

## Briefing on the Munro Review of Child Protection

The third and final report from the Munro Review of Child Protection was presented to Ministers on 10 May 2011, delivering a range of recommendations that are likely to have significant implications for the way that child protection services are run at a local level. Serious case reviews, early intervention, the role of Ofsted and reforms to the health economy all feature strongly, alongside a more general shift away from central prescription and towards individual discretion in local decision making – with quality assurance measures strongly focussed on providing the very best outcomes for children. This briefing unpicks some of the key messages from the review, while considering the implications for London.

### Summary

In June 2010, the government announced a national review of child protection, to be led by Eileen Munro, Professor of Social Policy at the London School of Economics and a prominent academic in the field of safeguarding and child protection. Following interim reports in September and January, the final report and recommendations have now been published, with strong implications for all agencies working to safeguard children.

The review is especially clear that the child protection system must be fully focussed on the needs of individual children and young people rather than centrally imposed processes and targets. With this in mind, the strongest message within the final report is a reduction in the level of government prescription, including the removal of some statutory timescales, with formal child protection procedures to be cut back and greater emphasis placed on local discretion and professional judgement. However, the review does suggest a new duty be placed on local authorities and partner agencies, to secure sufficient provision of local “early help” services for children, young people and families and to produce a strategy outlining how they plan to do so.

The report also highlights the importance of developing approaches and quality assurance measures that better reflect outcomes for children and young people, and recommends replacing Ofsted’s current programme of announced inspections with a more intensive process of unannounced inspections that examines the effectiveness of all agencies working within local safeguarding partnerships. Professor Munro’s second interim report had already recommended an end to Ofsted’s evaluation of serious case reviews, and this final report also suggests alternative methods for multi-agency approaches to learning from practice.

As local authorities across London consider service redesign in response to financial pressures, the review moves away from its otherwise strong advocacy for local discretion and takes an assertive stance on the role of Director of Children’s Services and Lead Member for Children’s Services, stating that these should not be diluted with additional responsibilities “unless exceptional circumstances arise”. The review is clear that all agencies must continue to prioritise child protection as budgets tighten and services reorganise, highlighting the key role of the local safeguarding children board in holding partners to account.

## **Analysis of key recommendations**

### **Local practice and reducing prescription**

Among a number of practice based recommendations, the review urges a revision of *Working Together to Safeguard Children* to mark a clear distinction between statutory regulations and non-statutory practice guidance. While the principles behind this recommendation are sound, particularly that of allowing greater use of professional judgement and local discretion, it is clear that the government must exercise extreme caution when considering which aspects of bureaucracy really do add little value, and which help professionals do their job and keep children safe. Detailed multi-agency guidance on complex issues, for example, can be essential to ensure that all agencies are working together from a solid knowledge base. On the other hand, LSCBs have long sought greater flexibility in the criteria for initiating formal case reviews and deciding the form that these should take, and any revision of statutory guidance would seem an ideal opportunity to introduce this.

The review also proposes a revision of the *Framework for the Assessment of Children in Need and their Families* to remove any central prescription around the format or timescales for completing risk assessments, including removing the distinction between initial and core assessments, an approach that is currently being piloting in four local authorities (including Hackney and Westminster). While this proposal certainly has advantages in terms of reducing bureaucracy and allowing more scope for local discretion, the review is clear that timeliness must not be allowed to slip as a result and the early findings from these pilots will be awaited with interest.

The report recommends a number of changes to strengthen the voice of local frontline practitioners, notably suggesting that local authorities be required to designate a Principal Child and Family Social Worker – a senior manager with lead responsibility for practice, who must remain involved in frontline child protection practice. This will be mirrored nationally with the creation of a Chief Social Worker within government. The review also suggests that local authorities and their partners should continually review the delivery of child and family social work, based on the latest evidence of effectiveness. Although the report highlights a number of good practice case studies, it leaves discretion for local authorities to develop systems that best suit local need.

### **Role of senior leaders**

Munro also places a strong emphasis on the role of senior leaders in ensuring effective safeguarding practice locally, recommending that the LSCB submit its annual report to the local authority Leader and Chief Executive. Subject to the passage of relevant legislation, this annual report will also be presented to the local Police and Crime Commissioner and the Chair of the Health and Wellbeing Board. This focus on the vital role of senior leaders is welcome, and could be reflected in a more thorough examination of their oversight of local safeguarding structures through the evolving inspection process, which is outlined in more detail below.

It is also important that the existing requirement for the local authority Leader and Chief Executive to produce an annual assessment of local safeguarding arrangements should remain in place, even in the absence of a statutory Children's Trust. It is crucial that senior leaders ensure that robust relationships are in place with their counterparts across the local safeguarding partnership as systems and structures continue to develop, ensuring that safeguarding children remains high on the agenda of all agencies.

## **Early help**

With increasing evidence that early intervention is cost effective and produces strong positive outcomes for children and young people, the review's emphasis on early help initiatives is welcome. Work is already underway in London to scope the potential for a range of information sharing models similar to the Multi-Agency Safeguarding Hub (MASH) recently rolled out in Devon and highlighted as good practice in the report, which we see as crucial to ensuring effective early action to safeguard children and young people. The Board is particularly supportive of the emphasis on early help as a joint approach between the local authority and statutory and voluntary sector partners which, taken alongside the government's existing pledge to increase numbers of health visitors, should be influential in embedding a strong commitment to early intervention and long term tracking of outcomes for children across the local safeguarding partnerships. However, the government will need to give some thought to resourcing for this new duty, since predicted savings may take some time to appear and it is vital that agencies are not discouraged by the short term costs involved.

## **Serious case reviews**

The Munro review recommends that LSCBs should use systems methodology in future reviews of serious cases, moving away from the specific features of an individual case to consider the deeper, underlying issues that influence multi-agency practice more generally. This is a far more collaborative approach, involving practitioners from an early stage and focussing on holistic factors rather than seeking to identify individual errors. The approach is strongly based on the system of root cause analysis that has been established in health for a number of years, and the London Board is currently piloting the recommended *SCIE Learning Together* model across several London LSCBs.

Early indications from the London pilots have been positive in terms of outcomes, although there is currently little evidence that the systems approach will prove to be a more cost effective model for reviewing serious case reviews. The Board has previously urged government to give greater consideration to the resource implications of these reviews, and will continue to do so as the pilots develop over the coming months. The Munro review also recognises the heightened anxiety amongst professionals following the decision to publish serious case reviews in full, particularly focussed around the protection of sensitive information about individual children and families, and suggests that a stronger focus on practice issues through the systems approach should help alleviate some of these concerns. This will be evaluated during the course of the London pilots, which will also draw out the interface with ongoing parallel review processes (such as domestic violence homicide reviews) and should produce a significant amount of learning for national consideration as these proposals develop further.

## **Ofsted and inspections**

The review finds that announced inspections are costly and create undue anxiety amongst professionals, recommending instead that Ofsted focuses on a detailed programme of unannounced inspections (the report also confirms a welcome end to Ofsted's evaluation of serious case reviews). The strong emphasis on a multi-agency focus to these inspections is particularly helpful, taking account of the full range of agencies working within local safeguarding partnerships and focussing attention on their contribution to the delivery of strong outcomes for children, young people and families. This robust approach should be crucial in ensuring that all agencies are fully aware of their safeguarding responsibilities, and should be mirrored in Ofsted's inspection programme for schools.

The report delivers a helpful message that the current system of performance indicators and targets has “skewed and misdirected local priorities”, highlighting that information cannot be viewed in isolation and must instead be seen holistically to provide a context for a more detailed analysis of the health of safeguarding arrangements in the area. Munro suggests a new ‘twin core’ of information collected nationally and standardised data published locally, available in appendix two of the report, but stresses that this information must be underpinned by more detailed discussion and analysis.

The report also highlights the benefits of more informal quality assurance approaches such as case audits and peer reviews, which the London Safeguarding Children Board has previously recommended after positive feedback from those conducted by our team of London regional safeguarding advisers. Case audits often prove extremely illuminating, and can provide a strong insight into the health of a service without the costs and bureaucracy associated with a more formal review. Peer reviews would ideally be conducted jointly, with local authority reviewers joining inspection teams in a similar model to that successfully employed by NHS London’s Safeguarding Improvement Team visits over the past year. Feedback from that programme has been excellent, with inspected areas responding positively to the peer element and peer reviewers seeing the process as an opportunity to learn and examine good practice first hand.

### **Health and education**

The report touches on the ongoing reforms to the health service, and raises concerns that safeguarding and child protection could become sidelined in the new arrangements. In particular, the crucial importance of named and designated professionals is highlighted, and the report notes that some areas are already seeing the erosion of previously well established local relationships as organisations are restructured or replaced.

The London Safeguarding Children Board shares these concerns and supports the recommendation for greater research into the possible impact of the reforms, but a number of issues are already apparent in London and the report should make it clear that dedicated safeguarding children expertise must not be reduced or diluted in the new health structures. The Board has recently written to the Chairs and Chief Executives of the new London Cluster PCTs, raising this and a number of other specific issues to ensure that the safeguarding of children remains robust during transition.

Whilst the direction of greater accountability, transparency, increased focus on choice, patient experience and the development of outcome measures are welcome, the significant organisational change taking place across London currently carries significant risk to arrangements for safeguarding children locally. Changes in key personnel, potential loss of expertise and capacity can all disrupt local partnership working arrangements, causing risks to safe information sharing and service delivery between key partners. It is important that organisations continue to give clear local strategic leadership to the safeguarding of children, maintain strong local partnerships and ensure operational delivery is sustained.

It is also disappointing to see that the review gives little focus to the large scale reforms currently taking place across the education system, simply highlighting the existing safeguarding duties on local authority maintained schools (section 175 of the Education Act 2002) and independent schools (section 157 of the same Act). However, the review does not consider the implications of free schools or increasing conversion of local authority maintained schools to academy status, which could place pressure on these arrangements.

## Comment

The central tenet of the review is a move to reshape the child protection system around the needs of individual children and young people, and this is welcome. Professor Munro is clear that she feels that local authorities and their partners have become too focussed on government targets and processes to the detriment of considering whether they are actually improving outcomes for children and families. Through the Board's team of regional safeguarding advisers, work to develop local, child and outcome focussed quality assurance frameworks is already underway in London, and the report's support for these principles is welcome.

However, it is clear from the work in London that strong local quality assurance mechanisms are essential to ensure that alternative methods which are developed for the future are safe and effective, and there must be provision made nationally for ongoing resources to support sharing and evaluation of learning and to negotiate regional approaches where necessary. It is important to note that the reforms suggested within Professor Munro's report are fundamental, many of the alternatives untested, and it is clear that the children's workforce do not yet consistently have the competencies needed to take on the level of responsibility suggested. The review's close ties to the ongoing Social Work Taskforce will be crucial in this respect, but strong levels of safeguarding expertise will be required across the full range of agencies working with children and young people – this is particularly relevant within the voluntary sector, which will be increasingly called upon to deliver services on behalf of statutory partners but receives little attention in the review.

The role of senior leaders is highlighted strongly in the report, and elected members will be particularly crucial in driving improvement within local authorities. The London Safeguarding Children Board is planning a series of events to support London's Leaders and Lead Members for Children's Services in this task, including a seminar looking in depth at the implications of the Munro Review on 15 June. This session will build on the outline presented here and provide a forum for Members to discuss local developments and share their own views on ways forward for London.

It is important to note that the government has yet to respond formally to the Munro Review, although a number of senior national figures have urged that the report's recommendations be accepted in full. As outlined above, however, several of the reforms suggested will require significant investment to implement effectively and it is crucial that this is not left to the increasingly stretched budgets available to local authorities and their partners. The success of the review will depend on local safeguarding partnerships implementing these reforms in full, and the government's response will be a key factor in determining their ability to do so.

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## Links

<http://www.education.gov.uk/munroreview/>

<http://www.londonscb.gov.uk/>

## Summary of recommendations

The Munro Review makes fifteen recommendations in total, which are reproduced below:

**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.

**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.

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

**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.

**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.

**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.