

On Monday 11 October, the London Safeguarding Children Board hosted a consultation workshop for practitioners from a range of agencies across London to consider the initial report of the Munro Review of Child Protection, consider possible improvements to the current system in line with the themes from the review and share local good practice. Following an introductory presentation from Professor Eileen Munro and questions from the floor, the group broke up into four facilitated workshop sessions, each focussing on a specific aspect of the review:

1. Learning lessons from practice to keep children safe – beyond serious case reviews
2. Evaluating performance and improving outcomes
3. Building sustainable models of early intervention
4. Best practice in effective local safeguarding partnerships.

This report highlights some of the key points from each session, and will be submitted to the Munro Review to supplement notes taken by members of the review team who attended on the day.

General

The most compelling point to emerge from the day's discussions was the need to ensure that the review has a strong multi-agency input and does not focus too heavily on LA children's social care responsibility for safeguarding to the detriment of the role and responsibilities of other agencies.

This point was raised consistently across all four workshops, and reflected real concern from practitioners that the review's first report pays insufficient attention to the crucial role that all partners and strong local safeguarding partnerships play in effective child protection arrangements.

It was the view of those present that a whole system analysis must consider the role and contribution of universal services, particularly health and education, in safeguarding children as well as in delivering targeted preventative services.

It was noted that the voluntary sector in particular, was virtually absent from the report and received just two meaningful mentions across the 55 page document. This was seen as especially concerning in the context of government plans to increase the responsibilities of the third sector as part of the Big Society agenda, and the group were keen to see this addressed in future work.

1. Serious case reviews

Flexibility in approach was highlighted as the key factor in an effective system for learning from practice. Some present were concerned that the Munro Review would lead to reviews of serious incidents moving from one rigid (and bureaucratic) orthodoxy to another, rather than taking the opportunity for a more considered approach that takes account of the circumstances of the case and local need.

It was accepted that a small number of cases would need to be the subject of transparent reviews for the purposes of public accountability but it was felt that government should focus on establishing a learning culture within safeguarding through supporting the development of a range of approaches to case review, accepting the potential for mistakes and ensuring that the purpose of reviews is very much on learning lessons rather than apportioning blame. It was seen as essential that this spreads to the very top (Ministerial) level, and ideally into the media.

The group was keen that the drive towards more effective reviews of serious incidents doesn't overshadow the learning that is done everyday, such as in local audits of practice, and colleagues from a health background were keen to stress that the Root Cause Analysis approach is now well embedded in health and produces very good learning.

2. Evaluating performance

There was a strong feeling that performance measures had inadequate focus on actual outcomes for children, with too much emphasis on process and individual agency targets. The group argued that the system needed to have a high level performance framework to bind all partners into focusing on outcomes for the child, with a strong emphasis on the experience of the user and issues of public confidence, and urged the review to be far more explicit on this. Several examples of local practice were identified for the review to build on.

The discussion also took in the role of the local safeguarding children board (LSCB) in gathering an overall picture of the local situation, the difficulty in focussing outcome measures on a wider audience than the local authority and the role of Ofsted in carrying out inspection in a way which linked to improvement and could reflect the development of local approaches.

The group was keen that the review considers the potential for high level outcome measures to be introduced which assess the contribution of the partnership rather than focussing purely on individual performance in order that all agencies be held accountable for the final outcomes.

3. Early intervention

Training came across as a key issue in these discussions, with participants unanimously agreeing that a lack of knowledge of child development and ‘what a healthy child looks like’ was a serious block to effective engagement in early intervention across all agencies. Longstanding issues with the common assessment framework (CAF), including too strong a focus on process ahead of the child’s needs, were seen as largely secondary to the overall need for stronger child development training for all of those working with children.

In line with comments around serious case reviews, there were also felt to be real issues arising from the current culture surrounding child protection work. In addition to feeling overloaded, the group felt that partner agencies were often scared of taking on responsibility for the risk of harm to a child, largely due to fear of blame if something then went wrong, and instead focussed on ‘transferring the risk’ over to social care.

The group also felt that prevention should have a far higher profile in government policy, particularly in times of budgetary constraints across all agencies. Effective preventative work is significantly cheaper than intervening once problems have been identified (however early this is done), but can have less immediately tangible benefits and may well suffer when budgets are being reviewed. Health visiting services were highlighted as a key example of this, where the reduction in a universal offer has impacted on the ability to provide preventative advice and support in cases where there may be high need.

4. Effective partnerships

The key point to emerge from these discussions was the potential for the LSCB to be a real force locally in holding safeguarding partners together and driving improvements in the quality of safeguarding practice and on safeguarding outcomes locally, although the group was clear that this is not always happening effectively enough in practice currently. The need for strong local leadership on safeguarding from the LSCB was highlighted as particularly important in the context of widespread spending cuts and structural change in the NHS. The group was keen that the Munro Review maintains LSCBs at the centre of local safeguarding practice and gives them greater powers to hold all local agencies to account for their contribution to safeguarding outcomes.

Culture was a key issue in these groups too, although discussions here focussed on the need for a culture where partners feel they can question each other’s practice and trust each other to address issues. There was a feeling that agencies are still prone to an attitude of acting unilaterally and reporting back to the Board, rather than the LSCB leading in a meaningful way.

Please see overleaf for more detailed notes from each of these sessions – please note that these are a record of the discussions that took place on the day, and the views represented are not necessarily those of the London Safeguarding Children Board.

Appendix 1: Notes from Workshop One

Learning lessons from practice to keep children safe – beyond serious case reviews

1. External involvement

- 1.1 The group heard that Ofsted are unlikely to continue their external evaluation function, which was welcomed since the current approach was seen to add little value to supporting improvement in safeguarding outcomes across the sector.
- 1.2 There was general agreement that the involvement of external individuals in a review can be extremely valuable, particularly in adding capacity, experience and even additional status (some reported difficulty in gaining high level involvement for regular internal reviews), but shouldn't necessarily be enforced. Instead, the group preferred a flexible system which can be adapted to local circumstances, rather than an assumption that independence will add value by its very nature.
- 1.3 Colleagues from the Met Police described their frustration at situations where the police Individual Management Review (IMR) authors are excluded from later briefings to ensure independence of the review from operational decision makers, which can actually have the negative impact through losing that officer's expertise and knowledge of the case.

2. Learning

- 2.1 The group discussed the inherent difficulty in producing a more effective process for embedding learning without creating yet more restrictive rules and regulations.
- 2.2 The process of debriefing workers after the event is often overlooked, when this is key to embedding the learning. Local learning events are a crucial way to learn from good practice, and one member of the group wondered if a Teacher's TV type arrangement for child protection would help agencies learn from good practice elsewhere.
- 2.3 The group was keen that the drive towards more effective reviews of serious incidents doesn't overshadow the learning that is done everyday, such as in local audits of practice. The London Board's multi-agency audit tools were highlighted as a good model for this type of learning.
- 2.4 Many practitioners were keen for case analysis to take place in a far more regular fashion, rather than relying on an intensive focus of a handful of cases.
- 2.4 Colleagues from a health background were keen to stress that the Root Cause Analysis approach is now well embedded in health, and produces very good learning. They therefore urged that any review of methodologies takes account of existing good practice.

3. Focus of reviews

- 3.1 The current approach was seen to focus too much on senior management and organisational structures and systems, to the detriment of the frontline workers actually involved in the case. They should be integral to any review, as a real part of the solution.
- 3.2 One practitioner described a recent internal review of a case which fell below the threshold for a serious case review. Rather than conduct a formal review, the local authority used a series of systemic interviews with staff from all agencies, focussing on what influenced thinking at the time of the case – this was seen as a really positive way to undertake a deeper level of reflection and embed learning through the review process itself.
- 3.3 There were concerns that the SCIE "learning together" model, though based on excellent principles, could turn out to be just as bureaucratic as the current system – local flexibility is key to ensure we are not moving from one rigid orthodoxy to another.

4. Culture

- 4.1 The group felt that developing a culture that accepts the potential for mistakes is essential, and that this must come from the very top – and preferably spread through the media and wider society. The focus should be firmly on reducing the risk, not claiming to remove it.
- 4.2 Poor practice identified through reviews is too often accepted as typifying the local authority, rarely as a unique breakdown in a usually effective system.

5. Publication

- 5.1 Although there was general agreement that there needs to be a way to share full reviews more widely amongst practitioners, the group did not agree that full publication was the most effective way to do so – not least due to concerns that doing so would hinder honesty and participation from practitioners. There was a sense that serious case reviews already create a sense of “trial by organisation”, and full publication could add to this perception. Furthermore, some of the group felt that the process of redaction could render the exercise largely pointless anyway, with overview reports essentially redacted to become executive summaries.
- 5.2 There was broad agreement that the principles of transparency and accountability were right, but that hindsight bias was integral to any subsequent reading of a serious case review.

Ian Dean, October 2010

Appendix 2: Notes from Workshop Two Evaluating performance and improving outcomes

1. Introduction – existing performance measures

1.1 The facilitator outlined the three existing measures of performance:

- a. Quantitative
- b. Qualitative
- c. Outcome/ impact.

1.2 In practice, there was too much focus on 1, very little on 2 and least of all on 3.

2. Views of children and young people and their parents and carers

2.1 It was also important to look at sources of information around performance, including the views of children and young people themselves, their parents and carers, frontline managers and management information systems.

2.2 The thrust of the Munro Review indicates a movement towards gathering information on outcomes; the views of children and young people and their families would be a critical source for this. Relatively little resource is currently spent on measuring the difference made to children's lives.

2.3 Agencies need to move beyond simply looking at the user as the customer of a service. A more sophisticated conversation is required. We need to look at measures of public confidence via the experience of the user and the confidence of the public in the system.

2.4 Some LSCBs were already utilising user surveys. In one borough, 40% of those responding found these useful. In the Met Police rape command, for example, a great deal of work is undertaken on victim feedback. This is more complex in relation to child abuse.

2.5 UEA was undertaking a study on behalf of the Office of the Children's Commissioner to gather the views of 30 children and young people from two LSCBs who were currently the subject of Child Protection Plans

TASK: The group was asked to provide examples of outcomes-based practice

3. Existing outcome measures and examples from practice

3.1 National child abuse indicator pilots:

8 pilots were underway to identify the volume of work undertaken by agencies. This includes data on:

- management of referrals within a specific timeline, i.e. 24 hours;
- volume of information requests;
- conferences attended – numbers and response provided;
- outcomes – how many offenders brought to justice.

3.2 NSPCC/ University of Central Lancashire – study on number of referrals to children's social care from police (public protection desks). In 5% of cases the child was found to have received a follow up service.

3.3 Other examples:

- Strengths and Difficulties Questionnaires (SDQs) used for all children in care when clinical assessments are made.
- CORE (Clinical Outcomes Research and Effectiveness) methodology for measuring outcomes.
- Scaling questionnaires.

- Assessment processes and recording via the Integrated Children’s System (ICS) give professionals the skills and time to work with families to determine outcomes at the end of the process and how the intervention helps.
- Team folders - leading to reflective practice, including learning lessons and evaluating outcomes.
- ‘Signs of safety’ model: What is going on? What needs to change? How?
- CAADA (Co-ordinated Action Against Domestic Abuse) – multi-site analysis, tracking of cases at two points (upon entry and after 4 months, or when case closed), quantitative research, notes taken via face to face interviews.
- ‘Worth’ project – similar approach to most serious cases. Those attending A&E and Maternity units are given the opportunity to disclose to medical staff that they are the victims of domestic violence, and to receive immediate support.
- Use of 3- and 6-monthly reviews in some Health services.
- Short vignettes (where has the child come from? Where has the child ended up?) – as used by Drug and Alcohol Courts and the Croydon Eclipse project. More general questions, e.g. is the child eating? Sleeping? This should be captured systematically. The NSPCC developed a scheme to do this.

4. Measuring outcomes in a partnership context: the role of the LSCB

- 4.1 The LSCB is there to lever the contribution of agencies towards common outcomes and to ensure that all partners are working towards agreed goals and priorities.
- 4.2 Strategic and operational role to identify types/groups most at risk and intervene to support them, e.g. Wave Trust model of family intervention.
- 4.3 Many existing outcome measures focus on the local authority, but how do we focus them on wider partners? Requires greater inputs from the Mental Health Trust, for example, in order to ensure the best possible outcomes measure and performance. The LSCB needs an overall picture of the local situation and powers to ensure all agencies contribute.
- 4.4 Should there be wider measures for assessing the contribution of partnership, (i.e. not just individual performance)? E.g. the Met Police contributes to performance indicators, etc. Should all agencies therefore be held accountable for the final outcomes?
- 4.5 Annual LSCB report is the key mechanism by which to evidence outcomes. LSCBs tend to report on activity but it is rare to get any analysis of the difference LSCBs have made to children’s lives.

5. Measuring performance - issues and challenges

- 5.1 Ask the same, right questions up and down the organisation.
- 5.2 Caution with over-reliance on outcome measures – softer measures are more problematic to manage and measure.
- 5.3 Importance of considering what value the information collected adds? What are the important outcomes to look at?
- 5.4 We need to be clearer about intervention methodology and skillset required of the workforce in order to be able to better measure difference.
- 5.5 Qualitative and quantitative measures are important, as well as benchmarking, e.g. per 10,000 children across London.
- 5.6 Although a shift to outcomes is desired timescales will also very important in relation to local performance measures.

- 5.7 What outcomes can we influence? One borough tracked the progress of children subject to Child Protection Plans via educational attainment – it worsened whilst they were on a protection plan and continued to do so.
- 5.8 Children and young people should only come off a child protection plan if a multi-agency meeting determines that the risk is reduced. Abuse escalates if unchallenged, it does not decline. Need for effective interventions to reduce risk. The problem is agreeing what the outcomes model should look like.
- 5.9 Midwives play a critical role as identified via serious case reviews, but how do they measure the impact of their work? Importance of developing the NHS Outcomes Framework on safeguarding.
- 5.10 We need to be careful about over-intervention, e.g. Family Intervention Projects can create a degree of dependency, rather than give parents the skills to do it themselves.
- 5.11 Need to adapt models given current financial restraints. The financial crisis is driving people back into core business.
- 5.12 Lack of outcomes-based work being gathered from agencies apart from children's social care, e.g. mental health Trusts, A&E.
- 5.13 Ofsted – the Munro Review is encouraging a more robust debate with Ofsted, which needs to be open to debate and more sophisticated analysis of local approaches. CAFCASS had responded positively to inspection from Ofsted as it made the agency challenge its own practice and improve.
- 5.14 Outcomes are there to benefit children. This requires a focus on the child, not on individual agency targets. The system has to bind all its participants into focusing on outcomes for the child. Munro needs to be more explicit about this.

Mike Scott, October 2010

Appendix 3: Notes from Workshop Three

Building sustainable models of early intervention

1. Child development

- 1.1 The key issue for partner agencies is knowing when to intervene, (e.g. when 'naughty' behaviour is actually 'conduct disorder'). Otherwise 'early intervention' just wastes money, e.g. in inappropriate referrals to Child and Adolescent Mental Health Services (CAMHS). If practitioners in all services working with children on a daily basis had a thorough grounding in child development/health normal behaviour, then this would be significantly reduced.
- 1.2 The breakout group were unanimous in agreeing that the single most important factor which needs addressing is the lack of knowledge of child development and 'what a healthy child looks like' across all the agencies, in particular LA children's social care, health and education. This lack of expertise creates unnecessary anxiety as well as fuelling bad decision-making and ineffective responses.
- 1.3 A new social work college should prioritise good child development training as well as it being a core part of training for relevant health and education professionals.

2. Outcome measurement

- 2.1 There is an insufficient evidence-base about the effectiveness of early interventions by different targeted services in a range of circumstances.
- 2.2 Measuring outcomes for early intervention is difficult. Reduction in referrals to LA children's social care may be part of it, but other experience is that it identifies more need. Robust longitudinal studies are needed.
- 2.3 Prevention is efficient i.e. effective and inexpensive, compared to early intervention, i.e. when problems have already been identified, which is expensive.
- 2.4 There is no robust system for monitoring children and families not coming to the attention of professionals.

3. Common assessment framework (CAF)

- 3.1 Universal services frequently complete a CAF with the intention of passing 'the risk' on to LA children's social care as quickly as possible.
- 3.2 CAF is experienced as an obstacle to helping a child. It has been 'professionalised' and diverts effort into assessment rather than practitioners 'having a sensible discussion' with the child, family and/or other practitioners, hearing what the issues are, making practical decisions and, in some cases, just 'holding the child or family's hand' through the difficulty.
- 3.3 The CAF has resulted in over concern about 'seeking consent' from the family, e.g. if a school has concerns about a child perhaps coming in dirty and tired, the school staff should be able to address this by talking to a practitioner from another agency without first seeking written consent from a family. It should be an automatic part of a school carrying out its daily functions of caring for children.
- 3.4 Partner agencies, e.g. GPs, need to be challenged to access information about local services on Council and other web pages (there was agreement that the will is missing).
- 3.5 The CAF has not assisted in children getting the right assessment. Where other assessments are commissioned parents are unhappy about having other 'experts' brought in, e.g. substance misuse, mental health etc and not being able to engage with one person.

3.6 The CAF has focussed attention on 'process' and not on the child. The Team Around the Child is the real issue. The CAF directs practitioners to ask 'who else can I involve?' whereas the real focus should often be on keeping other professionals away to not swamp the child/family.

4. Public health

4.1 We used to speak about 'prevention and early intervention'. The 'prevention' bit has been dropped. This is short sighted, prevention is health visitors building resilience in children and families long before they come to notice and need expensive interventions.

4.2 The breakout group agreed that prevention should have a higher profile.

5. Assertive outreach

5.1 Resourceful families will access services and will find and use necessary information about available support for themselves.

5.2 Barnardos is providing assertive outreach services from Children's Centres to engage the families who are unable to or avoid, using services to assist them.

6. Targeted services

6.1 Schools who have had best results achieved it by identifying the 2 -3 most worrying children and targeting resources to address their needs. These interventions comprise of engaging the families and teaching the teachers to manage the children.

6.2 With reduced resources targeted services are the only way forward.

6.3 One borough has a four year early intervention strategy with specialists able to target needy families linked to universal services such as schools, nurseries and GP surgeries.

6.4 Third sector services should be commissioned to do targeted early intervention because they are more likely to be able to engage with needy families better than statutory services.

7. Universal services

7.1 Universal services are losing out, and will do so much more as the cuts take effect and resources are targeted at the most needy families.

7.2 Universal services such as GPs do not perceive themselves as having responsibility for early intervention.

7.3 All universal services staff need to be working with the expectation of taking responsibility for identifying need and initiating early intervention. This is not currently the case.

8. Multi-agency working

8.1 It is too expensive for LA children's social care to release social workers to be co-located in partner agency teams.

8.2 The police have shifted their focus from 'criminalising the parent' (sanction detection) to 'what's best for the child'.

8.3 Multi-agency work would be easier and less fractious if IT systems could talk to each other.

8.4 As LA children's social care's budgets are cut they will have to rely more on partners such as schools and the NHS to deliver targeted support.

8.5 There is still not enough partnership working with the third sector. Mature, integrated teams have inter-personal relationships which transcend barriers. Published examples of this are Swindon and Lincolnshire.

9. Lead professional

9.1 Partner agencies have a real resistance to taking up cases because of the additional work it adds to an already heavy workload. It would be better to resource specialist settings, e.g. Children's Centres, to take on the Lead Professional role. Difficulty is that it negates the idea that the person already has a relationship with the child/family.

9.2 Practitioners do not want to be the sole responsible professional, prefer to be 'one of the network'.

9.3 Taking on the Lead Professional role should mean an automatic reduction in a practitioner's case/workload to allow time for helping the child/family. This does not happen currently.

10. Commissioning

10.1 There is a lack of co-ordination of early intervention services both within individual boroughs, e.g. their early years, looked after children and youth service provision; and also across boroughs. There is a case for cross-borough commissioning of both prevention (public health) and early intervention services.

11. The NHS

11.1 Where NHS services cross borough boundaries, e.g. mental health trusts, current experience is that different approaches by different boroughs to universal and targeted early intervention results in very different referrals into the NHS and is difficult to work with.

11.2 There is currently a notable lack of interest and involvement from GPs in early intervention. GPs avoid discussions with families at the early stages of issues. They also retain a distrust of how LA children's social care will respond to a referral.

11.3 In the past GPs engagement was fostered and supported effectively by social workers spending time every week in the surgery, this approach cannot now be resourced.

12. Public protection desks (PPDs)

12.1 One borough reported that they have a good system of cases going straight from the PPD to a panel that discuss and advise on the way forward for each case.

12.2 Another borough has a co-located multi-agency team to assess referrals coming in to PPD.

13. Defensive practice

13.1 In addition to feeling overloaded, agencies are scared of taking on responsibility for the risk of harm to a child. LA children's social care is partly responsible because they have developed a myth of the specialism needed to support children at risk. There is an issue about the fuzzy boundary within 'safeguarding' between 'family support' and 'child protection'.

13.2 Partner agencies are focussed on transferring 'risk' to LA children's social care.

13.3 Health professionals are concerned that not 'doing the right thing' will destroy their career. A telephone call giving advice is not feel sufficiently reassuring that their 'back is covered'.

13.4 Social work staff are now recording what they know and don't know at the time, so that hindsight doesn't condemn them.

- 13.5 Staff have taken to repeating verbal exchanges in emails to ensure that there is an inter-agency record as well as their own note in the file.
- 13.6 Staff do not have confidence that their decisions will be supported by their managers and agency.

14. Disabled children

- 14.1 Disabled children's complex needs mean that the Lead Professional system works well for them and their social workers.
- 14.2 Children with disabilities social work teams like the CAF because it gives them so much more information than they used to get about the family and who is already involved with the child.

15. Deskilled parents

- 15.1 The professionals in this breakout group spoke about how the 'system' conspired to make them feel deskilled, e.g. being given a booklet about your new baby and there being a section on page 2 about what will happen if you 'throw your baby down the stairs'.
- 15.2 Professionals in this group have been present at the 'school gate' to hear conversations amongst parents about 'taking your child to another A&E' if s/he is injured twice in relatively quick succession, to avoid the suspicion of harming your child.
- 15.3 Professionals have become more anxious and are projecting this anxiety onto parents and into families.
- 15.4 The 'massive' anxiety now carried by social workers is not relieved by consistently good supervision and training.

16. LA children's social work

- 16.1 Children's social work is highly complex and children's social workers should be highly skilled. The complexity of the work and the need for expertise should be recognised. It would follow that there is a clear distinction between the work universal services can undertake and the cases which must be referred to LA children's social care. It also requires that children's social workers are assisted to provide a high quality service consistently across the UK.
- 16.2 The breakout group agreed that the standard of social work is not consistently of the standard we would like it to be.

17. Solutions

- 17.1 One borough has allocated a social worker to each school to provide telephone advice for each potential referral.
- 17.2 Barnardos is resourcing Children's Centres to support partner agencies
- 17.3 One borough is putting new resources into its Children's Centres and other universal services to take on the role of Lead professional and co-ordinate the team around the child on a temporary (as needed) basis for targeted families identified as having needs which might escalate to LA children's social care thresholds.

Appendix 4: Notes from Workshop Four

Best practice in effective local safeguarding partnerships

- 1.1 Eileen Munro implied that there is too much intervention in the system and that LSCBs will have to subsequently change. This would require a massive change in culture for all partners, e.g. at A&E, Met Police etc if the LSCBs are to get involved in the 'nitty gritty' of how interagency relations actually work.
- 1.2 There is a huge level of anxiety across all partners at present about the idea of professionals being asked to taking on more responsibility, particularly with the loss of confidence after the death of Baby Peter, as there is a concern that they will personally be held to blame.
- 1.3 Statutory funding would help strengthen LSCBs and enable them to challenge partner agencies, who at present are responsible for funding the boards.
- 1.4 The cost of chairing LSCBs could prevent them from meeting more frequently and becoming more influential.
- 1.5 At present LSCBs are not really in control. Individual agencies take unilateral action and then report back to the board. LSCBs need to change so that they have the power to provide leadership (similar to Area Child Protection Committees).
- 1.6 London LSCBs are of variable quality and there is confusion about their focus. Some are solely focused on child protection while others take a broader view of safeguarding.
- 1.7 There was also concern that most LSCBs are too focused on social work as the local authority often predominated – e.g. health expertise is often ignored. However, it was felt that this is often due to not getting the right level of people there. Board members need to be senior enough to make decisions and effect change. The right guidance should bring health to the table more firmly.
- 1.8 It was agreed that LSCBs should balance a strategic view with a focus on practice where appropriate.
- 1.9 Training of board members is key. The voluntary and community sector has done a great deal to ensure that its members are fully engaged through training.
- 1.10 It is important that LSCBs focus on a small number of issues and resolve them before moving on to other areas of concern.
- 1.11 Information exchange was perceived to be the biggest issue facing LSCBs. Information needs to be shared in a safe, efficient and timely way in every area.
- 1.12 Management of uncertainty is key. We need to have a responsible attitude towards safeguarding and acknowledge that even when we have all the right information, children may still incur harm. This message needs to get across to the media as well as professionals.
- 1.13 Use of Root Cause Analysis is crucial to determine why behaviour happens in the first place.
- 1.14 How do LSCBs feed issues to key professionals, e.g. LA Chief Executives if they no longer report to Children's Trusts?
- 1.15 Independent Chairs reporting to Directors of Children's Services can be an issue for other partners who infer a lack of impartiality or multi-agency ownership.

- 1.16 Does an effective LSCB negate the need for partner agencies to scrutinise their own safeguarding provision?
- 1.17 Child Death Overview Panels were seen to be too parochial with a huge amount of time and energy invested for little output. This work could be picked up by public health but LSCBs still need to pick up on learning around safeguarding issues.
- 1.18 An effective board is one where partners feel they can question each other's practice and trust each other to address issues. Some members have to step up their engagement in order to do this.
- 1.19 Now is not the time to lose LSCBs as they hold safeguarding partners together locally at a time when the DH white paper proposes radical changes to the NHS and public sector cuts are likely to reduce capacity of social care professionals. We need stability with LSCBs at such a turbulent time.

Caroline Dawes, October 2010

Appendix 5: Eileen Munro presentation

Munro Review of Child Protection:

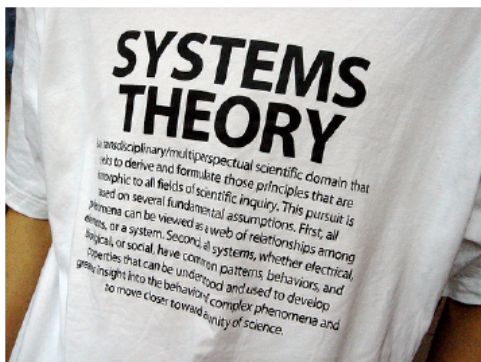
New approaches for London

London Councils

11 October 2010

Professor Eileen Munro, London School of Economics and Political Science
Munro Review, sponsored by the Department for Education, HM Government, England

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Education



Department for
Education



Track Combination

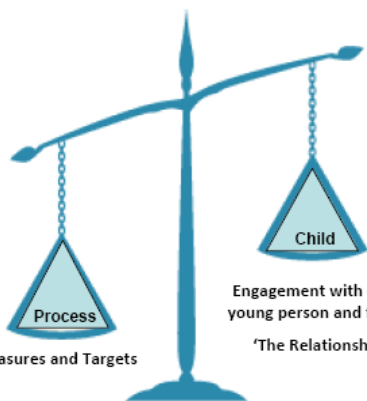
Rigid – reliant on rules and prescription

May not cope with variety of need being presented. Response likely to be 'rule bound'

Adaptive - accepting uncertainty and potential for errors

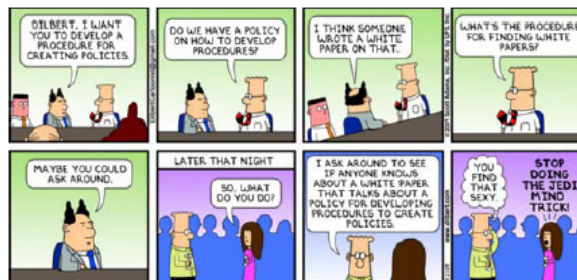


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Doing things right not doing the right thing

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Uncertainty

- Good decisions do not always lead to good outcomes
- Hindsight bias makes people overestimate how likely the adverse outcome looked beforehand
- Defensive practice does not AVOID risk but DISPLACES it, usually onto children and families

Department for Education

a new approach?



- Point of accountability is on the positive difference made to children and young people

Department for Education

milestones and support

- July - October 2010 : Analysis
- September - January 2011 : Policy and practice implications
- January - April 2011 : Framework for change
- Reference group – 8 areas of focus in phase 1

Review team at the department

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Department for Education

Next steps

- Stronger professional voice – national college
- Reduction in prescription and bureaucracy
- Front door reflections – helpful and safe responses
- Less delay for children and young people
- Local Safeguarding Children Boards and learning
- Inspection and performance systems focussed on outcomes and impact of practice
- A system that learns and uses regular feedback

Department for Education

Learning and adapting

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