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DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

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Care and Social Services Inspectorate Wales

HM Inspectorate of Probation
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HMIC
Inspecting policing in the public interest

Joint Inspection of Local Safeguarding Children Boards 2011

Overview

October 2011

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ISBN 978 0 7504 6650 9

WG 13560 (8)

Contents

Executive Summary

1. Safeguarding children and young people and protecting them from harm is crucial to the future and well-being of our society.

2. A core element of the Children Act 2004 Act was the requirement that each local authority establish a Local Safeguarding Children Board for their area. The Act places duties on specified agencies

> *(a) to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established*
>
> *(b) to ensure the effectiveness of what is done by each person or body for those purposes*

3. There were 19 LSCB's operating in Wales at the time of this inspection.

Purpose of the review

4. In 2008 Care and Social Services Inspectorate Wales (CSSIW), Estyn (the office of Her Majesty's Inspectorate for Education and Training), Healthcare Inspectorate Wales (HIW), Her Majesty's Inspectorate of Probation (HMI Probation), and Her Majesty's Inspectorate Constabulary (HMIC) all gave a clear commitment to resource a joint national inspection of LSCBs to reinforce the multi-agency nature of safeguarding and child protection. A significant programme of work followed across the inspectorates to develop a shared inspection framework for Local Safeguarding Children Boards.

5. The inspection evaluated the effectiveness of LSCBs using the framework of the self assessment and improvement tool (SAIT) which was commissioned by CSSIW, developed by independent researchers and

piloted by seven LSCBs. National benchmarks and descriptors for measuring LSCBs performance were agreed in 2008.

Main Findings

6. Since the publication of the report of Lord Laming's inquiry into the death of Victoria Climbié in 2003, a huge amount of work has been undertaken at national and local levels, with significant legislative, organisational and practice change taking place. Overwhelmingly, the cumulative evidence from previous inspections and performance data is that children are now better safeguarded and protected than they were prior to the changes which followed Lord Laming's report.

7. Statutory agencies, organisations, managers and professionals are working hard individually and collectively to do what is the very demanding, complex and difficult work of safeguarding and protecting children.

8. Despite this, the findings from this joint inspection are that generally LSCBs are not effectively fulfilling their responsibilities as set out in Section 31 (1) of the Children Act 2004. Fundamentally, they have difficulty in demonstrating how they are improving outcomes for children. There is no single or simple explanation for this situation as there are many factors which contribute to the success or failure of LSCBs.

9. This inspection has identified seven key factors which contribute to the effectiveness of LSCBs and which need to be addressed in further improving arrangements to safeguard and protect children in Wales. These are set out below.

Leadership

10. While LSCBs have been established to co-ordinate and ensure the

effectiveness of the work of organisations and professionals to safeguard and promote the welfare of children and young people, they do not have the power to direct them. LSCBs can therefore only drive change and improvement where there is a shared commitment and collective responsibility amongst all its members. While responsibility for establishing and the effective working of LSCBs rests with the local authority, a shared commitment to strong and effective leadership amongst the statutory partner organisations is essential. The chair of the LSCB has a key role to play in this. There is no evidence in Wales that where independent chairs have been appointed that this has improved leadership or the commitment of the member organisations. Securing effective leadership of the LSCB is crucial to its success, but the current arrangements are not consistently delivering this.

Governance and Accountability

11. *Safeguarding Children: Working together under the Children Act 2004* states that:

    - Each local authority should take lead responsibility for the establishment and effective working of LSCBs, although all main constituent agencies are responsible for contributing fully and effectively to the work of the LSCB.

    - LSCBs must be accountable for their work to their main constituent agencies, whose agreement is required for all work which has implications for policy, planning and the allocation of resources.

    - LSCBs programmes of work should be agreed and endorsed at a senior level within each of the main member agencies, within the framework of the Children and Young People's Plan.

12. The inspection found that in practice LSCBs are not accountable to and are not being held to account by statutory bodies or partner agencies.

There are no local mechanisms in place to scrutinise the work of LSCBs by external organisations. There was little evidence of effective challenge within LSCBs. LSCBs are not able to demonstrate that they can effectively hold statutory and partner agencies and partnerships to account. It is difficult to see how improvements to LSCBs can be made without clearly addressing the issues of governance and accountability.

Strategic Direction

13. Most LSCBs had established their strategic intent, high level aims and objectives . However, the inspection found that often there was little evidence of a shared understanding of the strategic direction and related activities by members or other partnerships. Further, it was difficult to see how the views of children, young people, practitioners and others influenced the LSCBs strategic direction and in turn, how the strategic direction is influencing practice on the ground. Limited performance management and a lack of effective citizen engagement raises the question as to how LSCBs can be confident that their strategic direction is the right one.

Structures

14. LSCBs operate within a complex framework of partnerships and organisational structures. These include Health, Social Care and Well Being Partnerships, Community Safety Partnerships, Children and Young People's Partnerships (CYPP) and Local Service Boards (LSB); four police authorities, seven local health Boards and 22 local authorities. On the one hand, this results in many of the same people sitting on more than one partnership, which can lead to the responsibilities of the partnerships becoming blurred (e.g. some CYPPs taking responsibility for safeguarding) and on the other hand a range of different people from one agency being involved in different partnerships and there being little clarity about how the cross cutting issues are dealt with. Recognising this, *Safeguarding Children: Working together under the Children Act 2004*

recommended, although did not make it mandatory, that consideration be given to the establishment of a Strategic Co-ordination Group in each local authority area to oversee the strategic operation of LSCBs and the partnership arrangements. The subsequent establishment of LSBs may have led to a view amongst some parties that LSBs could or should be fulfilling this role. There was some evidence of good partnership working as well as confusion about roles and responsibilities amongst the partners and partnerships. The evidence from this inspection points to the need for simplification and clarity of partnership arrangements.

Funding

15. To function effectively LSCBs need to be supported with sufficient and reliable resources. The Children Act 2004 places an obligation on statutory LSCB partners to support the operation of the LSCB either through direct funding or through the provision of staff, goods, services, accommodation or other resources. LSCB member organisations are together responsible for determining what resources are needed and how they will be provided. In practice, few LSCBs had agreed long term appropriate funding formulae and budgetary mechanisms. Many relied too heavily on the local authority to fund its activities. This is unsustainable and further reinforces the misconception that LSCBs are primarily the responsibility of local authorities. The funding arrangements for LSCBs have been a source of tension and dispute since their creation and this inspection confirmed that this continues to be the case. For LSCBs to function effectively there is a need to have in place secure arrangements which ensure appropriate levels of funding and resourcing to enable them to fulfil their responsibilities.

Performance Management and Quality Assurance

16. There is little evidence of meaningful outcome data and information being collected by LSCBs. There is a lack of a clear line of sight between the LSCB and front line practitioner and vice-versa. There is limited information about how the work of the LSCB is impacting on safeguarding

outcomes for children and young people. Without this it is difficult to determine if the strategic objectives of the LSCB are being achieved, or whether they are the right objectives. The absence of an outcome framework with clear shared objectives and milestones means that LSCBs find it very difficult to evaluate and evidence the impact of their work for the benefit of children and young people.

17. Despite all LSCBs having arrangements for undertaking multi-agency case audits, the quality of these is generally poor, sometimes they were not multi-agency, in most cases they did not fully identify the safeguarding issues. Reporting arrangements to the LSCB were weak with little evidence of challenge. Case audits are not enabling LSCBs to identify best practice or poor practice to improve the safeguarding and protection of children.

18. Although multi-agency training was a strong feature in LSCBs, there was limited evidence that this was being rigorously evaluated to ensure that staff received the appropriate level of training in accordance with their professional needs and responsibilities.

Citizen Engagement - Engaging with children, young people and others

19. While the inspection identified some innovative practice in terms of engagement, it found limited evidence of comprehensive approaches to engagement with children and young people, parents, carers and wider communities. Individual agencies have a range of approaches for engaging with citizens and local communities, but together as LSCBs this remains an area to be developed. In the absence of such engagement it is difficult for LSCBs to demonstrate to citizens how they are discharging their responsibilities. Effective engagement with citizens is essential if LSCBs are to demonstrate that their work is meeting the needs of local communities, doing the right things, in the right way, for the right people and at the right time

Summary

20. LSCBs were established in 2006 and there has been much activity since then to develop and build them. However, the findings from this inspection show that despite this, LSCBs are not yet able to effectively demonstrate how they are improving outcomes for children and young people in terms of safeguarding and promoting their welfare. This doesn't mean that organisations and professionals are not safeguarding and protecting children, nor does it mean that the work of LSCBs is having no impact on safeguarding outcomes for children. It means that they are unable to clearly evidence the impact of their work.

21. For LSCBs to have the lead role in safeguarding and protecting children and young people, they must be able to clearly demonstrate how their work is leading to improved safeguarding and protection of children.

22. If LSCBs are to deliver their statutory responsibilities to safeguard and promote the welfare of children the findings from this inspection need to be addressed at a national and local level.

23. There is a need for clear strategic direction at a national level with well defined objectives and outcomes, which also facilitate local decision making to meet the needs of children in their local communities. LSCBs must be enabled to effectively harness the collective resources, professional skills and knowledge of all agencies in safeguarding and protecting children. In return they must become clearly and publically accountable for their work to their local communities and nationally.

Section One: Introduction and background

Introduction

24. This overview report presents the findings of a national joint inspection of Local Safeguarding Children Boards (LSCBs) which included fieldwork visits to seven LSCBs carried out by inspectors from the Care and Social Services Inspectorate Wales (CSSIW), Estyn (the office of Her Majesty's Inspectorate for Education and Training), Healthcare Inspectorate Wales (HIW), Her Majesty's Inspectorate of Probation (HMI Probation), and Her Majesty's Inspectorate Constabulary (HMIC) between November 2010 to March 2011.

25. A core element of the Children Act 2004 Act was the requirement that each local authority establish a Local Safeguarding Children Board for their area. The Act places duties on specified agencies:

- Local authority children's services;
- Local health boards;
- NHS trusts
- Police services;
- Probation services; and
- Youth offending teams

(a) to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established

(b) to ensure the effectiveness of what is done by each person or body for those purposes

Background to the inspection

26. Following the introduction of LSCBs in October 2006 CSSIW, HIW, Estyn, HMI Probation, and HMIC, all gave a clear commitment to resource a joint national inspection of LSCBs to reinforce the multi-agency nature of safeguarding and child protection. A significant

programme of work followed across the inspectorates to develop a shared inspection framework for Local Safeguarding Children Boards.

27. The initial action was the development of an evidenced based self assessment and improvement tool (SAIT) for LSCBs in Wales. The purpose of this was to provide:

- LSCBs with a mechanism for evaluating their own performance
- shared descriptors for the functioning of LSCBs
- a base line for multi-agency inspection of LSCBs

28. The SAIT was commissioned by CSSIW, developed by independent researchers and piloted by seven LSCBs. National benchmarks and descriptors for measuring LSCBs performance were agreed in 2008.

29. In November 2008, following the death of baby Peter Connelly in Haringey, the Welsh Assembly Government undertook a series of actions to evaluate the adequacy of the arrangements in place across Wales to safeguard and protect children and young people. As part of these steps chairs of LSCBs were requested to provide an assessment of the effectiveness of their Boards by February 2009. These were later evaluated and tested by Care and Social Services Inspectorate Wales (CSSIW) through visits to every Welsh local authority and LSCB[1].

30. The SAIT was formally launched in May 2009 providing a shared standard against which further work could be measured.

31. The findings from the CSSIW visits to local authorities during 2009 culminated in a report: '*Safeguarding and Protecting Children in Wales: the review of Local Authorities and the Local Children Safeguarding Boards'* which was published by CSSIW in October 2009.

32. Overall the report identified that despite having a clear statutory basis individual Boards had not developed at the same pace. A number had

[1] Safeguarding and Protecting Children in Wales: The review of Local Authorities and the Local Safeguarding Boards [October 2009]

not secured the participation of all relevant agencies or the involvement of agencies at a senior enough level to make decisions and there was no evidence of alignment between the effectiveness of LSCBs and the quality of safeguarding practice, despite this being their primary purpose. Most LSCBs had no mechanism for evaluating how the work of the Board improved outcomes for children.

Methodology for joint inspection of LSCBS

33. The findings from the 2009 CSSIW inspection with other inspection reports provided base line evidence regarding the maturity and challenges facing LSCBs. This informed the parameters of the joint inspection in 2011.

34. In 2010 all LSCBs returned a completed a self evaluation using the SAIT. LSCBs had to assess their work against the five domains:

    - Improving safeguarding outcomes for children
    - Establishing the Board's strategic direction
    - Establishing effective governance
    - Building capacity
    - Delivering outputs

35. These are identified in the SAIT as critical to the effectiveness of working together to safeguard children in multi-disciplinary strategic partnerships

36. A pilot inspection of an LSCB took place in November 2010 and between January and March 2011 a team of inspectors from CSSIW, HIW, Estyn, HMI Probation and HMIC made site visits to a further six LSCBs.

37. The site visits focused on verifying the self evaluations of LSCBs and the progress that had been made by authorities in establishing an effective LSCB in accordance with the Welsh Government's guidance *Safeguarding Children - Working Together under the Children Act 2004.*

38. The site visits by inspectors were for a period of three days and

included observation of an LSCB meeting, interviews with the chair and vice-chair of the Board, statutory and non statutory members, and professional advisors as well as with the chairs of the other partnerships.

39. Inspectors scrutinised samples of cases audited by the LSCB, tracking the input and role of each agency involved. The focus of this activity was to identify how the Board gained a view of multi-agency safeguarding practice, the scope for professional challenge to promote learning and how this improved and informed front line practice.

Section Two : Findings

The main findings are grouped under the five domains evaluated by the inspectorates.

1. Self assessment

1.1 The joint inspection identified that elements of the LSCBs 'self assessment' of their own effectiveness was over-optimistic. It was clear that significant work was ongoing in all of the LSCB areas visited. A level of goodwill and a commitment to partnership working was in place, but in practice this was variable. There was a lack of rigour in the self assessment in some areas.

1.2 The SAIT was generally viewed as helpful in providing clarity about the building blocks for effective partnership working. However, the verification of the self assessments highlighted that a number of the LSCBS had not established the strong identity needed to ensure effective multi-disciplinary strategic partnerships, working to safeguarding children.

2. Improving safeguarding outcomes for children

2.1 LSCBs were unable to evidence how their work was improving safeguarding outcomes for children. They had very limited qualitative and quantitative information about safeguarding outcomes, and performance measurement was weak. There were no explicit outcome measures (which would usually be qualitative) described or prescribed by most LSCBs. Despite the availability of data there was little outcome information. Where there was some, there was little analysis. There was a lack of clarity about the desired outcomes from the work and about how to measure improved outcomes. LSCBs were able to identify

collective and individual agency outputs, but they could not link this to improvements in safeguarding and child protection outcomes for children receiving services. Nor could they evidence how their work with other partnerships was improving safety for all children. This is a fundamental weakness and while all Boards emphasised their commitment to working together on shared outcomes, there was little clarity about how to achieve this. Many Boards indicated that they would welcome the development of a national outcome framework to support them in their work.

2.3 Some Boards had identified particular groups of vulnerable children and young people whom they had prioritised, but this activity was often incident-driven and not part of an explicit agreed strategy. There were some examples of good work in attempting to improve outcomes for children in specific groups. One LSCB had conducted a review of children on the register to establish the rate of re-registration within a short period of time. This highlighted several important practice and policy issues for statutory agencies. In another example, a Board examined the statistical returns on domestic violence incidents which revealed that agencies had identified high levels of domestic violence assaults on pregnant women. This had challenged the Board to re-examine some policies and practices across agencies involved with these identified groups.

2.4 Some LSCB's had sought to identify the improvements made for children and young people subject to child protection procedures and plans. But the information considered often only related to process and outputs rather than outcomes. Data is predominantly collected in relation to one agency, social services, and there is little information regarding the service users' experience. There is evidence across LSCBs that different agencies had information about a wide range of vulnerable children and families but this was not being brought together to underpin a shared

outcome framework. Some Boards were looking to develop a results-based accountability model but this work seemed to be at an early stage and is not well understood by all members. Although unable to evidence improvements in relation to agreed outcomes for children, LSCB members reported that the process of agencies meeting regularly and having the opportunity to build relationships was important in itself and acted to improve local multi agency practice. While the importance of these relationships is recognised, the inspection found little evidence in terms of improved safeguarding outcomes for children and young people to support this.

2.5 LSCBs had not identified how their own work or that with other partnerships was improving safety for all children. The LSCB cannot undertake this work alone and most Boards had held development days with other partnerships about their respective safeguarding roles. There was considerable variability across Boards and between Board members regarding their understanding of the wider safeguarding agenda and there was little evidence that any LSCB has yet progressed to defining outcomes or setting objectives to improve the safety of all children.

Improving Outcomes for Children

Good practice:

- An audit undertaken by Wrexham Safeguarding Children Board identified that the Youth Offending Team had worked hard to advocate on behalf of a 17 year old with a troubled background and learning difficulties. His vulnerability and need for suitable accommodation were highlighted to both children's and adult social services. Once in settled housing the file was referred as an LSCB 'case of special interest' so that lessons could be learnt and good practice highlighted.

Quality assurance

- Caerphilly Safeguarding Children Board has developed systems to collect and analyse safeguarding data from a range of sources.

- Rhondda Cynon Taff Safeguarding Children Board uses performance data from children's social services alongside other data from Health Social Care Wellbeing Partnership ,Youth Offending Team and Community Safety Partnership to provide some proxy indicators as a means of understanding outcomes

3. Establishing the Board's strategic direction

3.1 There was limited or no line of sight to practice in LSCBs. Strategic documents tended to be aspirational, with an over-emphasis on the work of individual agencies as opposed to demonstrating a shared understanding and collective approach. There was an absence of synergy within the LSCB and little collective identification as a Board. There was not always a clear and shared understanding about which elements of safeguarding LSCBs were accountable for. Some LSCBs had identified the vulnerability of specific groups of children and had developed activities to address these. Overall, there was a marked absence of SMART[2] objectives which limited the ability to measure any progress or achievement. There was a lack of clarity about how partners held each other to account.

3.2 There was significant variance in LSCBs' understanding of their shared strategic direction. Most Boards had overestimated the progress that they had made in this area. Most Boards had recognised the need to have a shared understanding about the elements of safeguarding they were accountable for, but inspectors found that not all members were able to articulate their Board's strategic direction. It was rare for any service user's experience to inform the Board's strategic direction. In a number of instances LSCBs had not adhered to stated objectives due to competing demands such as serious case reviews, changes in

[2] SMART is specific, measureable, achievable, realistic and timelimited.

personnel and the configuration of the Board A considerable range of innovative work was being undertaken in relation to various groups of vulnerable children although much of this seemed to be reactive. Partners struggled to give a consistent account of which groups of children and young people the LSCB was accountable for and there was a lack of clarity regarding the objectives they were progressing to improve the quality of safeguarding for specific groups of children.

3.3 It was evident that the partnership working ethos was strong across the LSCBs but inspectors found that most agencies saw the LSCB as a responsibility of social services. A recurring issue was the need for the Board to be assured that its members' constituent agencies had an organisational understanding of their responsibilities and their role in delivering this. Often member agencies were found to identify with their own agencies priorities, contributing agency work on child protection to the overall position of the LSCB rather than delivering against a shared LSCB strategic direction. The lack of clarity regarding the Board's objectives and outcomes made it difficult for LSCBs to demonstrate their effectiveness in holding statutory partners to account. Generally, members reported that LSCBs were effective in promoting a professional trust between individuals which enable them to escalate and resolve operational issues. However, overall LSCBs are reliant on individual agencies reporting and evaluating their own performance. There was little evidence of challenge or detailed scrutiny of agency activity. Most Boards viewed this as something that they were working on but there was little confidence that the LSCB had any real ability to effectively hold member agencies account.

3.4 Most Boards had held development days with other strategic partnerships to determine lines of communication and accountability regarding safeguarding priorities. The LSCB has been a driver in promoting these activities. However, inspectors found that members of the various partnerships were not clear regarding the strategic inter-

relationships e.g. some partnerships did not recognise that their work supported the wider safeguarding agenda. Some partners had developed communication links between the various partnership groups although these were largely dependent on the cross over membership. Some Boards had sought to further formalise this and had negotiated reporting arrangements, or had designated partnership members as safeguarding champions.

Establishing a Strategic Direction

Good practice:

Working across Partnerships

- Monthly meetings between the Chairs of the partnerships in Caerphilly helped to develop understanding and joint work.

Working with specific groups

- Caerphilly Safeguarding Children Board had developed a guide for keeping children safe when using technology.
- Cardiff Safeguarding Children Board had promoted a multi agency initiative "Think Family "

4. Establishing effective governance

4.1 LSCBs had terms of reference, and arrangements in place to govern their operation. In practice the collective ownership of these was not always underpinned by a clear understanding of what this meant amongst individual partner agencies. There was limited evidence as to how the independent identity of the LSCB was established and widely recognised. There was a strong reliance on commitment from individuals rather than at an agency and Board level. Systems to ensure

multi- disciplinary practice were not well developed. There was little evidence that safe recruitment practices in partner agencies were checked by the LSCBs. Much time and resource was given to conducting serious case reviews and in responding to them, but generally LSCBs were unable to evidence how their actions in response to serious case reviews had improved outcomes for children and young people. Where LSCBs had appointed a business manager, this made a significant contribution to improving the overall operation of the LSCB.

4.2 Inspectors saw limited evidence of Boards having independence and individual identity, in part due to the frequent change of membership and inconsistencies in agencies' commitment to sending members to the Board meetings. The capacity of members to dedicate time and resources to the work of the Board was sometimes an issue of balancing the demands with their own agency's tasks and priorities. There was no clear knowledge or experience criteria set for most of the members of the Boards and not all Board members were clear what elements of safeguarding they were responsible for. Some job descriptions and role descriptions had been developed but it was unclear if they were acted upon and reviewed or appraised in all Boards. The membership of most Boards complied with the regulations specified in *Safeguarding Children: Working Together Under the Children Act 2004* although this fluctuated depending on staff changes.

4.3 A number of LSCBs found it difficult to demonstrate how they held individual agencies to account for anything other than attendance at meetings. There was a general lack of clear business planning across the Boards with little emphasis on benchmarking to measure overall effectiveness. Objectives and priorities were not always clear or visible nor were the mechanisms for measuring outputs or outcomes. There was heavy reliance on individual commitment to drive pieces of work forward in some cases rather than the Board setting out clearly defined objectives. Where key personnel were members of different partnerships, there was evidence of good sharing of ideas and policy initiatives across partnership bodies, but this was not always driven by Boards to ensure that communications were formalised. It was positive that most Boards had now introduced an audit of member agencies duties under Section 28 of the Children Act 2004 but there was limited auditing of the quality or the accuracy of Section 28 audits by LSCBs themselves.

4.4 Each LSCB had established an audit subgroup to provide LSCBs with information regarding front line practice. LSCBs saw auditing of cases as a means of having a line of sight on practice and of providing quality assurance. Inspectors found that the configuration of these sub groups varied across LSCBs and that generally the audit process lacked clarity and rigour. Audit sub groups were finding it difficult to identify a consistent audit tool or process that provided the range of information that they wanted. Some audits were process driven and missed the child and family experience. Inspectors were particularly concerned about the quality, and in some cases the quantity, of case audits which sub groups of all LSCBs undertook. This work rarely included full representation from all agencies, it lacked rigour and there was little evidence of challenge from within the LSCBs. The learning that took place tended to stay in the sub groups because of limited engagement with frontline staff. There was a lack of agency commitment to the collective work of the LSCB as an independent body.

4.5 Attendance at the sub groups was inconsistent with not all agencies well represented. Those involved in the audit did not always reflect those organisations involved with the child and family. Exclusion of agencies from the audit process was generally due to the make up of the standing audit group or a lack of understanding regarding agency involvement. Inspectors were surprised that the relevant agencies and the LSCB had not challenged this when the audit findings were reported to the Board. The terms of reference for audits were not always clear, most focused on process and compliance rather than the outcome for the child. Recommendations to the Board were not always underpinned by a clear understanding of the child's experience. Few Boards had developed feedback systems to promote learning for front line staff although some Boards had made links between the audit and training sub groups.

4.6 Overall there were few systems in place to ensure governance of multi-agency / multi-disciplinary practice. There were infrequent challenges between agencies regarding practice and learning. Where improvements in practice were identified it was not always clear that this had been ratified by all agencies, put into practice or reviewed for its effectiveness. Case audits often tended to focus on the actions of individual agency practice and were not able to describe the process for assessing and improving multi-agency practice. Some Boards had run multi-agency training and annual conferences, and two Boards developed multi-agency child protection forums for frontline staff. Boards did not currently monitor the impact of the training on multi-agency practice and accountability.

Establishing effective governance

Good practice:

Governance

- The development of a suicide strategy promoted a fast response and oversight around an unexpected death of a young person.(Rhondda Cynon Taff)

- Innovative practice was identified in respect of work undertaken by the police to raise the awareness of the LSCB and public protection units detailing their role, function and responsibilities.(Neath Port Talbot)

Collaboration

- Caerphilly LSCB is part of a south east Wales regional safeguarding group .This group had an overarching role in disseminating good practice from serious case reviews and improving regional safeguarding practice.

5 Building capacity

5.1 Apart from chairing meetings, the role and responsibility of the chair of LSCBs is rarely clear or consistent. All LSCBs had established sub-groups, but apart from the training sub-groups their effectiveness was unclear. In the majority of Boards there had been little agreement on the funding formula needed to support the Boards' work and development. There was no consistency in arrangements to fund LSCBs and in some cases little continuity from one year to the next. In some LSCBs it had proved impossible to reach agreement on the contribution that each agency should make, in others some agencies had not even been asked to make a contribution. In many it was the local authority that contributed either all or most of the funding for the operation of the Board. Given the length of time LSCBs have been in existence, there was a lack of shared commitment by statutory partners to their effective operation. As a result, the Boards were frequently unable to demonstrate value for money or identify their true cost in order to be able to identify future and current funding needs. Where the Board had appointed business managers,

resources were directed at activities which supported the priorities of the Board.

5.2 Members generally identified the chair's main function as chairing the LSCB meeting, and little else. There was frequently little clarity about the leadership elements of the role or the responsibility of this function to report to and work with other partnerships. Board members, whilst supportive of the chairs were not clear about how to challenge them if the need arose and what actions they could take to resolve any difficulties, for example if they considered there to be a conflict of interest. In many cases reporting arrangements for the chairs were not officially authorised or sanctioned by the Board. Where the chair was an employee of the local authority, they tended to report to the local authority chief executive but in their capacity as a senior officer of the local authority and not specifically as the chair of the LSCB. Inspectors found that the strength of leadership, and in particular the effectiveness of the chair and vice-chair was crucial to ensuring that the LSCB adhered to its stated objectives and did not get distracted. Some of the more confident Boards were chaired by the Director of Social Services who was respected by Board members and seen as having the relevant experience and breadth of authority needed. The role of the vice-chair was less well developed and in some areas did not prioritise attendance at the Board. Some LSCBs experienced difficulty in recruiting members to take on the key roles such as vice-chair and this reluctance could be seen to reinforce the view that the LSCB is primarily a social services responsibility.

5.3 There were significant variations in reporting arrangements for the Board itself, between areas in Wales. Some LSCBs had a clear expectation that their work or significant issues of dispute were reported to the Local Service Boards while others reported to different partnerships, such as the Children and Young People's Partnership. In some areas regular reports were submitted to the Local Service Board. Reporting arrangements were also unclear between various strategic partnerships for instance, the Children and Young People's Partnership, the Community Safety Partnership and the Health and Social Care and Well Being Partnership. Common membership on the different partnerships was generally recognised as supportive to improving good communication and planning. This common membership also supported a degree of co-ordination of priorities with other partnerships sometimes leading on major aspects of the overall plan.

5.4 Most Boards had established sub-groups to carry out the specific objectives of the LSCBs, and in some cases, these were working very effectively. The most effective sub-groups were clearly accountable to their Board, and this was reflected in the commitment shown by member agencies. In some Boards there appeared to be an extensive range of different sub-groups that added layers to the bureaucracy. This sometimes diluted the responsibility for measuring impact on outcomes . In addition, many of these sub-groups were chaired by the local children's social services officers and other agencies did not appear to take a lead responsibility. This reinforced the view that protecting children is primarily a role for the social services department.

Building Capacity

Good practice:

- Powys Safeguarding Children Board has developed a suicide prevention plan including children's residential homes and schools to promote safeguarding.
- Powys Safeguarding Children Board was working to establish child protection practitioner forums to support practice across the authority.
- The Rhondda Cynon Taff Safeguarding Children Board had established practitioner forums to support dissemination of information across the authority.
- Cardiff Safeguarding Children Board had secured Cymorth funding to promote safeguarding and to make communities aware of the functions of the LSCB.
- Wrexham Safeguarding Children Board had successfully negotiated a funding formula to provide the necessary staff and resources to progress the business plan priorities. For example, there is a dedicated training officer funded through the formula and directed by the LSCB. The formula does not meet all the costs of the LSCB's work but it is sufficient to manage core LSCB activities.
- The Neath Port Talbot Safeguarding Children Board had an agreed funding formula to secure the shared resourcing needed to meet its priorities. This formula was a mature arrangement which had been in place for a number of years.
- The Rhondda Cynon Taff Safeguarding Children Board had established useful links with another LSCB to work jointly on developing protocols and procedures and on promoting consistency in the delivery of training.

6. Delivering outputs

6.1 In the majority of LSCBs inspected there was little evidence of active engagement with children, young people and parents/carers in the development and review of their work. Engagement with the wider community was also at an early stage of development. All LSCBs had significant programmes of multi-agency generic training on safeguarding and child protection provided for large numbers of staff. However, this was seldom based on a multi-agency training needs assessment and the impact on practice was yet to be evaluated. It was not clear how LSCBs are effectively facilitating and promoting feedback to and from frontline staff.

6.2 Across the LSCB's reviewed there was limited active consultation with the children and young people generally and even less consultation and involvement with their parents and carers. Some Boards had made significant attempts to engage children and young people by supporting existing groups, developing digital formats to engage young people and to share their experiences with a range of professionals. In some cases this had not yet been evaluated or the impact of this involvement assessed. Some LSCBs had established formal arrangements with young people and in one case had established a young person's LSCB. Others had attempted to gain the views of young people through annual conferences and other events where specific issues were identified and developed for and with young people

6.3 There were some good examples of single and multi-agency training opportunities in many Boards. This was identified as important by members of LSCB's and as an area of strength which the staff and managers valued. There was a continued commitment across the Boards to support training and to encourage staff and managers to access it. There were also examples of Boards ensuring that training was available to third sector agencies, faith groups and community groups. However, generally the impact on practice had not been

reviewed and examined. There was little evidence of training needs assessment and evaluation being conducted and this limited the Board's strategic planning for training and workforce development in member agencies.

6.4 Inspectors saw little evidence of LSCBs communicating their work to the public. There had been very few targeted campaigns to identify and protect vulnerable groups through informing about priorities and describing what actions the public might take with the support of the LSCB to ensure greater safety of children and young people. The Boards' websites informing the public varied considerably across the areas with limited Welsh language information available on some websites. Most frequently the information referred to statutory responsibilities and not specific information to raise awareness about the Board and its member agencies and vulnerable children and young people. The websites were sometimes hosted on the local authority website detracting from the idea of the Boards having separate identities.

6.5 There were some limited examples of Boards actively promoting feedback to and from frontline staff about safeguarding policy and practice. Most LSCBs held an annual conference on specific topics and in some areas, LSCBs had supported the development of staff forums to support local practice. Occasionally, attendance at conferences and training from some agencies was disappointing, possibly because of the demands of work on some staff. Inspectors found very little evidence to demonstrate that the Boards were aware of the quality of practice in their member agencies, except in cases where outcomes had not been safe and the work had been subject of review. Boards gave details of how they regularly received reports; however these heavily relied on data from limited sources and some audit activity which reported largely on processes. The Boards could not provide evidence of effective systems to monitor and improve the quality of safeguarding practice as a result of

the reports they received. Inspectors concluded that overall, the Boards had a poor line of sight to practice which is exacerbated by the lack of engagement with frontline practitioners in the Board's activities, including auditing.

Delivering Outputs

Good Practice :

Engaging Children

- A "Junior LSCB "is well established in Powys and can demonstrate some impact on priorities for the LSCB.

Promoting learning

- The Chair of Caerphilly Safeguarding Children Board training sub-group had delivered three joint workshops with the Multi-Agency Public Protection Arrangements (MAPPA) coordinator and LSCB members. Some 300 practitioners and managers had benefited from this input.

Promoting safeguarding across the community

- Through its links with Parent Network the Caerphilly Safeguarding Children Board had distributed a 'keeping children safe' questionnaire to local parents and carers. The responses helped inform the ongoing technology safety campaign including a parent and carers 'techno safe' information leaflet.
- Cardiff Safeguarding Children Board as a result of an enquiry and an approach by the community had delivered a safeguarding awareness session to a city faith group. The multi-agency training team was led by the LSCB coordinator and the session was attended by a range of workers and community leaders. Valuable links were made within the community and child protection procedures updated. Follow-up safeguarding training was planned for the future.

- Rhondda Cynon Taff Safeguarding Children Board delivered six feedback sessions to 350 staff and local practitioners following the completion of a serious case review. This was to ensure that the "lessons learnt" were disseminated and understood by practitioners across all agencies. Members of the relevant serious case review panel helped deliver the sessions which were well received.
- Pembrokeshire Safeguarding Children Board adopted a stay safe project. This involved a group of young people with learning disabilities, supported by Action for Children, producing a 'Stay Safe' DVD which provided advice on matters such as bullying, handling money and transport. The messages were delivered through an animated story. supported by, a group of children with learning difficulties.
- The Crown Prosecution Service was invited to sit on the Neath Port Talbot Safeguarding Children Board which assisted communication and understanding of the complexities of bringing some child protection cases to prosecution.
- The Neath Port Talbot Safeguarding Children Board had proactively identified and responded to the issue of a controlled drug being used inappropriately by young people in a local area. This was brought to the LSCB by the Youth Offending Service and an information sharing hub was set up promoting coordinated action.
- Pembrokeshire Safeguarding Children Board has delivered tier 1 basic awareness child protection training to a number of staff across agencies.
- Pembrokeshire Safeguarding Children Board has issued 10,000 'safeguarding cards' with child protection contact details to agencies as a practical means of promoting safeguarding.

Appendix One

Policy and legislative framework

The Welsh Assembly Government introduced new legislation and guidance to safeguard and protect children following the Victoria Climbié inquiry. The roles and responsibilities of agencies and the Local Safeguarding Children Boards in Wales are set out in the guidance - Safeguarding Children – Working Together under the Children Act, 2004.

The well-being of children and young people is at the heart of the Welsh Assembly Government's policy for children and their families as detailed in Children and Young People: Rights to Action (2004).

Children Act 2004

Section 25

places a duty of co-operation to improve the well–being of children and young people on local authorities, relevant partners and such other bodies as the local authority considers appropriate.

Section 26

requires local authorities to prepare and publish a plan setting out their strategy for discharging their functions in relation to children and young people. The Children and Young People's Plan to include the arrangements for co-operation required under section 25 and be consistent with the strategic plans of local partners covered by that duty. The plan to be prepared in consultation with children, young people, carers and families and all relevant local organisations including the Local Safeguarding Children Board.

Section 28
places duties on specified agencies to make arrangements for ensuring that their functions are discharged having regard to the need to safeguard and promote the welfare of children.

Section 31(1)
requires each local authority in Wales to establish a Local Safeguarding Children Board for their area

The objective of a Local Safeguarding Children Board established under section 31 is-

(a) *to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established; and*

(b) *To ensure the effectiveness of what is done by each such person or body for those purposes.*

Safeguarding Children Working Together under the Children Act 2004 issued by the Welsh Assembly Government in October 2006 details the membership role, scope and function of Local Safeguarding Children Boards .This guidance sets out the relationship between:

Child protection and the wider safeguarding agenda

- *Ensuring that effective policies and working practices are in place to protect children and that they are properly co-ordinated remains a key role for Safeguarding Boards. Only when these are in place should Boards look to their wider remit of safeguarding and promoting the welfare of all children. (section 4.16)*

The accountability of the LSCB and that of individual member agencies

- *Whilst the LSCB has a role in co-ordinating and ensuring the effectiveness of local individuals' and organisations' work to safeguard and promote the welfare of children, it is not accountable for their operational work. Each Board partner retains their own existing lines of accountability for safeguarding and promoting the welfare of children by their services. The LSCB does not have a power to direct other organisations. .(section 4.20)*

The relationship of the LSCB with other partnerships

- *It is important that LSCBs exercise their unique statutory role effectively. They must be able to form a view of the quality of local activity, to challenge organisations as necessary, and to speak with an independent voice. To ensure that this is possible LSCBs must have a clear and distinct identity. The LSCB should not therefore be subordinate to or subsumed within local partnership arrangements in a way that might compromise its separate identity and independent voice. The LSCB should be consulted by the partnership on issues which affect how children are safeguarded and their welfare promoted. The LSCB will be a formal consultee during the development of the Children and Young People's Plan (section 5.5)*

Section 30

sets out the arrangements for inspection of functions under part 3 of the Act. CSSIW is leading work with other inspectorates and regulatory bodies including, Estyn, HIW, WAO, HMI Probation and HMI Constabulary, to ensure effective co-ordination of inspection develop protocols and to plan work to inspect and evaluate the effectiveness of services for children and young people, including the Partnerships.