Hull Safeguarding Children's Partnership

Annual Report

1 October 2019 – 30 September 2020

1. Introduction

1.1 This is the first annual report of the Hull Safeguarding Children's Partnership, following the implementation of new arrangements replacing the Local Safeguarding Children Board, with effect from 20th September 2019.

1.2 The production and publication of an annual report on progress is a requirement of *Working Together 2018* and is expected to provide an account of what has been done as a result of the new arrangements, including on child safeguarding practice reviews, and how effective the arrangements have been in practice.

2. Background and Context

2.1 The Children and Social Work Act 2017 abolished Local Child Safeguarding Boards (LSCBs). In their place a duty was placed upon local authorities, the police and clinical commissioning groups to establish multi-agency safeguarding arrangements. The three partners had an equal and shared statutory duty to publish their new, replacement arrangements by 29th June 2019 and to implement these by 29th September 2019.

2.2 The work of 'early adopters' was used to design Hull's new arrangements. What emerged was something of a 'hybrid' model, but based largely on the model developed in Bexley. The model which was developed by the Local authority Children's Services, was first shared with existing LSCB members and other stakeholders in June 2019, a few weeks before it needed to be published. There was a clear intention to strengthen focus on learning and improvement, streamline the partnership 'governance' arrangements, increase shared accountability and reduce dependence on a central 'business unit'.

2.3 In anticipation of these intentions, the capacity in place to support LSCB activity during the period leading up to transition (2018/19) had been significantly reduced. The independent chair of the LSCB finished in this role leading up to 'handover' in August 2019.

2.4 The published 'infrastructure' to support partnership safeguarding activity, was slimmed down to an Executive Board, a Learning from Individual Cases Group (replacing the former serious case review sub-committee), a Quality and Performance Group, the EHASH Management Board and a Safeguarding in Education group. The Executive Board comprises the three statutory partners at a senior level: the Director of Children, Young People and Families for the local authority, the Interim Director of Nursing and Quality for NHS Hull CCG and the Chief Superintendent (North Bank Divisional Commander) for Humberside Police.

2.5 The wide range of key safeguarding children 'relevant partners' (as defined in *Working Together 2018* and formerly statutory members of the LSCB) are described as 'stakeholders', with a wider network of safeguarding leads (including named and designated leads within health providers and designated safeguarding leads in schools) described as 'safeguarding champions'.

2.6 The published arrangements described a part-time operational manager role, a programme manager (to coordinate programmes of audit and learning aligned to priorities agreed by the executive board) and a 'learning hub' (made up of 3 representatives, one each from the police, CCG and CSC) to lead on learning and improvement across the partnership. There was some delay in implementing these arrangements: the programme manager post was filled in November 2019 and the 'learning hub' did not fully come together until January 2020. In the interim, work on establishing the new arrangements (the constitution, terms of reference, website development, communications etc.) was supported by the council's transformation team.

2.7 In January 2020, the half-time operations manager was redirected to their substantive role full-time.

2.8 There were also significant changes in leadership within the Local authority (with the AD Safeguarding leaving in the December 2019 and the DCS in the January) following an Ofsted Monitoring Visit that was highly critical of the progress of the Council's improvement plans. An interim DCS and Acting AD were appointed in the February.

2.9 The Council moved under a formal Direction by the Secretary of State in March and a Children's Commissioner was appointed

2.10 The 'learning hub' was paused in March 2020 due to the Covid-19 lockdown and the need for those officers to return to business critical roles in their host agencies. The full-time partnership business support officer also left that role in March 2020. Recruitment to vacant posts was paused pending the outcome of the review of arrangements agreed by the executive board.

2.11 The sub-groups have continued to meet but there has so far been a lack of clear, regular line of accountability between these groups and the Executive Board. The Executive Board has continued to hold fortnightly catch-up meetings and a formal monthly meeting throughout the period of the pandemic.

2.12 The existing Executive Board members were not directly involved in the design and development of the new arrangements. Given the background and context, the statutory partners identified and agreed a need for the arrangements to be to be reviewed to ensure fitness for purpose for the future. Whilst it was acknowledged that there were limitations in conducting a review during a pandemic, it was felt vitally important that new systems and processes needed to be adopted in order to be an efficient and effective partnership

2.13 This review commenced in July 2020.

3. Outcome of Review of Arrangements

3.1 Each of the three strategic leads led on a different strand of the review.

3.2 The CCG representative led on work to strengthen the scrutiny and assurance arrangements supporting partnership activity. It was agreed in September 2020 that the partnership would establish the role of independent chair and recruit a number of independent scrutineers to provide support and challenge of the quality and impact of learning and improvement work across the partnership in the future. This work is now described within an agreed 'Scrutiny and Assurance Framework' (Appendix 1).

3.3 An Independent Chair has now been appointed and will commence in the role in December 2020. The first independent scrutineer has also been appointed and will lead on a review of our practice and arrangements to keep children safe from the impact of domestic abuse.

3.4 The Executive Board has also identified the need to undertake a section 11 audit and assessment process across the partnership (this is a standard process to audit compliance with safeguarding duties under s11 Children Act 2004). This exercise will complete its first phase (audit returns across the partnership) by 31st January 2021.

3.5 The interim Director CYPFS led on a review of the dedicated capacity needed to support the partnership and to coordinate and lead the assurance, learning and improvement activity in the future. A full-time dedicated partnership manager post has now been established. Recruitment to this post is underway with the expectation of an appointment in December 2020. The original post of programme manager has been deleted to enable the creation of this key role.

3.6 No final decision has yet been taken about the 'learning hub' model and whether this can meet Hull's needs in the future. The 'hub' remains paused currently and it will be for the new manager, in conjunction with the Executive Board, to determine the capacity needed to ensure highly effective future arrangements.

3.7 The LSCB's pre-existing training and development capacity (leading and delivering a substantial annual programme of multi-agency safeguarding training) has been retained. The value of multi-agency training is well-evidenced, but there is an identified need to develop a more agile and 'blended' approach which is less reliant on classroom-based learning, more cognisant of the context of working lives across safeguarding and more explicitly linked to ongoing learning via local child safeguarding practice reviews (the replacement for serious case reviews) and audit. Work on reviewing the 'offer' will commence in December 2020, via a newly re-established learning and development sub-group.

3.8 Work on re-engaging key stakeholders has been led by the police representative and included a consultation event in July 2020, which included

a presentation from the police national lead on the child safeguarding reforms. As an outcome of this event, the HSCP agreed a number of improvement actions including improved communication with stakeholders and a need to develop clearer and more transparent governance arrangements.

3.9 Updates on this work have been communicated across the partnership via a newsletter (November 2020) and via a short presentation at December's 'Better Together' children's board. A 'stakeholder' event is being planned to take place in February 2021. The Executive Board will also consider proposals to further strengthen the role and function of sub-groups when it meets on 10th December 2020.

3.10 The Independent Chair of HSCP will meet with the Chair of Hulls Place based Board on a 6 weekly basis as the final line of accountability for the Partnership.

4. Child Safeguarding Practice Reviews & Serious Case Reviews

4.1 Work has continued during the period on completing and publishing serious case reviews (initiated but not finished by the LSCB) and notifying the national panel of any incidents of the death or serious harm to a child where abuse or neglect is known or suspected.

4.2 The HSCP has published two serious case reviews during the year, on behalf of the former LSCB. Publication of both reviews was delayed: in both cases the reviews were published after the conclusion of criminal investigations.

4.3 The HSCP published the Child H serious case review in May 2020. Child H died in February 2014 and the serious case review was completed early in 2016. The report and an addendum were published in May 2020 and can be accessed here Child H. There was a significant focus on the learning from Child H's death during the period from October 2015 through to April 2017, but the subsequent Ofsted inspection (2019) identified some similar practice weaknesses.

4.4 The serious case review in relation to serious injuries suffered by Baby B was published in September 2020. The addendum to this review also outlines the improvement activity undertaken across the partnership as a result of the learning, but similarly acknowledges that some of the weaknesses identified in social work practice also featured in the subsequent Ofsted inspection of 2019. The progress update included as part of the published report captures some of the most significant related improvement activity being implemented by the local authority to address these weaknesses. The report can be accessed here Baby B.

4.5 The local authority also made two notifications to the national panel (in January and February 2020). In respect of both notifications, the national panel agreed with the local decision, reflected in the rapid review reports, to carry out a local child safeguarding practice review. Interim guidance published in April 2020, acknowledged that local partners may not have been able to commence reviews whilst responding to the challenges of Covid. The interim arrangements came to an end late in September 2020 and both reviews have commenced.

4.6 The current Local Child Safeguarding Practice Reviews currently underway relate to the death (January 2020) of a ten-year old child and father in a house fire and an injury to a 2-year-old child (February 2020) already subject of a child protection plan. The injury was initially assessed as non-accidental and the rapid review, raised issues about how the risk of sexual harm to the child and older sibling had been assessed and managed.

4.7 In respect of both of these reviews, the HSCP is working in partnership with Hull University. The university is providing expertise to independently lead both reviews, providing an opportunity for local leads to develop expertise in leading reviews, and will help develop a blended approach to ensuring that the learning from the reviews is supported by high quality training to ensure that impact is maximised.

5. **Multi-Agency Safeguarding Improvement Activity**

5.1 Whilst, with the exception of the work on serious case reviews and local child safeguarding practice reviews, the HSCP has not directly led on additional learning and improvement activity during the period (for the reasons outlined in the report), the current local authority context (of intervention) has meant that there has been a significant amount of continuous improvement activity, much of which has, and will continue to, engage key safeguarding partners.

5.2 This improvement activity has included, but is not limited to: strengthening partnership engagement in EHASH ('front door') arrangements and implementation of the new 'portal': review of the pre-birth vulnerability pathway and establishment of multi-agency group to triage pre-birth referrals; re-establishment of the multi-agency domestic abuse triage in EHASH; multi-agency auditing of referrals and strategy discussions; a monthly thematic programme of multi-agency auditing led by the EHASH Board operational management group; ongoing multi-agency auditing of practice and decision-making leading up to and including initial child protection conferences; and the establishment of a number of themed task and finish groups to have oversight of partnership working to keep children safe during the pandemic.

5.3 The HSCP strategic leads are members of the Improvement Board which is currently overseeing the implementation of the local authority's improvement plan. The completed, and next phases, of the HSCP review and the re-invigoration of the wider children's strategic partnership (the 'Better Together for Children' Board) are designed to put in place the arrangements needed to

drive continuous improvement and scrutinise impact, when sufficient progress has been made to no longer need the current arrangements.

6. Multi-Agency Safeguarding Training

6.1 The former LSCB invested in a significant programme of multi-agency safeguarding training, including two full-time safeguarding training and development officers. It was agreed by the partners that this training provision would continue in the interim, pending a review of what is needed for the future. The current capacity to lead on multi-agency safeguarding training has been retained by partners following the first phase of the review of arrangements.

6.2 The existing training programme has continued to be provided during this period, although this has needed to be adapted and reduced since March 2020 when opportunities for face-to-face, classroom based training were severely impacted as a result of Covid-19.

6.3 Since March 2020, of necessity, a more 'blended' approach to the provision of training has been developed which provides the components of a more modern and flexible 'model' for the future. Although the number of participants has reduced significantly, for obvious reasons during the period (traditionally the annual programme has reached 7000+ participants on an annual basis), 1000+ participants, have accessed training, provided via a combination of face-to-face, virtual and e-learning methods.

6.4 In addition, the safeguarding trainers have worked with colleagues from the Learning from Individual Cases sub-group to deliver well-attended online seminars on learning from serious case reviews and local learning lessons reviews, with very positive feedback from participants.

6.5 The newly re-formed 'learning and development' sub-group will develop a revised 'offer' for the future, which will concentrate on a more 'blended' approach to learning (a greater mix of e-learning, classroom based, virtual, webinar, bite-sized etc.), with greater agility to respond quickly and with impact to learning from practice reviews and with a strengthened focus on the longer-term impact of training on practice.

7. Feedback from children and young people

7.1 The scrutiny and assurance framework agreed by the Executive Board in September 2020, emphasises the central importance of involving children and young people, and of learning from their experience, in the future work of the Board.

7.2 A new engagement strategy has recently been finalised, which includes plans to establish a network of young advisors locally. Better use needs also to be made of the key themes and issues raised by children via the existing range of 'voice and influence' activity locally: the "love staying safe" campaign led by the city's first young mayor; the strong and active children and young people's

parliament; the work of school councils; and, significant engagement activity within the local 'Headstart' programme.

7.3 Executive Board members acknowledge that direct engagement with children and young people, including meaningful opportunities for children to influence service development and improvement, remains a key area for further development. Developing these arrangements, and ensuring that they are in-built to all HSCP learning and improvement activity will be a key priority for the partnership manager, working collaboratively with young people's engagement leads across the partnership.

8. Conclusion

8.1 The arrangements published in June 2019, and subsequently (partially) implemented from September 2019 onwards were not sufficient to ensure an effective set of strategic safeguarding arrangements for Hull. This has limited the impact of the arrangements during their first year.

8.2 However, these limitations have been identified by the current statutory partner strategic leads and action has been agreed (as outlined) to strengthen the arrangements we have in Hull and deliver on an effective and clear safeguarding partnership.

9. Forward Plan

9.1 The outcome of the review has put in place the foundations for a more effective partnership. The following key activity has been agreed for the first six months of 2021:

9.1.1 Complete appointment of HSCP Manager to commence in post by 28/02/21.
9.1.2 Recruit to HSCP business support posts by 28/02/21.
9.1.3 Independent Chair will chair the Executive Board from January 2021.
9.1.4 Complete section 11 audit process, with self-assessments completed and returned by 29/01/21 and assurance events by 30/04/21.
9.1.5 Complete current Local Child Safeguarding Practice Reviews by 31/03/21.
9.1.6 A schedule of stakeholder meetings & events for the year will be established by 31/01/21.
9.1.7 Complete review of governance structure by 31/01/21.
9.1.8 Make final decisions about the 'learning hub' model (within 3 months of HSCP Manager commencing in post).
9.1.9 Design thematic learning programme focused on the impact of domestic abuse on children by 31/03/21.
9.1.10 Re-design the multi-agency safeguarding training programme by 31/03/21.
9.1.11 Establish and produce a monthly partnership safeguarding newsletter by 31/03/21.

9.1.12 Produce and publish a further progress report by 30/06/21 for the period up until 31/03/21.

9.2 Building on the foundations now in place and the key activity described above, further work will be completed in the first six months of 2021 on developing the medium-term strategy for the partnership, including a strategy for meaningful and ongoing engagement with children and young people.