HM Government

Working Together to Safeguard Children

Government response to public consultation

department for children, schools and families

March 2010

1. Introduction

The guidance

1.1 *Working Together to Safeguard Children* (Working Together) statutory guidance sets out how organisations and individuals should work together to safeguard and promote the welfare of children. It is addressed to practitioners and front-line managers who have particular responsibilities for safeguarding and promoting the welfare of children, and to senior and operational managers, in organisations that:

- are responsible for commissioning or providing services to children, young people, and adults who are parents/carers; or
- have a particular responsibility for safeguarding and promoting the welfare of children.

Background

1.2 On 12 November 2008 Ministers announced to Parliament that they had asked Lord Laming to prepare an independent report on the progress being made across the country to deliver effective arrangements to protect children, and to identify any barriers to effective, consistent implementation and how these might be overcome. Lord Laming published *The Protection of Children in England: A Progress Report*[1] on 12 March 2009. In order to drive up the quality of practice at the front line, Lord Laming made 58 specific recommendations relating to: leadership and accountability, support for children, inter-agency working, children's workforce, improvement and challenge, organisation and finance and the legal framework. The recommendations were accepted in full by the Government.

1.3 Seventeen of Lord Laming's recommendations (plus a further 6 that relate the statutory guidance to Chapter 8 on Serious Case Reviews) are being addressed through the revision of the statutory guidance Working Together, as is a further commitment from the Government's action plan[2] relating to the appointment of lay members to Local Safeguarding Children Boards. A full list of these recommendations and commitments is set out at Annex A.

1 http://publications.everychildmatters.gov.uk/eOrderingDownload/HC-330.pdf
2 http://publications.dcsf.gov.uk/eOrderingDownload/DCSF-Laming.pdf

The consultation

1.4 The public consultation on the revised Working Together ran from 18 December 2009 to 11 February 2010. A list of respondents is at Annex B. It was preceded by a separate consultation on the revised Chapter 8 of Working Together which ran from 31 July to 23 October 2009 (a new version of Chapter 8 being published on 18 December 2009, alongside the Government's response to that consultation) and a pre-consultation on how the Government proposed to address Lord Laming's recommendations through Working Together which ran from 20 November until 17 December 2009.

1.5 The Working Together consultation was supported by regional conferences. These were held on 4, 5 and 11 February 2010 in Manchester, Birmingham and London. They attracted a total of 480 delegates.

1.6 This document provides an overview of responses and a summary of key findings from the consultation. It also summarises changes made to further strengthen Chapter 8 since it was published on 18 December.

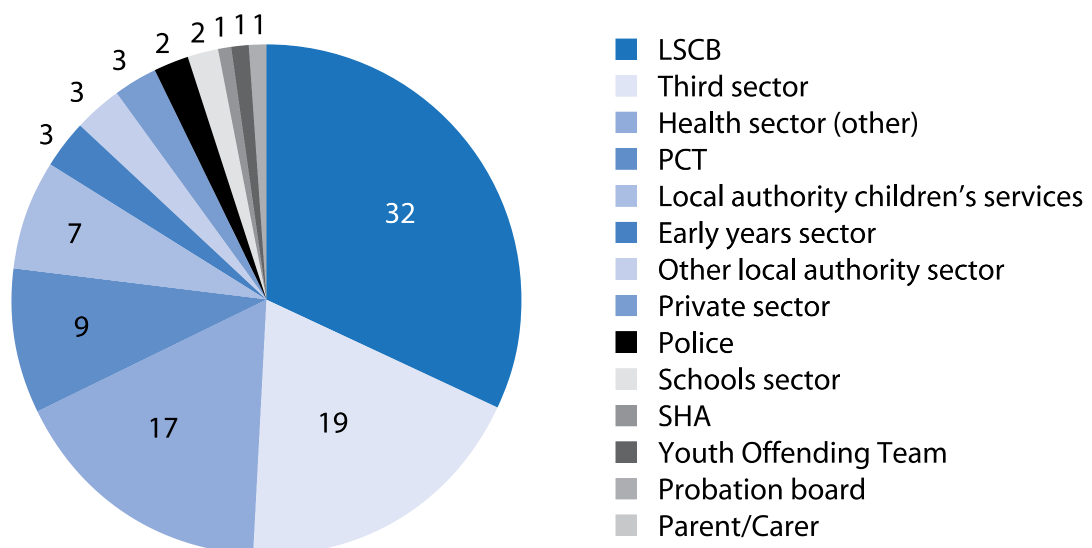
2. Overview of responses

2.1 The public consultation on Working Together received a total of 202 responses from a range of organisations. 91 responses were received online, 107 via email and 4 by post.

2.2 Respondents comprised:

- 63 Local Safeguarding Children Boards (LSCBs);
- 15 local authority children's services departments;
- 18 Primary Care Trusts;
- 36 voluntary organisations;
- 2 Strategic Health Authorities; and
- 68 other types of respondents, including police, probation boards, Youth Offending Teams, other local authority services, the schools sector, the early years sector, other health bodies, government bodies and parents/carers.

Breakdown of Respondents



All numbers are percentages

3. Key findings

General

3.1 Several respondents raised concerns about the way the draft combined statutory guidance, good practice guidance and findings from research, arguing that the draft was cluttered and lacked clarity as a result. There were also concerns about the overall length of the document. However, the majority of responses proposed additions to the document.

3.2 We recognise that most readers will use Working Together as reference material, dipping into sections of the document, rather than reading it from cover to cover. To facilitate this, we have colour-coded the sections of the document, and we will also produce a fully indexed, easily navigable web-based version in due course, with hyperlinks to relevant supporting guidance. *What to do if you're worried your child is being abused* will be updated to reflect the revised Working Together and in particular Chapter 5 on managing individual cases where there are concerns about a child's welfare and safety. The DCSF will also be working with stakeholders to produce a short practitioner guide to Working Together, and to consider what might be done to present the full document more effectively to ensure that the statutory requirements on safeguarding children are not inadvertently obscured by non-statutory guidance.

3.3 It is crucial that the respective roles and responsibilities of the Children's Trust and the Local Safeguarding Children Board are well understood. In response to the consultation responses we have revised both the Children's Trust Board statutory guidance and Working Together to make the relationships between the two Boards clearer.

3.4 Another key issue raised in responses, which is common to both sets of statutory guidance, was the interface between assessments – in particular, the fit between the assessment framework for children in need and their families, and the CAF. The Children's Trust Board guidance has been strengthened to make it clear that Children's Trust Boards have responsibility for ensuring that the arrangements for the Common Assessment Framework are in place in their area. In addition, Chapter 5 of Working Together has been revised to provide more clarity on the relationship between the Common Assessment Framework and the statutory guidance *The Framework for the Assessment of Children in Need and their Families*. Chapter 3 has also gives greater emphasis to the statutory responsibility of LSCBs to agree with partner agencies the local threshold criteria for deciding when to make a referral to children's social care and to ensure that these criteria are widely understood by staff across all agencies.

3.5 Respondents to the consultation were asked a number of specific questions about the draft guidance, and asked for suggested additions. Responses and key themes are split by chapter below.

Chapter 2

Does Chapter 2 sufficiently capture the wide range of partners who share responsibility for safeguarding and promoting the welfare of children?

Are their roles and responsibilities sufficiently clear?

3.6 76% of the 142 responses to the first question considered that the guidance sufficiently captured the wide range of partners who share responsibility for safeguarding and promoting the welfare of children. Just 18% of respondents took the opposite view, with 6% unsure.

3.7 There were 145 responses to the second question with no consensus on whether the roles and responsibilities were sufficiently clearly set out in Chapter 2. A small majority (53%) felt that the guidance here was clear enough with 41% disagreeing and the remainder unsure.

3.8 Comments mainly related to specific sections where respondents thought that greater detail was needed. Requests for more detail on specific sections needed to be balanced with other overarching concerns from some stakeholders that the guidance was becoming overly long and unwieldy. The text of this chapter has therefore been slimmed down where possible, with amendments intended to add clarity rather than volume.

Chapter 3

Does Chapter 3 clearly set out the LSCBs' responsibilities to improve the outcomes of children?

3.9 72% of 135 respondents agreed that Chapter 3 set out the LSCB responsibilities clearly. The main feedback received was in relation to the need for further clarity over the relationship between the Children's Trust Boards and the LSCB (see paragraphs 3.12–3.14, below).

Is the guidance clear enough on the responsibilities of LSCBs and partner agencies in relation to agreeing local thresholds for making referrals to children's social care services?

3.10 Responses to this question were mixed – 52% of 130 respondents said yes, 31% said no and 17% were unsure. Feedback highlighted the importance of having a common understanding of thresholds across local partners to ensure that appropriate referrals are made. Working Together has been strengthened in this area. Many respondents highlighted the importance of stating that the most effective arrangements happened by negotiation and agreement between local partner agencies – this has been highlighted in Working Together.

3.11 The interface and importance of CAF was a major issue raised – see paragraph 3.4 above.

Is the relationship between the LSCB and Children Trust Board clear?

3.12 The majority (62%) of the 136 respondents on this issue stated that the relationship between the LSCB and the Children Trust Board was clear. Some responses to the consultation, however, argued that the relationship between the two Boards needed further clarification. This view came out particularly strongly in the consultation events held by the National Safeguarding Delivery Unit.

3.13 Working Together has been strengthened in this area and the relevant section has been redrafted to be clearer on the relationship between the two Boards.

3.14 Respondents to the consultation also suggested that examples of governance arrangements between the two Boards would be helpful. The LSCB practice guidance resource pack that the NSDU has developed and published for consultation (alongside the publication of Working Together) includes a number of examples.

Are the expectations regarding the LSCB annual report clear?

3.15 There were 134 responses to this question. 84% of respondents felt that the expectations regarding the LSCB annual report were clearly set out in the consultation documents.

3.16 A few respondents suggested a range of issues that the annual report should cover and that had not been mentioned in Working Together in this context (e.g. honour based violence). We have not prescribed this level of detail in relation to the annual report. The guidance, however, makes clear that annual reports should provide an assessment of the effectiveness of local arrangements to safeguard and promote the welfare of children, set against a comprehensive analysis of the local safeguarding context. The report should recognise achievements and the progress that has been made in the local authority area as well as providing a realistic assessment of the challenges that still remain.

3.17 The annual report should demonstrate the extent to which the functions of the LSCB as set out in Working Together are being effectively discharged. This should include assessments of policies and procedures to keep children safe, including:

- the policies and procedures for the safe recruitment of frontline staff;
- an assessment of single and inter-agency training on safeguarding and promoting the welfare of children to meet the local needs;
- lessons learnt about the prevention of future child deaths which have been identified by the Child Death Overview Panel; and
- progress on priority issues (e.g. child trafficking, sexual exploitation and domestic violence).

3.18 Working Together has also been strengthened to ensure that the annual report should also include a clear account of progress that has been made in implementing actions from Serious Case Reviews completed during the year in question and, where action remained outstanding at the start of the reporting year, in Serious Case Reviews commissioned in previous years. Where Serious Case Reviews have been commissioned but not completed the annual report should note action already taken to learn lessons arising from the relevant cases.

3.19 The report should provide robust challenge to the work of the Children's Trust Board in driving improvements in the safeguarding of children and young people and in promoting their welfare.

3.20 Respondents suggested that a template for the annual report would be helpful. The LSCB practice guidance resource pack that the NSDU has developed and published for consultation includes one model template.

Are the expectations regarding the the appointment of lay members to the LSCB clear?

3.21 61% of respondents felt that the expectations were clear; 23% did not, and 15% were unsure. The main feedback was that examples of job descriptions and person specifications for the role would be very helpful. The LSCB practice guidance resource pack that the NSDU has published for consultation includes an example of an approach adopted by a LSCB where lay members have already been appointed.

Chapter 4

Are the respective roles and responsibilities of employers, Children's Trusts and LSCBs in respect of staff training set out clearly enough?

Would it be helpful to have more detail which sets out the generic elements of effective supervision for all types of practitioners?

3.22 66% of 137 respondents to the consultation question on training roles and responsibilities indicated that the relationship between the Children's Trust and the LSCB needed to be clearer in this respect. We have therefore strengthened the drafting, to make clear that:

- the Children's Trust is responsible for ensuring that workforce strategies are developed in their local areas;
- the LSCB is responsible for developing local policies for safeguarding and promoting the welfare of children in relation to the training of people;
- the LSCB should manage the identification of training needs and priorities and feed this back to the Children's Trust; and
- LSCBs should review and evaluate the provisions and availability of single and inter-agency training to ensure training reaches all relevant staff and feed this back to the Children's Trust.

3.23 The new table setting out suggested training for different target groups of staff at the end of this chapter has been well received.

3.24 In relation to supervision 77% of 133 respondents felt that the text was too heavily focused on social care and should be broadened out to include references to the importance of supervision for other professionals. We have therefore sought to strengthen the references to supervision in relation to other professionals.

Chapter 5

3.25 During the passage of the Apprenticeships, Skills, Children and Learning Act 2009 through Parliament, there was considerable debate about introducing legislation to require that a child be seen alone by a social worker when undertaking section 47 enquiries and during the time that a child is the subject of a child protection plan. In resisting this amendment, the Government gave a commitment to revise Working Together and consult on these revisions.

3.26 As agreed in Parliament, the consultation version of Working Together made it clear that the child should be seen by the lead social worker, alone when appropriate, in accordance with the agreed multi-agency plan. The social worker should record whether the child was seen alone, who else was present and the reasons for seeing (or not) the child alone. This revision was the subject of a specific consultation question.

Is the focus strong enough on understanding what the child's daily life experiences and wishes and feelings are when undertaking an assessment of a child in need and intervening, including where they are suspected to be suffering significant harm?

3.27 There were 125 responses to this question. 64% of responses agreed that the focus on the child's daily life experiences and ascertaining their wishes and feelings during assessments and interventions when working with children in need was strong enough. 26% considered it was not sufficiently strong and 10% were not sure. A number of respondents made the point that seeing a child alone was not in itself sufficient to develop a relationship with the child in order to develop mutual trust. The revised guidance has therefore been strengthened to emphasise the importance of having a child centred approach and of the lead social worker and other professional staff developing a therapeutic relationship with the child in the course of their direct work.

Is the guidance on when to make a referral to children's social care services clear?

3.28 There were 132 responses to this question. 66% of the responses considered that the guidance on when to make a referral to children's social care was clear. 18% responded that it was not and 15% were not sure.

3.29 In response to concerns raised about the relationship between the Common Assessment Framework practice guidance (Children's Workforce Development Council, 2009) and Working Together, the beginning of the chapter has been revised to make this relationship even clearer. In addition the guidance in Chapter 3 has been strengthened to emphasise the statutory responsibility of the Board to develop procedures and protocols on thresholds for referral to children's social care (see paragraph 3.4). The statutory guidance to Children's Trust Boards has also been strengthened to make it clearer that the Children's Trust has responsibility for the common assessment arrangements in the Board area.

3.30 A focus in the future work programme of the NSDU will be on supporting adult services to know when and how to make referrals to children's social care, in

particular where parental domestic violence, mental illness and substance misuse are identified in a family.

Do you agree with the proposal in Chapter 5 at 5.37 that an initial assessment, where one is undertaken, should be completed within a maximum of ten working days of the date of referral (this is a suggested change from the previous 7 day timeframe)?

3.31 There were 132 responses to this question. 74% of responses were in favour of the maximum timescale for initial assessments being increased from 7 to 10 working days. 14% were against it and 11% were not sure. (This is in line with responses to the separate consultation exercise on indicators and targets.)

3.32 Working Together incorporates this change. A number of the respondents also stressed the importance of continuing to focus on the quality of initial assessments. They did not want the change in timescales to detract from this.

For those looked after children who are also the subject of a child protection plan, do you agree that the child protection plan should form part of the looked after child's overarching care plan? Please give suggestions about how this proposal might be taken forward in practice.

3.33 There were 127 responses to this question. 85% of responses were in favour of the child protection plan being part of the child's care plan. 5% were not in favour of this proposal and 10% were not sure.

3.34 Responses to the public consultation on the Care Planning, Placement and Case Review (England) Regulations 2010 and accompanying statutory guidance *Putting Care into Practice*, which took place within a similar timeframe, were also positive about this proposed change. Those responding recognised however the different processes that are followed when reviewing child protection and child care plans. The proposed change is being incorporated into both Working Together and the Care Planning, Placement and Case Review (England) Regulations 2010 and accompanying statutory guidance but it is recognised that further detailed development work will need to be undertaken with looked after children, their parents and key professional groups including Independent Reviewing Officers about how to make this change work from a looked after child's perspective.

Chapter 6

This chapter provides references to other guidance which is supplementary to Working Together in respect of particular groups of potentially vulnerable children and categories of abuse. Do you have any comments on this chapter?

3.35 There were 125 responses to this question. 53% said yes; 43% said no and 4% did not know. The majority of respondents to this question were positive and welcomed the guidance included in this chapter. No additional issues have been included, as most of those proposed are already mentioned elsewhere in the guidance. Some drafting changes were made as a result of the consultation, mainly to reflect policy developments relating to child victims of trafficking such as the introduction of the National Referral Mechanism.

Chapter 7

3.36 Overall the changes to Chapter 7 have been welcomed and are regarded as reflecting the learning that has taken place since the child death review process became statutory from the beginning of April 2008. Clarity on the roles of registrars and coroners has also been welcomed, along with the increased clarity about how to respond appropriately to the deaths of children with life limiting illnesses.

The paragraphs on the roles and responsibilities of the Child Death Overview Panel (CDOP) now occur before those on the rapid response team. Does the revised structure of the chapter work? Please give any other suggestions for the order of these paragraphs.

3.37 There were 116 responses to this question. 73% of respondents found this change to be clear and the revised structure to provide a more logical and chronological approach to responding to both expected and unexpected child deaths. 22% of respondents were not sure and 5% disagreed with the change to the structure. As a result, the roles and responsibilities of the CDOP is now covered before discussion of the rapid response team.

Will the revised definition of preventability assist CDOPs in making decisions on whether a child's death was preventable? Please give any other suggestions for the definition.

3.38 There were 114 responses to this question. 57% of respondents agreed that the revised definition would assist CDOPs in making decisions on whether a child's

death was preventable and that the revised definition offered more clarity regarding preventable deaths. 33% of respondents were not sure and 10% said no.

3.39 Some of the responses asked for the revised definition to be supported by case studies, to show examples of the decisions made regarding preventability in a range of types of deaths.

3.40 To assist CDOPs we have commissioned the development of structured case studies. These will describe different scenarios and the decision made by the CDOP regarding whether the death could have been prevented, as well as the recommendations on what actions to take to prevent such deaths in the future. These illustrative examples are intended to assist panels in making consistent decisions as to whether a child death was preventable. The case studies will be published on the Every Child Matters website shortly.

Is the definition of 'unexpected ' child deaths clear? Please give any other suggestions for the definition.

3.41 There were 121 responses to this question. 77% of respondents agreed that the definition of 'unexpected' child deaths was clear. 13% of respondents were not sure and 10% said no. Therefore we have decided to retain the same definition in Working Together. The training materials of child death reviews will be updated to reflect this change.

Are the expectations regarding the involvement of parents in the process clear? Please give any suggested additions.

3.42 There were 125 responses to this question. 76% of respondents found that the expectations regarding the involvement of parents in the process were clear and that the guidance clearly indicated the level of involvement parents should have as well as the type of support they will need. 14% of respondents were not sure and 10% said no.

3.43 A number of consultation responses requested that the Government produce a national leaflet for parents, carers and family members to explain the child death review process.

3.44 The Government has commissioned the Foundation for Sudden Infant Deaths (FSID) to produce a leaflet which can be given to parents and members of the public to explain the child death review process and where they can obtain further information. The leaflet will be distributed to all LSCBs in March 2010. Reference to the leaflet has been included as a footnote in Chapter 7.

3.45 Some respondents argued that further guidance was required to explain why parents should not attend a CDOP meeting. We have revised the wording of Chapter 7 to clarify this position.

Chapter 8

3.46 The revised Chapter 8 has been integrated into the remainder of the statutory guidance. Although Chapter 8 was subject to a separate consultation exercise and was not included as part of the main public consultation on the rest of Working Together, the Government has taken the opportunity to strengthen further some of the requirements on Serious Case Reviews.

3.47 A template for executive summaries has been added to help ensure that all executive summaries provide a full, thorough account of SCRs and are transparent about the lessons that have been learnt and action that has been, and will be, taken. As part of their annual report every LSCB will need to include a progress update on the actions that have been taken in response to current and recent SCRs. A high level flowchart of the overall SCR process has been added, and minor revisions have been made to align Chapter 8 with the remainder of the guidance and provide greater clarity on the relationship between SCRs and child death review processes, and the role of Government Offices in providing advice, support, and challenge to LSCBs.

Chapter 9

Have you any suggestions about additional research findings that should be referred to in this chapter? Please give your suggestions with references.

3.48 There were 10 responses to this question. 50% of respondents did not have any suggestions for references to further research. 44% made other suggestions and 6% were not sure.

3.49 The chapter has been strengthened by cross-referencing to other key sources of relevant research reports and in particular the studies commissioned under the DCSF/DH research initiative. Where necessary the research findings on domestic violence, adult mental illness, substance misuse and learning disability have been updated.

Chapter 10

Are there other aspects of working with children and their families that you think ought to be covered in this chapter? Please give any suggested additions.

3.50 There were 109 responses to this question. 52% of respondents did not have any suggestions to other aspects of working with children and families that needed covering. 33% had other suggestions and 15% were unsure.

Chapter 11

Are there other groups of potentially vulnerable children or categories of abuse which you think should be mentioned in this chapter specifically?

3.51 There were 114 responses to this question. Responses were fairly evenly split: 42% of respondents to this question said that no further groups should be added, while 45% of respondents proposed adding particular additional groups of children. These included home educated children, children of substance misusing parents and those living away from home in a variety of other settings. Several of the groups suggested already feature elsewhere in the document, or are subgroups of those already identified in the chapter. The purpose of this chapter is to support the processes already set out for all children. No list of vulnerable groups can ever be fully comprehensive, and on balance adding further groups would add unhelpfully to the length of the document. However, a number of references to other pieces of guidance have been included.

Chapter 12

Are there other arrangements for managing individuals who pose a risk of harm to children which you think ought to be mentioned in this chapter? Please give any suggested additions.

Do you have any comments on the arrangements described in this chapter (e.g. MAPPA, MARAC)? Please give your comments.

3.52 There were 110 responses to this question. 30% suggested other arrangements; 55% did not and 15% were unsure. A section on the Child Sex Offender Review Disclosure process has been added in order to bring this section up to date.

3.53 63% of 104 respondents for the feedback in relation to the question inviting comments on the arrangements described in this chapter did not have any comments, whilst 29% did and 8% were not sure.

4. Annexes

Annex A: The Protection of Children in England: A Progress Report – Working Together recommendations

The Government's response to Lord Laming's report committed to addressing the following recommendations in the revised *Working Together to Safeguard Children* statutory guidance. This list excludes those recommendations that relate to Chapter 8 on Serious Case Reviews, which was subject to a separate consultation[3] and includes a commitment from the Government's action plan.

Recommendation 6

Directors of Children's Services, Chief Executives of Primary Care Trusts, Police Area Commanders and other senior service managers must regularly review all points of referral where concerns about a child's safety are received to ensure they are sound in terms of the quality of risk assessments, decision making, onward referrals and multi-agency working.

Recommendation 7

All Directors of Children's Services who do not have direct experience or background in safeguarding and child protection must appoint a senior manager within their team with the necessary skills and experience.

Recommendation 9

Every Children's Trust should ensure that the needs assessment that informs their Children and Young People's Plan regularly reviews the needs of all children and young people in their area, paying particular attention to the general need of children and those in need of protection. The National Safeguarding Delivery Unit should support Children's Trusts with this work. Government Offices should specifically monitor and challenge Children's Trusts on the quality of this analysis.

Recommendation 11

The Department for Children, Schools and Families should revise Working Together to Safeguard Children to set out clear expectations for all points where concerns about a child's safety are received, ensuring intake/duty teams have sufficient training and expertise to take referrals and that staff have immediate, on-site support available from an

3 Public consultation on a revised Chapter 8 of Working Together ran from 31 July to 23 October 2009. Government's response to this consultation is available at www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/seriouscasereviews/scrs/.

experienced social worker. Local authorities should take appropriate action to implement these changes.

Recommendation 13

Children's Trusts must ensure that all assessments of need for children and their families include evidence from all the professionals involved in their lives, take account of case histories and significant events (including previous assessments) and above all must include direct contact with the child.

Recommendation 14

Local authorities must ensure that 'Children in Need', as defined by Section 17 of the Children Act 1989, have early access to effective specialist services and support to meet their needs.

Recommendation 16

The Department for Children, Schools and Families should revise Working Together to Safeguard Children to set out the elements of high quality supervision focused on case planning, constructive challenge and professional development.

Recommendation 19

The Department for Children, Schools and Families must strengthen Working Together to Safeguard Children, and Children's Trusts must take appropriate action to ensure:

- *All referrals to children's services from other professionals lead to an initial assessment, including direct involvement with the child or young person and their family, and the direct engagement with, and feedback to, the referring professional; core group meetings, reviews and casework decisions include all the professionals involved with the child, particularly police, health, youth services and education colleagues. Records must be kept which must include the written views of those who cannot make such meetings; and*
- *formal procedures are in place for managing a conflict of opinion between professionals from different services over the safety of a child.*

Recommendation 20

All police, probation, adult mental health and adult drugs and alcohol services should have well understood referral processes which prioritise the protection and well-being of children. These should include automatic referral where domestic violence or drug or alcohol abuse may put a child at risk of abuse or neglect.

Recommendation 22

The Department for Children, Schools and Families should establish statutory representation on Local Safeguarding Children Boards from schools, adult mental health and adult drug and alcohol services.

Recommendation 23

Every Children's Trust should assure themselves that partners consistently apply the Information Sharing Guidance published by the Department for Children, Schools and Families and Department for Communities and Local Government to protect children.

Recommendation 25

Children's Trusts should ensure a named, and preferably co-located, representative from the police service, community paediatric specialist and health visitor are active partners within each children's social work department.

Recommendation 29

Children's Trusts should ensure that all staff who work with children receive initial training and continuing professional development which enables them to understand normal child development and recognise potential signs of abuse or neglect.

Recommendation 30

All Children's Trusts should have sufficient multiagency training in place to create a shared language and understanding of local referral procedures, assessment, information sharing and decision making across early years, schools, youth services, health, police and other services who work to protect children. A named child protection lead in each setting should receive this training.

Recommendation 51

The Children's Trust and the Local Safeguarding Children Board should not be chaired by the same person. The Local Safeguarding Children Board chair should be selected with the agreement of a group of multi-agency partners and should have access to training to support them in their role.

Recommendation 52

Local Safeguarding Children Boards should include membership from the senior decision makers from all safeguarding partners, who should attend regularly and be fully involved as equal partners in Local Safeguarding Children Board decision making.

Recommendation 53

Local Safeguarding Children Boards should report to the Children's Trust Board and publish an annual report on the effectiveness of safeguarding in the local area. Local Safeguarding Children Boards should provide robust challenge to the work of the Children's Trust and its partners in order to ensure that the right systems and quality of services and practice are in place so that children are properly safeguarded.

The Protection of Children in England: Action Plan

The wider public also has an important role to play, as keeping children safe is everyone's responsibility. It is right that Children's Trust Boards should actively seek the views of the local community and consult children, young people and their families when drawing up Children and Young People's Plans. We believe Local Safeguarding Children Boards arrangements should be opened up to wider public scrutiny through the appointment of two lay members drawn from the local community to the LSCB and we have brought forward an amendment to the Apprenticeships, Skills, Children and Learning Bill to require this. This will support stronger public engagement in, and understanding of, children's safety issues. The voice and experiences of young people should also strongly inform the LSCB's work.

Annex B: List of Respondents[4]

- Action for Children
- Advanced Childcare Limited
- Argon Associates Ltd
- Association of Directors of Children's Services
- Association of Lawyers for Children
- Audit Commission
- Avonsafe
- Barking and Dagenham CHS
- Barnardo's
- Barnet LSCB
- Boobyer, Roma (Leicester City Community Health Services)
- Boynton, Emily (Surrey County Council)
- Bracknell Forest LSCB
- Bradford Safeguarding Children Board
- Brent LSCB
- British Association for Sexual Health and HIV (BASHH)
- British Association of Social Workers (BASW)
- Brook
- Buckinghamshire Safeguarding Children Board
- Bury Safeguarding Children Board
- Cafcass
- Cambridge University Hospitals NHS Foundation Trust
- Cambridgeshire County Council
- Cambridgeshire County Council Children's Services
- Cambridgeshire Football Association
- Cambridgeshire LSCB

4 26 confidential responses and 4 anonymous responses were received.

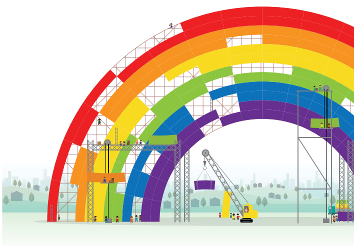
- Care Quality Commission
- Catholic Education Service for England & Wales
- Centre 33
- Children Are Unbeatable!
- Children's HIV Association of UK and Ireland
- Children's Rights Alliance for England
- Children's Society
- Children's Workforce Development Council
- Churches' Child protection Advisory Service (CCPAS)
- City Parochial Foundation
- Clarke, Jennifer
- Co-ordinated Action Against Domestic Abuse (CAADA)
- Crown Prosecution Service
- Catholic Safeguarding Advisory Service (CSAS)
- Cumbria LSCB
- DAAT
- Derbyshire LSCB
- Devon LSCB
- Durham LSCB
- Ealing Safeguarding Children Board
- East London NHS Foundation Trust
- East Sussex and Brighton & Hove CDOP
- Education Otherwise
- Enfield Safeguarding Children Board
- ESDW PCT/Hastings and Rother PCT
- Family Action
- Family Rights Group
- FPA
- Gateshead LSCB

- Goode, Sharron (Herefordshire Council)
- Goodwin, Denise
- Government Office for the South East
- Great Ormond Street Hospital for Children NHS Trust
- Greater London Domestic Violence Project
- Halton and St Helens PCT
- Hamilton, Sarah (NHS)
- Haringey Local Safeguarding Children Board
- Hart, Simon (Barnsley LSCB/LA)
- Herefordshire Safeguarding Children Board
- Hertfordshire Safeguarding Children Board
- HIOW LSCB CDOP
- Hogarth, Sheila (North Tyneside PCT)
- Hull Safeguarding Children Board
- Kent County Council Children's Services
- Kent Offending Service
- Kent Police
- Lancashire Safeguarding Children Board
- LB Tower Hamlets, Children's Social Care
- Leeds Children's Services/LSCB
- Lessof, Nick
- Lenaghan, Marian (Nottinghamshire Community Health)
- Lindley, Graham
- Links Group for Vulnerable Children, Adults and Animals
- Livesey, Anne
- Local Government Association (LGA)
- London Assistant Directors and Heads of Children's Social Care
- London Borough of Camden
- London Safeguarding Children Board

- Lucas, Ann (Sheffield City Council)
- Lucy Faithfull Foundation
- Meacher, Molly (East London Foundation Trust)
- Mencap
- Mitchell, Claire
- Murphy, Michael (University of Salford)
- NACRO
- NASUWT
- National Childminding Association
- National Children's Bureau (NCB)
- National Deaf Children's Society
- National Information Governance Board for Health and Social Care (NIGB)
- National Treatment Agency
- National Working Group on Child Protection and Disability
- NAVCA
- Newham LSCB
- NHS Brighton & Hove
- NHS Camden Provider Services
- NHS Doncaster
- NHS East Lancashire Community Health Services
- NHS Eastern and Coastal Kent
- NHS London
- NHS Sutton and Merton
- NHS West Midlands
- NHS West Sussex
- NHS Western Cheshire
- Northamptonshire LSCB
- North East London Foundation Trust
- Northumberland Safeguarding Children Board

- Northumbria Police
- NSPCC
- Oldham LSCB
- Oxfordshire CDOP
- PCCSF
- Peterborough Safeguarding Children Board
- Portsmouth LSCB
- Pre-school Learning Alliance
- Probation Chiefs Association
- Pumfrey, William
- Rotherham Metropolitan Borough Council
- Royal Berkshire Hospital Department of Community Paediatrics
- Royal College of Nursing
- Scott, Janis
- Sefton CDOP
- Shaw, Liz (London Borough of Barnet)
- Sheffield LSCB
- Smith, Hilary (Royal Manchester Children's Hospital)
- Smith, Hilary (Salford PCT)
- Smith, Joanne (Great Western Hospital Foundation Trust)
- Social Landlords Crime and Nuisance Group
- Somerset LSCB
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust
- South Tyneside LSCB
- South Yorkshire Safeguarding Children Nurses
- Southampton LSCB
- Southend Essex and Thurrock Strategic Child Death Overview Panel
- Southwark Safeguarding Children Board
- Staffordshire Safeguarding Children Board

- Stanley, Nicky (University of Central Lancashire)
- Suffolk SCB
- Tees CDOP
- Tees Local Safeguarding Children Board
- Telford & Wrekin Safeguarding Children Board
- Thick, Tony (Freeman Clinics Ltd)
- Thomas, Dorothy (NHS North Staffordshire)
- Tunbridge Wells Borough Council
- Unite/CPHVA
- Verkuyl, Douwe
- Vieira, Natalie
- Voice
- Warrington Local Safeguarding Board
- Warwickshire LSCB
- Watkins, Sue (Torbay Care Trust)
- West Mercia Police
- West Midlands Police Public Protection Support Unit, Crime Support
- West of England Child Death Overview Panel
- West Yorkshire Police
- West Yorkshire Probation Board
- White, Sue
- Whitehead, Jenni (Editor, Child Protection Update)
- Whitney, Ben
- Whitstone Head School
- Windsor and Maidenhead LSCB
- Women's Aid Federation of England (Women's Aid)
- Wolverhampton SCB
- Yorkshire Ambulance Service NHS Trust
- Youth Justice Board for England and Wales



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