about practice of any considered attention to the core dynamics, experience and methods of doing the work*'[121].

6.8   The focus of reforms has been on providing detailed assessment forms that tell the social worker what data about families to collect, how quickly to collect it and what

118 Department of Health (2008), Evaluation of the New Social Work Degree Qualification in England (available online at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086079)

119 The Social Work Task Force (2009), *Building a safe, confident future – The final report of the Social Work Task Force*, pp16. London, Department for Education (available online at http://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-01114-2009)

120 Davies, C**.** & Ward, H. (forthcoming), *Safeguarding Children Across Services: Messages from Research on Identifying and Responding to Child Maltreatment,* London, Jessica Kingsley Publishers**;** Turney, D., Platt, D., Selwyn, J. & Farmer, E. (2011), *Social Work Assessment Of Children In Need: What do we know? Messages from Research,* London, Department for Education, Research Report (available online at http://www.education.gov.uk/publications/RSG/AllPublications/Page1/DFE-RBX-10-08); Brandon, M. et al. (2010), *Building on the learning from Serious Case Reviews: a two year analysis of child protection database notifications 2007 – 2009*, London, Department for Education (available online at https://www.education.gov.uk/publications/standard/publicationdetail/page1/DFE-RR040)

121 Ferguson, H. (2011), *Child Protection Practice*, Basingstoke, Palmgrave Macmillan.

categories to use in recording it. While the forms set out what information is needed, organisations have given less attention to helping frontline staff know how to collect and analyse it. How to help solve problems has also had less reform attention. The responses collected by *Community Care* and the British Association of Social Workers (BASW) to the review's questions about practice echoed a picture of a managerial focus on process more than practice, with reduced time for providing help to children and families themselves so that, after assessment, children and families are generally referred to other services.

6.9   This 'rational-technical approach' has fed into a view that a good enough picture of practice can be gained from procedural manuals and from the written record where the results of the cognitive work are displayed. The claim that practice is 'transparent' has usually meant there is a written record of some aspects of practice – though if you talk to a social worker, you quickly realise how little of the thinking and action gets recorded. It has fostered a view that the more important part of social work is carried out on a computer. Good records are important: they are the future reference point for the child and provide an account of what actions have been taken and why by the local authority. But if we take the perspective of children and their parents, the most important part is when social workers meet children and families, try to communicate with them, work with them, and help them to change.

6.10   The explicit, cognitive aspects of the work are important but provide an incomplete account. Knowing what data to collect is useful, but it is equally useful to know *how* to collect them; how to get through the front door and create a relationship where the parent is willing to tell you anything about the child and family; how to ask challenging questions about very sensitive matters; and how to develop the expertise to sense that the child or parent is being evasive. Above all, it is important to be able to work directly with children and young people and their families to understand their experiences, worries, hopes and dreams, and help them change.

6.11   There is now a considerable body of research on how expertise, in whatever field, is developed. This provides valuable lessons for social work. Intuitive and analytic reasoning skills are developed in different ways, so child protection services need to recognise the differing requirements if they are to help practitioners move from being novices to being experts on both dimensions. Analytic skills can be enhanced by formal teaching and reading. Intuitive skills are essentially derived from experience. Experience on its own, however, is not enough. It needs to be allied to reflection – time and attention given to mulling over the experience and learning from it. This is often best achieved in conversation with others, in supervision, for example, or in discussions with colleagues. Michael Oakeshott draws attention to the limitations of a 'crowded' life where people are continually occupied and engaged but have no time to stand back and think[122]. A working life given over to distracted involvement does not allow for the integration of experience.

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122 Oakeshott, M. (1989), *The Voice of Liberal Learning*, pp33, New Haven, Yale University Press.

6.12 Klein[123] identified four key ways in which experts learn:

- engaging in deliberate practice, and setting specific goals and evaluation criteria;
- compiling extensive experience banks;
- obtaining feedback that is accurate, diagnostic, and reasonably timely; and
- enriching their experience by reviewing prior experiences to derive new insights and lessons from mistakes.

6.13 This account of professional expertise is crucial for thinking about how both individuals and the profession as a whole can be supported to develop their knowledge and skills in helping children and families.

Requisite expertise for child and family social work

6.14 The nature of expertise is examined in three sections: (i) relationship skills; (ii) reasoning and emotions in relationship-based practice; and (iii) using evidence.

Relationship skills

6.15 As pointed out in the first report, skills in forming relationships are fundamental to obtaining the information that helps social workers understand what problems a family has and to engaging the child and family and working *with* them to promote change. There is considerable research evidence to support the claim that relationship skills are important in helping people to change, whatever intervention method is being used[124].

6.16 Barlow and Scott report that:

> '*a recent overview of the evidence about effective interventions for complex families where there were concerns about (or evidence of) a child suffering significant harm, showed the importance of providing 'a dependable professional relationship' for parents and children, in particular with those families who conceal or minimise their difficulties'*[125].

6.17 A study of social work by Knei-Paz[126] showed the importance of relationship-based working and found it was the quality of the therapeutic bond established between social worker and client that was the basis for what was conceived of as a positive intervention.

> '*Helpers who are cold, closed down, and judgmental are not as likely to involve clients as collaborators as are those who are warm, supportive, and empathic'*[127].

123 Klein, G. (2000), *Sources of Power: How People Make Decisions?* London, MIT Press.

124 Wampold, B. (2009), *The Great Psychotherapy Debate, Models, Methods and Findings*, New York, Routledge.

125 Barlow, J. with Scott, J. (2010), *Safeguarding in the 21st century: Where to Now?*, pp24, Totnes, Research in Practice.

126 Knei-Paz, C. (2009), 'The Central Role of the Therapeutic Bond in a Social Agency Setting Clients' and Social Workers' Perceptions', *Journal of Social Work,* April 2009, 9:2, pp178–198.

127 Gambrill, E. (2006), *Social Work Practice: A Critical Thinker's Guide,* 2nd Edition, pp409, Oxford, Oxford University Press.

6.18 Skills identified as contributing to relationship building and positive outcomes include:

    i)   therapist credibility;

    ii)   empathic understanding and affirmation of the service user;

    iii) skill in engaging the user;

    iv) a focus on the user's concerns; and

    v)   skill in directing the user's attention to the user's emotional experiences[128].

6.19 Dale's[129] qualitative study of 18 families provides some examples of the qualities that families do *not* find helpful: being 'uninterested, ineffective, unsupportive, unreliable and unavailable'.

6.20 This review has heard that social workers sometimes feel inadequately trained to communicate with children. They may work with children of very varied ages, ethnicities, communication abilities and needs who require an equally varied range of skills in the social worker. Play and drawings may be more appropriate for some than anything resembling an 'interview'. In child protection work, the children may be very distressed and frightened, needing very sensitive skills in creating a level of trust where the child is willing to speak. The emotional impact of this work can also be very painful, making workers aware of how terrible some children's lives are.

6.21 Training in communicating with children and young people can solve part of the problem. There are also a variety of tools that can be used to help children communicate their views. The 'Three Houses' model described in chapter two, for example, provides a way for a social worker and child to have a conversation about what is going on, what worries the child, and what the child would like to happen, with the child adding drawings and comments to the house of good things, the house of worries, and the house of dreams[130]. This produces a graphic record that conveys very powerfully what the child's life is like and what he or she would like to happen.

6.22 Communicating with men is also a recurrent problem and leads to their being less visible in the way the case is managed, with their impact on their children being less well assessed or the direct focus of work. A study of cases where the men were known to be violent to their partners provides evidence of a lack of involvement or good assessment of the impact they are having on the children[131].

Reasoning and emotions in relationship-based practice

6.23 Focusing on the centrality of relationship skills draws attention to the roles of intuitive understanding and emotional responses. Conscious logical thinking has quite rightly been highly valued as a human attribute, but the traditional view that it is inherently superior to intuition and emotion has been overturned by

128 Ibid.

129 Dale, P. (2004), 'Like a Fish in a Bowl: parents' perceptions of child protection services', *Child Abuse Review*, pp13, pp137–157.

130 Weld, N. (2009), *Making sure children get 'HELD' : ideas and resources to help workers place hope, empathy, love and dignity at the heart of child protection and support*, Lyme Regis, Russell House Publishing.

131 Family Rights Group, (2011), *Working with risky fathers*, London, Family Rights Group.

developments in neuropsychology. Hammond[132] argues convincingly for the need to see logical and intuitive thinking on a cognitive continuum where we use a different balance between them depending on what task we are carrying out. Solving a maths problem is at the analytic extreme while calming a frightened child uses intuitive understanding. The importance of our intuitive reasoning capacity is also illustrated by the difference in size between our conscious and unconscious capacities:

> *'It is estimated that our sense organs collect between 200,000 and one million bits of information for every bit of information that enters our awareness. Conscious perception represents only the smallest fraction of what we absorb from our worldly encounters. It is the tip of an iceberg'*[133].

6.24   Research in neuropsychology suggests that our intuitive and emotional responses occur automatically and outside conscious awareness; we cannot choose to be only logical, thinking machines[134]. When a social worker visits a home and the father behaves in a threatening manner, his or her body reacts automatically, generating stress hormones in response to the perceived threat. Similarly, when an experienced social worker meets a family, he or she can quickly pick up an intuitive awareness of the state of the dynamics in the family – the warmth of the relationship between family members, or the level of fear felt by a child. Appreciating the importance of both logical and intuitive understanding and the contribution of emotions offers guidance on the different training needs in using them to best effect.

6.25   Intuition is sometimes presented as a mysterious or mystical process, but its physical location in the brain and the features of the process are understood. It is only mysterious in the sense that it is generally an unconscious process that occurs automatically in response to perceptions, integrating a wide range of data to produce a judgment in a relatively effortless way. It is very rapid and relatively independent of language, oriented towards identifying patterns. It need not remain unconscious but can be articulated and this ability can be improved with guided practice and with explicit attention to eliciting the evidence that the unconscious was noting and interpreting. Supervision and case consultations (discussed in chapter seven) are critical in helping practitioners draw out their reasoning so that it can be reviewed.

6.26   Gut feelings are neither stupid nor perfect. They take advantage of the evolved capacities of the brain and are based on rules of thumb that enable us to act fast and with astounding accuracy, shown, for example, in our ability to recognise faces[135]. They are not infallible, as research shows, because intuitive judgments are vulnerable to predictable types of error. Critical challenge by others is needed to help social workers catch such biases and correct them – hence the importance of supervision[136].

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132 Hammond, K.R. (1966), 'Probabilistic functionalism: Egon Brunswik's integration of the history, theory, and method of psychology' in *The psychology of Egon Brunswik*, (ed). Hammond, K.R, New York, Holt, Rinehart and Winston.

133 Thiele L.P. (2006), *The heart of judgment: practical wisdom, neuroscience, and narrative*, pp121, New York, Cambridge University Press.

134 Hammond, K. (2007), *Beyond rationality: the search for wisdom in a troubled time*, Oxford, Oxford University Press.

135 Gigerenzer, G. (2002), *Reckoning with Risk: learning to live with uncertainty*, pp228, London, Allen Lane.

136 Gilovich, T., Griffin D. & Kahneman, D. (eds.) (2008), *Heuristics and Biases: The Psychology of Intuitive Judgment,* Cambridge, Cambridge University Press.

6.27 Klein[137] and his colleagues have done valuable work in studying how experienced workers perform in real-life situations. Their studies of, among others, fire fighters, police officers, and pilots have helped them build a picture of how people make decisions and act that has direct relevance to understanding expertise in social work. Intuitive expertise is built up through pattern-recognition and this has implications for how social workers should be trained, managed, and provided with a career path that values and promotes the continual development of expertise.

6.28 The emotional dimension of working with children and families plays a significant part in how social workers reason and act. If it is not explicitly discussed and addressed then its impact can be harmful[138]. It can lead to distortions in social workers' reasoning because of the unconscious influence it has on where attention is focused and how information is interpreted. For example, a social worker can feel such compassion for the neediness of a mother that he or she fails to see her child's suffering. Social workers should always consider matters from the perspective of the child and ask themselves, 'What are the child's needs?'. The second harmful repercussion is on its impact on the workers themselves. Being exposed to the powerful, and often negative, emotions found in child protection work comes at a personal cost. If the work environment does not help support workers and debrief them after particularly traumatic experiences, then it increases the risk of burnout which, in the human services, has been defined in terms of three dimensions: emotional exhaustion, depersonalisation (or cynicism), and reduced personal accomplishment[139]. The SWRB's work on developing Standards for Employers is pertinent here.

6.29 The need for challenge by others is reinforced by the fact that intuitive reasoning '*generates feelings of certitude'*[140] and this characteristic makes it very attractive for the individual who is operating in a world of uncertainty. The downside of this is that the practitioner who has a 'gut feeling' about a case has a sense of confidence in that judgment that can make the person resistant to change or challenge. A frequent piece of feedback from parents who have submitted evidence to the review is that they felt that the workers they met in interviews or case discussions had already made up their minds and were unwilling to hear any alternative explanation of events or plans to deal with problems. This unwillingness risks errors in assessments being preserved, leading to inadequate plans for the child's safety and welfare.

6.30 Critical appraisal of the assessment and planning for a child and family, therefore, should be seen as central to good practice in reducing error. Ideally, this should be part of the culture and seen as not a personal attack but an outsider helping to pick up the unseen spots or offering a new angle on the problem. Supervision is one context in which this can happen: it should not be limited to this but something that colleagues or fellow professionals are able to do. The more punitive and defensive the culture, the harder it is for anyone to accept flaws in their reasoning.

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137 Klein, G. (1998), *Sources of Power: How People Make Decisions*, London, MIT Press; Klein, G. (2009), *Streetlights and Shadows: Searching for the Keys to Adaptive Decision Making,* Cambridge, MIT Press.

138 Howe, D. (2008), *The Emotionally Intelligent Worker*, Basingstoke, Palgrave Macmillan.

139 Maslach, C., Schaufeli, W. & Leiter, M. (2001), 'Job burnout', *Annual Review of Psychology,* 52, pp397–422.

140 Payne, J. & Bettman, J. (2007), 'Walking with the Scarecrow: The Information Processing Approach to Decision Research', in *Blackwell Handbook of Judgment and Decision Making*, (ed.). Koehler, D. & Harvey, N. Hoboken, NJ, Wiley InterScience.

> *'Child protection professionals are constantly making judgments that impinge on the rights of parents to be with and relate to their children and the parallel right of children to their parents. The stakes are high and child protection decision-making needs to be as explicit as possible and be available for review and scrutiny'*[141].

Using evidence

6.31 Evidence is fundamental in social work practice. Social workers use direct observation and evidence from the child, family or others who know them to form an understanding of what is going on. They can use evidence from research to inform their analysis of why any problems are happening and they can use evidence on effectiveness to guide their plans on how to help solve the problems. Currently, the use of evidence in the final two categories is very limited and improving this is one necessary element in driving up the level of expertise in the profession.

6.32 Evidence on child development has clear relevance to child and family social work and the Children's Workforce Development Council (CWDC) lists the core requirements of '*being able to recognise when a child or young person is not achieving their developmental potential, or when a child is displaying risky or harmful behaviour, or when their physical or mental health is impaired*[142].

6.33 Evidence on the natural history of problems can make substantial contributions to plans. Where domestic violence is an issue, for example, it might be thought that the children were safe if the parents separated but research[143] indicates that the violence continues in 50 per cent of cases, often during contact visits so social workers should not believe that the problem is necessarily solved by separation.

6.34 Evidence-based practice '*is the conscientious, explicit, judicious, use of current best evidence in making decisions about the care of individual patients*'[144]. Evidence-based practice is sometimes used in a narrow sense to refer to using methods of helping service users that have research evidence of some degree of effectiveness in some places where the methods have been tried and evaluated. Here it is used in the broader sense of drawing on the best available evidence to inform practice at all stages of the work *and* of integrating that evidence with the social worker's own understanding of the child and family's circumstances and their values and preferences. It is not simply a case of taking an intervention off the shelf and applying it to a child and family.

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141 Turnell, A. (forthcoming), *Building Safety in Child Protection Practice: Working with a strengths and solution focus in an environment of risk.*

142 Children's Workforce Development Council, (2010), *The Common Core of knowledge and Skills* (available online at http://www.cwdcouncil.org.uk/common-core)

143 Stanley, N., Miller, P., Richardson Foster, H. & Thomson, G. (2009), *Children and Families Experiencing Domestic Violence: Police and Children's Social Services Responses*, London, NSPCC (available online at http://www.nspcc.org.uk/Inform/research/findings/children_experiencing_domestic_violence_wda68549.html)

144 Sackett, D. Richardson, W. Rosenberg, W. & Haynes, R. (1997), *Evidence-based medicine: How to practice and modern medicine*, pp2. New Haven, Yale University Press.

'The field of practice is not a static, passive recipient of expert knowledge. Because the situation itself 'talks back', resists and constrains the practitioner's every move, effective practice is not so much a matter of having the right expert knowledge as of accommodating social work knowledge and expertise to the demands of the context with great flexibility'[145].

6.35   Randomised controlled trials can provide a valuable source of information since they show whether a method can work and if it is more (cost) effective than the services it was compared with. But well-tested interventions are geared to solving specific kinds of problems and all methods need the right environment in order to be effective. Learning to recognise which methods will be of help for the problems of a specific child and family in a given environment requires skill and training. The social worker has to be able to match the type of intervention to the nature of the family's needs and difficulties. This is in a context where children and families are likely to be experiencing multiple problems. Learning to use evidence-based approaches requires a combination of training, explicit analysis of family strengths and difficulties, and well-developed skills in observation and understanding.

6.36   While the review stresses the importance of using evidence from research, there are a number of points to remember in relation to using it critically. Evidence submitted to the review by Michael Little[146] summarises some key lessons about taking an evidence-based approach to practice:

- *any rapid review of evidence-based programmes runs the danger of selecting a short list of interventions and giving the impression that they have the potential to eradicate the problem in hand. Evidence-based programmes are not a cure-all for child maltreatment or any other aspect of child development. The list of challenges is long, but a few points are sufficient to inject caution.*
- *first, because other countries put a higher value on experimental evaluation methods in the context of children's social needs, many of the models that have been tested come from outside the UK. This does not invalidate them any more than Microsoft computers should be invalidated because they were invented in the US. But it does urge caution and re-testing to ensure that the ideas travel well and that we understand what it takes to implement them properly in UK settings. (Most partnerships doing this work in the UK are finding that, so far, the programmes do travel well.)*
- *second, the relative absence of rigorous evaluation in the UK means that it is simply not known whether home-grown interventions are effective. It may be that the UK boasts many more effective responses to child maltreatment than North America, Australasia or Scandinavia.*
- *third, if evidence-based programmes are not delivered with fidelity, that is to say if they are not delivered as they were intended to be delivered, with the correct levels of training, coaching and adherence to the manuals, they seldom achieve their intended benefits. Moreover, a model that has been shown to work before can be damaging when delivered badly. Getting the right staff, to deliver the right programmes, to the right people in the right way has proven elusive for some UK agencies.*

145 Turner, F. (2005), *Encyclopedia of Canadian Social Work*, pp319, Waterloo, Wilfrid Laurier University Press.
146 Submission by Michael Little, The Social Research Unit, to the review.

- *fourth, there is a difference between proving an intervention in trial conditions and seeing the effects at scale with several tens of thousands of children. Most evidence-based programmes have little market penetration. It is for this reason that results from interventions like Family Nurse Partnership that is reaching seven per cent of eligible children within three years of its introduction to the UK are attracting so much attention.*
- *fifth, mainstream systems, such as social care and the police, have little experience of delivering evidence-based programmes, most of which depend on short-term, marginal funding. Getting systems ready for evidence-based programmes and evidence-based programmes ready for systems is fundamental to any progress in this area.*

6.37 As regards the delivery of evidence-based programmes, there is also a danger in the other direction. Programmes that work do so for a reason: there is an underlying mechanism in virtue of which they work. Often the underlying mechanism will travel from another country, but exactly what it takes to call it into play will be different in England. For instance, educating parents, including fathers, about how to deal with anger may be effective in England as well as elsewhere, but in some cultural groups in England doing so by forcing them to attend public classes may be experienced as a public humiliation, which will have counterproductive effects.

6.38 Evidence-based practice is often presented as an alternative to authority-based practice but, to use it competently, social workers must have some ability to critique it so their training needs to include research methods. When reading material about what is said to be an evidenced approach, they need to be wary for marketing techniques that mislead. Eileen Gambrill[147] has warned of the use of propaganda in the Evidence-Based Practice (EBP) literature distorting the findings of research. Citing Ellul[148], she defines propaganda as '*encouraging beliefs and actions with the least thought possible*' and contrasts it with critical thinking: '*arriving at well-reasoned beliefs and actions based on critical appraisal of related arguments and evidence*'. She identifies its major appearance in EBP in relation to inflated claims of knowledge. When reporting studies of practice, common ploys to convey an exaggerated account of the strength of the findings are:

i)   *hiding the limitations of the studies, for example reporting final results but not detailing how many families dropped out of the study before completion;*
ii) *preparing incomplete research reviews of a practice or policy that omits negative findings;*
iii) *ignoring counterevidence to views promoted;*
iv) *selective publication of research findings – studies with negative findings are less likely to be published, distorting the overall presentation of studies of a particular way of helping; and*
v)   *arguing ad hominem (attacking critics instead of responding to their criticisms).*

147 Gambrill, E. (2010), 'Evidence-Informed Practice: Antidote to Propaganda in the Helping Professions', *Research on Social Work Practice*, 20, 3, pp302–320.
148 Ellul, J. (1965), *Propaganda: The formation of men's attitudes*, New York, Vintage.

6.39 Oxfordshire County Council provide an impressive example of how, with partner agencies, it has adopted a range of evidence based programmes[149], including interventions based on social learning theory, Family Nurse Partnerships, Family Group Conferences and Parents under Pressure. All staff working on these programmes have undertaken the required specialist training and are in receipt of high quality supervision and consultation.

> *'These types of evidence-based programmes are expensive to set up but there is increasing evidence that, by avoiding the need for looked after children to move to more intensive and expensive placements, they not only provide better outcomes for children and young people but are cost effective … Collectively in Oxfordshire, these intensive programmes have contributed to lower than average numbers of Looked After Children and resulted in identifiable savings within the existing Children and Young People's budget. They have helped to address general recruitment issues for foster carers, resulting in an 11 per cent rise in fostering. All types of carers (including foster carers and adopters) have reported improved levels of support resulting in improved long term stability (67–75 per cent in 2009/10), reduced adoption breakdowns and quantifiable savings in excess of £400,000'.*[150]

Child and family social work capabilities

6.40 The SWRB is leading work to develop a Professional Capabilities Framework[151]. This aims to set out clearly what is expected in terms of a social worker's knowledge, skills and capacity and how they build over time as they move through their careers. It has developed a degree of consensus, amongst the profession, that a single set of expectations of what is required of social workers is essential. It is the ambition of the SWRB that, over time, this Framework will be built upon so that the expectations of social workers working in different specialist fields are articulated. This review believes that an important early step for the Professional Capabilities Framework is to set out the capabilities necessary for effective practice in child and family social work. The review strongly endorses the capabilities on professionalism; values and ethics; diversity; rights, justice and economic wellbeing; contexts and organisations; and professional leadership. With regard to the three capabilities on knowledge, critical reflection and analysis, and intervention and skills, the review consider it would be useful to amplify what these mean in relation to child and family social work. It is not claimed that the following capabilities are *special* to child and family social work but it is for others to decide whether they are relevant to other branches of social work.

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149 Department for Education (2011), *Prospectus: Delivering intensive interventions for looked after children and those on the edge of care or custody and their families* (available online at https://www.education.gov.uk/publications/ standard/publicationDetail/Page1/DFE-00034-2011#downloadableparts)

150 Submission by Fran Fonseca, Oxfordshire County Council, to the review.

151 Social Work Reform Board, (2010), *One Year On Report*, London, Department of Health.

6.41 This review believes that, as a minimum, the capabilities being developed for child and family social work must include:

Knowledge:

- knowledge of child development and attachment[152] and how to use this knowledge to assess a child's current developmental state;
- understanding the impact of parental problems such as domestic violence, mental ill health, and substance misuse on children's health and development at different stages during their childhood; and
- knowledge of the impact of child abuse and neglect on children in both the short and long term and into adulthood.

Critical reflection and analysis:

- ability to analyse critically the evidence about a child and family's circumstances and to make well-evidenced decisions and recommendations, including when a child cannot remain living in their family either as a temporary or permanent arrangement; and
- skills in achieving some objectivity about what is happening in a child's life and within their family, and assessing change over time.

Intervention and Skills:

- recognising and acting on signs and symptoms of child abuse and neglect;
- purposeful relationship building with children, parents and carers and families;
- skills in adopting an authoritative but compassionate style of working;
- skills to assess family functioning, take a comprehensive family history and use this information when making decisions about a child's safety and welfare;
- knowledge of theoretical frameworks and their effective application for the provision of therapeutic help;
- knowledge about, and skills to use and keep up-to-date with, relevant research findings on effective approaches to working with children and families and, in particular, where there are concerns about abuse or neglect;
- understanding the respective roles and responsibilities of other professionals and how child and family social workers can contribute their unique role as part of a multi-disciplinary team; and
- skills in presenting and explaining one's reasoning to diverse audiences, including children and judges.

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152 For evidence of the importance of social workers having an understanding of child development and attachment see: Aldgate, J. (2006), 'Children, Development and Ecology', in *The Developing World of the Child,* (eds.) Aldgate, J., Jones, D., Rose, W. et al. pp17–34, London, Jessica Kingsley Publishers; Davies C. & Ward H. (2011), *Safeguarding Children Across Services: Messages from research on identifying and responding to child maltreatment*. Executive Summary, London, Department for Education, Research Report DFE-RBX-10-09; Marchant, R. (2009*), Making assessment work for children with complex needs,* in *The Child's World,* (ed.) *Horwath, J.,* chapter 12, London, Jessica Kingsley Publishers; and Brandon M., Sidebotham P., Ellis C. et al. (forthcoming) *Child and family practitioner's understanding of child development: lessons learnt from a small sample of serious case reviews*. London, Department for Education, Research Report.

6.42 The need for these professional capabilities must drive the content and delivery of social work initial training and continuing professional development as well as performance appraisal systems, supervision arrangements and organisational structures. But it is essential that these Professional Capabilities Framework does not become another bureaucratic burden which could hamper frontline practice. They should drive excellence in practice by helping recruit the right people who participate in appropriate and effective qualifying and post-graduate training and who are properly scrutinised in their ability to do their jobs. However, this should not be a box-ticking exercise.

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

Acquiring the expertise in the first place: social work initial training

6.43 Not all newly qualified social workers are emerging from degree courses with the necessary knowledge, skills and expertise; and they are especially unprepared to deal with the challenges posed by child protection work. Degree courses are not consistent in content, quality and outcomes – for child protection, there are crucial things missing in some courses such as detailed learning on child development, how to communicate with children and young people, and using evidence-based methods of working with children and families. Theory and research are not always well integrated with practice and there is a failure to align what is taught with the realities of contemporary social work practice.

6.44 The SWTF identified a number of significant issues in education and training which need urgent attention, and the review agrees with their importance. These are to:

- begin with clear, consistent criteria for entry to social work courses – with a new regime for testing and interviewing candidates that balances academic and personal skills – so that all students are of a high calibre;
- provide courses where the content, teaching, placement opportunities and assessment are of a high standard across all providers –proposing, for instance, advanced teaching organisation status for agencies providing high quality practice placements to social work students; and
- culminate in a new supported and assessed first year in employment, which would act as the final stage in becoming a full, practising social worker.

6.45 The CWDC has developed a new Masters-level entry route into social work. The Step Up to Social Work programme is aimed at graduate professionals who are selected through a rigorous assessment process involving Higher Education Institutions (HEIs), social work managers and service users. The first cohort of the Step Up to Social Work programme started in autumn 2010. The programme is intended to provide a close match between training and child and family social work practice, bringing local authorities and higher education together in partnership. Although very early days, there are some positive messages emerging

from the programme. More than 10 applications were received per place in the first cohort and there is already significant interest in further intakes. It will be important to monitor the progress of this programme and consider what lessons can be drawn more widely for initial social work education.

6.46   While this review endorses the SWTF's work which is now being taken forward by the SWRB, there remain issues around how to provide sufficient incentives for employers to prioritise the teaching of social work students. In the tough financial climate, investing in the training of social workers may seem to be a luxury, but if all social workers were excellent practitioners, savings would be made elsewhere in the system as the costs of poor social work practice will not be so great.

> ### Recommendation
>
> **Employers and HEIs should work together so that social work students are prepared for the challenges of child protection work. In particular, the review considers that HEIs and employing agencies should work together so that:**
>
> i.   **practice placements are of the highest quality and – in time – only in designated Approved Practice Settings;**
>
> ii.   **employers are able to apply for special 'teaching organisation' status, awarded by the College of Social Work;**
>
> iii. **the merits of 'student units', which are headed up by a senior social worker are considered; and**
>
> iv.   **placements are of sufficiently high quality, and both employers and HEIs consider if their relationship is working well.**

Demonstrating expertise: the courts

6.47   The quality of social work assessment and planning is highly visible during care proceedings. The Family Justice Review (FJR) is running concurrently with this review, with a focus on the role of the courts and the justice system in the timely protection of children from harm. Delays in the court processes, when applying for care orders, are a major concern because of their harmful effect on children. This review aims to complement the FJR's work by improving the quality of social work practice. Poor quality preparation of cases by local authorities is significant, but by no means the only factor in causing delay, since it leads to adjournments and requests for additional assessments. In public law, cases take on average 53 weeks to conclude[153]:

> *'Two months of delay in making a decision in the best interests of a child or young person equates to one per cent of childhood that cannot be restored'*[154].

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153 Ministry of Justice, Judicial and court statistics (available online at
   www.justice.gov.uk/publications/judicialandcourtstatistics.htm)
154 District Judge Nick Crichton, (1 July 2010), Family Drugs and Alcohol Court, Wells St, London.

6.48 The FJR interim report offers the following evidence of why delays occur[155]:

> *'Pressure in the social care system sometimes shows itself in a local authority's activities in relation to court proceedings. Studies consistently show that local authority applications to court are often missing key documents, such as core assessments and complete care plans. A study in 2009 found that 40 per cent of cases started without a Core Assessment[156]. Previous studies noted that between 34 per cent and 57 per cent of cases were missing this critical document[157]. We have heard complaints of poor preparation for court, poor presentation in court and failure to comply with directions.*

> *'The Public Law Outline is based on an expectation that local authorities will carry out a thorough analysis of the issues before coming into court. This, in theory, should lead to quicker and simpler proceedings. Local authorities in effect feel let down by the courts who do not rely on their work. Courts in turn feel the work is of insufficient quality. This creates mistrust and sparks a vicious cycle of inefficiency and delay.*

> *'Judges increasingly do not trust assessments by local authorities. The commissioning of ever more expert reports is one result together with the creation, then, of a vicious cycle in which local authorities may not commission reports themselves. This also affects the social workers, who lose confidence and can feel bullied by judges and advocates.*

> *'Improving the skills of court social workers is also important. We have heard examples of courts and judges providing mock court experience and feedback and believe these examples are important and should be encouraged.'*

6.49 In line with findings on children's experiences generally in the child protection system, the Family Justice Council's Voice of the Child sub-group found:

> *'A common theme in the feedback from interviews with children who have experienced family proceedings is that they felt that the proceedings were 'happening' to them and that they felt excluded, powerless to influence, contribute to or even make their voice heard in the process'[158].*

6.50 Findings on causes of delay included the absence of a guardian at the beginning of proceedings, and negotiations between the local authority and the parents' lawyers, where the latter were requesting additional assessments and the local

155 Family Justice Review, (2011), *Family justice review: interim report,* London, Ministry of Justice, Department for Education and the Welsh Assembly Government (available online at http://www.justice.gov.uk/publications/family-justice-review.htm)

156 Jessiman, P., Keogh, P. & Brophy, J. (2009), *An early process evaluation of the Public Law Outline in family courts,* Ministry of Justice Research Series 09/10, pp16, London, Ministry of Justice.

157 Brophy, J. et al. (2003) noted 34% and Masson, J. et al. (2008) noted 57%. Brophy, J., Jhutti-Johal, J. & Owen, C. (2003), *Significant Harm: child protection litigation in a multi-cultural setting,* London, Ministry of Justice; Masson, J., Pearce, J., Bader, K., Olivia, J., Marsden, J. & Westlake, D. (2008), *Case Profiling Study,* Ministry of Justice Research Series 4/08, London, Ministry of Justice (available online at http://www.justice.gov.uk/publications/docs/care-profiling-study.pdf)

158 Family Justice Council, (2008), *Enhancing the Participation of Children and Young People in Family Proceedings: Starting the Debate* (available online at http://www.family-justice-council.org.uk/docs/Participation_of_young_people.pdf)

authority felt unable to object because they thought the court would overrule them if they did so.

6.51   Another finding from this research was that ' *Professionals share a common belief, founded on research evidence and concern for human rights, that it is in the best interests of children who cannot remain with their families to be placed with a member of their extended family'*. Recently, DfE has produced statutory guidance for local authorities reporting that, although research findings are not conclusive, the findings are broadly supportive of family and friends care as a viable option and suggest greater scope for its use[159]. When a court order is being considered the statutory guidance emphasises that consideration of potential alternative carers should always be fully explored before making an application under section 31 of the 1989 Act, provided that this is the most appropriate way to safeguard and promote the child's welfare[160].

6.52   This review carried out a focused nationwide trawl to explore the issues that contribute to delay and to develop an understanding of effective practice from a local authority perspective in order to improve the journey for a child and young person through care proceedings. As a result of this trawl, a workshop run by Hammersmith and Fulham, and consultation with the Family Justice Council's Safeguarding Committee, the following issues were identified as important in effective practice:

- prior to care proceedings being initiated, if family network meetings are offered at an early stage then all possible kinship care arrangements can be identified at the earliest opportunity and appropriate assessments undertaken;
- allocating someone to act for the child or young person early in proceedings allows the individual to understand the interests of the child and young person and be able to fully participate from the start in order to minimise delay and reach an early resolution on behalf of the child or young person;
- the effective authorisation of cases within local authorities will help to minimise delay and prevent duplication. This includes effective resource and legal planning meetings occurring at the outset to make decisions and allocate sufficient resource with the plan being reviewed at a legal planning meeting to make sure that it continues to meet the needs of the child and young person;
- specialist teams are able to give sound advice to social workers which allows for appropriate conversations to take place between all involved in the case. When social workers and their team leader are regarded as part of the legal team that presents the case, this too supports greater involvement and improves case control;

159 Department for Education, (2011), *Statutory guidance for local authorities on Family and Friends Care* (available online at
https://www.education.gov.uk/publications/eOrderingDownload/Family%20and%20Friends%20Care.pdf)

160 Department of Children, Schools and Families, (2008), *Children Act 1989 Guidance and Regulations, Volume 1: Court Orders*, chapter 8 (available online at
http://www.education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-10500-2008)

- when senior/consultant social workers are allocated to or co-work on care proceedings this allows carers and courts to have confidence in their work and helps to reduce the challenging of assessments. To achieve this confidence, the senior/consultant social worker needs to be fully familiar with the child's life, the people involved and the case background;
- training social workers in the procedural and presentational aspects of courts improves their ability to produce a care case that is more likely to achieve best outcomes for the child or young person; and
- effective engagement takes place within the family justice system, possibly through the local Family Justice Boards proposed in the interim report of the Family Justice Review, so that learning goes on between courts, local authorities and all partners so that both local and national practice is informed and adapted on an on going basis.

6.53   A number of the FJR recommendations in their interim report complement the factors that contribute to effective practice set out above including:

i)   *The requirement that local authority adoption panels should review the suitability for adoption of a child whose case is before the court should be removed;*

ii)   *Cases must be managed and timetabled strictly in accordance with the 'Timetable for the Child'. This concept needs to be redefined and given greater legal force;*

iii)   *There should be research about the use of the 'letter before proceedings';*

iv)   *There should be judicial continuity in all cases, including amongst magistrates;*

v)   *The criteria against which it is considered necessary for a judge to order expert reports should be made more explicit and strict; and*

vi)   *The development of multi-disciplinary teams to provide expert reports to the courts has merit.*

6.54   The FJR also supports the review's view that the child protection system should become better at learning and adapting, making the following observation:

'There is also a role for everyone in the system, including the judiciary, to share lessons with a view to collective improvement in performance. The Service should also ensure there is a focus on continuous learning amongst the professionals involved in family justice, and that practice is able to adapt to changes in social trends, demands on its services and user expectations'[161].

Multi-disciplinary work

6.55   Like the FJR, this review has been impressed by the trial being conducted at the Family Drug and Alcohol Court in the Inner London Family Proceedings Court. Details of its evaluation are provided in the following case study.

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161 Family Justice Council, (2009), *Mapping Exercise on Interdisciplinary Training* (available online at http://www.family-justice-council.org.uk/703.htm)

Case Study

Findings from the Brunel University independent evaluation of the Family Drug and Alcohol Court

The Family Drug and Alcohol Court (FDAC) is a new approach to care proceedings, in cases where parental substance misuse is a key element in the local authority decision to bring proceedings. It is being piloted at the Inner London Family Proceedings Court. It began in January 2008 and runs until March 2012. It is funded by the Department for Education, the Ministry of Justice, the Home Office, the Department of Health and the three pilot authorities (Camden, Islington and Westminster). It is the first court in England and Wales to take a problem-solving approach to care proceedings.

FDAC has a specialist multi-disciplinary team attached to the court which includes adult substance misuse workers, child and family social workers, and adult and child psychiatrists. Team members use a variety of methods, including motivational interviewing, to engage parents. Reflective practice is used to promote objectivity. The team works closely with the network around the family and coordinates the different parts of the plan. Regular planning meetings with parents, social workers and other professionals help promote a clear division of responsibilities and avoid duplication. At court, the same judge deals with the case throughout and regular court reviews of parents' progress are held without the presence of legal representatives.

The independent evaluation conducted at Brunel University by Professor Judith Harwin, Mary Ryan, Jo Tunnard, Dr Subhash Pokhrel, Bachar Alrouh, Dr Carla Matias and Dr Sharon Momenian-Schneider[162], funded by the Nuffield Foundation and the Home Office, indicates that this problem-solving court approach is more successful than ordinary court and service delivery in engaging parents with lengthy substance misuse histories. The majority of families had been known to children's services for many years and had multiple psychosocial problems.

The study tracked all cases entering FDAC in the first 18 months of the pilot and compared them with cases involving substance misuse entering ordinary care proceedings at the same time. Of these, 41 FDAC and 19 comparison families reached final order by the end of the fieldwork period.

The evaluation found that:

●   More FDAC parents had stopped misusing drugs or alcohol at the end of the care proceedings than those in the comparison group (48 per cent v 39 per cent mothers and 36 per cent v 0 per cent fathers);

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162 Harwin, J., Ryan, M. & Tunnard, J. (in press), *The Family Drug and Alcohol Court (FDAC) Evaluation Project Final Report* (will be available online at www.brunel.ac.uk/fdacresearch)

- As a result, family reunification at the end of proceedings was 18 per cent higher in FDAC than comparison cases: 39 per cent of FDAC mothers were reunited with their children by the final court order, compared with 21 per cent in the comparison group. A follow-up study will examine the longer-term outcomes in cases where children went home;
- FDAC parents accessed substance misuse services more quickly, received a broader range of services, and were more successful at staying in treatment throughout the proceedings. More FDAC parents received help from housing, benefits and domestic violence services;
- There was a more constructive use of court time and fewer contested hearings. When parents could not control their substance misuse, children were placed more quickly in an alternative permanent family (on average seven weeks quicker);
- There were cost savings to local authorities, and potential savings identified for the court and the legal services commission. The average cost of the FDAC team per family is £8,740 over the life of the case. This is off-set by the savings to local authorities from more children staying within their family. FDAC also reduced costs through:
  - shorter care placements (£4,000 per child less);
  - shorter court hearings and fewer hearings with legal representatives present (saving local authorities £682 per family) ;
  - fewer contested cases; and
  - savings in the work of the specialist team that is equivalent to the work carried out by experts in ordinary care cases (£1,200 per case less).
- All but two of the 36 parents interviewed would recommend FDAC to other parents. They particularly liked the emotional and practical support from the FDAC team and seeing the same judge every time. All the professionals considered FDAC to be a better approach than ordinary care proceedings and were clear that it should be rolled out. So did the parent mentors.

A small-scale study can make only tentative suggestions about what lies behind its results. But the single biggest difference between FDAC and comparison cases was the receiving of FDAC by parents in the pilot authorities. Otherwise, the families were very similar. The FDAC specialist multi-disciplinary team is now trialling a pre-birth assessment and intervention service in the three pilot local authorities. This aims to improve outcomes through earlier intervention at a pre-court stage.

Given research evidence on the fragility of reunification when parents have misused substances, the evaluation has recommended that a short-term aftercare service from FDAC should be developed, to help parents sustain their recovery and continue providing safe care.

Parental substance misuse is a significant factor in up to two thirds of all care proceedings and, according to a London survey, was the most frequent parental factor in long-term children and family social work, affecting 34 per cent of all cases.

6.56 This case study is one example of a growing body of evidence of the value of creating multi-disciplinary teams whose main task it is to undertake intensive assessments and then therapeutic work based on the findings from their assessment. These new teams require professionals who are trained in the selected interventions. Staff in these teams come from a range of professional backgrounds including clinical psychology, community psychiatric nursing, family therapy and social work and are trained in selected methods of helping.

6.57 Implementing intensive evidence-based interventions offers encouraging results. With more effective interventions, more children are able to remain in or return to their family, or have other decisions about permanence made more quickly. This should mean better and timelier outcomes for children, better outcomes for parents even when they are not able to be the permanent parents for the child, and a better trained, competent workforce, who are more satisfied with their work. The growing evidence on their effectiveness and cost-effectiveness leads the review to encourage local authorities to consider creating multi-disciplinary teams as part of their service provision for children and families.

Chapter seven: The organisational context: supporting effective social work practice

With the reduction of prescription, leaders in local authorities will need to set about creating a learning system that constantly seeks to improve the quality of help that vulnerable children and families receive. To retain a focus on this primary aim, they will need to pay close attention to the views and experiences of both children in receipt of child protection services and the social workers who help them. To do this the review recommends the creation of practising Principal Child and Family Social Workers to communicate frontline concerns to all layers of management. In order to foster good practice, local leaders should also help their workforce develop and maintain its skills and in this they should be supported at a national level by the General Social Care Council and its successor, the Health and Care Professions Council. To encourage learning and improvement nationally, the Government should create the role of Chief Social Worker for England to advise Ministers on what they can do to assist social workers in improving practice. Finally, the relationship of social work with the media is discussed, highlighting the importance of the profession being able to communicate its essential work.

Local systems that develop expertise

7.1   To be able to practise well, social workers have to be employed in an organisation that supports them and their professional development. Ferguson's research on direct work with children and families concludes:

> 'The extent to which social workers are able to delve into the depths to protect children and explore the deeper reaches and inner lives of service users – the degree to which they feel able to get up and walk across the room to directly engage with, touch, and be active with the child or follow through on seeing kitchens and bedrooms – is directly related to how secure and contained they feel in separating from the office/car. They can only really take risks if they feel they will be emotionally held and supported on returning to the office that their feelings and struggles will be listened to. Workers' state of mind and the quality of attention they can give to children is directly related to the quality of

support, care and attention they themselves receive from supervision, managers and peers'[163].

7.2   The review has heard from many social workers and managers that, all too often, their working environments fall short of the basic conditions needed to practise safely and effectively. Too many previous reforms have not addressed the child and family social work operational system as a whole. This system has a number of different but inter-related components that each need attention for a whole systems change to have a chance of being most successful. One change in one part of the system will affect all the other sub-systems. All parts of the system need to be aligned and mutually reinforcing.

7.3   The review, in making the recommendations in this chapter, is able to build on the firm foundations of reform created by the Social Work Task Force and the Social Work Reform Board. The newly formed College of Social Work will also play a key role in the shared efforts to drive up the quality of social work practice.

The role of leadership

7.4   Reform of the child protection system will depend heavily on strong, skilled leadership at a local level. Leaders need to know their organisations well and constantly identify what needs to be realigned in order to improve performance and manage change. Developing these leaders is, therefore, critical to success. The review is aware of the Government's support of the sector to develop a strong cadre of skilled leaders and it is essential that this continues if the child protection system is going to be well managed – particularly through a period of change. The work that has been done by the National College of Leadership provides a valuable resource.

7.5   Any change to local child proctection systems will need the full support of the whole organisation so that the required actions are properly supported and facilitated. The review has found, for example, that most bureaucracy which limits practitioners' capacity and ability to practise effectively, is generated and maintained at a local level. This includes financial and personnel arrangements, procedural requirements, poorly functioning or under resourced ICT arrangements. To undo these arrangements requires commitment, resource and focus. To generate and complete change of this scale also requires different behaviours and expectations from local politicians, chief executives and senior officers, so that the demands placed on child and family social work services are directly related, so far as is possible, to improving and supporting frontline practice. A one-size-fits-all approach across a local authority's departments is unlikely to address the current complexities and vulnerabilities of child and family social work or sufficiently support the necessary changes ahead.

7.6   Managers have to satisfy the needs of both today and tomorrow. They provide day-to-day stable and consistent management of child protection services. But they also exercise leadership to challenge and bring about change and improvement focused on securing a better future. Leadership will be needed throughout organisations to implement the review's recommendations successfully, especially to help move from a command-and-control culture

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163 Ferguson H. (2011), *Child Protection Practice*, Basingstoke, Palgrave Macmillan.

encouraging compliance to a learning and adapting culture. Managers also need to balance improving service efficiency and effectiveness with the need to manage increasing financial pressures.

7.7   Leadership is often only understood in terms of individuals at the top of the hierarchy, but it is much more than the simple authority of one or two key figureheads. Leadership behaviours should be valued and encouraged at all levels of organisations. At the front line, personal qualities of leadership are needed to work with children and families when practising in a more professional, less rule-bound, way. Practitioners need to challenge poor parenting, and have the confidence to use their expertise in making principled judgments about how best to help the child and family.

7.8   Changing the way organisations manage frontline staff will have an impact on how they interact with children and families. There is evidence that workers tend to treat the service user in the same way as they themselves are treated by their managers[164].

7.9   For some organisations, the change will need a move away from a blaming, defensive culture to one that recognises the uncertainty inherent in the work and that professional judgment, however expert, cannot guarantee positive outcomes for children and families. The organisational risk principles listed in chapter three need to underpin practice. In child protection, a key responsibility of leaders is to manage the anxiety that the work generates. Some degree of anxiety is inevitable. Whilst practitioners have a key role in protecting children, their safety and welfare cannot be guaranteed. Additional anxiety is fuelled by the level of public criticism that may be directed at child protection professionals if they are involved in a case with a tragic outcome. In the review's analysis of why previous reforms have not had their intended success, unmanaged anxiety about being blamed was identified as a significant factor in encouraging a process-driven compliance culture. As William Tate wrote to the review:

> *'Managers should use their leadership role to monitor and improve (i) the way the system continually learns and adapts; (ii) what the system requires of front-line workers; and (iii) how healthy and free of toxicity is the work environment. They will need a high level of awareness of how organisations perform as systems'*[165].

The redesign of local systems

7.10 Evidence tells us how best to help children and families and this, therefore, carries implications for how practice needs to be organised and supported. There is not a single way of doing this as there is much variation in local circumstances. It is, therefore, essential that local leaders fundamentally consider if their service is configured optimally to meet the needs of children and families. Changes will inevitably need to be made and it should be kept continually under review.

164 Schneider, B. (1973), 'The perception of organizational climate: The customer's view', *Journal of Applied Psychology*, 1973, 57, pp248–256.

165 Submission by William Tate, Fellow of the Centre for Leadership Innovation at the University of Bedfordshire, and the Director of the Institute for Systemic Leadership, to the review.

7.11   This review considers that an effective local system would have the following characteristics:

- a clear understanding of the capabilities required by staff, based on theory and best practice evidence;
- an operational structure and systems (practice and managerial) which enable all social workers to spend most of their time undertaking effective work that directly benefits children and families and which values continuity of social worker with children and families;
- a robust selection process for all staff in that structure, so that the requisite knowledge, skills and methodological interests that are needed locally are present and that all recruits have the necessary personal qualities required to develop and learn;
- a clear view on what local regulation is absolutely necessary to enable social workers to do their jobs in a reflective way;
- comprehensive and sufficiently resourced professional development activity to give practitioners the necessary skills set and effect positive and demonstrable change in children and families;
- arrangements for practitioners to have frequent case consultations to explore and reflect on their direct work and plans for children and families, which is separate from on-going case supervision arrangements;
- arrangements for frequent case supervision for practitioners to reflect on service effectiveness and case decision-making, separate from arrangements for individual pastoral care and professional development;
- arrangements for managers to observe practitioners' direct work with children and families in both family and multi-disciplinary contexts;
- a demonstrable teaching culture, where all managers and leaders are actively and frequently involved in a mix of case consultation, direct work with children and families and the teaching of theory and practice; and
- a learning culture which results in the organisation knowing its child and family social work service and making adjustments to facilitate its practice effectiveness with families and improve outcomes for children.

Recommendation

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

7.12   Some organisations have already started to reconfigure their services along these lines. The case study below sets out an approach used by the London Borough of Hackney. Further details of this are contained in Appendix D.

Case Example

Hackney's Reclaiming Social Work – A Whole Systems Change
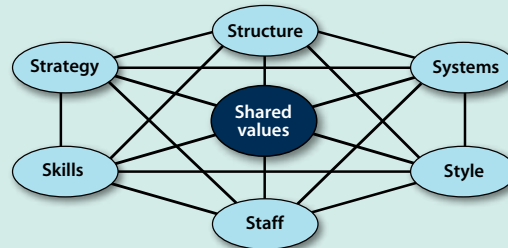
Changing child and family social work services in Hackney involved a whole systems approach based on the '7-S' model of systems change. The framework recognises that for a whole systems change to be most successful, seven key areas need to change simultaneously and be aligned with the central goal of the organisation.

Shared Values: Staff in the organisation share a similar outlook and approach to the work undertaken with families, including a fundamental commitment to keeping children safely together with their families wherever possible and the belief that judgments made about families must always be made within a context of emotional intelligence and empathy.

Structure: All cases are held within multi-disciplinary Social Work Units, which consist of a Consultant Social Worker, a Social Worker, a Children's Practitioner, a Family Therapist or Clinical Practitioner (1/2 FTE) and a Unit Coordinator. The units have a high degree of autonomy and each family is known to each member of the unit, with direct work undertaken by different unit members as appropriate. The unit coordinator provides enhanced administrative support, for example, by completing all data entry, freeing up time for practitioners to spend on direct work with families. All cases are discussed at weekly unit meetings. This is the key mechanism for information updates, analysis, reflection, planning and decision-making.

Systems: Systems have been redesigned to ensure that, so far as is possible, those systems enhance professional practice. For example, this means a focus on: reductions in local procedures, family-focused recording systems, qualitative case review and practitioner-led organisational learning mechanisms, delegated financial authority to all practitioners in units, and devolution of almost all decisions to the allocated social worker.

Style: All staff are encouraged to work collaboratively and respectfully, inviting family and other members of the system (including those in the child's wider system such as family, school and other services) to join in finding solutions to the presenting difficulty. Messages are clear that the driver for decisions should be the interests' of children, not procedural and/or service specifications.

Staff: Recruitment of high quality practitioners (with a shared vision to radically improve the quality of social work) is a priority in Hackney.

Skills: The service is prescriptive about methodology (adopting Social Learning Theory) and promotes a systemic approach to practice.

Strategy: The organisation needs professionals who have a high level of skill, who are interested and able to design and deliver interventions that work, as well as properly manage social work casework. Risk management is the highest context for all practitioners. A skilled and stable workforce, with capacity and motivation to help families, will reduce the numbers of children needing to come or remain in care. This significantly reduces commissioning costs, which can then be reinvested back into preventative services or released as year-on-year efficiency savings. Swift action is taken to permanently remove children where necessary, with practitioners working hard to ensure alternative permanent arrangements are secured.

Amongst the benefits, identified by a London School of Economics and Human Reliability evaluation, have been:

- workload stress is significantly reduced in Social Work Units compared to traditional teams;

- enhanced support for practitioners and increased ability to reflect and discuss practice;

- units support reflective learning and skill development through shared approach to case management;

- the mix of skills within the Units help staff make more informed interpretations of family dynamics;

- unit structure enables practitioners to spend more time in direct work with families;

- use of evidence-based methodological approaches provide enhanced capacity to assist families in making positive changes with better outcomes for children (CORC data);

- increased staff morale has reduced sickness (55 per cent) and agency rates (from 50 per cent to seven per cent), resulting in fewer changes for families;

- significant reduction in the number of children becoming looked after and increased placement stability;

- lower numbers of children being subject of child protection plans for a second or subsequent time, or for two years or more and overall;

- improved interaction with families and other professionals;

- better consistency and continuity in care;

- reduction of bureaucratic constraints on practice enables practitioners to spend more time with families; and

- higher levels of practitioner autonomy, resulting in fewer delays for families.

7.13 The review was asked to consider the potential of Social Work Practices in the future provision of services. Appendix E describes what social work practices are and the developments which have taken place since their introduction in 2008. The findings from an independent evaluation will be published in 2012.

7.14 As part of any redesign, all systems should be reviewed to determine if they help or hinder frontline practice. This obviously will include any practice procedures and guidance but more often ignored is the detail of business processes for finance, personnel and room bookings, for example. Most critical, however, is the provision, maintenance and review of ICT systems. Many social workers who took part in the online conversation, held by Community Care for the review, reported that their locally procured computer systems were substantial obstacles to good practice.

7.15 The impact of technology on human performance is complex. As Woods *et al* point out, the conventional view is that new information technology and automation creates better ways of doing the *same* tasks[166]. However, it is more accurate to say that any new technology is a *change* from one way of doing things to another. It alters the tasks that humans are expected to perform and it can, in subtle and unexpected ways, influence and distort the way they carry out their part of the process.

7.16 Recording is a key social work task and its centrality to the protection of children cannot be over-estimated. Getting effective recording systems in place to support practice is critical. In the first two reports from this review there has been discussion of the Integrated Children's System in response to national concern about the impact this recording system has had on social work practice. Although mandatory requirements to use the prescribed recording system, endorsed by the previous Government, have recently been removed, most systems currently in use were developed on that basis. A major challenge for local redesign is therefore to develop, with social workers, new ICT systems to meet their case recording needs.

7.17 In designing or procuring new software, local authorities should have regard to the following three principles:

- recording systems for child and family social work should meet the critical need to maintain a systemic and family narrative, which describes all the events associated with the interaction between a social worker, other professionals and the child and their family;
- ICT systems for child and family social work should be able to adapt with relative ease to changes in local child protection system needs, operational structures and data performance requirements; and
- the analysis of requirements for ICT-based systems for child and family social work should primarily be based on a human-centred analysis of what is required by frontline workers; any clashes between the functional requirements that have been identified by this process and those associated with management information reporting should normally be resolved in terms of the former.

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166 Woods, D., Johannesen, L., Cook, L. & Sarter, N. (1994), *Behind Human Error: Cognitive Systems, Computers and Hindsight,* pp163, Ohio, Wright-Patterson AFB.

Listening to the front line

7.18 An intrinsic part of developing a learning and adaptive system is the creation of channels through which frontline practitioners can notify those in authority of how the current operational arrangements and other features of the practice system are affecting their work with children and families.

7.19 Overarching budgetary decisions, for example, can have a disproportionate effect on child and family social work services. The review heard several examples of management decisions having unintended, negative consequences on frontline practice, several of which related to the procurement of inappropriate ICT systems. But the review also heard from social workers in one area where the council had made a decision that no local authority employees would be allowed to claim expenses for taxis. This had the unintended consequence that social workers had to take extremely vulnerable children on public transport, despite the fact that they may have been in a state of acute distress. Whilst the council certainly did not intend for this to happen, the effects at the front line were highly undesirable.

7.20 Local authorities must start to take a stronger lead in ensuring that theirs is both a listening and a learning system. There must be a stronger commitment by all levels of local administration to understand how senior management decisions impact on frontline social work.

7.21 For this reason, the review is recommending that local authorities should designate a Principal Child and Family Social Worker. This role would take responsibility for relating the views of social workers to all levels of management, whose decisions affect the work of frontline social workers through Directors of Children's Services, Chief Executives, Lead Members, Council Leaders, and the Chief Social Worker.

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

Listening to children, young people, and their families

7.22 In any review and redesign, just as the system must listen to the experiences and views of the professionals working with children and families, so it must listen to the children themselves. Besides many social workers feeling that they lack the necessary skills and confidence in undertaking direct work with children, another obstacle is lacking the necessary time. Social workers' priorities are, in large part, not a personal choice but set by the organisation in which they work. Evidence submitted to this review and to Lord Laming's 2009 progress report shows the extent to which frontline workers prioritise the bureaucratic aspects of their work and complying with performance indicators. This leaves time to spend with children and young people and develop good quality relationships low on the list and, consequently, frequently omitted.

7.23   Children's experiences of bureaucracy are that their social workers are liable to change, that appointments are cancelled and that workers are under stress. Responsibility for improving practice with children and young people lies with managers who should prioritise creating a space for it to happen. However, even with these changes, the review questions the widespread model of a frontline social worker predominantly working alone with the child and family.

7.24   The review also questions how reasonable it is for a single worker to prioritise time with a child when conducting an enquiry into an allegation of abuse or neglect or subsequently working with the child and family when other aspects of the work are also so important. The model developed in Hackney, of having a children's practitioner who not only works directly with the child but represents the child's views and needs in case discussions, offers an interesting alternative. In consultation, children have raised the concern that a worker specifically for them might be junior and so the person making key decisions would not know them personally.

7.25   Many local authorities are already consulting widely with children and their families, obtaining feedback across a range of issues including their safety. It is good practice for local authorities to facilitate mechanisms whereby children who are receiving services from children's social care, but are not in care, could contribute their views of child protection process and have an impact on service development. The following case study provides an example of how this can be done.

> Worcestershire Safeguarding Children Board work in partnership with Worcestershire County Council's Participation and Engagement Team to offer children who are over the age of 12 and have experienced child protection services in the last two years, the opportunity to meet other children with similar experiences. The group meets up about once a month although more often if they are producing materials such as a DVD[167] which was created to inform professionals about the views and wishes of children and young people in child protection processes. The DVD has been used to assist worker training and has been viewed by over 16,000 people on-line.
>
> The sessions last approximately two hours, with the first half devoted to a 'fun' session, craft or cooking, followed by an hour of 'work'. The sessions are young people led. For instance, they planned the whole of the DVD, wrote the scripts, decided the characters, drew them and then agreed the important messages the DVD should give out.
>
> The Worcestershire Safeguarding Children Board (WSCB) are keen to include the views of children and young people in all areas of their work. For instance, the young people's panel said that during Child Protection meetings, they are sometimes asked to leave when sensitive issues are being discussed. They were sent to wait in 'boring' waiting rooms with nothing to do. WSCB took this on board and provided a budget for the Young People's Panel (YPP) to create toy boxes to be kept in the waiting rooms. The YPP spent time planning the contents and did the shopping. All the content ideas came from the young people.

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167 Worcestershire Safeguarding Children Board (2010), *Have My Say, Hear Me Out* (DVD) (available online at www.arts-extend.com/worcester)

7.26   There are, of course, numerous tools and methods that practitioners may be using to understand children's feeling and experiences. An interesting model can be seen at Appendix F. What is vital is that children have a method by which they can give their feedback and that action is taken to address any concerns.

7.27   This report has emphasised the importance of listening to children but parents also need to feel listened to and can give valuable feedback on how the system is working. Many parents have contacted the review and their stories illustrate how powerless they can feel and how this diminished their motivation to work with social workers to change family life.

Creating careers that value expertise

7.28   Local leaders not only have a responsibility for configuring that their local system correctly, but also for the development of their staff. The review's second report set out the limitations of a career pattern that offers few promotion prospects except by making a move into management. It takes time to develop practice expertise but many social workers spend only a short time in frontline practice. Those who do stay in practice rarely have more than one or two opportunities to progress into more senior practice roles. The review has concluded that undervaluing practice experience in social work careers in this way is highly problematic. Promoting practice-based career pathways is recommended for two key reasons: firstly, to enable more practitioners to remain with at least some of their duties including direct contact with children and families; and secondly, so that organisations enable all practitioners to spend *most* of their time undertaking effective work that directly benefits children and families and which values continuity of care for children and families.

7.29   The absence of alternative routes for promotion often means the best, most talented and knowledgeable practitioners often leave local authority frontline practice to work in the voluntary sector, where they are able to spend more time directly engaging with children and families, or move into local authority management roles. The SWRB has stressed the need for an alternative career path to the managerial route. This review supports the view that experienced social workers should be able to follow a career path that takes them to very senior levels in the organisation without losing their prime focus on developing professional social work expertise.

7.30   The review believes that a radical redesign of who does what within child and family social work contexts, particularly those within local authority settings, should be considered. This will require a *local* review of administration, line management, supervision and case consultation arrangements, as well as the potential for developing new, more senior practitioner posts engaged in case work, teaching and coaching both in the 'classroom' and in family homes alongside practitioners less skilled and experienced.

7.31   The value of administrative support to social workers is often misunderstood or worse, disregarded, often being selected as the prime target for cost saving measures. For professional and safe practice within limited resources, however, this is often a false economy. The review has found that social workers spend too much time on administrative tasks and too little time undertaking effective direct

work with children and families to help them change. The complex nature of family life, often involving large sibling groups, and the many multi-professional input, often required for successful and well considered casework, demands organisation and task-focused work. Naturally, some requires direct professional input, but much of it only requires professional guidance while the task itself can be undertaken by support staff. Examples include: arranging meetings, booking rooms or taxis, arranging supervised contact, entering data, minute taking of meetings, making travel arrangements, accompanying parents and/or children to appointments.

7.32 A major problem in many local authorities is recruiting and retaining statutory social work staff. Evidence[168] from studies of high turnover amongst social workers indicates that the problem would be reduced if staff were better supported and provided with more opportunities to engage in direct work with children and families rather than referring on to others and being left with burdensome administrative tasks. Emerging findings, from a study in Northern Ireland into resilience and burnout amongst child protection social workers, highlight the importance of the first year in practice in setting expectations, ability and motivation to develop expertise. Factors that developed resilience and helped to retain staff included: the critical role of the team leader in providing support and supervision (some experienced a manager whom they described as 'burnt out'), the importance of team cohesion, and of emotional expressiveness – of being able to debrief from distressing experiences. Administrative demands were problematic and some coped by working very long hours so that they could do the direct work with children and families that they saw as essential to good practice. This, however, is not a long-term solution[169]. These findings reinforce the Social Work Task Force's recommendation that the assessed and supported year in employment should be the final stage of becoming a social worker in the future.

7.33 Social workers are often reliant on one person for case reflection, practice knowledge and managerial skill set. Decision-making on cases is frequently the responsibility of that manager, despite the manager often not knowing the child and family very well, if at all. This leaves the social worker in an awkward predicament, holding case responsibility, but with little autonomy for decision-making. Flexibility in accessing other reflective opportunities to think differently about what is happening in a family and what might help, can be very limited. A common experience amongst social workers is that the few supervision opportunities are dominated by a managerial need to focus on performance, for example, throughput, case closure, adhering to timescales and completion of written records. This leaves little time for thoughtful consideration of what is happening in the lives of children and their families.

7.34 After considering the range of potential knowledge and skills that social work staff could use, the review has concluded that the traditional view of the frontline worker carrying a caseload with a modest amount of supervision needs to be modified. An alternative is to see the frontline worker as akin to a junior doctor,

168 Barak, M., Nissly, J. & Levin, A. (2001), 'Antecedents to retention and turnover among child welfare, social work, and other human service employees: What can we learn from past research? A review and metanalysis', *Social Services Review,* 75, pp625–661; Healy, K. and Oltedal, S. (2010), An institutional comparison of child protection systems in Australia and Norway focused on workforce retention, *Journal of Social Policy, 39, 255–274.*

169 Anecdotal evidence submitted by Paula McFadden, doctoral student at University of Ulster, to the review.

who takes a proactive attitude to accessing consultation and on-going training from more experienced colleagues and can contact a specialist when dealing with complex and challenging cases. Consideration should also be given to the nature of casework responsibility, and what that actually means in practice, given that decision-making is often not within the gift of the social worker.

7.35   Any revised career pathway will need to consider what levels of responsibility should be given to each role within the organisation. In a possible career trajectory, newly qualified social workers, for example, will need a lot of support and guidance, and will need to be exposed to the full range of tasks in order to develop. However, as a practitioner becomes more skilled, opportunities to occupy more senior roles with financial reward appropriately aligned to increasing levels of responsibility, could be provided. Whilst this naturally extends to decision making and complexity of case, thought should also be given to providing opportunities for senior practitioners to teach and coach more junior staff.

Continuing professional development

7.36   If child and family social workers are to develop their capabilities throughout their careers, it is essential that they engage productively in continuing professional development (CPD). The review places a premium on CPD and it hopes, with the adoption of a stronger teaching and learning culture within local systems (as set out in the previous section), that local leaders and staff will share the review's view on its importance. CPD takes many forms and this review supports more co-working on cases, on-the-job practice coaching, as well as more formal local teaching programmes in particular areas of knowledge, skill set and intervention methods.

7.37   Formal HEI-accredited CPD courses play a fundamental role in the development of social work expertise. At present, many of these HEI-accredited courses sit within the General Social Care Council's (GSCC) Post-Qualifying (PQ) Framework. In their final report[170], the Social Work Task Force said that:

> 'The current post-qualification (PQ) framework of nationally accredited courses, in effect since 2007, includes some excellent provision for both the adult and children's workforce. Where there are strong partnerships and good collaboration between employers and HEI – for example in commissioning, planning and developing current PQ courses – this has led to a more strategic approach to ongoing learning and the exchange of knowledge, more sharing of resources; and positive steps to develop and update practice.

> 'However, CPD is not yet properly valued and supported in all places and organisations. We have heard that the framework as a whole is not sufficiently coherent, effective or widely understood, with weaknesses in choice, flexibility and relevance. Take up has varied across the country and has been disappointing overall. There are considerable barriers in many parts of the country to social workers undertaking courses, including lack of employer support and, particularly, a lack of time due to heavy workloads.

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170 The Social Work Task Force (2010), *Building a safe, confident future – The final report of the Social Work Task Force*, Department for Education, London (available online at https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-01114-2009)

> *'Social work lacks shared understanding of the overall direction, shape and content of its programme of professional development. The current position is a recipe for inconsistency, confusion and poor practice. It is bad for retaining people in social work and for the status of the profession. We need more employing organisations ready to support ongoing training and learning (as well as initial training), in support of a profession with a much clearer sense of what career long development should mean. Success in improving CPD will therefore depend heavily on shared commitment from employers, educators and professionals. All must devote the time and resources that will be necessary to bring about a major shift…..Organisations themselves have to take responsibility for developing a strong learning culture and be seen to support this culture in tangible ways.'*

7.38   The SWRB is developing proposals for the future CPD system which it is due to publish this year. Since the Social Work Task Force's final report, however, the Government has announced the transfer of functions from the GSCC to the Health Professions Council (HPC). This transfer of functions is expected to occur in 2012, subject to the progress of the legislation to enable it to happen. It is important that when the transfer of functions from the GSCC to the HPC occurs, the notion of HEI-accredited post-qualifying courses within a national framework is not lost. Unlike the GSCC, the HPC, as a regulator, does not provide such accreditation except in the case of Advanced Mental Health Professionals (AMHPs). However, the College of Social Work should play a key role in working with the HPC to drive forward the development of CPD. The College of Social Work could develop and hold a national framework for CPD linked to the HPC standards. It should also consider a role for itself in developing and maintaining the national CPD framework, following on from the GSCC's post-qualifying framework. HEIs should continue to provide child and family social work CPD courses and to work with local social workers, service users, carers, local authorities, and other employers so that these courses meet their needs. The SWRB's proposals on partnership agreements for education and CPD provide a foundation for improving provision in this way[171]. The College of Social Work may also have a role in approving individual CPD courses within the post-qualifying framework and in advising members on how to meet their CPD requirements.

7.39   The social work regulator also has a strong and important role to play in relation to CPD. When a social worker applies to renew their registration, the regulator will consider whether they have met its requirements in relation to CPD. If the social worker fails to meet these requirements, the regulator is able to refuse the renewal of registration. The HPC operates a model with the professions that it currently registers that relies on an audit of a small percentage of CPD profiles rather than a points-based or time-based system. The HPC believes that this system promotes quality and appropriateness of CPD over amount. In taking over the duty to regulate social work, the HPC would operate this system for the first year and then, in the light of experience, decide whether it is sufficiently rigorous in a profession which has severe issues in relation to the quality of and access to social work CPD. The HPC model will set out:

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171 Department for Education (2010), *Building a safe and confident future: One Year On, Detailed Proposals from the Social Work Reform Board* (available online at
http://www.education.gov.uk/publications/standard/publicationDetail/Page1/DFE-00602-2010)

- clear standards of proficiency, developed with the profession, and tailored specifically for social workers;
- a fitness to practise system which will look at the conduct and competence of social workers in the round; and
- scope for a more rehabilitative approach to be taken to social workers through the imposition of a range of sanctions such as placing conditions on registration.

Supporting social work nationally: Chief Social Worker

7.40 In addition to changes in local systems, there is also a need to develop learning at a national level. The review was asked to consider whether there is a strong argument for the creation of a Chief Social Worker role in central Government. In considering this question, the review looked at comparable models in other English Government Departments and in other countries. In the Department of Health, a Chief Medical Officer is responsible for advising Ministers on health matters, preparing or reviewing health policy, leading press conferences and presenting new policy to the media. Amongst the functions of the Chief Social Worker in New Zealand are the provision of professional social work advice to Ministers, and the promotion of professional social work practice. Recently, a Chief Social Work Adviser has been appointed in Scotland, with the responsibility for providing professional advice to Ministers, providing professional leadership to social work, and for promoting social work's role in protecting vulnerable individuals and groups.

7.41 At present, in England, there is no permanent professional presence for social work within Government, despite the fact that Government policy can fundamentally influence social work practice, and the service that people receive.

7.42 A Chief Social Worker would be the final piece in the jigsaw to enable *all* parts of the system learn, because central Government has its own part to play in this process – principally via statute, regulation and inspection. Government must develop the means to understand how its policies and procedures affect both practice at the front line and the experience of children, families and adults. A Chief Social Worker would also cast a light on the practice of social work in order that the daily challenges facing social workers are clear to Government as well as raising the status of social work. Having a senior social work position in Government would send out a strong message that this work is valued and important. For these reasons, this review *does* consider the role of a Chief Social Worker to be a valuable one.

7.43 Through discussion with a range of professional bodies and academics, the review considers the scope of a Chief Social Worker spanning both children and adults to offer distinct benefits. These include, recognising the interconnectedness of issues facing children and families as well as not unintentionally dividing the social work profession. It would make good sense for this role to report jointly to the Secretaries of State for Health and Education.

7.44 In outline terms, a Chief Social Worker for England might be given responsibilities to: advise Ministers on social work practice issues, consult with the profession in preparing that advice, promote continuous improvement in localities by helping to

facilitate learning from good practice, and highlight the importance of social work. Consequently, the role might encompass the following specific functions:

(i) Provision of professional advice to Government

- provide well-informed, high quality and timely professional advice to Ministers and Government about all aspects of social work provision in order to inform the development of social work policy and related policies (for example health, justice and education) as appropriate;
- advise Ministers and Government on the challenges and opportunities surrounding the provision of social work services and the key role social work plays in contributing to the achievement of national and local outcomes;

(ii) Promotion of continuous improvement

- promote system improvement by, amongst other things, encouraging the adoption of evidence-informed practice;

(iii) Communications and relationship management

- promote social work's role in protecting vulnerable individuals and groups, and helping to maintain the confidence of the public and stakeholders in the quality of care and social work services;
- help to raise public awareness and understanding of the role of care and social work services;
- promote social work values across government policy development; and
- promote the exchange of knowledge and experience through professional networks, publications and media.

7.45   Whilst the Chief Social Worker's role should span social work with children and adults, the review has a view of what the Chief Social Worker's specific remit in relation to child and family social work may encompass. This includes:

- advising Government on the effectiveness of statute, regulation, guidance and inspection affecting child and family social work;
- contributing to the preparation or review of child protection policy;
- helping to promote action to improve the outcomes for children who are being, or likely to be maltreated; and
- consulting with key partners to enhance the quality and standards of inter-agency child protection working (this might involve, for example, the regular convention of professional bodies to make representations on the effectiveness of *Working Together*).

7.46   In giving advice, the Chief Social Worker would include in his/her considerations:

- the views of Principal Child and Family Social Workers;
- the views of the College of Social Work;
- the views of children and young people known to social services collected at a local level; and
- the learning from Serious Case Reviews and other types of review.

7.47   In order to fulfil such a challenging role, the Chief Social Worker would need to be an experienced and highly respected social worker, capable of conveying 'practice intelligence' and influencing Government policy at the highest level. The Chief Social Worker would sit within a complex national and local child protection system, so it is essential that relationships are clearly mapped out.

Picture of the new system
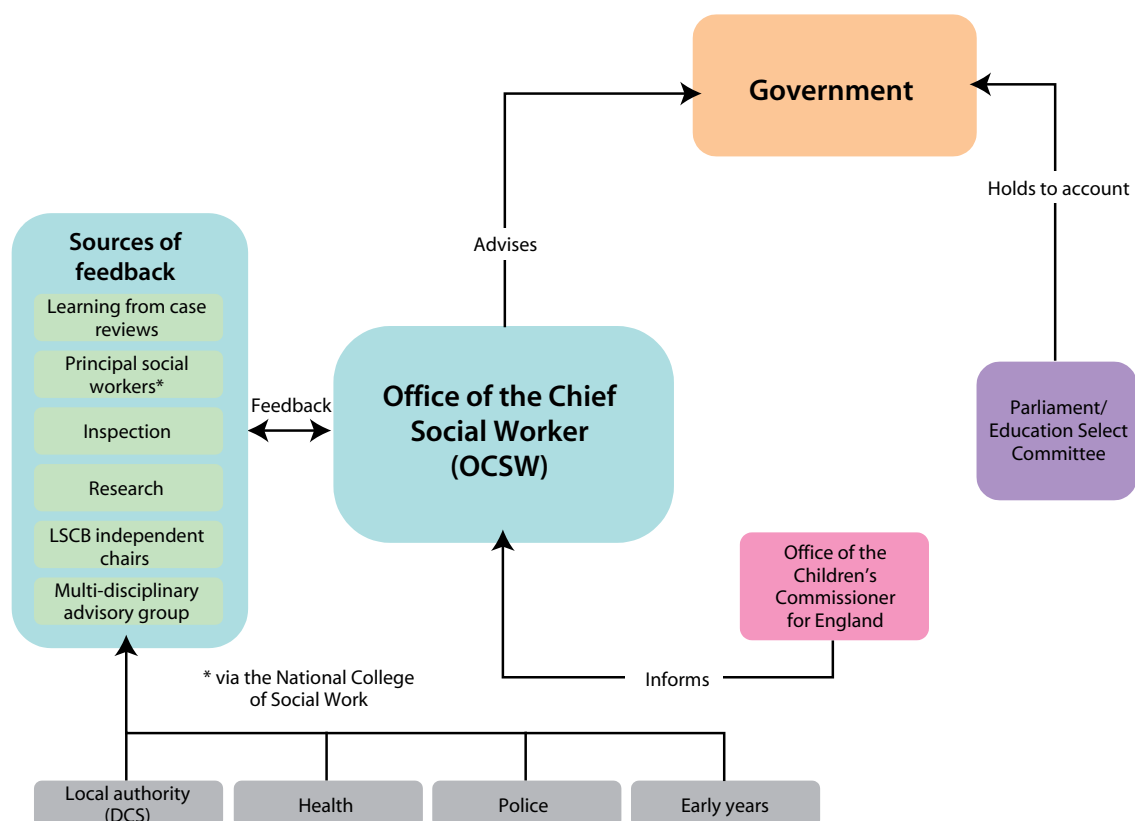
7.48   The Chief Social Worker would need to communicate with Principal Child and Family Social Workers in each local authority in order to maintain an understanding of how practice operating at the front line and what Government could do to help make improvements. Similarly, the Chief Social Worker might disseminate their findings to local authorities in order to help them by providing solutions to local problems faced by social work.

7.49   Whilst the primary responsibility of the Chief Social Worker would be to report to and advise Ministers, however, the Secretary of State for Education could choose to delegate their responsibility to report to Parliament on the Children Act 1989[172]. In addition, there would be an expectation that Parliamentary select committees would occasionally ask the Chief Social Worker to give evidence to their inquiries. Lastly, the Chief Social Worker could play a valuable role in liaising with the media to help explain the architecture of the profession and to promote the important function that social work plays in providing services to vulnerable children and adults.

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172 Children Act 1989, section 83(6) (available online at http://www.legislation.gov.uk/ukpga/1989/41/contents).

7.50   As with the Government-based advisory roles in other departments or countries, the role of Chief Social Worker would be distinct from that of the corresponding professional body. The College of Social Work has a vital and substantial role to play in leading the profession, voicing the concerns of its members, clarifying the profession's role, and advising on training and professional development[173]. The role of the Chief Social Worker, in contrast, would be to advise Ministers on the areas in which central Government intervention could make a difference to the practice of social work. The Chief Social Worker would, however, consider the views of the College in giving Ministers advice.

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

The public image of social work: media and public relations

7.51   In *Building a Safe and Confident Future* (2010)[174], the Task Force recommended a new programme of action on improving public understanding in relation to social work. It specifically recommended that the College of Social Work be created to take a lead role in this area. In evidence given both to the Task Force and this review, a number of senior journalists commented on the lack of a clear, strong voice for social work in the national debate[175].

7.52   With the establishment of the College of Social Work, this is changing. Though a very young organisation (due to become a legal entity in Autumn 2011) the College has begun to develop its services, which include a Policy and Communications Unit that offers:

- resources for journalists;
- balanced and informative case studies about different aspects of social work;
- social work spokespeople who can be called upon to speak on a range of national and local social work issues;
- a national programme of advice events for:
  - social work employers, to help develop their skills in working effectively with the media; and
  - national and local media to help foster a deeper understanding of social work; and
- a plan for its growing membership to contribute to national and local debates about the profession.

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173 Information on the college of social work available online at http://www.collegeofsocialwork.org/about-us/

174 The Social Work Task Force, (2010), *Building a safe, confident future – The final report of the Social Work Task Force*, London, Department for Education (available online at https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-01114-2009).

175 The Social Work Task Force, (2010), *Building a safe, confident future – The final report of the Social Work Task Force*, pp47, London, Department for Education (available online at https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-01114-2009).

7.53 In addition, it is hoped that the appointment of a Chief Social Worker will provide a national figure to discuss key issues relating to social work with the profession, the public and the media.

7.54 Given the sustained nature of the negative media images of social work that have been commonplace, social workers and social work employers should also take the opportunity to work proactively with local and regional media to present a more positive, balanced view of social work and its importance to society. A number of studies have highlighted this negative media attention:

- a literature review[176] on representations of social work and social workers in the media found that the media had taken a 'hostile' position to social workers since the 1970s[177]; and
- an analysis of press reporting of social work in national daily and Sunday newspapers in England between 1 July 1997 and 30 June 1998, showed that nearly two thousand articles were devoted exclusively to discussions of social work and social services. The 15 most common messages, accounting for 80 per cent of the total, were negative with regard to social work and included: 'incompetent', 'negligent', 'failed', 'ineffective', 'misguided' and 'bungling'[178].

7.55 Local authority communications and press teams, already equipped with the contacts, resources and expertise to promote positive stories in their local area, working together with local authority-employed social workers, have a real opportunity to make a difference. Whilst it is understood these teams have a wide range of services to represent in the media and that it can be difficult to have positive stories reflected to the public, this work should be prioritised.

7.56 Research on how the police service has approached and organised its communications since the 1990s indicated the adoption of a more integrated approach, with communications having been 'built in, not bolted on' as a central part of organisational structures championed by the Association of Chief Police Officers (ACPO). This approach, which includes media training for police at every level, was developed as a reaction to the realisation that effective communication is essential for good policing and '*too important to be ignored*'[179].

7.57 The College of Social Work, through its Policy and Communications Unit, is developing a range of tools and services that can help support social workers, their employers and the media to work together to promote a more balanced public image of social work. It will offer support for local authorities to help them prioritise this work, so that public sector employers of social workers can lead by example.

176 Galilee, J. (2006), *Literature review on media representations of social work and social workers*, Edinburgh, Scottish Executive (available online at http://www.socialworkscotland.org.uk/resources/pub/SocialWorkersandtheMedia.pdf)

177 Elsley, S. (2010), *Media Coverage of Child Deaths in the UK: The Impact of baby P: A Case for Influence?*, CLiCP Briefing, The University of Edinburgh/NSPCC (available online at http://www.clicp.ed.ac.uk/publications/briefings/Briefing%208%20-%20Media%20&%20Child%20Deaths.pdf)

178 Parton, N. (2009), 'From Seebohm to Think Family: reflections on 40 years of policy change of statutory children's social work in England.' *Child and Family Social Work*, 14, pp68–78.

179 Mawby, R. C. (2008), 'Built-in, not bolted-on', *Public Service Review,* Home Affairs 17, pp149–50.

Responsibilities

7.58 There are a range of different parties who have responsibilities in relation to the way social work is represented in the media:

- **the College of Social Work** holds the responsibility to provide an independent, national voice for social work and a source of expertise about the profession. Social workers, social work employers and journalists should take advantage of this expertise and work with the College to help it provide the right information and advice;
- **the Chief Social Worker** (if this recommendation is accepted), should become a nationally-recognised figure, who can represent social work within Government and in the media. It is hoped that the Chief Social Worker would build relationships with the media and public and become a trusted source of accurate and balanced information about social work practices, on both an ongoing basis and in response to high profile incidents;
- **social work employers, particularly local authorities**, have a responsibility to encourage their communications and press teams to work with social workers to find stories that the media will be interested in publishing. They should also work with the media to make sure they are as well informed about the complexities and difficulties that are inherent to social work, and the importance of social work to a healthy society. It is also recognised that some local authorities may be reluctant to prioritise social work for media attention, even in relation to positive stories, for fear of a later backlash in the event of future crises. If perceptions of social workers are to improve, the profession needs support from communications professionals, managers and leaders within the local authority;
- **social workers** (especially those employed by local authorities) must work more closely with in-house communications and press teams, so they can work together to help the media and public understand the role of social workers. Good relationships, based on trust, should be built up between local authority communications teams and social care teams, with a clear understanding that sharing information with the local authority communications and press teams is not the same as sharing information with the media. Working together, social workers and communicators should define proactive, long-term strategies for sharing information which is neither unlawful or against the express wishes of involved individuals' wishes. It is understood that fear of negative media coverage can cause reluctance in social workers and their employers to share even positive information. Social workers are the only people who can give a real and current account of how it feels to do their job and have a responsibility, working together with local communications professionals, to do this to help effect change;
- **journalists and others working in the media** have a responsibility to report accurately and responsibly, questioning whether the reporting they are involved is in the best interests of vulnerable children as well as the public interest;

- **public figures** who represent or discuss social work, especially in response to serious incidents that have occurred, should give calm and thoughtful responses that do not lead to knee-jerk reactions or conclusions. Responses by local and national politicians and leaders should recognise the need for professional judgments and actions to be thoughtfully reviewed, for lessons to be learned and any professional malpractice identified; and
- **other professionals involved in child protection work** should also give thoughtful responses, as described above, in relation to their views and explanations of what may have occurred in relation to child protection incidents, and at other times when they are discussing social work. Social workers and those representing them in the media should be similarly thoughtful when referring to other professionals.

Enhancing sensitive and responsible coverage

7.59 Child protection is naturally of great public interest and will always be extensively reported by the media. This review is not concerned with looking at how to inhibit such reporting, but how to enhance responsible and sensitive coverage, which both acknowledges the difficulties facing those that work in this highly complex area and holds those who are involved to account for their actions.

7.60 There is a delicate balance that social workers, their employers and the media should aim to strike when reporting on child protection issues:

- social workers and their employers should work proactively with the media to inform the debate as much as they can, without compromising clients' right to privacy under the law; and
- the media should provide a scrutiny role and has a responsibility to make sure reporting is balanced and accurate, and recognises the complexity of this work of the profession more generally.

7.61 Presenting the full picture in relation to the complexities of child protection can help society to understand more about what child protection work entails. A one-dimensional view however, can impact on the child protection system in a way that makes it less safe for children. The information in chapter one illustrates how public attitudes can be altered following high profile child deaths. Data presented in the review's second report discussed how a lack of public confidence in child protection professionals can help create spikes in demand that social care teams struggle to cope with, making it more difficult to react quickly to the most serious of cases. Morale among social workers can also be damaged, leading to more social workers leaving the profession and making it more difficult for the profession to attract candidates.

7.62 Decisions about the protection of children are among the most difficult that any professional group has to take, and often involve social workers making difficult judgment calls, such as whether a child should be moved from the family, based on whether there is evidence or suspicion of maltreatment, or how best to work with a family unit in an attempt to improve relationships between different family members.

7.63 To aid understanding about child protection work, while holding those involved to account, media reporting could also helpfully recognise factors that are common to child protection cases, such as:

- adults perpetrating child abuse are often skilful at hiding that abuse from social workers and other professionals;
- in many circumstances social workers face both legal and professional constraints that make it very difficult for them to be able to communicate openly about the full circumstances of a case that is under the media spotlight;
- child protection is a multi-agency business – social workers, schools, police and others are all involved. It is tempting to seek to identify one particular agency as having failed, but it is more useful to look at the wider picture in terms of the services that have been involved; and
- while there is a natural tendency when confronted with the horrors of a child protection case to seek to find someone, or some organisation, to 'blame', the harsh fact of the matter is that in the first instance blame, if it is to be attributed, must be laid at the door of the perpetrator or perpetrators.

7.64 Just as the media's reporting of mental health issues has, over recent years dramatically improved for the benefit of all, it is hoped that a similar improvement can be brought about in the area of child protection. The Society of Editors has expressed its willingness to meet the College of Social Work to discuss the possibility of developing a guide for reporting on child protection issues to encourage informed and informative coverage.

7.65 Unlike the police, who deal with very serious incidents routinely and have clear and transparent ACPO guidance governing their work, social workers and their employers are called upon infrequently to work with the media on serious child protection issues and have no guidance or strategy to refer to when such a situation arises. The College of Social Work will consult with a range of communications professionals, journalists, social workers on a set of principles for effective handling high profile incidents, as part of their national programme of advice events for social work employers and national and local media. Details will be available from 18 May at www.collegeofsocialwork.org.

Discussing social work within the legal framework

7.66 In 2010, the Local Government Association produced guidance entitled *Giving Social Work a Voice: how to improve social workers' relationship with the media*[180]. This sets out useful approaches that social workers and communications professionals can explore with relevant legal teams to prevent good work done by social workers from going unnoticed. This is necessary because publishing information relating to child protection cases is likely to involve significant legal risks.

7.67 Decisions about what information can be made public must be made in consultation with legal advisers on a case-by-case basis, and giving due

180 Local Government Association, (2010), *Giving Social Work a Voice: how to improve social workers' relationship with the media* (available online at http://www.lga.gov.uk/lga/publications/publication-display.do?id=11396179)

consideration to the welfare of all children and adults involved. Legal considerations are likely to include:

- whether the information could, by its nature, be protected under the Data Protection Act 1998;
- whether disclosure of information might breach the European Convention on Human Rights (ECHR) right to privacy and family life;
- any reporting restrictions imposed by a Court or under legislation;
- whether disclosure can be justified as necessary or relevant in relation to clinically confidential information; and
- whether the information could be capable of being used to identify living individuals whose identity is not already common knowledge, such as teachers, social workers or paediatricians.

7.68   The review has heard and understood the difficulties inherent in sharing information about social work, especially when information is sought in connection with particular child protection cases. Most social workers and their employers are well aware of the legal framework they work within. It is right that they are vigilant about working within the law to protect individuals' privacy and therefore do not share specific personal or case details with the media. Many journalists are aware of the legal restrictions that apply and will often understand why information is restricted.

7.69   Adhering to these restrictions, however, does not affect the right social workers and their employers have to talk about their work more generally, or to work with their communications teams to discuss ways of helping the media and public to understand child protection work and what it involves, without revealing confidential or case-specific information. It is important to remember that there is much to say about social work that is positive and that sharing, in the right way, is in the public interest and good for the profession. When information is not readily shared as part of the profession's usual business, the media and public does not have the context in which to understand the negative stories that are commonplace in times of crisis. A further lack of information at times of crisis, when the appetite for information increases and the profession becomes more nervous of speaking out, can create a space in which inaccurate stories are able to flourish.

7.70   The College of Social Work is establishing a pool of spokespeople, who will be equipped to work with the media when information about the profession is requested. These spokespeople will not be aware of the specifics of any serious incidents that are being investigated at a given time, so could be particularly useful in offering a more general but knowledgeable view of social work practices.

7.71   More general information about, for example, the kinds of cases social workers are involved in and day-to-day processes, is less likely to excite media interest than more specific information about individuals. Therefore, communications and press colleagues should work with social workers to help provide ideas about how this information could form the basis of positive and informative media, and help them feel confident and supported in talking to and working with the media.

7.72 Social workers may wish to consider making approaches to families or young people over 18 for their consent to share appropriate, positive and interesting stories with the media, working with communications and press colleagues for advice. Where people are happy for their story to be shared, but want to protect their identity, social workers and communications professionals should consider whether there is value in sharing an anonymised version with the media. It is up to the profession and individual social workers and local authority communications and press teams working together, to decide how much legally-shareable information is placed in the public domain. However, strategies for helping social workers to talk about their work in the media should be prioritised.

Chapter eight: Conclusion

8.1   This review was given a remit to improve child protection, with a particular focus on early intervention with children and families, the transparency and accountability of the system, and the expertise of the social work profession. Since the individual reforms of the past have all seemed intelligent and well thought through, it seems puzzling that they have not achieved their intended goals and, in some ways, have led to unwanted outcomes. The review has therefore looked at the child protection system as a whole to examine how individual policies, assessment tools and management practices interact to affect the quality of frontline work.

8.2   The review has identified many examples of high quality work and exciting innovations. It has also reviewed the research evidence and concluded that there is now a substantial amount of evidence available on how best to help parents bring up their children safely and well. The potential quality of service that could be achieved across the country is therefore high.

Unintended consequences

8.3   However, a systems analysis has revealed how the cumulative effect of previous reforms has been to create a very regulated and prescribed working environment. This has been particularly apparent in social work, where the over-bureaucratisation is reducing the time workers spend with children and families, building strong relationships, so that they can better understand and help them. Reforms have been implemented through top-down direction and regulation, which has contributed to problems and led to an over-standardised response to the varied needs of children. Managerial attention has been excessively focused onthe process rather than the practice of work. In social work, targets and performance indicators have become drivers of practice to a degree that was never intended by those who introduced them. In turn, this has created an image of the inspection process that perplexes those Ofsted inspectors who seek to take a wider and more qualitative assessment of practice. This top-down approach has also limited the system's ability to hear feedback from children, families or frontline workers about problems in practice. The system's poor ability to learn from feedback is also evidenced in the findings of Serious Case Reviews (SCRs) which have, over the past two decades, repeated the same messages. Even in those SCRs which concluded that deficiencies in knowledge and skills were at the heart of practice errors, recommendations have tended to focus on increasing compliance with a growing number of procedures[181].

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181 Rose, W. & Barnes, J. (2008), *Improving Safeguarding Practice: Study of Serious Case Reviews 2001–03*, London, Department for Children Schools and Families (available online at https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-RB022)

8.4   The priority given to process over practice has led to insufficient attention being given to whether children and young people are benefiting from the services they receive. Any future reform programme must make outcomes for children and young people the prime measure of whether the system is working well. This is the best strategy for keeping attention on what is happening to children. For this reason, the review has set out recommendations for substantial reform of how inspections are conducted, so that more attention is paid to the experiences of children, young people and their families and the effectiveness of help offered to them. In place of the current system, which has been a part of the compliance culture, there should be more attention given to learning and adapting. This will require practitioners, and leaders in particular, to learn to expect the possibility of error, always seeking, and adapting in response to, feedback and making sure that what is learned makes a difference to practice and therefore outcomes for children and young people. The new inspection framework should examine the child's journey from needing to receiving help, and explore how the rights, wishes, feelings and experiences of children and young people inform and shape the provision of services.

8.5   The evidence that children and young people have given to the review vindicates the Government's decision, within weeks of the formation of the Coalition, to express concern that the child protection system is not working as well as it should. They have said that, above all, they want a trusting and stable relationship with an adult who provides them with help and information when they need it. Yet, for too many, this is not achieved. Ofsted reported recently[182] that, '*the child was not seen frequently enough by the professionals involved, or was not asked about their views and feelings*'. The Children's Rights Director[183] reports that too many children become looked after without their opinions having been sought. The Children's Commissioner has found that there is a tendency to focus on the needs of parents with insufficient attention given to the needs and concerns of the child[184]. Refocusing child protection on the needs and experiences of the children whom the system exists to protect is the ultimate aim of this review's recommendations.

Rethinking the place for regulation and procedures

8.6   During the course of this review, there have been references to data collection as a 'burden'. Data about the experience of children and young people are essential for managers to know whether they are providing a good service and whether that service is contributing to better outcomes. The central issue is, therefore, not about whether data collection is a burden. Rather it is about whether it provides the information necessary to evidence the impact and effectiveness of work undertaken to help and protect children and young people.

8.7   A key intention of this review is to help the system shift from a compliance to a learning culture. This aligns well with current Government policy, which seeks to

182 Ofsted, (2011), *The Voice of the Child: learning lessons from serious case reviews* (available online at http://www.ofsted.gov.uk/Ofsted-home/Publications-and-research/Browse-all-by/Documents-by-type/Thematic-reports/The-voice-of-the-child-learning-lessons-from-serious-case-reviews)

183 Ofsted, (2011), *Children's Care Monitor 2010* (available online at http://www.ofsted.gov.uk/Ofsted-home/Publications-and-research/Browse-all-by/Care/Children-s-rights/Children-s-care-monitor-2010).

184 Office of the Children's Commissioner, (2011), *Don't make assumptions': Children's and young people's views of the child protection system and messages for change* (available online at http://www.childrenscommissioner.gov.uk/content/publications/content_486)

improve the balance between central prescription and local freedoms. The review recommends reducing the degree of central prescription in order to increase the scope for professional exercise of judgment and expertise. However, rules and freedom are not inherently good or bad but depend on context. While the set of recommendations are largely biased towards increasing professional autonomy, some additional prescription is recommended. The review has looked at child protection systems in other countries. This provided many valuable lessons on good practice but it also revealed the difficulties when responsibility for child protection is not shared well. This country has a commitment to shared professional responsibility for the safety and welfare of children and young people and an associated set of procedures for working together that sets a shining example. Simple, clearly understood procedures have great merit when several people from different agencies need to work together. They allow professionals to know what to expect from others and what their own role is. In child protection, the group who come together around a particular child or family may not have much prior acquaintance and so this level of predictability contributes to efficiency and effectiveness.

8.8   The current procedures apply to professionals when they work together on cases of abuse or neglect. However, the review is recommending that there is a need for some degree of regulation when they work together at earlier stages in family problems. The duty to protect children and young people includes both a duty to detect and intervene when they are being abused and/or neglected *and* to offer support to families so that fewer children suffer neglect and abuse in the first place.

Early help

8.9   The case for more help at an early stage for children and families has been accepted since at least the introduction of the Children Act 1989. The current Government has repeated the commitment, setting out in the letter of appointment for this review that one of the principles underpinning the Government's approach to reform is early intervention. It has also demonstrated its commitment by establishing three other reviews looking at aspects of the issue, led by Graham Allen MP, the Rt Hon Frank Field MP and Dame Clare Tickell. They have all independently reached similar conclusions to this review around the importance of providing help at the earliest possible opportunity in order to improve outcomes for children, young people and families.

8.10 Besides a moral concern to minimise any adverse experiences for children and young people, research now indicates both that there are more demonstrably effective ways of supporting families so that they do not become abusive or neglectful, and that such services are cost-effective in the longer term[185]. Numerous agencies and services play some part in providing these services. The review considers that attention to coordinating them is essential to maximise efficient use of resources. With significant reforms underway in all the main services, there is a danger of inefficiencies resulting if reforms do not take account of the repercussions for other services. To this end, the review is recommending that the Government should require local authorities and statutory partners to

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185 Knapp, M., Parsonage, M. & McDaid, D. (eds.) (2011), *Mental Health Promotion and Mental Illness Prevention: The Economic Case*, London, Department of Health (available online at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_126085)

make sufficient provision for early help and to set out their arrangements to develop and implement this locally for children, young people and families.

8.11   The review is also concerned to reduce one aspect of prescription in the provision of early help. This is in relation to *how* professionals practice and implement the Government's current policy on the 'Common Assessment Framework'. Confusingly, the phrase seems be used to describe both the policy and the form. Whilst the review supports the principle which sought to provide early help to children and young people, there is conflicting evidence on whether the form is contributing to improved practice or not. In line with other recommendations, the review considers that local areas should have the flexibility to make decisions on revising the form to suit local needs. In doing so they should work closely with other professionals involved with children, young people and families to agree both the evidence and theoretical basis for a subsequent offer of early help.

Recognising abuse and neglect

8.12   Mention has been made of the need for all who have contact with children and family members to notice signs of abuse or neglect. Many services have contact with adult family members and can pick up signs of problems. The association between parental problems, such as poor mental health, domestic violence and substance misuse, and abuse and neglect is well-established[186]. Adult services are therefore vital in recognising the possible impact that such problems may be having on children. Similarly, children and young people rely on the police being sufficiently aware of the link between domestic violence and the harm done to them when witnessing or being caught up in violence. GPs and health visitors are well placed to identify problems early and arrange access for children and families to therapeutic and support services. While practitioners in social care and the health service are well positioned to respond to abuse that manifests itself in a crisis, those working in early years settings and schools see children on a daily basis and are often in a better position to identify chronic forms of maltreatment such as neglect and emotional abuse. The availability of social work expertise to help staff is important here.

Uncertainty

8.13   As the review has described, abuse and neglect can be hard to see, with many of the indicative signs or symptoms being ambiguous and possibly having other benign explanations. Moreover, some parents go to extreme lengths to conceal the truth. There is a degree of uncertainty about recognising that children and/or young people are suffering significant harm that cannot be eliminated, though training helps professionals to know what to look for and procedures help them know what to do with their concerns. Managing this inescapable uncertainty is a problem that bedevils child protection services around the world and examples from this country illustrate how this central problem influences priorities in practice. If uncertainty is managed by referring even small signs of concern to children's social care, then the level of demand for assessment is so high that it absorbs the bulk of resources, and provision of early help to children and families is cut in consequence. Families then only get access to help when problems are very

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186 Cleaver, H., Unell, I. & Aldgate, J. (in press) *Children's needs – Parenting Capacity. Child abuse: Parental mental illness, learning disability, substance misuse and domestic violence*, 2nd edition, London, The Stationery Office.

severe and hard to resolve. Moreover, it means that many children are subject to intrusive and distressing enquiries but the families are finally deemed non-abusive and offered no help.

8.14 This situation was summarised in Government-funded research published in 1995[187]. It was also noted that many of the children investigated, although not warranting a child protection response, were from families who were struggling and could benefit from offers of help. In 1995 the then Conservative Government introduced a policy that sought to rebalance services so that more attention was given to working with children and families. The policy intention was to improve children's outcomes with the more investigative, coercive intervention being kept to a minimum. However, social work services remain heavily biased towards dealing with child protection, and family support services have failed to materialise at the rate intended[188] .

8.15 The last Government took a wider approach to helping children and young people. It drew on evidence that many of the factors that led to abuse or neglect were also the factors that resulted in a range of adverse outcomes for children, such as poor educational achievement and increased anti-social and offending behaviour. Early help was again seen as the desirable goal and the efforts of all those working with children and young people were harnessed within the 'Every Child Matters: Change for Children' policy.

8.16 However, workers still face the problem of knowing when a voluntary, supportive service is not appropriate because children are suffering abuse or neglect to a degree that requires a statutory response. The review has been impressed by those places developing multi-agency teams to assess referrals and to talk to referrers about what is worrying them. A key characteristic of these teams has been the presence of a skilled and experienced social worker. The emerging evidence indicates that this approach appears to be shifting the investigative question from 'is this a child protection case or not?' to 'does this child or young person need help and, if so, which service is appropriate?' It also appears to help, to a certain degree, to manage the understandable anxiety about possibly missing a case of serious harm. Ensuring that those supporting children and families feel confident about *when* to refer to child protection is crucial in reducing the numbers of children who get referred to children's social care, but are not deemed to warrant a child protection response. Further, it is likely to lead to better identification of those children and young people who are suffering, or likely to suffer, significant harm. This is because there is less resource expended on prioritising large numbers of referrals and more time spent with children and families.

Social work expertise

8.17 Improving social work expertise was a specific focus of the review. Social work as a profession has been the subject of extensive central prescription because of well-founded concerns about standards and practice. However, the extent of that prescription has not been helpful, resulting in a degree of bureaucratisation that has unintentionally distracted from key aspects of practice by absorbing too much

187 Department of Health (1995), *Child Protection: Messages from Research*, London, HMSO.
188 Aldgate, J. (2002), *Evolution not revolution: Family support services and the Children Act 1989*, in *Approaches to Needs Assessment in Children's Services*, (eds.) Ward H. & Rose W., pp147–165, London, Jessica Kingsley Publishers.

professional time. As the system's dependency on rules and prescription has grown, there has been insufficient freedom and confidence in the exercise of professional judgment. There has also been a worrying change in the priority afforded to building strong relationships with children, young people and families, and working directly with them.

8.18   The prescription of *how* to practice has sapped the profession's ability to develop its own knowledge and skills base. Most worryingly, there has been so much focus on improving social work skill in the timely assessment of children and families, that insufficient attention has been given to providing social workers with the knowledge and skills to *help* them. In the light of the growing body of evidence about the effectiveness of methods of solving problems and changing behaviour, this omission is grave. The work of the Social Work Taskforce and the Social Work Reform Board are key to improving social work. The newly formed College of Social Work will play a central role in developing the profession's ability **t**o improve its level of expertise.

8.19   The review has been consulting closely with a number of local authorities and learning from local leaders, managers, and front line practitioners who have made innovations to support professionals. They have sought to increase the knowledge and skills of the workforce and to create less prescriptive working environments. These authorities are creating a learning culture, where change is expected as a consequence of that learning. Their receptiveness to regular feedback from the front line is helping to create an adaptive environment with greater opportunity to exercise appropriate professional judgment. These areas are making progress towards child-centred practice but make it clear that this is, to some degree, *despite* the prescriptive elements of the national statutory and regulatory framework. Some of them have recently been granted exemptions from statutory guidance by the Government, as a result of this review, so that they can be more ambitious in their innovations and act as a pilot for a less prescriptive system.

8.20   In order to improve social work expertise, the review has concluded that the current framework for social work practice should be revised. At present, a frontline social worker carries a caseload (often very heavy) with limited access to supervision, which is narrowly focused on the performance management of cases. The review considers that the range of available knowledge and skills that could contribute to meeting the varied needs of children and families makes this workload unmanageable. It is more appropriate to conceive of the frontline worker as akin to a junior doctor who has access to many more senior doctors with specific areas of expertise to help in the management of any one case.

8.21   In view of this, the current career structure should be replaced with one that allows more opportunity for people to stay in practice while gaining seniority within the organisation. It considers that the development of individual expertise and of the profession's knowledge base has been seriously hampered by a career pattern requiring people to leave practice in order to get promoted. It also recommends that each local authority should have a designated Principal Child and Family Social Worker who is still actively involved in practice and who would help in the development of practice expertise in that authority. These Principal Child and Family Social Workers will provide feedback from the front line to help managers and partners in their ongoing review and redesign of the ways in which child and

family social work is provided. They should draw on the evidence of effective help and support practice that implements evidence-based ways of working with children, young people and families.

Priority for funding

8.22   Reform of the social work profession should significantly improve outcomes for children and young people by making best use of available evidence about what helps to solve the problems in children's lives. Increasing the expertise of the social work workforce requires investment. However, those areas where the review has seen ambitious local reform to upgrade the knowledge and skill of the workforce are quickly seeing savings overall. Skilled help can enable more children and young people to stay safely with their families, bringing significant savings. Initially resources will be required to develop the additional expertise and training necessary to set the profession off on a new path and this is an area that the review considers to be a priority for investment.

Multi-agency learning

8.23   Local Safeguarding Children Boards (LSCBs) have a key role in monitoring local arrangements to safeguard and promote the welfare of children and young people and in assessing how well the many parts of the system are working together. The review has recommended that their functions should be strengthened to include monitoring the effectiveness of help given to children and families, including early help since this has so much bearing on how many children and families are referred and responded to by children's social care.

8.24   LSCBs also monitor multi-agency working through conducting SCRs when a child or young person dies or is seriously injured and abuse or neglect are considered to be factors. These SCRs have tended to contribute to the prescriptive culture by concluding with recommendations for more regulations and procedures that seek to minimise the risk of missing a case of abuse or neglect. The review recommends adopting a systems methodology for these case reviews akin to that being developed in the health sector. It is felt that this approach is likely to produce deeper and more valuable lessons about *why* problems have arisen and thus offer fresh perspectives on how their incidence can be reduced.

Managing anxiety in the system

8.25   Anxiety is already a major force in the system because of the complexity and emotional intensity of work with families where children could be or are being harmed. As already discussed, anxiety about missing a case of abuse or neglect leads to the high level of referrals to children's social care. Social workers, in turn, can be driven by anxiety into applying to remove children from their birth family at a lower level of risk. Waves of anxiety travel through the system when there is a high profile death, leading to more referrals being made. The media and the public have a role to play in taking a more realistic view of the impossibility of eradicating all uncertainty from child protection. The false hope of eliminating risk has contributed significantly to the repeated use of increasing prescription as the solution to perceived problems. Consequently, this has increased defensive practice by professionals so that children and young people's best interests are not

always at the heart of decisions. It is major challenge to all involved in child protection to make the system less 'risk averse' and more 'risk sensible'.

8.26   In the past, evidence of problems within the system has too often been seen as evidence of insufficient central control. The review is proposing an alternative view that the system is complex and it is not possible to predict or control it with precision. This should lead to the recognition that the unintended will happen. In turn, feedback then becomes the more important mechanism for monitoring the functioning of the system and, when problems are picked up, the system needs the flexibility to learn and adapt. A more constructive way to achieve improvement is for Government to provide clarity around roles, responsibilities and accountabilities, set out what goals the system should aim for, and leave professionals to judge how best to help and protect children and young people.

A balanced system

8.27   The tenor of these proposals resonates with the Coalition Government's policy on localism. The State's responsibility to protect children and young people means Government must continue to provide a clear legal framework, setting out what vulnerable children, young people and their families should expect from the collective efforts of local agencies. However, the review recommends stripping away much of the top-down bureaucracy that previous reforms have put in the way of frontline services, as described above. In the context of a localist approach, however, it should be remembered that all children and young people are vulnerable by virtue of their age, immaturity and dependence on adults. It is therefore equally important that some prescriptions remain in respect of unparalleled life-changing decisions about children's safety and the potential to remove them from their birth families.

Implementation

8.28   In responding to this review, the Government will have to manage the inevitable anxiety of giving greater discretion in how local agencies exercise their statutory duties. In doing so, the review cautions against cherry picking reforms in isolation; removing prescription without creating a learning system will not secure the desired improvements in the system. On the other hand, delaying the removal of prescription until services show they can take responsibility prevents them from demonstrating it. The review also cautions against taking a short-term approach to the implementation of these reforms. The depth of change recommended in this report means it will take time for experience with new ways of working to accumulate to the point where they can be fully effective. However, in the light of research evidence of effectiveness, it should ultimately lead to substantial improvements in services and outcomes for vulnerable children.

Appendix A: Analysis of impact of increased prescription in social work

Causal Loop Diagram exploring systemic impact of efforts to improve social work through increased prescription of practice

Developed in collaboration with Dr David Lane, London School of Economics and Political Science.
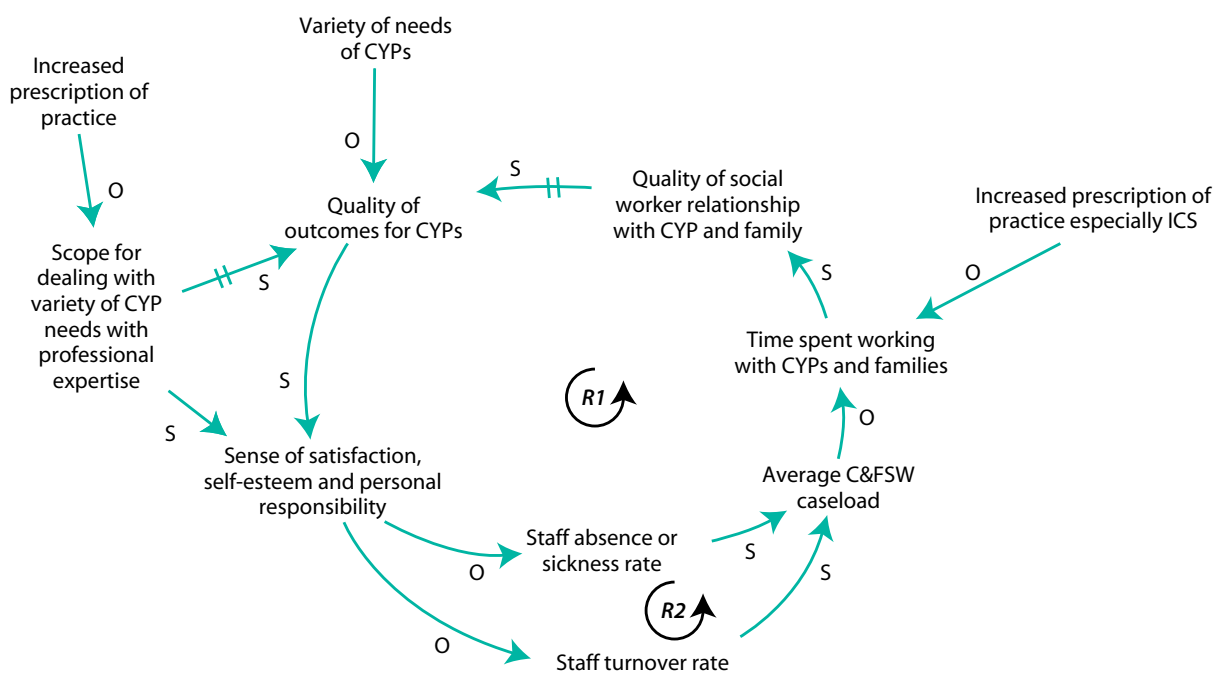
1   The increase in rules and guidance governing child and family social work activity over the past two decades has had a number of unintended consequences on the health of their profession and outcomes for vulnerable children and young people. Some are illustrated in this 'causal loop diagram'.

2   The quality of the outcomes for children and young people delivered by child protection services is heavily influenced by three factors. First, the wide variety of needs that children and young people have; the more variety, the harder it is to meet those needs. Second, professionals can only work within the scope that they are allowed for applying their professional expertise. If that scope is increased, alongside an investment in building social workers' capabilities, then it is likely that

outcomes for children will improve. Third, outcomes are also improved when professionals establish and maintain high quality relationships with children, young people and their families.

3   Increasing prescription for the ways in which child and family social workers respond to children and families' needs has had a number of ripple effects in the system. These have primarily manifested themselves as unintended consequences on the ability of children's social care to protect children and young people and feedback effects (see below for definition) forming damaging 'vicious circles'.

4   For example, too much prescription of practice, which diminishes professional responsibility for judgments and decisions, has an unintended consequence of reducing the job satisfaction, self-esteem and sense of personal responsibility experienced by child protection workers. This leads to the further unintended consequence of increasing amounts of time taken off absent or sick. In fact, this goes on to create a reinforcing loop, R1 (see below for definition): those still at work have to take on larger caseloads and in turn have less time to build relationships with children and families; in time, this reduces the quality of the outcomes for children and young people, which further reduces the sense of job satisfaction.

5   Another unintended consequence of prescription is that dissatisfaction with the role causes high staff turnover. Again, this creates larger caseloads and reduced contact time with children, young people and families, so another vicious circle is created, R2.

6   Two other influences are illustrated, each exacerbating the ripple effects. Too much prescription reduces scope for professionals to respond appropriately to each individual case and, though it takes longer for the effect to play out, this reduces the quality of outcomes for children and families. In addition, the large amounts of time social workers are forced to spend on Integrated Children's System (ICS), reduces the time they can spend directly engaging with children, young people and families. Both of these can be seen as unintended consequences of burdensome rules and guidance. However, they also strengthen the two feedback effects (reduced job satisfaction due to increased caseloads as a result of absence and high turnover), making these loops even more damaging.

7   Although only a few 'ripple effects' are illustrated here, they are indicative of a range of unintended consequences resulting from an overly-prescriptive approach to child and family social work. This collection of reinforcing loops has restricted the capabilities of the profession, increasingly reducing its effectiveness.

Systems Ideas Used Here

8   Causal Relationships

This concept derives from the System Dynamics field[189]. An arrow linking variable A to variable B should be read as 'a change in the value of A produces a change in

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189 Forrester, J. W. (1961), *Industrial Dynamics,* Cambridge, Mass, M.I.T. Press; idem (1968), *Principles of Systems,* Cambridge, Mass, Wright-Allen Press.

the value of B'. The qualitative nature of the link is indicated by a 'link polarity'. These should be read as:

- 'S': the variables move in the same direction *ceteris paribus*, so a change in variable A produces a change in variable B in the same direction: if A goes up, B goes up.
- 'O': the variables move in the opposite direction *ceteris paribus*, so a change in variable A produces a change in variable B in the opposite direction: if A goes up, B goes down.
- double bars on a link indicate a particularly long delay in the causal connection.

Note that the link polarity says nothing about the size, or quantity of the change. The indication of the effect is qualitative only. Moreover, there is no presumption of a linear relationship between the two variables[190].

9   Requisite Variety

In general terms, the idea of 'Requisite Variety' is that a policy in a controlling system must have available a variety of responses that is at least as great as the variety of circumstances it seeks to control[191]. In simple terms, a controller must be flexible enough to cope effectively with the full range of situations it will encounter.

In the case of child protection this implies that, because the variety of needs is very high, a similarly wide scope in the nature of any interventions is required to identify in what areas help is necessary and what support services should be offered.

10   Feedback Loops

A concept also drawn from System Dynamics, feedback loops arise when the previous value of some variable influences its current value in some way. Although feedback loops arise as balancing and reinforcing, only the latter occurs in this illustration:

- 'R': in isolation, reinforcing loops operate so as to amplify any changes to variables within the loop. Over time, the values of variables will 'snowball', becoming greater or accelerating downwards. If the result is desirable then we speak of this as a 'virtuous circle'. If the result is unwanted then it is a 'vicious circle'.

N.B. The descriptions of behaviour over time given here are true only for isolated loops. In a system with many interacting loops the behaviour over time can be very complex, to the point of defeating normal human intuition about what should happen and why[192].

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190 Information on this type of diagram can be found in: Lane, D. C. (2008), 'The Emergence and Use of Diagramming in System Dynamics: a critical account', *Systems Research and Behavioral Science*, 25(1), pp3–23.

191 Ashby, R. (1956), *An Introduction to Cybernetics,* London, Chapman & Hall.

192 Forrester, J.W. (1975), 'Counterintuitive behaviour of social systems', in Collected Papers of Jay W. Forrester, pp211–244.

Appendix B: Munro Review of Child Protection – Draft Performance Information Set

1   It is essential that high quality data are used intelligently at local and national levels to drive improvements in practice that benefit children and young people. An important aspect of the review has been to suggest a refocused and reduced 'twin core' of data which sets out the minimum information requirements of central government and recommended data for use by local areas.

2   At national level, information will be used to monitor the national impact of system changes and for policy development. Nationally the information outlined below will be supplemented by data on preventable child deaths (an additional outcome), which is not included in this set because the small sample size means that it cannot be used for local comparability and benchmarking. Local areas will be able to draw from the national data outlined in this annex, as well as the additional data produced and held locally using standardised definitions (also outlined in this annex), to understand changes in concentrations of need and trends over time, as well as to inform:

- service planning and development including through the Joint Strategic Needs Assessment; and
- service improvement including self evaluation, sector-based improvement (including peer reviews) and inspection activity.

Health and wellbeing boards, as they are established, will also wish to take an interest in this information.

3   The performance information set outlined below should be regarded as information that, taken together, helps to provide context for discussions about the health of child protection services in local areas. In isolation, they do not clearly indicate good or bad practice and are therefore called information, not indicators.

National Information Items

Domain and descriptions	Information Item	Data Source	Category	Rationale
Outcomes • Crimes against children • Injuries to children	The rate of offences against children per 10,000 CYP population	Police Crimsec3 statistics	Outcome	An important negative outcome to monitor is when multi-agency preventative and protective services are failing to prevent offences against children and young people from happening
	Hospital admissions caused by unintentional and deliberate injuries to children and young people	HES statistics	Outcome	Key outcome measure which looks at both deliberate injuries (child protection) and unintentional injuries (wider safeguarding). The intention would be to change this measure to hospital presentations, not just admissions, once the relevant data collection is more established and reliable
Workforce • State of workforce • Agency staff	Social worker: a) Vacancy rate b) Turnover rate c) Absence/sickness rate	New national data collection	Service information	Together, these would provide a good picture of social worker capacity and workforce stability, factors which contribute to overall quality of service provision
	Percentage of social work posts filled by agency workers	New national data collection	Service information	
Timeliness • Days to offer help	Average number of working days taken to decide whether a child is 'in need' and offer to help from the point of contact/referral	CIN Census	Service information	Provides an indication of how quickly the assessment and provision of help to children in need takes place, without setting a target number of days

Domain and descriptions	Information Item	Data Source	Category	Rationale
Plans • Length of plan • Repeat plans • Number on plans • Re-referrals (previously on plan)	Percentage of cases where children who have been on child protection plans in the past 12/24 months are re-referred to children's social care	CIN Census	Service information	Provides an indication of how effectively the original CPP dealt with the initial child safety/welfare concerns
	Percentage of Child Protection Plans lasting two years or more	CIN Census	Service information	Provides an indication of case drift/issues not being resolved
	Percentage of children becoming the subject of Child Protection Plan for a second or subsequent time (within two years)	CIN Census	Service information	Provides an indication of the effectiveness of the original child protection plan
	Number of children on Child Protection Plans (rate per 10,000 population)	CIN Census	Service information	Provides a comparable measure of numbers of CPPs
Flow • Referrals leading to a social care service	Percentage of referrals/assessments leading to the provision of a social care service	CIN Census	Management information	Provides data on flow through the CP system. Will also show cases where assessments happen but no services are provided
• Referrals leading to a non-social care service	Percentage of children who are judged not to meet the CIN threshold (section 17a) that are provided preventative or other services outside of social care	CIN Census	Management information	This will be an important indicator of early intervention/family support services provided to children/families who do not meet statutory thresholds. It is intended that that there could be a number of categories e.g. domestic violence services

Domain and descriptions	Information Item	Data Source	Category	Rationale
Activity ● Rate of assessments ● Rate of enquiries ● Type of referral (child) ● Type of referral (adult) ● Source of referral	Rate of assessments per 10,000 population	CIN Census	Management information	Provides a comparable measure of throughput
	Rate of section 47 enquiries per 10,000 population	CIN Census	Management information	Provides a comparable measure of numbers of section 47 enquiries carried out
	Referrals to children's social care categorised as (physical/emotional/sexual) abuse or neglect (rate per 10,000 population) at start of CIN episode	CIN Census	Management information	Provides a comparable measure of referrals under the four main categories
	Percentage of referrals to children's social care from: a) The police b) The health service c) Education d) Other sources	CIN Census	Management information	Taken together will give an indication of where referrals are coming from and the level of understanding of referral thresholds
	Percentage of referrals to children's social care from: a) The police b) The health service c) Education d) Other sources that result in no further action	CIN Census	Management information	

Domain and descriptions	Information Item	Data Source	Category	Rationale
Activity (continued)	Referrals to children's social care where parents/carers' mental health, substance abuse or domestic violence is a feature (rate per 10,000 population), measured at the start of the CIN episode	CIN Census	Management information	Provides a comparable measure of referrals where parental problems are a contributory factor. Should be disaggregated
	Children becoming the subject of a Child Protection Plan for physical, mental and sexual abuse or neglect) (rate per 10,000 population)	CIN Census	Management information	Provides a comparable measure of Child Protection Plans under the four main categories. Should be disaggregated
	Children who are the subject of a section 47 enquiry	CIN Census	Management information	Provides a measure of children who are the subject of a section 47 enquiry

Local Information Items

Domain and descriptions	Information Item	Data Source	Category	Rationale
Outcomes • Children's perceptions of safety	Percentage of children and young people engaged with children's social care services who report that they feel safe: a) At home (top priority) b) At school (potentially useful for change over time measurement) c) In their local area (locally useful but not comparable between areas)	Standardised local authority level surveys	Outcome	It is crucial that feedback from children and young people is sought so that it can inform learning and drive service improvement
Workforce • Caseload • Changes of social worker	Number of changes of social worker in contact with the child from first contact with children's social care	Local systems	Management information	Provides an indication about the consistency of relationships between providers of services and children and underlines the importance of continuity
• Social worker survey • Other agency surveys	Average social worker caseload	Local systems	Management information	Enables workload monitoring but allows for diversity in the way that cases are managed locally

Domain and descriptions	Information Item	Data Source	Category	Rationale
Workforce (continued)	Percentage of children and young people's social workers who consider that:	Standardised local authority level surveys	Management information	It is crucial that feedback from social workers is sought so that it can inform learning and drive service improvement
	a) Their interventions have improved the safety of children			
	b) They received adequate professional supervision and support			
	c) Their caseloads are manageable			
	d) They are able to spend enough time with children and young people			
	Percentage of staff from:	Standardised local authority level surveys	Management information	It is crucial that feedback from partner agencies is sought so that it can inform learning and drive service improvement
	a) The police			
	b) The health service			
	c) Education			
	who consider that they have a good understanding of children's social care referral thresholds and procedures			

Domain and descriptions	Information Item	Data Source	Category	Rationale
Timeliness ● Days to put on plan/initiate care proceedings	Average number of working days taken to decide on a Child Protection Plan or initiate care proceedings following the decision determining that course of action	Local systems	Service information	Provides an indication of how quickly CPPs are made/care proceedings are initiated. (Could be split into separate CPP/care indicators)
User experience ● Survey of children and young people ● Survey of parents	Percentage of children and young people engaged with children's social care services who agree that their views were listened to by professionals	Standardised local authority level surveys	Service information	It is crucial that feedback from children and young people is sought so that it can inform learning and drive service improvement. Also, if evidence about this is part of inspection, then it becomes a higher priority in daily practice
	Percentage of parents engaged with children's social care services who agree that their views were listened to by professionals	Standardised local authority level surveys	Service information	It is crucial that feedback from service users is sought so that it can inform learning and drive service improvement

Domain and descriptions	Information Item	Data Source	Category	Rationale
Activity ● Child seen in accordance with plan	Percentage of cases where the lead social worker has seen a child in accordance with their Child Protection Plan	Local systems	Service information	It is crucial that the child is seen (alone when appropriate) by the lead social worker in accordance with the CP Plan: the child should be spoken and listened to and their wishes and feelings ascertained (in accordance with their age and understanding). This is part of developing and sustaining a relationship with the child as well as observing possible signs of maltreatment and reviewing the child's developmental progress. Some of the worst failures have occurred when social workers have lost sight of the child.

Appendix C: Signposting

1   The review was remitted to consider the potential value of having a national means of providing a quick and reliable way of identifying whether a child or young person is, or has been, the subject of a child protection plan or whether they are, or have been, looked after. The review has concluded that the arguments for and against such a national system are finely balanced and that there is no compelling case to recommend one at this point.

2   The problem underlying this issue is how to facilitate good risk assessment by making available relevant information which highlights existing problems and concerns about a child's safety and welfare. A theme in Serious Case Reviews (SCRs) is that a lack of information sharing between the many agencies involved in supporting some children and families often contributes to inaccurate risk assessments[193]. With this in mind, many systems and processes have been introduced across various agencies in an attempt to promote the sharing of information, but with varying levels of effectiveness. The statutory guidance *Working Together*[194] states that *'it is essential that legitimate enquirers such as police and health professionals are able to obtain this information [information included on the local authority IT system about a child's safety and welfare, including whether they are the subject of a child protection plan], both in and outside office hours'*.

3   However, effective communication is not just a matter of moving a datum from one computer to another; it is 'the process by which information is transferred from one person to another *and is understood by them*'[195]. A consistent finding from SCRs is that there is often a failure in the human performance, rather than an absence of the required framework, process, or procedures for sharing information. Therefore, in considering whether a national database of the two categories of children (those who have been, or are, the subject of a child protection plan and children who are, or have been, looked after) would make a significant contribution to children's safety and welfare, the review sought to establish how current arrangements were working so the added value of a signposting system could be estimated.

4   The guidance in *Working Together* constitutes the current position. Any professional, such as a doctor or police officer, who is concerned about a child can contact the relevant local authority for this information. Some of those interviewed for this review preferred this mechanism because it gave access to detailed information on the context of any previous involvement with social care.

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193 Ofsted, (2010), *Learning lessons from serious case reviews 2009–2010* (available online at: http://www.ofsted.gov.uk/content/download/11643/136464/file/Learning%20lessons%20from%20serious%20 case%20reviews%202009%E2%80%932010.pdf).

194 HM Government, (2010) *Working Together to Safeguard Children,* paragraph 5.150, London, Department for Children, Schools and Families (available online at https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010).

195 Reder, P. & Duncan, S. (2003). 'Understanding communication in child protection networks', *Child Abuse Review*, 12 (March April), pp82–100.

These practitioners felt this was far more helpful than knowing only if the child was the subject of a child protection plan, particularly when making difficult and complex judgments about risk of possible harm. The biggest criticism is that these conversations can involve a long wait which can cause problems, for example, in a busy A & E department, and this can discourage people from seeking this information.

5   Fieldwork undertaken for this review found that, besides meeting the statutory guidance, there are a range of additional mechanisms for sharing some information about children, usually whether the child is the subject of a child protection plan. Following the recommendation of Lord Laming[196], the Department of Health wrote to the chairs and chief executives of all NHS Trusts. This letter highlighted a report by the Care Quality Commission and made a number of recommendations, one of which was that all trusts should have *a system for flagging children for whom there are safeguarding concerns'*. Many trusts have interpreted this as a need to ensure children who are the subject of child protection plans are flagged so that clinicians are aware of this status when they see the child. Most hospitals and GP surgeries now have some kind of system for flagging a child's electronic record to indicate that he or she is the subject of a child protection plan.

6   The current systems for sharing this information are varied and vary in efficiency. Some local authorities currently share regular lists of children with child protection plans with a variety of multi agency partners, including A&E departments, GPs' surgeries and the police. The processes used to achieve this are often inefficient and error prone. Secure email is commonly used, but hard copy lists are also sometimes sent. There is concern and confusion about what should and should not be done when it comes to sharing this sensitive information. These lists are then used by named professionals, for example a named nurse for safeguarding children, to update independently maintained IT systems. Clearly this takes a lot of time, and errors are likely to creep in. Children who are no longer the subject of a plan may not always be accurately removed, and security is hard to guarantee. The fact that data is not shared immediately means that practitioners are often relying on inaccurate and out of date information.

7   There is a problem when families move across local authority boundaries and are therefore not picked up on in any local system. This is more acute in metropolitan areas and there have been efforts to address this. Child Protection Online (CPoL), and subsequently Child Protection 24 (CP24), were NHS electronic systems for sharing lists of children subject to child protection plans between several local authorities and hospitals, principally to address problems surrounding perceived unreliable practices for sharing these lists and the difficulties of sharing across multiple local authority boundaries. While CPoL generated emails to social workers when a child they had responsibility for was treated in A&E, CP24 was simply a database to enable health practitioners to consult up to date lists of children who are the subject of child protection plans in the local authorities covered by the system. In both cases, funding was ultimately withdrawn, and a variety of explanations have been offered including: changing priorities for government; a preference for using hospital systems which could integrate all information on a
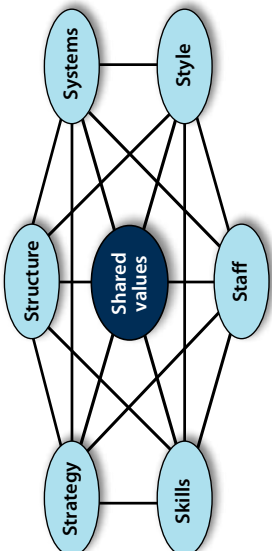
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196 The Lord Laming, (2009), *The Protection of Children in England: A Progress Report*, London, The Stationery Office (available online at https://www.education.gov.uk/publications/standard/publicationdetail/page1/HC%20330)

child in one place rather than requiring clinicians to make a separate check on a different system; and poor use of CPoL due to poor levels of technical IT support leading to a lack of reliability compared with alternative approaches.

8   Besides variation in how local areas deal with the problem of sharing information, there is considerable dispute about the value of knowing that a child is the subject of a child protection plan. While some consider it may improve risk assessment (though there is no clear evidence that it has improved outcomes for children), others fear that it is just as likely to damage it because absence of a plan may give people a false reassurance so they take no further action. 72 per cent of children who were the subject of a SCR between 2007–09 had never been the subject of a plan[197] so it has limited value as a predictive factor.

9   There are potential national ICT developments in health and the police that may offer some solutions in the future by providing more straightforward ways of recording that a child is the subject of a plan. Health professionals have indicated that it is more convenient to check only a single system, and that introducing additional checks on additional systems is time consuming and a disincentive, which can lead to unintended consequences (for example, the system is rarely checked, and even local cases are missed). This would suggest that allowing trusts to use their existing systems, or potentially making use of the Summary Care Record if a national system is required for Health, might be a way forward.

10   The remit was also to consider children who are looked after by the local authority. In general, the information that they are looked after is sensitive and should not be shared widely without consent. Evidence from children is that they are very upset by their status becoming general knowledge. However, there is a significant problem of children going missing and, for this sub-group, a national database could be helpful. Developments in police ICT offer a potential solution. The police are developing a national database for missing people, and there has been some discussion about providing a mechanism for people involved in the care of looked after children immediately to indicate on this system if they go missing.

11   In summary, the arguments for and against a national database to give easy access to information about whether a child is the subject of a child protection plan are finely balanced and hence the review concludes that there is no compelling case to recommend one. However, the current system could be improved by local authorities operating a more efficient 24 hour access service so that concerned others were readier to phone and check. This would resolve some of the problems reported to the review.

197 Brandon, M. Bailey, S. Belderson, P. (2010), *Building on the learning from serious case reviews: A two-year analysis of child protection database notifications 2007–2009*, London, Department for Education, Research Report (available online at https://www.education.gov.uk/publications/standard/publicationDetail/Page1/DFE-RR040).

Appendix D: An example of system re-design: A case study from the London Borough of Hackney

Areas of innovation What are you doing differently?	Early findings: Who does the new approach feel different for?	How has this impacted on the children and families
1. Creating Whole Systems Change In reshaping children's social care services in Hackney a whole systems approach was adopted. This approach was based on the 7S model of systems change (the **McKinsey 7S Framework** is a management model developed by business consultants Waterman and Peters in the 1980s.), which recognises the interplay between different parts of an organisational system and the importance of ensuring that changes in all areas are aligned to the central goal for the organisation.	Having a clear set of shared values ensures that all staff in the organisation have a similar outlook and approach to the work undertaken with families. In introducing and embedding the Reclaiming Social Work initiative changes were made to: • structures – creating Social Work Units (see below) • systems – creating new procedural approaches, recording systems, quality assurance frameworks and streamlining bureaucracy (see below) • style – encouraging a more collaborative approach in both direct practice and staff support • staff – ensuring staff with the necessary skills and ability are recruited and supported to develop and practice at a high level, thus improving morale	Significant reduction in numbers of children Looked After from 354 on 31st March 2008 to 276 at 31st December 2010. (see graph page 11). Unit structure provides better coordinated support for children and families with practitioners able to spend more time in direct work with families. Use of evidence-based methodological approaches provide enhanced capacity to assist families in making positive changes with better outcomes for children. Increased staff morale impacts on sickness and agency rates which reduces changes in social workers for families. Providing practitioners with further autonomy minimises delays in responding to requests from families – practitioners no longer need to seek management approval before taking action.

Areas of innovation What are you doing differently?	Early findings: Who does the new approach feel different for?	How has this impacted on the children and families
Careful attention was paid to each aspect of the system in the implementation process and the organisation continues to pay attention to the alignment of these factors whenever new innovations are considered, ensuring that changes that take place aren't just about structure, and that attention is paid to the way we work, as well as what we do. Examples of specific areas of innovation are given below. All of these are aspects of the wider systems change.	• skills – investing in methodological training for staff and adopting an 'Action Learning Set' model for training delivery (see below) • strategy – setting a clear vision about the outcomes that we want to achieve for children and their families and how we do this	

Areas of innovation What are you doing differently?	Early findings: Who does the new approach feel different for?	How has this impacted on the children and families
2. Social Work Unit Structure		
All cases are held within Social Work Units which consist of a Consultant Social Worker, a Social Worker, a Children's Practitioner, a Family Therapist or Clinical Practitioner (1/2 FTE) and a Unit Coordinator. These units have a high degree of autonomy and a shared understanding of and responsibility for cases, with the CSW holding overall casework responsibility. Each family, child and young person is known to each member of the unit and direct work is undertaken by different unit members as appropriate. The unit coordinator provides enhanced administrative support freeing up time for practitioners to spend on direct work with families. All cases are discussed at weekly Unit meetings. This is the key forum for updating information, analysis, reflection, planning and decision making. Providing different expertise and perspectives within the social work unit aims to enable a better assessment of risks to the child and a broader assessment of interventions.	Findings from a research study undertaken by the LSE which explored differences between the unit structure and the traditional 'team' structure included: ● overall, factors relating to workload and stress are significantly better in social work units. ● staff working in Units reported a strong sense of openness and support and ability to share and discuss ● 55 per cent fall in staff days lost to sickness ● improved staff stability/drop in agency workers ● significant positive differences between Social Work Units and traditional systems. The new approach supports reflective learning and skill development through its shared approach to case management.	Since the introduction of the model we have seen: ● a significant reduction in the numbers of children becoming looked after ● increased placement stability ● lower numbers of children being subject to Child Protection Plans for a second or subsequent time ● lower numbers of children subject to Child Protection Plans for two years or more ● lower number of children subject to Child Protection Plans overall ● improved interaction with families and other professionals ● better consistency and continuity in care ● a reduction of constraints on practice.

Areas of innovation What are you doing differently?	Early findings: Who does the new approach feel different for?	How has this impacted on the children and families
	• within units the mix of skills helps staff to make more informed interpretations of family dynamics, through the additional perspectives of clinicians and child practitioners using a reflective approach	
3. Integrated Methodological Approach Two key evidence-based methodologies are used to underpin practice within the service. These are Systemic Family Therapy and Social Learning Theory. Clinical staff within the Social Work Units support other members of the unit to apply systemic methodologies within their thinking and practice. Clinicians also deliver direct interventions with children and young people and their families. In addition to staff within Social Work Units delivering interventions informed by Social Learning Theory (SLT), a range of Family Support services that deliver SLT based programmes within the family home are also available.	Provides a shared theoretical framework for practitioners to guide and inform thinking, creating a shared 'language' Practitioners at all levels have knowledge and skills to support families to make changes that reduce risk of harm to children. Social Work practitioners perceive themselves as agents of change, collaborating with families to assist them to find their own solutions to problems.	Families receive a range of services that have an evidence base for their effectiveness, to support them in making changes to meet the needs of their children. Significant reduction in the numbers of children looked after in the Borough.

Areas of innovation What are you doing differently?	Early findings: Who does the new approach feel different for?	How has this impacted on the children and families
This commitment is supported by a high level of investment in methodology training provided by nationally recognised professionals and academic institutions. Approximately 36 per cent of relevant unit staff have completed the foundation year of systemic family therapy training over the past three years and approximately 55 per cent of front line staff have been trained in the delivery of the Parenting Positively (an SLT based programme) approach.		

Areas of innovation: What are you doing differently?	Early findings: Who does the new approach feel different for?	How has this impacted on the children and families
4. Strengthening the Front Door The First Response Team was set up in June 2009. The team is staffed by qualified and highly skilled social workers. The Team's role is to: ● screen all new contacts and make a judgement about whether they meet the criteria for a service from Children's Social Care, applying threshold criteria that have been agreed at a strategic level across all key agencies ● signpost or refer on contacts that are not judged to require an intervention from Children's Social Care ● offer consultation and advice to other professionals on Child Protection issues, including provision of training and on-going liaison with other agencies ● track patterns of contacts by type and by agency.	Clearer and more consistent decision-making at the 'front door'. Clarity about the rationale for decision making with referrers. Further work is being undertaken to ensure that all agencies are familiar with the agreed threshold criteria. Initial checks are undertaken prior to the case being allocated for assessment, enabling a clearer understanding of existing areas of concern, which enhances assessment planning processes Improved communication and stronger relationships with other agencies. Clearer understanding of 'emerging' practice issues and identification of agencies that may require support in developing their understanding of child protection issues (either due to inappropriate contacts or low numbers of contacts).	Fewer families becoming 'caught up' in child protection systems inappropriately. More controlled workloads within Children's Social Care due to inappropriate referrals not being accepted, leading to higher quality intervention on those cases where intervention is required. Families assisted in receiving the level of support that they need – either from Children's Social Care or other services.

Areas of innovation What are you doing differently?	Early findings: Who does the new approach feel different for?	How has this impacted on the children and families
5. Action Learning Set Approach to staff Training and Development Core training for all staff is provided through 'Action Learning Sets'. These bring together cohorts of 10–15 staff with similar roles, who are at a similar developmental level, to share learning and engage in collective problem solving. Each learning set meets at regular intervals throughout the year (approximately six weekly) for facilitated workshops, where they will receive some training input and have opportunities to explore dilemmas in relation to real examples from their practice. The training input is partly defined by the organisation's identified priorities but is also influenced by feedback from participants and facilitators. Participants are encouraged to bring research and new ideas to each session and reflect on what they have learned previously.	Training input is more responsive to organisational priorities, the developmental level of staff and the learning requirements of staff in particular roles. Input can be changed at short notice to respond to emerging organisational learning. Staff are supported to develop skills in collective problem solving and in working collaboratively. They also have the opportunity to contribute to the learning of others, developing skills in this area.	Enhanced skills of staff group increase capacity for more effective intervention and support for children and families.

Areas of innovation What are you doing differently?	Early findings: Who does the new approach feel different for?	How has this impacted on the children and families
There are plans in place for piloting this model within the LSCB training programme in the coming year, with a view to bringing together professionals from a range of agencies to develop expert knowledge on specific issues (the initial plan is to pilot an Action Learning Set in relation to children who demonstrate problematic sexual behaviours		
6. New approaches to Child Protection Conferences A new approach to conducting Child Protection Conferences has been developed and implemented over the past six months. This draws on the Strengthening Families and Signs of Safety models.	Less time spent in conferences going through written reports and more time spent discussing and exploring issues of risk. Clearer identification of the actual level of risk and risk factors in some cases. More potential for maintaining the engagement of families throughout the conference but particularly at the planning stage, where engagement might previously have been affected by a decision to make children subject to a CP plan.	Family feedback indicates that the new format is much clearer and that having information written on the wall during the conference has helped them to understand what is happening. Families also reported that they feel that there was more attention in the new format to how they were feeling. Comparison of evaluation undertaken with families attending the new and old styles of conferences showed that, although scores were generally high for previous arrangements, under the new format families felt more able to express their views, felt that clearer information was shared about strengths and risks, felt more confident that the plan would make things safer and felt more confident that they would be able to fulfil their parts of the plan.

Areas of innovation What are you doing differently?	Early findings: Who does the new approach feel different for?	How has this impacted on the children and families
The new approach places a greater emphasis on family participation, engaging the family in thinking about what needs to change and devising plans for how change might happen. The approach also incorporates a more transparent and rigorous process for identifying risks and strengths and a clearer framework for planning future intervention. The format requires participants to collectively identify what the specific risks are, what strengths there are within the family, protective factors which may mitigate the risk, and any complicating factors. These factors are recorded on the wall as the conference progresses so that all participants can see them. At the end of the conference a plan is constructed and decisions are then reached about whether this needs to be a Child Protection (CP) Plan or a Child in Need (CIN) Plan.	Professionals have fed back that the new system is clearer and more focused with clearer outcomes being set. Unanticipated learning has included that: ● some conferences under the new format are taking longer than previously as there is more discussion and time spent exploring specific issues ● recording formats have needed to be revised to ensure that all pertinent information and the rationale for decision making is effectively captured	

Areas of innovation What are you doing differently?	Early findings: Who does the new approach feel different for?	How has this impacted on the children and families
7. The Quality Framework – new approaches to organisational learning Over the past two years the organisation has developed a more systemic approach to monitoring the quality of work being undertaken. Aspects of this approach have included: ● a shift away from relying largely on quantitative data to understand performance ● a commitment to gathering information and feedback about our performance from multiple sources ● involvement of front line practitioners in evaluating and understanding performance ● encouraging staff at all levels to identify systemic and organisational factors that impinge on the delivery of high quality services to families ● a commitment to understanding how systems can be improved to support positive and safe practice rather than locating blame in individuals	Managers are better informed about the quality of the work being undertaken and about areas where changes need to be supported. These are effectively fed into a Service Development Plan which is collectively monitored by the senior management team on a fortnightly basis. New and emerging issues where staff development is required can be quickly fed into Professional Development plans. Practitioners are aware of practice issues and themes identified by senior managers and contribute fully to the organisation's understanding of these and to the identification of solutions where these are required. Staff have been able make managers aware of issues that affect their ability to do their jobs, leading to numerous improvements to systems and processes including:	Building upon our organisational learning is key to ensuring outcomes for children and families continue to improve. Our ability as an organisation to recognise excellence and error, to share that learning and to constantly embed changes, is vital if our practice system is to continue to evolve. A range of activities are in place to assist us in understanding our practice system: what it does well and what we can do to promote excellent practice, what goes wrong and what we can do to mitigate against the risks of those errors reoccurring. Through this process we seek to change our approach to practice management. A systems approach forms the theoretical basis for Reclaiming Social Work. A full systems approach should capture and apply learning and best practices as they develop in the micro-systems within which Social Work Units operate.

Areas of innovation What are you doing differently?	Early findings: Who does the new approach feel different for?	How has this impacted on the children and families
The safeguarding, quality and improvement and training and development functions within the service have been integrated, creating a 'learning hub' within the organisation. New methodologies have included: • the introduction of quarterly 'case review' days, where all members of the management team review a range of cases, collectively share observations and identify practice and systems themes and then discuss these themes with Consultant Social Workers in structured workshops • the introduction of an email address to which staff could provide feedback and report frustrations about systemic and organisational issues that affect their ability to do their jobs, with a commitment from managers that these will be addressed.	• improvements in the electronic document filing system to make it easier to locate documents • reworking of recording formats to support good practice better • changes in HR and recruitment policies • changes in financial systems to expedite payments and rationalise processes	

Areas of innovation What are you doing differently?	Early findings: Who does the new approach feel different for?	How has this impacted on the children and families
8. Dispensation in relation to the Assessments and Core Group meetings. As part of the process for the Munro Review of Child Protection, Hackney was given dispensation to suspend a number of requirements that are currently laid out within the statutory guidance temporarily. These are: ● the distinction between Initial and Core Assessments, ● timescales for the completion of assessments and ● timescales for Core Group meetings. Clear guidance about processes and expectations was issued to the services involved (attached), which included that: ● assessments should aim to determine as soon as possible whether ongoing intervention was required as soon as possible ● assessments should be focused and proportionate to the issues of concern	The dispensation arrangements have only been in place for a relatively short period of time and learning at this stage is very tentative and largely impressionistic. Recording formats that support a considered and focused approach to assessment are already in use within the organisation and there are well-embedded processes in place to ensure that progress on all cases is reviewed on a weekly basis within weekly unit meetings. Analytical thinking within assessment practice is supported through clinical input in unit meetings. There were initial expressions of both enthusiasm and anxiety from practitioners about the removal of prescribed timescales.	It is too early to know what the impact of the dispensations will be on children and their families but the hypothesis that we are working to are that: ● to assess risk accurately, practitioners need to be able to exercise discretion about the extent and scope of the assessments that they undertake. The timescale for these should be guided by well-informed professional judgements about the activities that are necessary to complete an assessment that is 'fit for purpose'. We believe that such an approach would promote a greater level of professional analysis throughout the assessment process and more accurate and helpful assessments, ● while in many cases the current six week timescale for Core Group meetings is appropriate, in some cases a lesser or greater frequency may better suit the work being undertaken and having discretion about the timing of meetings will enable these to operate in a way that is most conducive to achieving good outcomes on each individual case.

Areas of innovation What are you doing differently?	Early findings: Who does the new approach feel different for?	How has this impacted on the children and families
• families should be kept fully informed of progress, planned activities and anticipated timescales • engagement in assessment should not delay the provision of additional support • assessments should be deemed to be complete when there is sufficient understanding of risk and need to make a well-informed decision about what further support is needed • all units should have a process in place for planning and tracking progress on assessments • Core Groups should continue to be held at regular intervals, which in most cases would be approximately 6 weekly, but that the decision about exact timing should be made on a case by case basis, informed by an understanding of the individual family	Early observations from data analysis and quality assurance activity have included that: • fewer assessments have been completed within 10 working days than under previous arrangements with a moderate increase in the number of cases open within the service • audit of a sample of 25 per cent of open assessments showed that work was being actively undertaken on all of these The QA processes that are in place will enable us to closely monitor trends as the pilot progresses and to make adjustments within the system if these are required.	

Areas of innovation What are you doing differently?	Early findings: Who does the new approach feel different for?	How has this impacted on the children and families
A broad range of quality assurance measures were put in place to ensure that the impact of the pilot is closely monitored, to enhance learning and ensure that remedial action can be taken swiftly if any difficulties or risks are identified. These measures include: ● weekly data monitoring and case audit by Group Managers ● regular meetings with Consultant Social Workers to gain feedback and identify practice issues ● regular attendance at weekly unit meetings by Group Managers ● feedback meetings with families ● case review day for senior managers to review practice ● feedback to be sought from referrers ● feedback meetings with Child Protection Conference	Early observations in relation to Core Groups are that, whilst these are continuing to happen with a similar frequency to previously, under the new arrangements the timings of these are being set in a way that is more supportive of good practice (e.g. Core group being scheduled to take place 2 weeks after a multi-agency meeting to reach agreement with the young person and child about school attendance targets to allow time for this to be tested and reduce duplication of meetings)	

Areas of innovation What are you doing differently?	Early findings: Who does the new approach feel different for?	How has this impacted on the children and families
9. Recruitment The recruitment process for social care staff in Hackney has been designed to ensure people with appropriate skills and knowledge are appointed to posts within Children's Social Care. ● senior Managers (including the Assistant Director and Heads of Service) shortlist applications and make up the interview panels for all unit staff. Recruitment is prioritised by senior managers, emphasising the clear investment the organisation has in getting the right people into the right roles. ● each shortlisted applicant is asked to undertake a written assessment (designed to enable them to evidence the different skills required for the specific role) and a verbal reasoning assessment. Invitation to interview is dependent on performance at a rigorous assessment process, therefore only staff who perform at an appropriate level are invited to interview.	● staff feel that senior managers are genuinely invested in the workforce. ● such tailored assessments are often privileged for more senior roles, therefore applicants are clear that the social work profession is valued by the organisation. ● practitioners consider the assessment process challenging, they are therefore confident in the calibre of their peer group (if appointed). ● managers are more confident in their workforce. This is partially due to their confidence in the rigour of the recruitment process. As a result of this confidence practitioners are afforded higher levels of autonomy than in a traditional setting.	● higher staff morale has meant that the service has fewer agency staff, less sickness and therefore a much reduced turnover of staff in units, which has resulted in more stability for families. ● by recruiting high calibre practitioners the service is ensuring the quality of work with families continues to improve. ● higher levels of practitioner autonomy, minimises the need for practitioners to check decisions with senior managers, resulting in fewer delays for families.

Appendix E: Social Work Practices in Children's Social Care

1   The review was remitted to consider the place of Social Work Practices (SWPs) in the future provision of services. SWPs were initially proposed in 2007, to provide social work services for looked after children. They are small, autonomous, social worker led organisations that contract with a local authority to deliver social work services to looked after children (LAC). The development of the model envisaged that the greatest gains might be realised by an organisational structure in which social workers, and others in the practice, would own and control a majority share in the organisation, and be able to develop other appropriate social businesses from the practice base.

2   The SWPs are groups of social workers delivering social work services to around 100 to 200 children in care. They generally have a turnover of around £3–4million per annum, with the majority of this funding being used for the placements of the children and young people. They usually have as partners, or employ, a number of other professionals within the practice, such as a practice manager and various support workers. Because of volatility of costs, and in order to encourage new developments, a new form of commissioning has been developed for the practices, with a focus on outcomes, and a greater degree of partnership inherent in the contracting arrangement between local authority and practice. The level of funding provided for SWPs is exactly the same as for existing social work services for that particular cohort of LAC, but, by virtue of their organisation and management, they have a great deal more discretion in using that funding.

3   The rationale behind SWPs is that a number of serious shortcomings regarding social work with LAC have continued as problems over many years, including a lack of consistent care for children, low morale and high turnover of social workers, and a lack of innovation. Factors that contribute to this are the short time that social workers stay in post; slow decision making; and a need for, but a lack of, innovative solutions – for example in the provision of help for education and skills, and in support post care. A working group was set up by the then Department for Education and Skills to explore whether establishing social work practices might offer a way of addressing these problems.

4   The Group reported in 2007, and recommended that some SWPs be established initially on a pilot basis[198] and the then Government accepted all the report's

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198 Department for Education (2007), *Care Matters: Transforming the Lives of Children and Young People in Care – Green Paper* (available online at http://www.education.gov.uk/publications/standard/publicationDetail/Page1/CM%206932)

recommendations[199]. There are five existing practices, although only one is in the full public services mutual model (the professional practice model) that the original working group thought most preferable – tendering processes have made it difficult to establish the mutuals model, an issue that the national Cabinet Office Mutuals Task Force is now examining. Around five more practices are in the pipeline, which may result in one or two more mutual practices. A call for further local authorities to set up SWPs was launched on 4 March 2011 as a second wave of pilot expansion.

Positive signs from the SWPs include:

- social workers being able to spend more time with the children and young people in their care through more flexible time management;
- decisions taken much closer to the children and young people, with quicker turnaround times;
- staff satisfaction levels, as staff feel empowered with more control over the day to day management of the practice; and
- increased financial flexibility to deliver a better outcome for the child or young person by stepping back and thinking creatively about resource use.

5   SWPs are emerging as a successful addition to social work delivery, providing innovative service developments, enthusing staff and users, and showing that it is possible to spend money in different ways to reduce overheads, while still working with some of the most difficult care situations. They have dispelled some myths about the difficulties of change, and shown new possibilities for services to provide better continuity of relationship and have better knowledge of the children and young people that they serve. As part of the 'family' of services they are proving that they can add to the learning about best quality service developments.

6   The existing SWPs are being independently evaluated by the University of Central Lancashire in association with the Social Sciences Research Unit of the Institute of Education and the Social Care Workforce Research Unit at King's College, London. The evaluation began in 2009 and the findings will be published in 2012. It is examining the process of setting up SWPs, the outcomes and experiences of children and young people within the pilots, the benefits to social workers compared with those working under standard conditions, and the impact of the SWPs on the local authority. This study will inform future decisions about developing SWPs.

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199 Department for Education (2007), *Consistent Care Matters: Exploring the potential of social work practices* (available online at http://www.education.gov.uk/publications/standard/publicationdetail/page1/DFES-00526-2007)

Appendix F: An example of feedback from children and young people: The Child Outcome and Session Rating Scale[200]

A model produced by The Heart and Soul of Change Project

200 Barry L. Duncan, Scott D. Miller[8] & Jacqueline A. Sparks, (2003) The Child Outcome and Session Rating Scale
available online at: www.heartandsoulofchange.com. The authors hold the copyright for this rating scale.
Any use of this model by an agency, group practice, clinic, managed behavioural care organization, or
government requires separate application for a group license and payment of appropriate fees. To apply for or
obtain information regarding a group licence, see website.

Child Outcome Rating Scale (CORS)

Name _____ Age (Yrs):_____

Sex: M / F ____

Session # _____   Date: _____

Who is filling out this form? Please check one: Child _____ Caretaker _____

 If caretaker, what is your relationship to this child? _____

How are you doing? How are things going in your life? Please make a mark on the scale to let us know. The closer to the smiley face, the better things are. The closer to the frowny face, things are not so good. *If you are a caretaker filling out this form, please fill out according to how you think the child is doing.*

Me
(How am I doing?)

|---|

Family
(How are things in my family?)

|---|

School
(How am I doing at school?)

|---|

Everything
(How is everything going?)

|---|

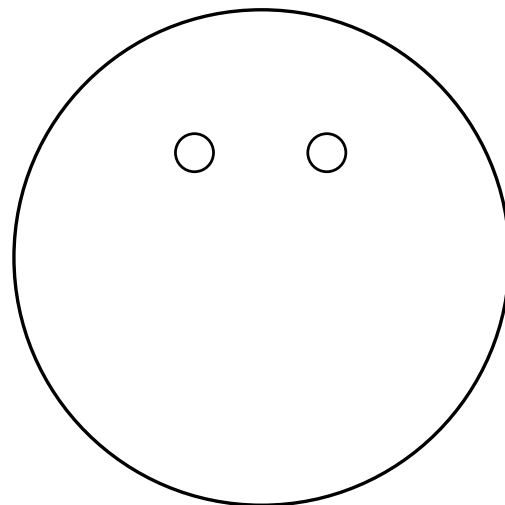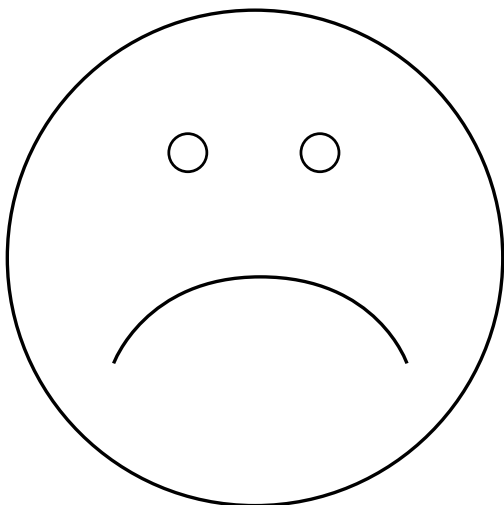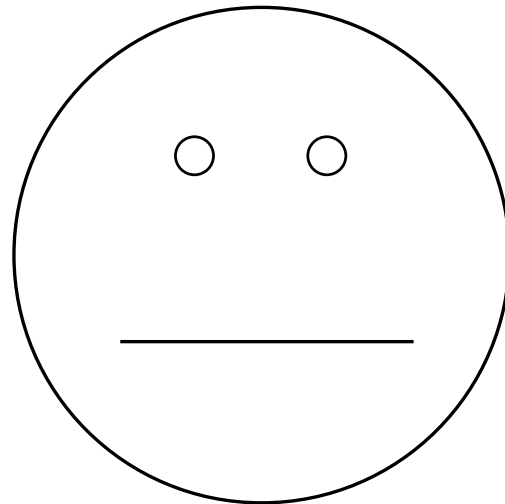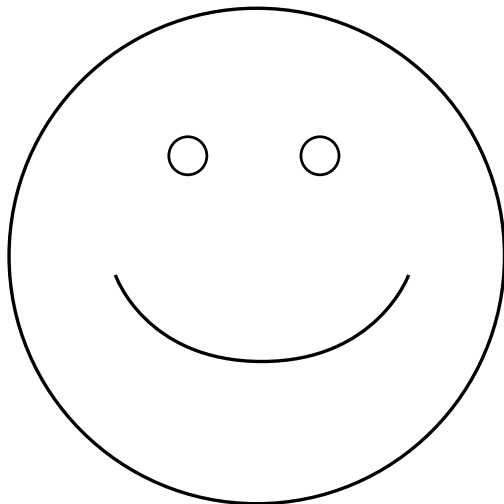**The Heart and Soul of Change Project**

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www.heartandsoulofchange.com

© 2003, Barry L. Duncan, Scott D. Miller, & Jacqueline A. Sparks

Child Session Rating Scale (CSRS)

Name _____ Age (Yrs):_____

Sex: M / F ____

Session # _____   Date: _____

How was our time together today? Please put a mark on the lines below to let us know how you feel.

Listening

_____   _____
did not always
listen to me.   listened to me.

How important?

What we did   What we did and
and talked about   talked about were
was not really   important to me.
that important
to me

What we did

I did not like what   I liked what we
we did today.   did today.

Overall

I wish we could   I hope we do the
do something   same kind of
different   things next time.

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Young Child Outcome Rating Scale (YCORS)

Name _____   Age (Yrs):_____

Sex: M / F ____

Session # _____   Date: _____

Choose one of the faces that shows how things are going for you. Or, you can draw one below that is just right for you.

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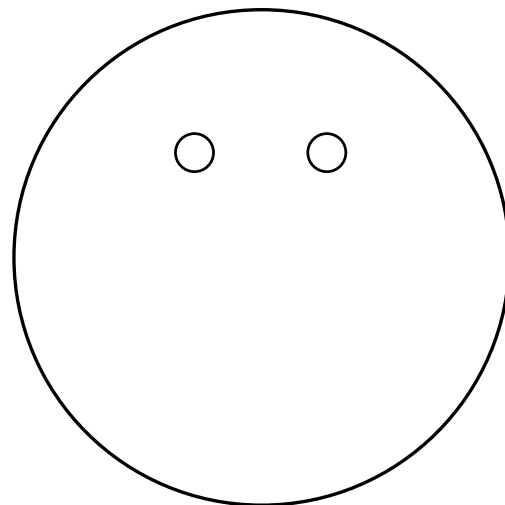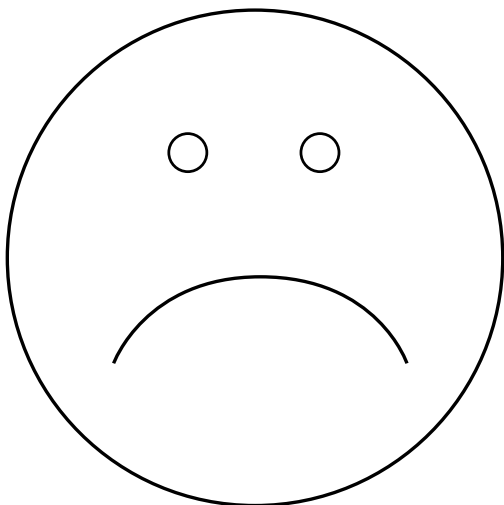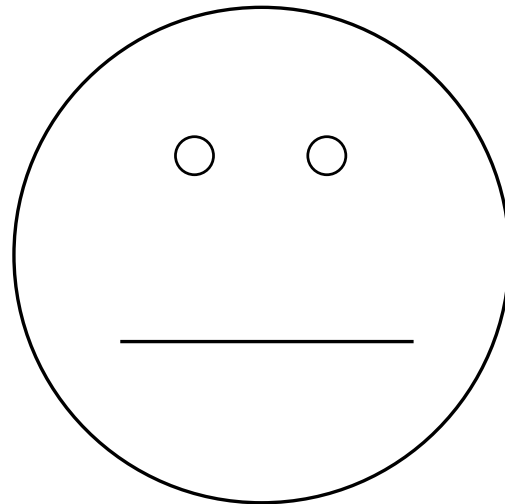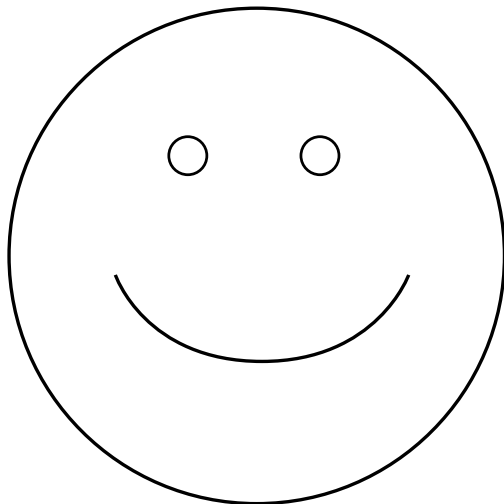_____

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Young Child Session Rating Scale
(YCSRS)

Name _____ Age (Yrs):_____

Sex: M / F ____

Session # _____   Date: _____

Choose one of the faces that shows how things are going for you. Or, you can draw one below that is just right for you.

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