Hull Safeguarding Children's Partnership

Progress Report

1 October 2020 – 31 March 2021

1. Introduction

1.1 This Hull Safeguarding Children's Partnership (HSCP) published its first annual report in January 2021 (covering the period 1st October 2019 – 30th September 2021), 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.

1.3 In January 2021, the HSCP Executive Board agreed that an update on progress would be produced and published (covering the period 1st October 2020 – 31st March 2021 (this update) and 1st April – 30th September 2021) prior to the completion of the next full annual report for the financial year 2021/22. This will also align the HSCP annual report with other key reporting cycles.

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 annual report described the process of designing the new arrangements which were published in June 2019 and implemented in September 2019, along with some of the delays in achieving full implementation.

2.3 By the end of March 2020, it was clear that the published arrangements, and the process of designing them, were not going to deliver a 'fit for purpose' safeguarding partnership. The three executive leads (for the local authority, police and clinical commissioning group), none of whom had been in these roles during the design phase, paused elements of the arrangements and agreed the imperative to review them.

2.4 The review commenced in July 2020. The Council had also moved (in March 2020) under a formal Direction by the Secretary of State in March and a Children's Commissioner was appointed.

2.5 The first phase of the review was completed in September 2020, with the Executive Board taking key decisions about revised future arrangements, designed to get the basics right and lay the foundations for real and sustainable improvement, with a focus on:

2.5.1 Strengthening arrangements for independent scrutiny and challenge and for ongoing assurance activity;

2.5.2 Building the dedicated capacity needed to lead and drive partnership work, and;

2.5.3 Re-engaging in a meaningful way at strategic level with the wider group of key 'relevant agencies' who had been marginalised and disenfranchised within the published model and by the process for designing the new arrangements.

2.6 The outcomes of this work were described in the annual report, together with the planned next steps in implementing the decisions taken. The report also reflected that further work was needed in developing the governance structure to support partnership working, the lines of accountability between the sub-groups and the Executive Board and the final make-up of the business support unit supporting, leading and coordinating the work.

2.7 This update, therefore, primarily focuses on the progress made in laying those foundations for the future, so that the next update and the full annual report for 2021/22 can describe impact and the difference the arrangements are making to improve safety for Hull's children.

2.8 Despite that the focus has primarily been upon ensuring that the right building blocks are in place, the focused Ofsted visit in March 2021 found that: *"A significant change in leadership style in children's social care is starting to reap dividends, helping to transform the partnership landscape as evidenced, for example, by Hull's Safeguarding Partnership Arrangements, which have been refreshed and re-energised."*

3. Independence, Scrutiny and Assurance

3.1 The executive leads agreed that the role of independent chair should be created, to provide leadership and challenge. Kay Durrant was appointed to this role in November 2020, started in role in December 2020 and has chaired the Executive Board since January 2021. Significant progress has been made in the first three months (up to 31st March 2021) with a focus on establishing key working relationships individually with executive leads, the local authority chief executive and lead member and with the strategic leads of the 'relevant agencies', including the voluntary and community sector. An initial meeting with 'relevant agencies' took place in March 2021 with a commitment to continue on a quarterly basis in the future.

3.2 Simultaneously, a first appointment was also made to the role of independent scrutineer and it was agreed in January 2021 that the scrutineer would lead on a first programme of thematic learning, focusing on the effectiveness of local practice and responses in safeguarding children from the impact of domestic abuse. The scope for this piece of work was agreed by the Executive Board in February 2021, with a commitment to complete by August 2021. The research element of this work was completed by 31st March 2021, pulling together the

available learning from local and national serious case reviews, Ofsted inspections, local multi and single agency auditing and from emerging best practice nationally.

3.3 The CCG executive lead led on designing the scrutiny and assurance arrangements for the partnership. The scrutiny and assurance framework was agreed and published in October 2021.

3.4 As set out in the annual report, the partnership undertook a section 11 audit (self-assessment) process, supplementing the successful exercise undertaken across all of Hull's schools in June 2020. The process was launched in early December 2020, with a self-assessment return date of 29th January 2021. There was a very good response to this across the partnership with an extension period for completion to the end February 2021 being granted to a small number of partners and organisations. When in post, the HSCP Manager will lead, with colleagues, on analysing the returns and identifying a number of priority themes for further focused improvement work, overseen by the Quality Assurance and Performance sub-group. The analysis will be presented at the Executive Board in May 2021.

4. Strengthening Capacity to support partnership work

4.1 As part of the review of the published arrangements, it was agreed that a new post of HSCP Manager was needed to provide leadership and ensure coordination of partnership improvement activity. An appointment was made to this role in December 2020. The post holder had not taken up the role during this reporting period but a confirmed start date of 12th April 2021 had been agreed.

4.2 Progress in recruiting to the agreed business support roles has been delayed, but a full-time business support coordinator is now expected to take up this role early in July 2021. This will enable, over time, the necessary support of the executive board, the chair, the manager and the various sub-groups to be provided from one central point

4.3 It was also agreed in September 2020, that the 'learning hub' (a key element of the published arrangements which was paused at the start of the pandemic in March 2020) would be suspended and that the capacity needed to drive improvements, would be reviewed by the HSCP Manager within three months of commencing in post. Any proposals will be taken to the Executive Board in August 2021 in the light of the business plan agreed by the Board in July 2021.

5. HSCP Governance Arrangements

5.1 It was acknowledged as part of the review of arrangements that further work was needed to strengthen the governance arrangements (including the partnership sub-groups) and the clear lines of reporting and accountability to the Executive Board. This work was completed and endorsed by the board in February 2021.

5.2 The main decisions taken to further strengthen arrangements were:

5.2.1 The addition of an executive education lead from Hull's Learning Partnership as a full member of the Executive Board (effective from February 2021)

5.2.2 The need to re-establish a strong and effective contextual safeguarding strategic partnership, and;

5.2.3 A commitment to explore with the adults safeguarding and community safety partnerships the opportunities for closer joint working on agreed and shared strategic priorities and on workforce development.

5.3 A chair and vice-chair have been identified for the contextual safeguarding sub-group and two workshops with a wide range of partners and stakeholders planned for April 2021 to design the new arrangements. At the same time an expression of interest has been submitted to the Tackling Child Exploitation programme for bespoke support to help Hull develop effective arrangements which make a real difference to children. A decision is expected in late April 2021 as to whether or not this bid for support has been successful. (We have subsequently heard that we have been successful).

5.4 A rolling programme of regular (quarterly) reporting by the chairs of the board's sub-groups to the executive board has also been established: reports have been received between January and March 2021 from the chairs of the learning from individual cases, education safeguarding, EHASH, quality assurance and performance sub-groups. This is beginning to strengthen accountability and the ability of the executive leads to influence the work of the sub-groups and to understand and address any barriers to progress.

5.5 A first meeting was also held in March 2021 between the chairs, executive leads and managers of the three strategic partnerships to agree the principle of greater alignment and joint working for the future. This was a positive first meeting, chaired by the HSCP independent chair. Future regular meetings were agreed to further develop the detail.

6. Child Safeguarding Practice Reviews, Serious Case Reviews and other learning

6.1 There have been no new notifications made to the panel in relation to the death or serious injury of any child where abuse or neglect is known or suspected. Work has continued during the period on completing the two child safeguarding practice reviews which commenced in early October 2020.

6.2 In relation to one of these reviews, the death in 2020 of a 10-year-old girl in a house fire, all of the individual agency reflective learning reports have been completed and considered by the multi-agency panel for that review. A successful practitioner learning event was held early in March 2021 and the draft report is scheduled to be considered by the panel in late April 2021. It is

anticipated that the report will be ready for publication by late June 2021, subject to negotiation with the coroner who will be completing the inquest into the death in early August 2021.

6.3 A decision has been taken to stand down the second review which was underway at the start of this reporting period. The panel has been notified. The original notification in February 2021, and subsequent rapid review, were triggered by an injury (fractured clavicle) to a two-year old girl who was already subject of a child protection plan, under the category risk of sexual harm. During the subsequent family proceedings further expert medical opinion was provided and accepted by the court, indicating that the injury was most likely accidental. The judge also ordered that the child and their sibling be reunified with parents, the threshold for separation based on risk of sexual harm, not having been reached. In these circumstances, the executive board took the decision not to complete and publish the review.

6.4 There remains one serious case review (completed in November 2019 by the local safeguarding children board) which has not yet been published. Publication has been delayed in this case due to an ongoing criminal investigation into the circumstances of the death of this (nearly) two-year-old child. A decision in relation to any criminal charges was anticipated imminently after the end of this reporting period. A programme of multi-agency learning in relation to this review is being planned and designed.

6.5 As part of work to improve the way in which learning is disseminated, and impact measured, the partnership safeguarding training and development officers are much more directly involved in the work of the learning from individual cases group, so that there will be greater agility and flexibility in designing learning programmes to reach a bigger volume of practitioners and managers in the future.

6.6 In addition to the formal reviews, the partnership has also initiated a 'deeper-dive' multi-agency audit to identify any learning in respect of children from an eastern European country who returned to their native country shortly after the children were made subject of interim care orders and whilst investigations into unexplained head injuries to the youngest child were still ongoing. By 31st March 2021, the multi-agency learning conversations were concluded and the learning about practice agreed. The conclusions will be considered by the learning from individual cases group in June 2021.

6.7 In addition, work has been undertaken, in response to a ministerial request in late September 2020, to monitor and track the safety and wellbeing of babies born during the pandemic into families where there have been previous safeguarding concerns. This work was requested based on analysis of an increase in notifications to panel during the first six months of the pandemic in respect of the death or serious injury of vulnerable babies. This work has been refreshed periodically as new 'batches' of birth notifications have been received and has provided assurance about the safety and progress of these babies.

7. Multi-Agency Safeguarding Improvement Activity

7.1 In addition to the work on practice reviews (described above) and the section 11 audit work, 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.

7.2 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; 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.

7.3 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.

7.4 The executive board is holding an additional meeting in June 2021, now that most of the necessary governance and support arrangements are in place, to agree a business plan for 2021/22. This will include an agreed programme of multi-agency auditing for the remainder of the year.

7.5 The local authority has also decided to introduce and implement 'Signs of Safety' as the practice model for working with children, young people and families. The model is intended to be used from early help, through safeguarding and with children looked after and across the whole partnership. The executive board had a presentation in January 2021 on the model (supplementing the presentations already made at the 'Better Together Board' and also agreed that the dedicated partnership safeguarding trainers will become local Signs of Safety trainers. By the end of the period over 500 practitioners and managers from the wider partnership had attended Signs of Safety briefings, with access to the two-day training planned for many from July-October 2021.

8. Conclusions and Next Steps

8.1 Significant progress has been made (and acknowledged by Ofsted inspectors) in re-establishing and re-invigorating the partnership which had lost some focus, capacity and impetus in the period leading up to and after implementation of the new arrangements.

8.2 The essential building blocks are now mostly in place (or in hand) so that the partnership is now more strongly positioned to demonstrate impact over the next year.

8.3 As indicated above, the executive leads have set aside time in June 2021, along with the independent chair and manager, to agree the business plan and priorities for the next twelve months. There are, however, some key pieces of work already agreed, as detailed below.

9. Forward Plan

9.1 The outcome of the review and the work undertaken subsequently to implement the decisions has put in place the foundations for a more effective partnership. The following key activity has already been agreed for the first six months of 2021/22:

9.1.1 Recruit to HSCP business support posts by 31st July 2021 (with the first post taken up by 8th July 2021.)

9.1.2 Develop section 11 themed improvement plan overseen by QA & P sub-group by 30th June 2021.

9.1.3 Complete domestic abuse thematic learning programme by 31st July 2021, reporting on learning and key recommendations for improvement to the executive board in August 2021.

9.1.4 Take final proposals for the business support structure to executive board by 31st July 2021.

9.1.5 Complete and publish the safeguarding practice review and publish the outstanding serious case review by 31st July 2021, supported by a focused, flexible and 'blended' learning programme.

9.1.6 Establish the contextual safeguarding sub-group by 30th June 2021 and identify a permanent chair and work programme for the learning and development group by 31st July 2021.

9.1.7 Update and improve the HSCP website within two months of the bespoke HSCP business support capacity coming on line – by 31st August 2021

9.1.8 Agree the business priorities for the partnership for the next twelve months by 30th June 2021

9.1.9 Complete a review of the effectiveness of the existing neglect tools and strategy (by 31st July 2021) and agree further work needed to re-invigorate.

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.