

Wood Report

**Review of the role and functions of
Local Safeguarding Children
Boards**

March 2016

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Review of the role and functions of Local Safeguarding Children Boards

Foreword

1. The Secretary of State for Education, the Rt Hon Nicky Morgan MP, and the Minister of State for Children and Families, Edward Timpson MP, asked me to lead a fundamental review of the role and functions of Local Safeguarding Children Boards (LSCBs) within the context of local strategic multi-agency working. This was to include the child death review process, and consideration of how the intended centralisation of serious case reviews (SCRs) will work at local level. I began this review in the first week of January 2016 and presented my report on 31 March 2016.

2. I want to thank all those involved in responding to this review. I received an exceptional level of response to the survey, the deep dive exercise, the large number of meetings attended and the call for written submissions.

3. In this review I have seen enthusiasm and desire for improvement; innovative and informed ideas for new ways of working; and a steely and determined focus on protecting children.

4. It is correct to say that all of us do play a part in keeping our children safe. But the business of ensuring we have effective policies and systems in place to do so falls on a small number of people in each local area. We owe a great debt to these people. They work day in and day out to check that the systems we have to protect children work effectively and take action or commission solutions when they do not. But there is more we need to do if our service to protect children is to keep ahead of new threats and risks and to cope with the dynamics of ever-present change, more complex and sophisticated threats and reducing resources. I believe our system needs significant reform to ensure it can meet these challenges and become consistently effective overall.

5. We have examples of outstanding organisation and practice but we need to improve such that we can move to a new level of consistent effectiveness. We can only do this if we act on the evidence already compiled from Ofsted reviews of LSCBs, evidence in the reporting of serious case reviews and from the clear messages from the consultation I have undertaken. We should not hide from the reasons why we are not as effective overall as we should be. These are found at national and local level; they are evident in all professions; exist in all agencies; and are present in all regions.

This evidence shows bureaucratic processes; too much timid inquiry at practitioner and system level; an unwillingness to challenge partners when they opt out of cooperating; and too much acceptance of less than good performance at both the level of agency performance and individual practice.

6. If we are not willing to follow the evidence of the need for improvement we open our services to being characterised as being ineffective in their ability to achieve their principal purpose of protecting children.

7. National bodies in the health services, the police and local government must stop ignoring the organisational boundaries which get in the way of multi-agency operational working. They must set out the strategic framework which will support practice leaders to develop and deliver a national system for protecting children which is seen to be the best in the world.

8. We now need clear action by national government to reform our framework for multi-agency arrangements and improve learning from serious events affecting children. We need a more effective statutory framework, reward initiative and innovation and ensure both of these are focused on supporting and developing our practitioners to improve the services provided to protect children and young people.

Executive Summary

9. This report sets out a new framework for improving the organisation and delivery of multi-agency arrangements to protect and safeguard children. It contains recommendations for government to consider. These recommendations suggest that appropriate steps should be taken to recast the statutory framework that underpins the model of Local Safeguarding Children Boards (LSCBs), Serious Case Reviews (SCRs) and Child Death Overview Panels (CDOPs). The report argues that on a scale of prescriptive to permissive arrangements, the pendulum has locked itself too close to a belief that we should say how things should be done as opposed to what outcomes we want for children and young people. Taken together, the recommendations I have made propose fundamental reform to the way we do things.

How the review was undertaken

10. The recommendations are based on the information I have received from a wide range of sources and evidence gathered from discussions with a large number of groups and individuals. I took part in over 70 meetings, conversations and events, and received over 600 sets of comments and other submissions in response to my questionnaire.

11. I was able to consider a range of research findings on LSCBs and SCRs, and to look at the work of improving SCRs funded by the DfE innovation programme, and the pilot areas looking at new models for organising LSCBs. I took account of helpful findings from the Cabinet Office Implementation Unit, which was commissioned by the Child Protection Implementation Taskforce to support the review by gathering additional evidence on multi-agency working.

12. A number of the discussions I have had with interested parties throughout the course of this review, and submissions received to the consultation, have highlighted examples of good multi-agency practice. Such practice happens every day across the country, where LSCBs do good work and are successful. In reforming the multi-agency system we must build on these examples of effective working.

The case for fundamental change

13. Overall, the responses I have received make clear to me that the case for fundamental reform is based on a widely held view that LSCBs, for a variety of reasons, are not sufficiently effective. The limitations of LSCBs in

delivering their key objectives have been fully exposed in this review and by the work of Ofsted. There needs to be a much higher degree of confidence that the strategic multi-agency arrangements we make to protect children are fit-for-purpose, consistently reliable and able to ensure children are being protected effectively.

14. In answer to questions in the survey about the coordination and effectiveness roles of LSCBs, 62.5% said they felt the coordination role was effective and 52.8% said they ensure the effectiveness of the work. These are not telling majorities: in fact, this is a low level of support. Surely we can only be satisfied when support for such critical activity is as close as possible to 100%.

15. The Local Government Association and Research in Practice¹ found there was a lack of clarity on the role and expectations of an LSCB, and too often that the effectiveness of an LSCB is due to the ability of the Chair. They found dissonance among the partners between the accountability and the authority of an LSCB - a point that the general research evidence also picks up. Lord Laming identified this issue earlier² and proposed the need for a new model to ensure collective accountability. One chief executive of a local authority suggested LSCBs were not effective because “they were hard wired to be full of contradictions”. It is clear that the duty to cooperate³ has not been sufficient in ensuring the coherent and unified voice necessary to ensure multi-agency arrangements are consistently effective.

16. I would also add that national government departments do not do enough to model effective partnership working between themselves for local agencies. The join up demanded of local partners is not particularly evident at national level.

17. The cost of the current arrangements to key agencies such as the police, health and local government is not sustainable. Too much of practice leaders’ time is taken up in servicing the architecture of multi-agency arrangements. Examples given by Police and Crime Commissioners and other leaders show that the wide range of Boards, Committees and other bodies established to consider similar issues as the LSCB, compounds a growing demand on officers to attend meetings and produce reports. At a time of growing pressure on available resources, time and money should be

¹ Baginsky, M. & Holmes, D. (2015), A review of current arrangements for the operation of Local Safeguarding Children Boards

² The Lord Laming, (2003), The Victoria Climbié Enquiry

³ Children Act 2004, section 10

focused on front line service delivery and not diverted to bureaucracy and meetings.

The proposed multi-agency arrangements

18. I think there is merit in the suggestion that LSCBs were essentially predicated on interfamilial child abuse and are not in a good position to deal effectively with a remit to coordinate services and ensure their effectiveness across a spectrum encompassing child protection, safeguarding and wellbeing. They have neither the capacity nor resources to do so. These three phrases have become confused and are confusing. Some use them interchangeably; others draw a clear distinction between each. This needs to be clarified so that protecting children is the focus of multi-agency arrangements.

19. To carry out fundamental reform involves, in my view, replacing the existing arrangements for LSCBs with a new, more effective statutory framework that sets out the strategic multi-agency arrangements for child protection.

20. A key finding in this review is that the duty to cooperate⁴ is not a sufficient vehicle to bring about effective collaboration between the key agencies of health, the police and local government. These three agencies should determine, for an identified area, multi-agency arrangements for protecting and safeguarding children. They should draw up a plan that describes how their services, in partnership with other agencies, will deliver the new statutory framework.

21. Leadership is not effective enough in delivering multi-agency arrangements. New statutory arrangements should require health, local authorities and the police to make clear their leadership responsibility for multi-agency arrangements, to include the identification of a chief officer in each of the agencies to have responsibility and authority for ensuring full collaboration with those statutory arrangements.

22. All areas should be required to move towards new multi-agency arrangements for protecting children within a prescribed period. In this way, the existing legislative framework underpinning LSCBs would cease to operate as new arrangements come into being.

23. In addition, we must move away from the highly prescribed model we have for delivering multi-agency arrangements. A more effective, precisely

⁴ Section 10, Children Act 2004

defined statutory framework focused on protecting children allows for much more flexibility in terms of how those arrangements are made. We should be asking for outcomes for children and young people to be improved, not how they are organised. We are seeing innovation and flexibility in the way partnership working between the police, health and local government is responding to the needs of older people. We should seek that for children and young people too. We should look at incentivising all applicants for devolution deals to include arrangements for safeguarding children as part of their combined authority arrangements, but that is only a start.

24. There are therefore, two things we must do:

- introduce a more effective statutory framework to focus the arrangements on child protection and to ensure key agencies collaborate to deliver more effective services; and
- move away from an over prescriptive system to one that encourages and authorises local areas to determine how they organise themselves to improve outcomes for children and meet the requirements of the new framework.

25. If we achieve these two things, the impact they will have is to allow practice leaders the space to be more innovative in organising services to better protect children and to drive closer, more effective collaboration between the key agencies.

Serious Case Reviews

26. We do not have a national learning framework for considering the lessons of the tragic events that take a child's life or seriously harms them. Despite guidance to the contrary, the model of serious case reviews has not been able to overcome the suspicion that its main purpose is to find someone to blame. Although there has been some improvement in the quality of some reviews the general picture is not good enough and the lessons to be learned tend to be predictable, banal and repetitive.

27. We need a fundamental change. Government should discontinue Serious Case Reviews, and establish an independent body at national level to oversee a new national learning framework for inquiries into child deaths and cases where children have experienced serious harm. The framework should be predicated on high quality, published, local learning inquiries; the collection and dissemination of local lessons; the capacity to commission and carry out national serious case inquiries; and a requirement to report to the Secretary of State on issues for government derived from local and national inquiries.

28. Both local and national inquiries will be most effective if there is a skilled cohort of accredited reviewers. The new body should be charged with setting out and consulting on a process of accreditation and on-going development for national reviewers.

29. The new national body should consider what factors characterise a good inquiry. They should consult with those who are the most experienced in understanding and delivering models of review and draw up a good guidance framework. This should lay out the standards of quality required in local inquiries in much the same way as it is proposed the new Health Safety Investigation Branch (HSIB) will develop a national standard for high quality serious incident investigations in the NHS.

30. In combination, these ideas will bring about a national resource of learning built on the foundations of effective local learning and skilled reviewers.

Child Death Overview Panels

31. Local CDOPs are passionate about the work they do and the learning they identify. Despite this, I am persuaded by the argument that child deaths need to be reviewed over a population size that gives a sufficient number of deaths to be analysed for patterns, themes and trends of death. In many areas, regional gatherings of CDOPs provide a source of data and intelligence which, when analysed, leads to the identification of key issues relating to the deaths. We need to encourage this regionalisation and consideration should be given to establishing a national-regional model for CDOPs. The introduction of a national database has to be a priority for implementation. This would assist the collection of local information and a national analysis of child deaths to inform regional CDOPs.

32. The NHS has published the National Maternity Review-Better Births, (NMR-BB)⁵. This contains a number of recommendations about child deaths. The report recommends that the new HSIB should set a common, national standard for high quality serious incident investigations. The HSIB will be prioritising maternity issues in its first year of operation. In addition it is proposed to develop a standardised perinatal mortality review tool. Both of these developments are likely to have implications for the way in which CDOPs consider child deaths.

33. Over 80% of child deaths have medical or public health causation. For babies and infants the cause is often related to congenital factors and in the

⁵ National Maternity Review - Better Births 2016 4.61; 4.63

early teenage/ adolescent age range the causation is related often to injury. Clinicians estimate that only 4% of child deaths relate to safeguarding or require an SCR to be carried out.

34. From within the NHS I have heard a clear preference that CDOPs should be hosted within its framework. In my view, the Department for Education is not in the best position to provide the necessary support required for oversight of this process. If Health has oversight of the policy the necessary specialists are likely to feel more ownership of the process. In these circumstances and given proposals in the NMR-BB I think that ownership of the arrangements for supporting CDOPs should move to the Department of Health.

Moving Forward

35. I believe the recommendations in my report pave the way for a fundamental reform of the system for protecting and safeguarding children. They provide for a more relevant, and in my view tougher, statutory framework that will:

- ensure the contributions made by the health service, the police and local government are better coordinated and deployed toward creating a safer, more consistent, national framework protecting and safeguarding children and young people;
- clarify and lay out the responsibilities of a lead chief officer in health, the police and local government in ensuring effective multi-agency arrangements;
- promote innovation, and deliver efficiency in the design of local arrangements to safeguard children and young people,
- establish a National Learning Framework overseen by a new independent body to promote higher quality inquiries into the tragic events which affect children and young people with a capacity to carry out a national serious inquiry; and
- create a more effective model of learning from the deaths of children.

36. If we can balance a more effective statutory framework with the promotion of innovation at local level it will release resources to focus on the front line of practitioners engaging with children, young people and their families. We will see the outcomes of this in the development of more highly skilled practice leaders and practitioners using their professional skills and judgement in casework as opposed to form filling and data collection.

37. If we want to achieve a safer system to protect children, we must create the environment in which better skilled practitioners can practise and get on with the work of protecting children.

The case for fundamental reform

38. In this review I took account of a wide variety of evidence and information. I considered a range of previous research findings on LSCBs and SCRs. I took account of helpful findings from the Cabinet Office Implementation Unit, which was commissioned by the Child Protection Implementation Taskforce to support the review by gathering additional evidence on multi-agency working. As part of the review I took part in around 70 meetings, conversations and events, and received over 600 sets of comments and other submissions in response to my questionnaire.

39. A number of the discussions I have had with stakeholders throughout the course of this review, and submissions received to the consultation, have highlighted examples of good multi-agency practice. Such practice happens every day across the country, where LSCBs do good work and are successful. In reforming the multi-agency system we must build on these examples of effective working.

40. Clear governance arrangements, mature and well developed partnership arrangements, focused priorities, conducting good section 11 audits and good challenge to partners are, according to Ofsted the characteristics of the most effective LSCBs. However, Ofsted found these to be evident in under a quarter of those reviewed.

41. In answer to the two questions in the survey about the coordination and effectiveness roles of LSCBs, 62.5% said they felt the coordination role was effectively carried out and 52.8% said they ensure the effectiveness of the work carried out. These are not telling majorities: in fact, it is shocking that such low levels of support are recorded for the coordination and effectiveness of multi-agency services to protect and safeguard children. Surely we can only be satisfied when support for such critical services is as close as possible to 100%.

42. The responses have made clear to me that the case for reform is based on a widely held view that LSCBs, for a variety of reasons, are not sufficiently effective. The limitations of LSCBs in delivering their two key objectives – to coordinate agencies in safeguarding children and to ensure they do so effectively⁶ – have been fully exposed in this review. We need to devise a more effective model of working, one that deals with these limitations and to which we can ensure all agencies are fully committed. Consequently, if we are to deliver on these two key objectives, we need to have a much higher

⁶ Children Act 2004

degree of confidence that the strategic multi-agency arrangements we make to protect children are fit-for-purpose, consistently reliable and able to ensure children are being protected effectively.

43. The findings of the 80 plus reviews carried out by Ofsted suggest that too many LSCBs are not effective enough and many lack purpose and or leadership. A small number hold agencies to account for the delivery of services to protect children, but too often there is an absence of a presiding mind to take issues forward and ensure each agency plays its critical role in the work.

44. Work by the Local Government Association (LGA) and Research in Practice⁷ found there was a lack of clarity on the role and expectations of an LSCB, and too often that the effectiveness of an LSCB is due to the ability of the Chair. They also found there was dissonance among the partners between the accountability and the authority of an LSCB - a point which the general research evidence also picks up. Lord Laming identified this issue earlier⁸ and proposed the need for a new model to ensure collective accountability. One chief executive of a local authority suggested LSCBs were not effective because “they were hard wired to be full of contradictions”. It is clear that the duty to cooperate⁹ has not been sufficient in ensuring the coherent and unified voice necessary to ensure multi-agency arrangements are consistently effective.

45. The evidence suggests strongly that SCRs are not effective in helping the national and local systems for protecting children to improve. SCRs take too long to report and result in recommendations that add little real insight into how or why a system has not worked as intended. The quality of reports is too varied with the very good examples being the exception.¹⁰

46. This problem with learning is also evident in the way child deaths are reviewed. While some examples of good local learning are evident, the structural framework around reviews does not allow for coherent national learning. The system is overseen by the Department for Education, but that department is not best placed to bring the technical and specialist medical leadership required to lead a national system of review.

⁷ Baginsky, M. & Holmes, D. (2015), A review of current arrangements for the operation of Local Safeguarding Children Boards

⁸ The Lord Laming, (2003), The Victoria Climbié Enquiry

⁹ Children Act 2004, section 10

¹⁰ National panel of independent experts on serious case reviews (2014). First annual report

47. There are many reasons why we must have effective multi-agency arrangements for protecting children. I think there are three that are currently not sufficiently clearly achieved.

1. To bring to bear the skills and resources of key national and local agencies to ensure they are all working effectively together to provide the most focused and relevant services to protect children;
2. To support the development of highly skilled practitioners in each agency working with children cross agency; and
3. To provide a high level of public assurance that the system to protect children is kept closely under scrutiny and review with proactive action to secure that.

48. In considering multi-agency arrangements for protecting children, I believe it is necessary to identify three areas of service delivery as absolutely key. The agencies are those relating to health, the police and local government. We need to ensure that at national and local level these three areas are at one in agreeing how to hold to account one another and the services they deliver individually and collectively. Some have pointed to the broad Corporate Parenting duty on a local authority as the type of model to apply to the three key agencies in respect of their role in protecting children.

49. Clearly, other agencies, probation, the courts, the voluntary and community sector, are vital players. Cafcass plays a very important role in protecting children. Their work is crucial ensuring the best interests of children are in the forefront of discussion in court and they have made a significant contribution to the work of LSCBs, e.g. by organising joint training, and through their contribution to SCRs – over 100 in the last five years. Despite the efforts of other agencies, however, without greater collaboration and understanding between the three identified I do not think the current situation will improve as significantly as is necessary.

50. I would also add that national government departments do not do enough to model effective partnership working between themselves for local agencies. The join up demanded of local partners is not particularly evident at national level. Indeed, local partners will often say that they are following government department guidelines as a reason for not committing fully to local multi-agency discussion and decision making. There is also a lack of join up when one government department looks at an issue without consulting fully or thoroughly other government departments; indeed there is some evidence that join up within government departments is absent. The lack of join up across government has in part led to the expanding remit given to

LSCBs and the growth of bodies and boards which are looking across the experiences of children and families, resulting in duplication of effort and a lengthening of decision making chains. This adds a significant additional cost to delivering public services and a strong case has been made by leaders in health, the police and local government that it is distracting senior staff in particular from supporting front line practice. Other agencies take a similar view. Cafcass told me that:

“... generally the experience within Cafcass has been that LSCBs make little significant impact on local practice. LSCBs have expanded their scope beyond the core business of child protection into a multitude of safeguarding matters. Section 11 is one such example which has been subject to widespread ‘mission-creep’, morphing from being a proportionate check on arrangements into an increasingly elaborate and ineffective mechanism for evaluating practice. It absorbs huge amounts of resource to little, if any, benefit, that would be much better spent on the frontline.”

51. The remedy for this problem is to reform multi-agency arrangements to protect children and to ensure that everything we do in setting up such arrangements is tested against the likelihood that it will promote and improve the quality and impact of practice, such that outcomes for children improve.

Detailed issues identified during the review

52. Below are some of the key comments made and concerns raised during the review process, both during the many meetings and discussions I have had, and through the consultation process and the written submissions I have received.

Multi-agency arrangements

53. There is a clear appetite for fundamental reform to the arrangements for LSCBs. Comments made include suggestions for:

- Greater emphasis on, and modelling of cross agency strategic and operational collaboration in working to protect children at Government Department level, especially as between Health, Local Government, the Department for Education and the Home Office. The sector does not hear a consistent and unified voice, in fact the opposite is often remarked on.
- Clarifying the purpose and function of multi-agency arrangements in relation to protecting children.
- Consideration of whether the core model of child protection which was designed to deal with abuse and neglect within a family setting can cope effectively with more complex issues of safeguarding, e.g. trafficking children, child sexual abuse/ exploitation, female genital mutilation, radicalisation and extremism which may require a broader, community wide response.
- Greater definition of the spectrum of child protection-safeguarding-wellbeing and how different aspects are governed and scrutinised within multi-agency arrangements for protecting children.
- Rationalising governance and accountability structures in multi-agency arrangements – e.g. LSCBs, Safeguarding Adults Boards, Community Safety Partnerships, Health and Wellbeing Boards, Local Family Justice Boards.
- Greater permissiveness in the way multi-agency arrangements for protecting children are organised and delivered. This includes issues of scale to do with population size; geography; and the operational arrangements of local agencies – particularly in the police and health services.
- Multi-agency arrangements for protecting children to have a greater degree of authority over their constituent agencies, often referred to as the need for “teeth”.

- Clarification of the issue of accountability. As the development of a wide diversity in models of delivery continues, particularly in education and health provision, issues are being raised as to overall responsibility for governance and accountability in the local system for protecting children.
- Leadership of multi-agency arrangements is neither clear nor consistently effective. Despite the post of independent chair of the LSCB reporting to the local authority Chief Executive and statutory guidance on the role of the Director of Children’s Services and the Lead Member, the situation is unsatisfactory and leadership expectations are focused on the local authority. This does not have sufficient impact in relation to senior leaders in the police and the range of health services. Greater transparency and guidance on the statutory responsibilities on the three key agencies and how these are expressed in terms of leadership across the system of protecting children was requested.
- Ensuring any changes made to multi-agency arrangements for protecting children include a strengthening of the independent element in the leadership and scrutiny of them.
- Guidance to local agencies on how they can focus on ensuring the services being provided under their remit are effective.
- Ensuring that high-level multi-agency arrangements for protecting children are focused on strategic issues, while encouraging and incentivising practice leaders to focus more easily on undertaking multi-agency operational issues. This in effect would be a decoupling of the coordination role from that of ensuring effectiveness.
- Clearer guidance on the funding of multi-agency arrangements for protecting children to ensure appropriate levels of resources are made available particularly by the three key agencies.
- To keep Safeguarding Adults Boards separate from LSCBs. The Association of Directors of Adult Services, commenting on this issue, gives three reasons for this:
 - The distinct differences in relation to capacity/rights/coercion;
 - The significant provider dimension to adults’ work and the overlaps with care quality; and
 - A concern that the “high profile” of child protection will ‘drown out’ the needs of adults.

Serious case reviews

54. There is general acceptance that SCRs are not adding significantly to learning from critical incidents resulting in the death of, or serious harm to, children. Comments include the following:

- There is widespread agreement that the belief that it is vital to find out who was responsible as opposed to how improvements can be made, has corroded the ability to provide effective learning and created a degree of scepticism as to the purpose of an SCR. This belief remains despite guidance in Working Together to the contrary.
- There is a large measure of agreement that the system is not sufficiently focused on rapid, proactive or analytical assessment of the lessons necessary to improve the arrangements for protecting children. It is cumbersome, often too costly and, insufficiently independent of the agencies involved in the review. Lord Laming sees a problem with the inquirer being too familiar with the context of those inquired into.
- The quality of reports is a matter of concern to the independent national panel and both of their annual reports have pointed to the significant variability in the quality of reports and the skills of the authors.
- There is too much delay caused by the clashing of various inquiries e.g. the investigations carried out by the police, the deliberation of judicial processes, domestic homicide reviews. There must be a clearer acceptance within all agencies of the principle of transparency and learning.
- Some believe the name for inquiries should focus on a rapid response to a critical event and differentiate between rapid local learning and a national organised inquiry. There is some evidence that the term 'SCR' has been misunderstood and is now tarnished.
- Opinions are mixed as to how effective the national panel of independent experts on SCRs has been. Some argue that there is little evidence of an impact on learning, while others have welcomed advice on specific issues connected with SCRs. There is a view that the creation of a new body to support excellence in undertaking inquiries could be helpful.

Child Death Overview Panels

55. The 2006 LSCB regulations require child deaths to be reviewed. The key objectives are to learn lessons in order to improve the health, safety and wellbeing of children and to reduce future incidence of preventable child deaths.

- There are currently 89 CDOPs covering 148 LSCBs, and increasing numbers are looking at sharing a service.
- Colleagues from health advised me that more than 80% of the child deaths considered by CDOPs have clinical or public health causation. The remainder include a number of deaths related to safeguarding.
- Respondees emphasised the importance of learning from cases the sponsoring government department will need to promote this in all parts of the health service.
- There is support for a model which ensures that at a local level those bodies that are accountable for health scrutiny play a role as effective conduits of learning.
- To many clinicians and Directors of Public Health, to draw conclusions from data there needs to be a significant population size to give a testable number of child deaths. The size is not agreed but talk ranges from 650,000 to one million or more.
- There are many examples of local learning from CDOPs but I am advised that there is little if any evidence from data that can inform a national discussion.

56. The Healthcare Quality and Improvement Partnership and NHS England are currently sponsoring a project to test the viability of a national CDOP database and this will report in the summer. It has been made clear to me that there is clear, and widespread, support for the introduction of an effective national database.

Analysis of findings

Multi-agency working

“Cooperation between services should be recognised to be essential and not limited by convenience.”

Lord Laming

57. After a child death in 1974, local authorities were required to set up Area Review Committees (later Area Child Protection Committees - ACPCs) to develop a strategic approach to child protection. The death of Victoria Climbié and the report by Lord Laming¹¹ led to the establishment of LSCBs under the Children Act 2004, replacing ACPCs. LSCBs' statutory membership includes representatives of local authorities, health services, the police, schools and youth justice institutions. LSCBs' primary objectives are to coordinate members' actions with regard to children's safeguarding and welfare, and the effectiveness of those actions.

The Framework

The remit of Multi-Agency Arrangements

58. The work of the police, health services and local government in protecting children is covered by a range of statutory duties and statutory guidance. This statutory position does not apply as comprehensively to other agencies. It is essential that these three agencies cooperate to ensure the framework of multi-agency arrangements is effective, well governed and supports front line practice. These agencies are responsible for the greater range of services that protect children and provide the largest share of resources and staff. They are the key agencies in setting out the strategic framework within which all agencies work together to protect and safeguard children.

59. These three are well supported by other agencies such as youth justice, probation, schools and the voluntary sector, that play a critical role in improving outcomes for children. However, without agreement and full collaboration between the police, health and local government, the necessary strategic decisions necessary to underpin effective practice will not be taken.

¹¹ The Lord Laming, (2003), The Victoria Climbié Enquiry

60. Action for Children (2008)¹² reported that across the UK, there had been 98 separate Acts of Parliament affecting children passed since 1987; and over 400 different initiatives, strategies, funding streams, legislation or guidance and organisational changes to services affecting children and young people over the previous 21 years. Half of these were in 2002 – 2008. Many of these have fallen in scope to LSCBs.

61. I think there is merit in the suggestion that LSCBs were essentially predicated on interfamilial child abuse and that they are not in a strong enough position to deal effectively with a remit to coordinate services and ensure their effectiveness across a spectrum encompassing child protection, safeguarding and wellbeing. They have neither the capacity nor resources to do so, and it is debatable whether the task itself is feasible. In a sense these three phrases have become confused and are confusing. Some use them interchangeably; others draw a clear distinction between each. In effect they genuflect to a past era of 'Every Child Matters' and its five core dimensions. I am not convinced that framework is the relevant or right one for the nature of risk and challenge faced by children and young people today.

62. Working Together to Safeguard Children (2015)¹³ makes clear that when the core business of child protection is secure LSCBs should go beyond it to work to a wider remit. From the evidence of Ofsted's reviews and what has been said in the consultation, I contend that only a small number of LSCBs have achieved this secure position, yet all seek to deliver against the wider remit.

63. Some of the confusion we face in the broader architecture of working with children (e.g. LSCBs, Community Safety Partnerships, Safeguarding Adults Boards, Health and Wellbeing Boards, Local Family Justice Boards) is caused by a lack of clarity about this spectrum and a belief that multi-agency arrangements in themselves will remedy all the identified risks, because we intuitively think they should.

64. All agencies have a key role across this spectrum. Each agency delivers services against specific statutory requirements, for example local authorities in children's social care. But each has a different, complementary purpose in the leadership and practice role at various parts of the spectrum. By virtue of their link to the legal process local authorities have the lead agency role for child protection (interfamilial abuse, neglect and harm), the police have a leading role in safeguarding (domestic and sexual violence, youth violence, gangs and extremism-radicalisation) and health in wellbeing

¹² Action for Children, (2008), As long as it takes: a new politics for children

¹³ HM Government (2015): Working Together to Safeguard Children

(sexual health, obesity, mental health). While there is no exact or perfectly discrete definition of these roles, it is evident at ground level.

65. In one response to the consultation, a senior official in a voluntary organisation said that the concepts of 'protecting' and 'safeguarding' have become blurred by the increase in issues such as on-line grooming, child sexual exploitation and radicalisation and that reform is necessary to support priority areas of work and intervention particularly given referral rates and workloads.

66. The good practice we have today in multi-agency working is not sufficiently acknowledged and is often unrecognised by strategic leaders. We have a tendency to look at strategic multi-agency arrangements as a first response to a concern about practice. Would it be more productive if we looked at it from a practice perspective and sought solutions by building on what we already do well as opposed to trying to craft a formulaic response in the form of new strategic plans or arrangements? The point here is that practice in child protection across the spectrum is usually best when it is coordinated and multi-agency, but leadership has to be distinct and clear. Baroness Jay told me *"An issue which belongs to everybody round the safeguarding board table, effectively belongs to nobody."* This comment goes to the heart of a failing in the LSCB model, a rhetorical exhortation against the unwillingness of an agency to put a collective decision or action before their own. The question LSCBs cannot answer is "what happens when the power of a chair to influence partners fails?" Lord Laming put this succinctly when he told me *"Cooperation between services should be recognised to be essential and not limited by convenience."*

67. This becomes increasingly important as we move further along a path toward identifying, developing and supporting leaders of practice across all agencies and devolving decision taking and responsibility to the point of actual service delivery, and clearly delineating the different, but complementary, expertise as between practice leadership and strategic management.

68. As we navigate this path we need to ensure everything we do is designed to improve what practice leaders do on the front line. If we are distracting practitioners from their work by a series of demands on their time to attend meetings, discuss reports and gather and provide more information for consideration we are not making best use of their expertise and the opportunity to improve outcomes for children and young people. Multi-agency bodies should focus on the key strategic issues that can only be resolved in a multi-agency meeting of senior leaders. If they were able to do this, more of

our practice leaders' time could be focussed on developing, delivering and improving multi-agency practice.

69. What are the key strategic issues that need to authorise and underpin effective multi-agency practice? Reflecting on all I have heard and read during the course of this review, I have come to the conclusion that the issues that the strategic board should focus on are:

- Determining the physical area of operation covered by multi-agency arrangements.
- The authorising vision for multi-agency arrangements, the partnership commitment.
- The resource framework, e.g. the cost of the multi-agency strategic decision making body, the cost of agreed initiatives, e.g. joint training, agreed local research, innovation in service design.
- The method to assess outcomes of multi-agency practice, including how intervention happens if performance falters, and how 'independent' external assurance/scrutiny will be utilised.
- The strategy for information and data sharing, including to allow for identification of vulnerable children in need of early help.
- High-level oversight of workforce planning, e.g. gaps in skilled areas.
- A multi-agency communication strategy on protecting children.
- Risk strategy, identifying and adapting to challenges including new events, and establishing a core intelligence capacity.
- The model of local inquiry into incidents.

70. These points create the framework within which practice takes place and allows practitioners to focus on getting on with the job.

71. If this were the strategic agenda for the decision making multi-agency body for an area, the need for extensive sub groups, presentations from practitioners, and repetitive consideration of reports which have been through other fora would not exist. A slim body is more likely then to engage top decision makers and their ability to commit their organisation to the decision to be taken is more probable than is the case with the duty to cooperate.

72. Given the law is clear on the responsibilities of local agencies, from assessment through to the removal of a child from their family and for permanency, the contention has been put to me that we do not need a set of

multi-agency statutory duties. It is argued that the fact that the statutory basis of LSCBs has not resolved the problems they were established to remedy is further evidence of the ineffectiveness of that multi-agency framework. I am not persuaded by this approach. This is partly because I believe that it is the core duty to cooperate that is not sufficiently effective, but also because I agree with the points made to me about balancing effective statutory provisions with greater freedoms to arrange services according to local assessment and agreement. We must find a mechanism to go beyond the duty to cooperate in the Children Act 2004 and make clear that each of the three key agencies is required to hold combined responsibility for delivering effective multi-agency services to protect children, recognising the different contribution each makes along the spectrum from child protection to safeguarding to wellbeing. An approach that concentrates multi-agency decision making on strategies and effectiveness will assist that search.

73. There is merit in the argument that multi-agency statutory guidance should focus on child protection – as underpinned and defined by law. If that were the case, the broader spectrum of safeguarding and wellbeing could be managed within a much more permissive framework at local level focused on the organisation of cross agency practice and service delivery.

74. 'Prevent' is an example of how agencies can cooperate effectively together within a light-touch framework. In respect of extremism and radicalisation, the Channel process of Prevent has made progress in identifying young people at risk and devising multi-agency strategies for protecting them from being drawn into greater risk. These approaches involve the police working closely with children's social care, schools, youth workers and the health service, each bringing to bear the intelligence and information they hold. Some areas have set up social inclusion panels which are multi-agency bodies of practice leaders that design plans to support young people within their local setting and divert them from risk.

75. I am persuaded by the argument that ensuring effectiveness should be decoupled from the oversight of coordinating of services in local multi-agency arrangements. More should be done at local level to demonstrate the effectiveness of the arrangements we have in place to protect children and young people. Doing this will give confidence to partners within the system and to the wider community. It will be for a local area to show how effective its arrangements are for improving outcomes for children and young people, but there should be a requirement that they have such a measure in place. Public confidence will be influenced by the robustness of the assessment made if within the local system there is a clear demonstration of how an independent perspective has informed the judgements made.

Recommendations

1. To replace the existing statutory arrangements for LSCBs and introduce a new statutory framework for multi-agency arrangements for child protection.
2. To require all areas to move towards new multi-agency arrangements for protecting children within a prescribed period. Local areas/regions would need to establish a plan which would describe how services would:
 - Meet the new statutory framework;
 - be coordinated;
 - be led by senior officials;
 - be evaluated for their effectiveness;
 - involve a role for independent scrutiny;
 - engage with children and young people; and
 - be held to account.

The existing legislative framework underpinning LSCBs should cease to operate as new arrangements come into being.

3. To require the three key agencies, namely health, police and local authorities, in an area they determine, to design multi-agency arrangements for protecting children, underpinned by a requirement to work together on the key strategic issues set out in this report and referenced in recommendation 2.
4. For new statutory arrangements to require health, local authorities and the police to make clear their leadership responsibility for multi-agency arrangements, to include the identification of a chief officer in each of the agencies to have responsibility and authority for ensuring full collaboration with those statutory arrangements.
5. For government to provide guidance on:
 - a. Drawing up a local proposal to provide strategic multi-agency arrangements to protect children.
 - b. The meaning of the terms Child Protection, Safeguarding and Wellbeing, clarifying the part of this spectrum to be covered in multi-agency statutory arrangements
6. For government departments (Department of Health, Department for Education, the Department for Communities and Local Government and the Home Office) to provide a clear, joint statement explaining their commitment to multi-agency arrangements and explaining how all local partners will be supported and required to play a full and committed role.

Accountability and diversity in service delivery

76. The English model of multi-agency arrangements puts a high premium on the need for clear lines of accountability and governance. We seek to develop and maintain this by placing a duty to cooperate on key agencies. As our model of public services has moved to a focus on autonomy, self-management and independence within devolved structures we have sought to clearly separate commissioning from delivery, e.g. Clinical Commissioning Groups (CCGs) and Hospital Trusts. As an unplanned consequence we have stretched the notion of accountability for the whole local system – whether in health, education or public services more generally – to the extent that the duty to cooperate in itself does not always ensure an arc of accountability across services. In some cases it has meant that the notion of a coherent local service across varied providers has not always been evident. Many of those who have contributed to this review have identified the shortcomings of this. Reference has been made to examples of schools, GP practices, children’s homes, hospital trusts and others not acknowledging the role they play in and for the local system, believing their individual service is the only system for the responsibilities and duties they carry out.

77. This tension is seen too often in the multi-agency arrangements for protecting children through the relationship between the local authority, local health services and the police. It is often manifested in the difficulty in agreeing financial contributions to the LSCB; difficulties in sharing information and data between agencies; attendance of senior staff at the Board; the carrying out of the role of the local authority designated officer; and the delivery of local arrangements – with attendance at child protection conferences still being referred to as a problem.

78. I do not think this is a small issue. As the dynamic of delivering public services continues to focus on diverse delivery models, to encourage new commissioners and providers to become engaged it will be necessary to consider carefully how we maintain a focus on high levels of accountability – across the system and within agencies – while supporting greater devolution of responsibility to a wider range of providers. This will be particularly important to achieve if all schools are to become academies. The complexity of this development for the organisation of multi-agency arrangements for protecting children must be clearly thought through and not underestimated.

79. We have to think beyond a duty to cooperate to consider how, without impacting on autonomy, we ensure we have a fully accountable multi-agency system for protecting children in all settings.

Demand for services and resources at a time of austerity

80. This Review takes place at a time of growth in demand for services to protect children and an increasing pressure on the resources available to meet need. The Department for Education's Children in Need Census data shows that in 2014-15 over 630,000 referrals were made to children's social care services. Over 550,000 assessments were carried out by social workers resulting in over 400,000 children being identified as in need of support. Over 160,000 children were subject to section 47 enquiries and over 62,000 children became subject of a Child Protection plan. Over 31,000 children were taken into the care of a local authority. Over the period 2009-10 to 2014-15 there was an almost 80% increase in Section 47 enquiries and a 27% increase in children with child protection plans at 31 March.

81. The National Audit Office (NAO) states that spending by local authorities on 'Safeguarding Children and Young People's Services' was 5% higher in 2014-15 when compared with 2013-14. The Children's Society states in their 'Everybody's Business' report¹⁴ that when they reviewed the income of 32 LSCBs, the amount per young person varied from £6.95 per young person in one Northern metropolitan borough to just £0.81 per young person in one large county area.

82. The cost of multi-agency arrangements to protect children has not been fully assessed or reviewed. The NAO audit framework for their study of child protection (January 2016) estimates that about 2% of the total national spend of £2 billion made by local authorities on safeguarding children and young people services in 2014-15 is spent on LSCBs.

83. The way in which costs are identified varies across areas and no standard formula exists. The costs for the local board usually include the cost of the Chair, the cost of the team and a budget for training. Some include a wider variety of costs but these are usually those incurred by the local authority. No clear cost of the time for officials from health, the police or other agencies to attend the LSCB or its sub groups exists. The fact that in many areas the Chair of the LSCB has said that key agencies have not been able to agree to make a consistent contribution to the funding of the LSCBs itself suggests a weakness in the model.

84. At a time of increasing pressure on resources across the public services the three key agencies, health, local authority and the police have identified significant staff costs for attendance. This is particularly a matter

¹⁴ Everybody's Business: How we work with Local Safeguarding Boards to tackle child sexual exploitation (2015)

raised by Police and Crime Commissioners (PCCs) and Chief Constables, and colleagues in health. It has been argued that the full cost of servicing the multi-agency architecture for protecting children and vulnerable adults is increasingly difficult to justify as it is diverting resources from front line practice and occupying increasingly significant time from leading practitioners. Research by a PCC, whose area covers five LSCBs and Safeguarding Adults Boards, has identified that police officers were required to attend 1,200 meetings in one year – this did not include attendance at child protection conferences. In response to the consultation for this review, the ADCS told me “It is unsustainable and frankly unrealistic to expect police forces and other public service agencies operating on footprints larger than that of a LA, to have to support, contribute to the cost of funding, and secure senior personnel attendance at multiple LSCBs”.

The three key sectors

The Police Service

85. I met with a range of PCCs, Chief Constables and other senior police officers including from the counter terrorism command. They have provided me with a very clear picture of the breadth and complexity of the issues that pose a risk and threat to children and the pace with which the sophistication of that risk becomes more covert and encompassing.

86. Several key points about multi-agency arrangements were made. In particular, I heard a view that the arrangements lacked sufficient impact; were too bureaucratic; were not sufficiently intelligence led; and required a very substantial demand on police time to attend meetings within their structure.

87. A strong case was made for clarifying leadership, particularly across the police, health and the local authority and for serious attention to be given to the range of structures, boards and agencies that were involved in arranging meetings that discuss children. A particular point was made about the impact on a police service when it has to service and support numerous LSCBs in the police area. This is not just in terms of the impact on police officer time but that fact that within those LSCBs there could be several differing approaches to practice and initiatives to deal with issues, e.g. child sexual exploitation, triggers for removing children from their families.

88. A number of those I met put forward a strong argument that local PCCs should be given a statutory role to lead multi-agency arrangements for protecting children. They saw that the increasing role the police are playing in dealing with domestic violence, sexual abuse and exploitation, trafficked

children, youth and gang violence, extremism and radicalisation of young people meant that their cross agency role was becoming more critical in safeguarding children, and they argued that they were able to organise cross agency resources more effectively. In addition the democratic mandate of a PCC meant that they would carry a clear line of accountability to the public for the effective performance of services.

89. This issue is integral to the balance between prescriptive and permissive in future multi-agency arrangements. In my view, it would not be appropriate for the arrangements to be led by a PCC. Principally this is because the statutory duties of the local authority in child protection and its links directly to the family courts require it to take the leadership role. Further, given the remit of a PCC is being looked at to see if it should be expanded to cover other Blue Light services, the required discrete professional led focus on child protection, linked to the family court, would be unlikely. I do not think the PCC should take the lead on multi-agency arrangements to protect children.

90. If in a more permissive model e.g. a community partnership approach is constructed around part of the safeguarding and wellbeing services for children to cover issues such as trafficking, gangs, peer on peer and organised group sexual exploitation of children, radicalisation and extremism, the leading role of the police service in these services, and the direct links to the criminal justice system, would indicate a need to consider how leadership by the PCC and accountability would be structured. PCCs have a critical role in the broader safeguarding agenda and I would want to see them play a very significant leading role in designing the community led response to this complex agenda.

91. The model of multi-agency safeguarding hubs (MASHs) has been particularly praised by some, including senior police officers and PCCs, as a new more forensic form of early identification of children at risk. Other commentators are less convinced of the effectiveness of the model. We need to know more about the impact a MASH is having on the early identification of children and young people at risk, and how and if the intelligence it gathers is driving improvement in outcomes.

92. I think there are important lessons to be considered from the experience of multi-agency working in the Prevent and Channel programmes, particularly aspects like the Social Inclusion Panel operating in Tower Hamlets. Similarly, given the strong views held about the multi-agency work undertaken in MASH services, it would be useful to undertake a detailed national assessment of them.

Recommendation

7. The Department for Education should review what approaches to early cross agency intervention and intelligence gathering to identify children and young people at risk are most effective, including considering whether the MASH model offers an effective approach.

The Health Service

93. Safeguarding vulnerable people in the NHS is described in the Accountability and Assurance Framework (AAF), the current version of which was published in June 2015¹⁵. This document sets out the safeguarding roles, duties and responsibilities of all organisations commissioning NHS health and social care. Section 27 of the Children Act 1989 requires NHS agencies (and others) to help a local authority to discharge its safeguarding duties toward children. These agencies must do so as long as it is compatible with their duties and does not hamper their own functions.

94. The NHS is a complex and multi-layered organisation. It comprises separate and discrete agencies and has undergone a number of significant reorganisations in the past period. One was the introduction of CCGs: as commissioners of services for their local population, they are responsible for commissioning most hospital and community healthcare services. The AAF requires CCGs to demonstrate they have appropriate systems in place for discharging their safeguarding duties including effective inter agency working with LSCBs. Safeguarding forms part of the NHS standard contract and CCGs must agree with their providers what contract monitoring processes are used to demonstrate compliance with safeguarding duties. The framework is clear on these matters and lays out how NHS England maintains oversight of safeguarding. This includes a national steering group to provide support and advice on delivering the AAF. NHS regions must provide assurance to the steering group on the effectiveness and quality of safeguarding in their area. The AAF is therefore a comprehensive document. However, this review has raised a question as to how effective it is in ensuring a full contribution by all health agencies to multi-agency arrangements.

95. In this review it has been made clear to me that despite the AAF there are many challenges with the contribution health services are making to LSCBs. These include a view that the wider partnership is not always included in discussion about the commissioning of health services for children and young people, the lack of representation of senior staff, the inability to agree

¹⁵ NHS England (2015), Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework

one health voice or priority, disputes as to whether safeguarding responsibilities rest with the CCG or the provider – often seen in debates as to which body makes the financial contribution to the LSCB (with the issue being passed between the two), and effective completion of section 11 audits. In combination these concerns suggest that the current arrangements for multi-agency working cannot sufficiently bring about the full contribution or cooperation of the NHS family of agencies.

96. This difficulty may well be because of the complexities of the NHS arrangements and the existence of discrete bodies that are not geared to offer one authoritative voice on health issues. It may be the complexity of multi-agency arrangements and the large number of sub groups and boards they have to service, or it could be the lack of coterminosity of boundaries between health bodies and other local agencies. I think each of these factors plays a part in creating this difficulty. In addition I think two other factors impact. First, there is the fact that LSCB agendas often contain a mixture of operational, business and strategic matters, which creates a confusing picture and a loss of focus on what the key strategic issues are that need to be dealt with, and the health representatives in attendance who can deal with them. Second, there is a real problem if it is not practically possible for the health services themselves to cooperate in their contribution to local multi-agency arrangements to protect children. While some health services have developed with their partners specific services to deliver community health services for young people and some have forged impressive partnerships with social care services to identify and protect vulnerable children within particular local authorities, it is not evident that the LSCB framework has been effective in promoting these linkages. A Designated Nurse of a CCG told me, “Since reorganisation the NHS has become fragmented. Difficult to hold GPs to account....the Provider commissioner split has had an enormous impact on working together – brick walls have been erected between the services.”

97. If we can focus the purpose of multi-agency arrangements on a set of strategic issues, all of which support practice leaders to take forward multi-agency practice to protect and safeguard children, it must be feasible to devise an approach, in a reconfiguration of multi-agency arrangements to protect children, that allows for one Chief Officer of the NHS family in an area to be approved to speak with the necessary authoritative voice. This would ensure that the collective NHS contribution can be effectively made in local arrangements.

Recommendation

8. NHS (England) should consider how their AAF for safeguarding vulnerable people could be amended to place greater emphasis on how local health agencies fully participate in multi-agency practice.

Local government, schools and education

98. I have considered whether schools should be added to the list of three key agencies to set out the strategic framework for protecting and safeguarding children and young people in an area. All types of schools, nurseries and colleges have a critical role to play in ensuring children are safe, that early help is well organised and for liaising with their local authority in respect of child protection and safeguarding procedures. They are at the forefront of developing early intervention and alerting the system to a child's needs. Multi-agency arrangements to protect children apply to all children in an area irrespective of the place they attend for education. The local authority has the responsibility to ensure each and every child in its area is protected. In that sense they are the agent of the local community and have responsibility for all of its children. I believe therefore they are in a position to represent all children. One school cannot do this and it is not possible for 24,000 schools nationally to be represented with one voice. Given the responsibilities a local authority has in the wider lives of children and young people it can be an effective voice. This does not mean that schools, nurseries and colleges have no role in designing, representing, influencing or delivering services in the multi-agency arrangements. It does mean their main business of working to ensure all children in all schools receive a first class education can be undertaken in a strategic framework that has the full backing of the three agencies and underpins the development of practice to identify early children and young people at risk.

99. Keeping Children Safe in Education (2015)¹⁶ sets out clearly how all schools, maintained, faith, free schools, academies and independent, should act when dealing with any concerns they have about safeguarding children. It is also clear that all schools must provide information to LSCBs if requested to do so.

100. Too often in this review I have been told by DCSs, police officers and staff in the NHS that it is increasingly difficult to engage schools, particularly academies and free schools, in the wider arrangements for safeguarding in an area and to provide information when requested. When Research in Practice looked at these issues they identified evidence of this but also the view of

¹⁶ Department for Education (2015), Keeping Children Safe in Education

some schools that the local authority or LSCB was not aware of the arrangements schools had made to protect children. I have been advised that there is a need to further clarify that it is the responsibility of every school, irrespective of its status, to comply with the same arrangements as any other school in an area. The National Police Chiefs' Council told me:

“Given the rising number of academies further consideration is required relating to the role of LSCBs and their capacity to influence and coordinate safeguarding activity across them. Schools are a key stakeholder in this area in terms of information sharing, identification of need and delivering prevention materials/ advice. It is extremely important that their activities are coordinated/ joined up with other local safeguarding partners.”

101. It has also been suggested that where schools are part of a multi academy trust the school should have a direct safeguarding relationship with the LSCB and not just one via their chain. The responsibilities of chains should be further clarified such that their focus in respect of safeguarding children and local multi-agency arrangements to protect children are clear. This must be resolved and it will be essential to do so in a world in which all schools are academies and hundreds of multi academy trusts exist.

102. A number of Directors of Children's Services (DCSs) and chairs of LSCBs have raised the lack of effective statutory provision about children in unregistered school settings or receiving home education. They point to the fact that public agencies do not have the right to gather information on the children in such settings and have no way of assessing the level of risk children face. This issue is not covered in multi-agency arrangements and it needs to be.

103. In some areas, a significant number of children attend independent faith schools for their period of statutory education. A number also attend unregistered settings, which to all intents and purposes are schools. In these settings there is an absence of national guidelines or procedures on allowing access to the property to check the details of children in attendance and to assess whether or not the setting meets the requirements of a school. For those charged with carrying out safeguarding duties on behalf of the local authority this creates a gap in their knowledge of children in their area as they have no lawful way of assessing any potential safeguarding risk. A similar issue exists in respect of children who are home educated. The majority of parents who arrange home education for their children work closely with, and share information with, the local authority. However, this is a voluntary act on behalf of the parent and a number of parents are not willing to provide information to the local authority. In both of these cases the local authority is

not able to assess either the quality of education being received by the child or whether there are any safeguarding issues that require attention. This needs to be addressed urgently. New guidance should be provided which makes clear the responsibility of parents to ensure information about their child's education is provided to the local authority and proprietors of unregistered school settings should be required to fall into scope of the local multi-agency safeguarding arrangements and to be registered with an appropriate body.

104. As more resources are devolved to schools, and the role of local authorities in education changes to accommodate the passing of responsibilities to schools, a significant question arises of what the role of a school is in intervening early when things seem to be going wrong for a child or young person. Resources provided for early intervention by local authorities have been reducing¹⁷. Evidence for this can be seen in the closure of children's centres and the cessation of their outreach services. Reasons like this are advanced to explain the increase in referrals to children's social care in most local authorities. We need to be clear as to what it is reasonable to expect schools to do to support children and young people. Referral to services outside the school is not a route that is likely to be available other than for those with the most challenging needs. This early intervention work is something schools will increasingly be expected to do, and in a fully academised school system there needs to be absolute clarity about the early help role played by schools. There should be a national discussion with schools on this issue and it will need to feature centrally in the proposed Department for Education review of the role of the local authority in education.

105. In conclusion, there is a case for primary legislation to strengthen the framework around unregistered settings and what constitutes a school, as opposed to a religious centre. Linked to this, the current guidance with regard to children who are educated at home – which some parents of children who attend unregistered settings will claim – needs urgent review in order to enable local authorities to fulfill their safeguarding responsibilities and ensure the wellbeing of those children. I welcome therefore the proposal in the White Paper, "Educational Excellence Everywhere"¹⁸ to consider the role of the local authority in ensuring the safety of children in these settings; this needs to be undertaken soon.

¹⁷ Association of Directors of Children's Services (2014) Safeguarding Pressures, phase 4.

¹⁸ Department for Education (2016), Educational excellence everywhere

Recommendations

9. Keeping Children Safe in Education should be reviewed to ensure it covers child protection and safeguarding issues in respect of unregistered school settings, independent schools and home education. There should also be clearer guidance on the role played by the police and the NHS in that process. Keeping Children Safe in Education should make clear what role, if any, academy chains will carry out in respect of child protection and safeguarding children.
10. The role of schools in providing early help to children and young people should be included in the Department for Education's review of the role of a local authority in education. This should include the role of the police and health services.

Leadership and related issues

Leadership

106. Leadership of multi-agency arrangements is a critical issue. It is not clear who leads the arrangements currently. This is at both local and national level. Some have made the point that in a sense leadership has moved from local to national decision making as evidenced by the prescriptive way in which local services are required to make their arrangements to protect and safeguard children. The message from the survey is that 41% of respondents said 'No' to the question 'is it clear who should lead multi-agency arrangements?'

107. At the centre of the leadership framework is the statutory guidance provided for the DCS and the Lead Member. This covers the range of children's services including significant aspects of education. The role of the DCS has over the last few years been broadened to cover other key areas of public service, e.g. public health and adult services. Indeed in over half of local authorities the DCS is also the Director of Adult Services.

108. The relationship between a DCS and the Chair of an LSCB is not without its tensions, and while in most cases it is a strong and clear partnership, in others it is not and this is reflected also in the survey. This is sometimes made more complicated because of the important relationship between the Chair and the local authority's chief executive. The Association of Directors of Children's Services see the DCS as the leader of the system because of the statutory responsibilities they have in respect of children. Others offer a different view. They point to the fact that the system has become skewed toward the local authority with the key role of senior leaders in health and the police not recognised within the multi-agency statutory

framework. As a consequence, and despite the best efforts of many Chairs of LSCBs, the activities of the partnership often lack the full contribution and agreement of parts of the health, local government and police systems who point to complexities and priorities within their own organisation. This has been referred to as no one having the *authority* to lead the arrangements.

109. The Deep Dive carried out by the Cabinet Office Implementation Unit found this to be a barrier to effective leadership. This was expressed by some Chairs of LSCBs they interviewed as not having the levers to deal with a lack of cooperation by partner agencies. This was identified as particularly challenging in the case of independent parties such as schools (especially academies), GPs and CCGs. This lack of a unified approach is also a characteristic of much of the cross government department working, which often flatters to deceive when discussing multi-agency commitments.

110. One way of overcoming this may be to ensure that within multi-agency strategic decision making the local police, health and local government structures identify a chief officer to carry full plenipotentiary powers in agreeing the strategic plans for protecting children. In this way, with a clear set of issues of strategic importance to deal with, we may have a more balanced approach to cross agency leadership. As a plenipotentiary appointed from within their own agency they will have the agreed authority of the various parts of their service area. For example in Health, they would be the person who spoke for the commitment of each of the component, separate parts. Within each agency the responsible chief officer would continue in their leadership role to carry all the relevant responsibility for the specific statutory duties placed on the agency, e.g. those relating to child protection in a local authority.

111. The White Paper, Educational Excellence Everywhere, states that the Department for Education will be considering the implications of the changing role of a local authority in education on the positions of the DCS and Lead Member. This will give an opportunity to consider the impact of a changing role on the statutory guidance underpinning both roles. Taken alongside the changes in social work leadership with the key focus on practice leaders, this proposal opens up a discussion on leadership across the multi-agency system and allows for consideration to be given to the role of chief officers in health and the Police in ensuring each area has effective multi-agency arrangements to protect children. It would make sense to review the statutory guidance in this context of clarifying leadership roles across the partnership.

112. Elected members to a local authority have the role of ensuring delivery of effective services to their residents. Their democratic mandate gives them a

unique role in the delivery of multi-agency arrangements. On behalf of a local authority the Lead Member for children and young people has a specific role in ensuring the services designed to protect and safeguard children are effectively organised and delivered. Elected members seek also to ensure representations on behalf of residents are made to other agencies, particularly health and the police, responsible for a wider range of public services.

113. Elected members should be encouraged to give more public scrutiny of services to protect children, the assessment of their effectiveness and openness about learning from serious incidents. This would allow elected members to give a stronger assurance to the public that children and young people are being protected. This along with further openness and transparency in the governance arrangements of the health and police services (with a clear role for the PCC), point to what more that could be done to build public confidence that the three agencies are working together to protect and safeguard children.

Recommendations

11. To consider whether the statutory guidance in relation to DCSs and Lead Members is necessary in light of the new White Paper and recommendations made by this review.
12. To consider issuing new guidance on the responsibilities of a chief officer nominated by each of health, the police and local government to agree the multi-agency arrangements and processes in an area.

Independence

114. Both in the survey and during consultation, great emphasis has been placed on the importance of independence as a factor that assures objectivity and credibility for multi-agency arrangements. The principal points were the need for independent scrutiny of our multi-agency system and in SCRs the need for independent and objective analysis.

115. In its response to the consultation, Ofsted said it had seen no evidence that the independence of the Chair of an LSCB brings more effective working. Its view is that the effective leadership and influence of the Chair is more important in supporting effective multi-agency arrangements than their independence. The LGA, which found a similar message in its recent research¹⁹, supports this view. The Association of Independent LSCB Chairs believes that an independent broker or commissioner is needed to hold

¹⁹ Baginsky, M. & Holmes, D. (2015), A review of current arrangements for the operation of Local Safeguarding Children Boards.

statutory services and their partners to account for the difference services make to children. The Youth Justice Board told me that the independent chair “acts as a balance to prevent the domination of one partner.” Some respondents questioned the objectivity and/or credibility of independent Chairs in the current arrangements, given that the Chair is appointed, paid and performance managed by the local authority. The Children’s Commissioner told me:

“LSCB Chairs are appointed by the Local Authority Chief Executive. Given that they exist to hold the local authority and other partners to account, their ability to robustly challenge poor performance is perhaps limited.”

116. I think there is an important role for independent scrutiny and assurance in multi-agency arrangements. While the appointment of an independent Chair is one way of achieving that, there are others that could be considered, for example, independent multi-agency audits of specific themes of work; focused external impact assessments on multi-agency training; an independent advisory group to “tell it as it is” to key decision makers; or a challenge session for the leadership and governors of individual agencies on the impact of their contribution to multi-agency working to protect children. And of course, the regulatory bodies will also look at these issues during their routine inspection and there will also be Joint Targeted Area Inspections (JTAs) – thematic inspections that will cover a number of areas and specific themes for investigation.

117. A factor in this is the nature of the multi-agency arrangements and whether or not the role of independent scrutiny is subject to statutory guidance. Public confidence is likely to be enhanced when it is evident that there has been an independent element in judging the effectiveness of services to protect children. Independence can also assist when there is disagreement between the leaders responsible for protecting children in the agencies involved in multi-agency arrangements.

118. In respect of inquiries into serious events, I think transparency in local models needs to be more evident. The opportunity for independent review should always be considered. In national inquiries the importance of independent and objective leadership will be essential.

Children and Young People

119. As well as holding a productive meeting with the Children’s Commissioner, I also received a detailed note based on what children had told her. She said

“Many children complain to my office about poor co-ordination between agencies - especially when things have gone wrong. This will often take a number of forms:

- being exposed to risk because agencies have not taken responsibility for their safeguarding needs;
- experiencing different responses from different agencies when the same issue is reported;
- being required to recount their story and information many times to different professionals causing additional distress;
- being unclear as to whom to talk to or report. This may also mean being unclear who will be the most responsive to their needs (children have often reported good and bad responses from various agencies suggesting that a coherent response has not been embedded across agencies themselves);
- being unclear which agency is responsible for which issues;
- being referred on without a clear referral back if the issue is not resolved.”

120. These comments are pertinent and telling. I also met three groups of young people to discuss issues they had identified in respect of protecting children. Young people were keen to ask questions as to how the multi-agency system operated and how sensitive it was in identifying the key issues of concern to young people. They described for me a number of ways in which they had been involved in providing information and advice to local authorities, the police, health agencies and the LSCB.

121. I am particularly thankful to Cafcass for arranging for me to meet with a group of young people. These young people shared with me their thoughts about the threats facing them. They stressed how important it was for vulnerable young people to feel confident that public agencies are working together to protect them and keep them safe. They stressed how important it was for adults to be alert to the sensitivity of many issues facing young people, in particular cultural awareness of a young person’s religion, language, community and background. They raised the issue of the pressures young people face, particularly in respect of grooming and the ease with which online approaches are made to very young children. They also queried whether enough was being done to support children and young people’s emotional and mental health.

122. I saw evidence of the outcome of surveys that had been conducted; of discussions and statements made by local Youth Parliaments; of leaflets and other information designed by and for young people. Hackney Youth Parliament had been commissioned by the LSCB to make a film for school students on the theme of child sexual exploitation. They explained the planning of this and how their contacts directly with young people with whom they consulted helped them identify peer on peer sexual exploitation as a key issue as opposed to their original idea of a young person being exploited by an older man. I thought this was a good example of how young people's views on the risks and threats they face may differ from those adults might have identified. They have produced a very effective leaflet called 'Say Something' and their film can be found on YouTube.

123. The Participation People invited me to discuss with a group of young people from Wandsworth the work they had been doing with their peers to raise awareness of safeguarding issues. The group was clear about the existence of the complicated risks young people faced and how they needed to develop resilience and knowledge to combat bullying, violence and personal safety. The members were keen to encourage public bodies to do more to find out the opinions of the most vulnerable young people facing the greatest risks. In particular they wanted to stress the impact on children who were removed from their home and placed in another area and pointed to the serious problems that can cause. They also raised the issues of relations with the police services. This was done in a thoughtful manner – for example they had a very interesting critique of the way in which police measured crime in terms of ethnicity.

124. These examples of engaging with young people are also seen across the country. We need to ensure we do this more regularly using a variety of approaches. It is worth noting that this work was achieved without young people being a formal part of the LSCB. This point of engaging with young people in an open and exploratory way was also made by the Children's Commissioner, who pointed out how ineffective engagement can sometimes be if we simply involve individual young people as a tokenistic part of the formal structure. Those leading local services, and the thinking and planning of the decision makers involved in multi-agency arrangements, should ensure that engagement with young people is always covered in their work and should see young people as an intrinsic and critical partner in helping to redesign and improve the services we provide to protect and safeguard them. But this should be done in a creative and thoughtful way and not by simply seeing young people as another group to appoint to panels or be consulted with.

The wider landscape

Inspection

125. The process of inspection is, in my view, intrinsically linked to improving our services to protect children. It is vital therefore that inspection is organised and structured in a manner which can most effectively bring about necessary improvement – this is at all levels of quality not just when services are poor.

126. To be effective inspection must be seen to add value, it must be proportionate, and forensic in its analysis with clear pointers to how improvement might be achieved. Critically, it must be seen to be of consistently high standard and reliable. Thus far inspection of multi-agency arrangements has not met this standard and has not been seen within the sector as credible. One of the reasons for this was the fact that the inspections were more co-located than joint. Often the individual regulator would comment on how their agency experienced the role of the other agencies as opposed to inspecting what that agency contributed to the cross agency arrangements to protect children.

127. A criticism is made that the first tranche of reviews of LSCBs as part of the Single Inspection Framework (SIF) followed a narrow model of what an LSCB should be like and what it should do and they were tick-boxed against what is laid out in Working Together. These comments are still made. There is no statutory requirement to carry out reviews of LSCBs. There is little more we can learn from continuing these reviews. Over 50% have been reviewed, and, particularly given the resources required to carry them out, serious consideration should be given to whether or not they should continue.

128. The new arrangements for thematic JTAs show promise and provide an opportunity for considering how they might look at multi-agency arrangements in a selected group of areas. The JTA looks at the experience of children and their families and improving outcomes for them is a key task of multi-agency arrangements. We would need to ensure that these early signs are not overcome by a drift into a formulaic inspection of multi-agency arrangements.

129. In this model, inspection of multi-agency arrangements would therefore be viewed through two lenses. The individual inspection of each agency carried out by their regulator, (the Care Quality Commission, Ofsted (post SIF) and Her Majesty's Inspectorate of Constabulary) and the thematic JTA. This would help us to build a strong picture of the effectiveness of the

arrangements and create sufficient feedback to ensure learning in the wider system from good practice.

130. The model of inspection of children's social care has not been, until recently, sufficiently flexible to consider how new and innovative models of delivery are to be assessed, as their structural arrangements are not covered within the inspection framework – this was also the case where models of social work delivery are outside the normal methodological or structural models. This is probably because Ofsted is required to inspect against Working Together which drives an over-emphasis on process rather than the experience of the child.

131. There is a strong view within the sector that the model of inspection of the 'front-door' that was short and unannounced, provided a clear list of strength, areas for development and priority actions was the most helpful in assisting areas to improve the services they provided.

132. The impact of the wide variety of inspection on children services, e.g. SIF and SEN-Disability create a very significant demand for resources on the inspectorate and local authorities. The level of resource taken up by preparing for, undergoing and learning from inspection is considerable and can mean it is not therefore available for front-line practice. In addition the workload on the inspectorates this creates reduces the frequency with which they can inspect an area and the capacity to undertake thematic reviews.

133. When a new model of inspection is introduced, after the completion of the SIF, consideration should be given to a short, unannounced inspection – one that has the capacity to be extended to a fuller inspection if the lead inspector has serious cause for concern that children are at risk. This should also consider how multi-agency arrangements for the area add to the effectiveness of the child protection front door. A strong narrative judgement describing strengths and areas for improvement can be much more effectively linked to improvement than a single word judgement on one or more areas of activity. These judgements with their overlong grade criteria encourage agencies to play to the recipe and ensure that inspectors adopt best fit assessments rather than a reasoned overall judgement.

134. Serious consideration should be given to whether the need for the existing arrangements for separately inspecting services such as SEN-Disability could be replaced by credible, accountable, local models of assessment against a national framework.

135. If inspection is to aid and support a self-improving system, it must be afforded the capacity to introduce nimble models of inspection which are focused on the quality of practice and the effectiveness of service rather than the level of compliance with a detailed framework for inspection with a set of complex grade criteria which in themselves tend to focus agencies of cooking strictly to the recipe. We have seen significant steps forward in school inspections. They are now proportionate, informative, timely and effective in helping leaders identify and work on improvement. We need to transfer these lessons to the way we inspect services for protecting children. Unless we do this we run the risk of missing out on the real value inspection can add and continue to add unnecessary cost to a process that will not have a sufficient impact on driving improvement.

Recommendations

13. The Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Her Majesty's Inspectorate of Probation should review their inspection frameworks to ensure they focus on child protection practice without being burdensome on service providers. Their inspections should be proportionate and always assess the contribution the agency they inspect makes to successful multi-agency working.
14. There are too many separate inspections of local authority children's services: this is over burdensome, costly and needs urgent attention. In replacing the Single Inspection Framework (SIF), Ofsted should be encouraged to develop a model that is not burdensome, is unannounced, short in duration (5 days), and focuses on the child protection practice. It should identify strengths and areas for development in the local authority.
15. The JTAI should not replicate the inspection of the child protection front door. That should be a discrete inspection. The JTAI should concentrate of key themes in the life and experience of children and young people e.g. domestic violence, child sexual abuse, children with a disability, missing children, youth violence, gangs and neglect. In carrying out these thematic inspections the focus would be on the multi-agency approach and the outcomes for children achieved by it.
16. The review of an LSCB as part of the SIF should be discontinued at the earliest possible time.

Responding to changing risks

136. Increasingly we recognise the complexity and connectedness of the ways in which children and young people are being targeted and put at risk of harm, abuse and exploitation in both a family setting and the wider

community. Cases being referred to children's social care often feature a combination of neglect, physical and emotional abuse, domestic violence, including alcohol and drug abuse, financial and on line exploitation, fear of child sexual exploitation, child trafficking, gang activity and violence. Recently issues to do with extremism and the radicalisation of children and young people have been included in the referrals. In response we have broadened the remit of LSCBs to cover these issues and in some areas developed MASHs to sift the volume of referrals and information received from schools, the police, health and the public. Some refer to the high prevalence of a 'toxic trio' (substance abuse, mental health and domestic violence) in cases referred for assessment.

137. However, there is little evidence that we have responded to this level of complexity with intelligent analysis and adjusted the models of prevention and intervention accordingly. We still encounter difficulties in sharing information between agencies and even in new approaches like MASH we have to create discrete spaces with physical barriers and extensive protocols to ensure a social worker does not have access inadvertently to information held by health or police services or vice-versa. In my meeting with the Centre of Excellence for Information Sharing, they told me that one of their key objectives is to influence national partners where national barriers restrict local services. Their input in helping to improve information sharing would be very timely.

138. It is clear that at local level agencies sometimes over police themselves with concern about data protection and confidentiality and do not share even the most prosaic of information. We really must improve on this position. It is disappointing that we have still to find a sensible way to collect and share information without resorting to patrolling the boundaries between agencies to make sure nothing leaks across them. Sharing information is not a barrier to those who combine to exploit and abuse children.

139. Our response to the increasing sophistication and complexity of those targeting children and young people must be improved dramatically if we are to mitigate these risks. The recent research by the NSPCC²⁰ shows a very worrying increase on the number of children and young people being put at risk. Their survey found that the number of child sex offences reported to police throughout the UK rose last year to a record 45,456.

140. The LSCB model is predicated on child protection within the family. Extending its remit further into safeguarding and wellbeing has, some argue,

²⁰ <https://www.nspcc.org.uk/fighting-for-child/news-opinion/child-sex-offences-uk-record-rise/>

diluted its focus on a core of child protection and its structure and authority are not designed to cover this wider remit. The response to the threats posed to children and young people requires a more sophisticated response across the three key agencies of health, local government, and the police. Simply adding to the remit of an LSCB or providing additional guidance on more areas of high risk will not in themselves make the changes and improvement needed to ensure practitioners on the ground can respond more effectively or cooperatively.

141. We need to create a coherent and comprehensive cross agency capacity, led by a forensic analysis of the data and intelligence received, to move in a timely manner from referral to analysis to action. This should be a core strategic requirement on each of the three key agencies. Our multi-agency arrangements need to be underpinned by such a new, intelligence led approach.

Recommendation

17. For the Home Office and Departments of Communities and Local Government, Health, and Education to issue joint advice and guidance on the critical importance of effective and speedy sharing of information and data in relation to protecting and safeguarding children. This should focus on the expectation that unless there is specific legal impediment information must be shared.

The complex multi-agency landscape

142. A significant number of people stated that the current landscape within which multi-agency arrangements operate is becoming increasingly complicated. The problems of defining an area and its boundaries has been raised on many occasions, with examples of a police or health service for one area having to serve several LSCBs in that area, each of whom may have different policies, procedures and requirements. Scale is also an issue in terms of population size, geography (rural, urban for example), coterminosity of organisational boundaries and the way in which command and control or governance arrangements within an organisation may not sit in scope to any one LSCB area.

143. In putting together these arrangements, groups of Chief Constables, local authority Chief Executives and health leaders will need to agree how far they are willing to go to ensure the new body acts strategically on behalf of their constituent parts and the precise balance between central and local decision making. Without a clear agreement on these points, an authorising

environment will not exist and the problems of the current arrangements will be replicated.

144. Increasingly proposals are being developed by groups of local authorities, health and police services to take account of the scale of their areas- e.g. population size, geography, different service organisational boundaries and spans of control with individual agencies. These are being designed to improve services by reducing duplication and shortening command lines. I was able to discuss work being undertaken by a number of cross authority/agency bodies including:

- Greater Manchester on creating a new multi-agency body to deal with complex safeguarding across ten authorities;
- Birmingham Safeguarding Children Board Transforming Programme, changing the function of the Board to concentrate on scrutiny, assurance and evaluation; and
- West Midlands LSCB Chairs System Change Project, to reassign a number of functions from individual Boards to be carried out in a regional model.

145. This work should be incentivised and encouraged by government departments. The applicants for devolution deals who have a deal in place or are in negotiations should be invited, if they have not already done so, to include proposals for transforming multi-agency arrangements for child protection and safeguarding services more widely in their bids.

146. Consultees pointed also to the overlap between committees, especially across LSCBs, Health and Wellbeing Boards, Community Safety Partnerships, Local Family Justice Boards, Safeguarding Adults Boards, Children's Trust arrangements (where they are still being operated) and a range of local and national bodies. In the interim report of emerging findings of the Review of the Youth Justice System the authors state they are keen to support local areas by a "*...more streamlined accountability and monitoring system that reduces central prescription and allows greater freedom for innovation and collaboration between local partners.*" This is exactly the approach advocated in this review.²¹

147. People referred to a duplication of attendees, agenda items being referred between agencies, the generation of additional reports and a significant demand on the time of officials. The National Probation Service told me, "*Currently there is significant overlap in the priorities/policies/delivery*

²¹ Ministry of Justice, (2016), Review of the Youth Justice System: An interim report of emerging findings

within these partnership structures (for example around child sexual exploitation) and a need for greater strategic coordination.” The Children’s Society commented, too, that ‘there continues to be a plethora of formalised fora that touch upon the safeguarding of children it is a complex picture and sometimes militates against overall effectiveness in safeguarding children..... If reform can bring greater clarity to such an issue, this would be welcome.’

148. I believe it is necessary for government departments to give serious consideration to the impact this wider group of bodies is having on the efficiency and effectiveness of the system to protect children. It is a matter that should be reviewed particularly if the proposals in this report are taken forward.

Recommendations

18. To incentivise all applicants for devolution deals to include in their proposals arrangements for establishing multi-agency arrangements for protecting children.

19. Government departments should review the range of Boards and guidance (e.g. Health and Wellbeing Boards, Local Family Justice Boards, Community Safety Partnerships) with a view to reducing the burden, and therefore cost, on the health agencies, the police, local government and other agencies.

The role of the voluntary and community sectors

149. There was a very impressive response to my review by the voluntary and community sector. I met with the chief executives, or their representatives, of the five larger organisations working to protect children. They and others gave me clear evidence of the critical role they play.

150. They explained that their contribution to multi-agency working is at every level of activity. They commission services, provide specialist services (e.g. in relation to child sexual exploitation), they help develop the voice of children and young people, provide early support for children and families at risk, lobby for improvement to services, provide helplines and specific guidance to all agencies and widely promote the need to be alert to, aware of and speak out about the need to protect children.

151. In addition they play a direct role in both LSCBs and SCRs and provide a wide range of training and dissemination of good practice guides. Cafcass, for example, play a very important role in protecting children. Their work is crucial ensuring the best interests of children are in the forefront of discussion

in court and they have made a significant contribution to the work of LSCBs, e.g. by organising joint training, and their contribution to SCRs – over 100 in the last five years. However, it is not feasible for Cafcass to attend all LSCBs regularly as it would be a major draw on their resources. This is a problem faced by other agencies, for example the National Probation Service.

152. I was given a very helpful document by the NSPCC which gave a clear picture of their members' experience of being part of an LSCB. Two particularly important points made in this document were the absence of any formalised training when they joined an LSCB and the fact that best practice was rarely covered in either LSCB activity or SCRs. Others pointed to the need to find novel and thoughtful ways of engaging with children, especially younger ones.

153. In a permissive structure it may be possible to work more closely with the voluntary and community sector to develop more flexible ways of using their expertise. It is very important, however, to be clear that the contribution is not made by national or larger bodies alone. In small, local projects very valuable work is undertaken with small groups of children and young people who face significant risk. Tailored activities in partnership with schools and other community organisations ensure a wide link to early help for families and children and this is an important aspect of the preventative services needed to protect children. The contribution made by the voluntary and community sector will continue to be a very important part of the national and local framework to protect children and we need to think harder about how we can engage them and support the valuable work they do.

Serious case reviews

“It would be good if SCRs focused on why people acted as they did, not just reporting what they did. For this reason, it is hard to inquire into practice several years later when the relevant people aren’t around to talk.”

Professor Eileen Munro

154. Since their inception, LSCBs have had a specific function to conduct SCRs. Following the 2011 Munro Review of child protection²², Working Together emphasised LSCBs’ duty to commission and publish SCRs, but gave them the freedom to determine their format.

155. There is general agreement that the system has not made the most of the learning available from carrying out SCRs. Working Together sets out the importance of maintaining a local learning framework and lays out seven principles that should apply to it. These principles apply to the culture and organisation of reviews. There is little on the features that characterise what a good review looks like. The absence of a national framework for learning, despite the full repository held by the NSPCC, means that sharing of learning is at best ad hoc. Although full of important information and analysis, the biennial reviews of SCRs have not been turned into an effective tool for promoting such a national framework. In the absence of an effective framework there remains a risk that the valuable information contained in the forthcoming report of the triennial review will fail to make an impact on national learning.

156. Despite guidance in Working Together, too often the purpose of a local SCR is considered to be to find out who made a mistake. This has created a defensive culture in which exhaustive chronological narrative is produced by agencies so as to ensure the most complete contextualisation of an event is provided to the lead reviewer. SCR reviewers talk about the pressure they often face from agencies to over mediate the circumstance of an event, leading to the development of flaccid recommendations. Agencies have referred to authors who seek out and concentrate on small incidents deep in the past in search of a clear evidential circumstance that explains what went wrong.

157. Respondents to the consultation have spoken about the importance of the methodology used in SCRs. The freedom to choose introduced by Working Together (2013) has led to a number of different approaches being

²² Munro, E, (2011), The Munro Review of Child Protection: Final Report. *A child-centred system*

utilised. In a draft version (February 2016) of the Triennial Review of SCRs, 2011-14 nine different review types (excluding blended approaches or hybrid reviews) were identified. Models used included the Social Care Institute for Excellence Learning Together approach and the Significant Incident Learning Process. 103 of the 175 cases studies did not state a particular method or identified a blended or hybrid approach, many using the traditional model of gathering together Individual Management Reports. Eileen Munro has suggested that the existence of a wide breadth of methods indicates that both commissioners and lead reviewers may benefit from better training and support about what is needed.

158. I believe the SCR is now a discredited model. There is very little promulgation of the effective learning from a review and good practice that is undertaken tends to be hidden, receiving no publicity or focus. The criticisms of it outweigh the improvements identified in the second report of the national panel of independent experts on SCRs.

159. In this review I met with and heard from a significant number of independent SCR authors. I was impressed with the clarity of their critique of the SCR system and process and their suggestions as to how to improve the model of inquiry. They accepted that there was variation in the quality of reviewers, and they argued strongly for a national model of accreditation and professional development to ensure a sufficiency of high quality reviewers going forward.

160. Ideas which have emerged from the Learning into Practice Project funded via the Department for Education's Innovation Programme are very encouraging and the project has clearly tapped into a strong cohort of those involved in commissioning and writing reports of inquiries. For example, the project's work on Quality Markers could provide valuable help for both commissioners and reviewers. I have also seen interesting models developed by groups of local authorities, for example the "Local Commissioning of SCRs" document of guidance commissioned by the East of England Children's Sector Led Improvement Board which lays out an impressive Learning and Improvement Framework. I received a paper from one experienced reviewer who convincingly argued that reviews are ineffective unless the knowledgeable reviewer is able to work directly with the staff and managers who were involved in the incident. This is not always the case in an SCR as more senior officials tend to front the agency's presentation and reports. In making this comment I am conscious of the advice offered by Eileen Munro that simply discussing the experience of those directly involved in an event may not be sufficient. She points out that as errors often arise from the interaction of several areas of weakness in a system, and not

generally through a mistake made by one player, it is important to consider and understand the systemic factors which may have occasioned the event.

161. The SCR is a costly process with some reviews being budgeted for in the region of six figures; reviews take far too long to complete and this is often aggravated by the carrying out of simultaneous inquiries by the police, coroner, Domestic Homicide Reviews and so on. Despite reported improvement the recommendations of reviews tend to be predictable and or banal, unfocussed and not addressed to specific individuals or organisations, e.g. better information sharing; more communication between partners; more curious inquiry; do more to engage the young person/family. There are too many occasions when significant energy, legal advice and argument are expended on discussion about publication and redaction and as a consequence a general view emerges that there is something to hide.

162. Nationally we should be able to promote the learning from the local inquiries and reviews - over 350 SCRs in the last two years using a range of methodologies. There is significant support for a national learning framework. Such a framework would provide support to local investigators and commissioners in order to improve practice and further enskill practitioners in local areas.

163. We should build on this support and take the necessary steps to enhance our learning culture. This should include the creation of a new national body to develop the proposed national learning framework.

164. In March 2015 the Public Administration Select Committee report recommended that there should be a new independent body to conduct patient safety investigations in the NHS. In its response, the Government agreed that there should be an independent capability at national level to offer support and guidance to NHS organisations on investigations, and to carry out certain investigations itself. This is being established and will come into operation in April 2016. This may offer a model for a national body in respect of child protection and safeguarding – one that is independent of government and the key agencies, and operates in a transparent and objective fashion to ensure learning is the key element of all inquiries. Its remit might cover:

- the vision, learning being the key purpose of inquiry;
- accreditation, the expertise and professional development of lead reviewers;
- best practice, in setting out a methodology for local inquiry;

- guidance, on the range and use of methodologies of inquiry;
- guidance, on the circumstances that would merit a Local Learning Inquiry (LLI);
- the model to gather learning from LLIs;
- the dissemination of learning through a national network and national report; and
- the criteria for establishing a National Serious Case Inquiry (NSCI).

The remit should be subject to consultation so as to ensure national support for the framework.

165. The first step in developing a national learning framework should be to make absolutely clear that the purpose of an inquiry into an event is to identify learning points to feedback to the system so as to promote improvement.

166. The framework must be predicated on a model of effective local inquiry. These must be rapid inquiries (RI) and directly engage the practitioners involved in the case being inquired into. An experienced senior practitioner chosen from the leadership of one of the key agencies involved should lead this. After an initial assessment of the RI, the practitioner should advise whether or not a further stage, an LLI, is necessary and if so, draw up terms of reference, determine the methodology to be used and appoint a lead reviewer. The timescale should be short, preferably no more than three months; the methodology chosen should be predicated on timeliness. It should be made clear this is an examination of the practice involved in the event, and there should only be exceptional reasons why another investigation would be a reason for delaying the inquiry.

167. The National Maternity Review 2016 “Better Births”²³ (NMR-BB) makes a number of proposals that merit study in the child protection and safeguarding world. The proposal for a new body, the Health Safety Investigations Branch (HSIB) is tasked to set a common, national standard for high quality serious incident investigations. Such a standard, which I see as different from a methodology, could help the effective carrying out of an LLI. The report states that, *“Removing the threat of individual clinicians being branded negligent would improve the effectiveness of serious incident investigations and help ensure similar mistakes were avoided.”* If a national body to oversee inquiries were created they could consider whether or not

²³ NHS England (2016), National Maternity Review- Better Births

such a proviso should exist in the model of inquiries looking at child protection.

168. In respect of LLIs, there has to be transparency and the identification of areas of learning, including learning from things that went well in the event being looked into. The three key agencies, health, the police and local government have clear and transparent structures for accountability. These should be used to report publically on the lessons to be drawn from LLIs and the action taken in and by the agency. Regularly, local authorities, health bodies and arrangements for accountability of the police consider reports on a wide range of issues; these should be used to receive reports on the learning derived from critical events and show how systems have been changed to bring about further improvement. In this way there would be no need to fret over publication or to delay reporting as the systems of accountability are in place and the LLI is focused on learning. If there were issues in a case that relates to the behaviour or competence of individuals they are most sensibly and effectively dealt with through the staff competence and disciplinary processes of the relevant agency.

169. Once completed, the learning from an LLI would be reported to the national body. It would then analyse the reports as they came in and provide a national data and intelligence set which points to areas of learning and good practice. If on analysis an issue appeared in several separate reports across a number of areas the national body could carry out an NSCI to draw together lessons from the reports and propose recommendations for national distribution. This would not involve a reopening of a specific case but would require local discussion and interview.

170. There are a number of events that are particularly complex, involve issues of great and shocking gravity or are very specialist or specific by nature of the circumstance of an individual, and would benefit from a forensic style investigation by qualified practitioners. This capacity could be provided by the national body, in liaison with the local area(s) involved. The national body should be independent of a government department and in carrying out its NSCI it must be completely independent of the agencies involved in the event being inquired into. It would discuss with the local agencies the operation of the NSCI but it would draw up the terms of reference, determine the appropriate methodology and appoint the individual/team to undertake it. Once completed the report of the inquiry and the learning identified would be published.

171. The criteria for NSCIs would need to be subject to further consultation. Circumstances might include cases that crossed several local administrations

or agencies such as police areas or health bodies; children and young people who have been trafficked for the purposes of abuse; incidents that involve complex issues such as consanguinity or particular medical conditions. The number of such cases is likely to be around twenty a year.

172. A new national body should consider what factors characterise a good inquiry into events in which children die or have faced serious harm. They should consult with those who are the most experienced in understanding and delivering models of review, consider the relevant literature and the Triennial Review of SCRs and the annual reports of the national panel of independent experts and draw up a good guidance framework. This should lay out the standards of quality required in local inquiries in much the same way as HSIB will develop a national standard for high quality serious incident investigations. They should also provide a guide to the various types of review being used, identifying the circumstances that they are particularly appropriate to. This will ensure local areas have access to comprehensive guidance and advice on the conducting of an LLI.

173. Both LLIs and NSCIs will be most effective if there is a skilled cohort of accredited reviewers. The new body should be charged with setting out and consulting on a process of accreditation and ongoing development for national reviewers.

174. In combination these ideas will bring about a much needed national resource of learning built on the foundations of strong local learning and skilled reviewers. The new body will need a sponsor/host. I do not think this should be the national panel of independent experts on SCRs. There are three reasons for this. First I think it should be led by a range of people with specific sector expertise as well as non sector insight, second, the promulgation of a National Learning Framework will require a full time structure with employees, and third the new body will require a direct investigative capacity. The structure, purpose and remit of a new body should be considered carefully and similar developments of inquiry, e.g. HSIB, the model introduced by the Welsh Government and the proposed What Works Centre should be looked at to inform the decision as to the national home.

Recommendations

- 20 To emphasise in all national guidance that the main purpose of inquiring into an event is to improve the systems we provide to protect children.
21. To discontinue Serious Case Reviews, and to establish an independent body at national level to oversee a new national learning framework for

inquiries into child deaths and cases where children have experienced serious harm.

22. For the Department for Education to set out the key tasks for the new body to determine. These should include:
 - the creation of a new national learning framework;
 - the process by which the notification of an event takes place;
 - the process for establishing an NSCI;
 - best practice guidance on delivering a proportionate approach at local level to the carrying out of LLIs;
 - providing new guidance to cover best practice in undertaking single and multi-agency inquiries, including the importance of a rapid response and transparency in publicising how an area has learned for the event and what has changed in local practice; and
 - advising how learning can be reported through existing local accountability structures so as to ensure transparency and promote learning.
23. Once established, the new body to carry out consultation on the introduction of this new model.
24. For the new body to be required to report to the Secretary of State, identifying the lessons for government from learning derived for LLIs and NSCIs.
25. On the creation of the new body, to end the national panel of independent experts on SCRs.
26. To require the new body to be responsible for overseeing a new model for learning from serious events affecting children.
27. To ensure that this model is driven by proportionate LLIs, whose reports should be published and sent to the national body.
28. To ensure the new body has the capacity to commission and or carry out National Serious Case Inquiries (NSCIs).
29. To amend as appropriate the legislative framework to introduce this new model of inquiry.

Child death overview panels (CDOPs)

“I feel very strongly that the child death review process is best located in the Department of Health.”

Baroness Helena Kennedy, Chair of the Royal College of Paediatrics and Child Health (RCPCH) working group on sudden unexpected death in infancy.

175. In 2003, three high profile criminal cases involving the prosecution of mothers for causing the deaths of their babies created public consternation. As a result a working group was set up chaired by Baroness Kennedy, supported by the RCPCH and the Royal College of Pathologists. They published: *Sudden unexpected death in infancy. A multi-agency protocol for care and investigation* (September 2004)²⁴. This concluded, “*The need for a compulsory national protocol for the investigation of a sudden unexpected death in infancy is now vital. The creation of national principles and procedures is at the heart of this report and underpins the framework for a compassionate, professional investigation of such deaths.*” As a result CDOPs were set up.

176. The 2006 LSCB Regulations set out the requirement for all LSCBs to review the deaths of all children who are normally resident in their area (not just unexpected deaths) and agreeing local procedures for responding to unexpected deaths of children. Working Together 2006 had a focus on responding rapidly to an unexpected death of a child, and from 1 April 2008 CDOPs took on responsibility to review all child deaths. The Department for Education oversees the policy on CDOPs. It provides a national data collection service and an annual Statistical First Release, ‘*Child Death Reviews*’ report on the information it has received. In 2013 a research report²⁵ commissioned by the Department for Education recommended that a national database be established to collect information about child deaths from each CDOP. NHS England and the Health Quality Improvement partnership (HQIP) commissioned The National Perinatal Epidemiology Unit, University of Oxford to undertake a feasibility study on the creation of a national database. This is due to report in the summer of 2016. Subject to a number of points of clarification I hope that the report will advise that a national database is both necessary and feasible. If this is the case, it is important that this is expedited.

²⁴ The Royal College of Pathologists and The Royal College of Paediatrics and Child Health (2004). *Sudden unexpected death in infancy. A multi-agency protocol for care and investigation*

²⁵ Child death reviews: improving the use of evidence, research report by Jenny Kurinczuk. Kurinczuk, J. J. & Knight, M. (2013), *Child death reviews: improving the use of evidence*. Research Report

Currently the gathering of data on child deaths and the analysis of them are incomplete and inconsistent. This means there is a gap in our knowledge and we are not sufficiently extracting learning from the data and intelligence we have available.

177. Over 80% of child deaths have medical or public health causation. For babies and infants the cause is often related to congenital factors and in the early teenage/adolescent age range the causation is related often to injury. Clinicians estimate that only 4% of child deaths relate to safeguarding or require an SCR to be carried out.

178. During my review I met with a wide range of individuals and groups involved with CDOPs. This included senior consultants in the NHS, lead clinicians for NHS England, a large group of practitioners in Dorchester, the university researching the feasibility of the database, CDOP managers, Coroners and Directors of Public Health. In addition, Chairs of LSCBs and DCSs advised me on the importance of CDOPs in informing the Joint Strategic Needs Assessment conducted by health and wellbeing boards and the important role played by social workers, the police and other non-medical professionals in the review process.

179. During this review the NHS published the National Maternity Review- Better Births, (NMR-BB)²⁶. This contains a number of recommendations about child deaths. In particular it refers to occasions where things go wrong before, during or after labour and a child is left seriously disabled or dies. After such incidents it makes clear that there must be a comprehensive multi-professional investigation resulting in local learning and an open and honest explanation. Currently there is no standard approach to investigation and it is undertaken very differently across organisations. The paper recommends that the new Health and Safety Investigation Branch (HSIB) should set a common, national standard for high quality serious incident investigations. HSIB will be prioritising maternity issues in its first year of operation. In addition it is proposed to develop a standardised perinatal mortality review tool. Both of these developments are likely to have implications for the way in which CDOPs consider child deaths.

180. A number of Directors of Public Health and consultant paediatricians expressed the view that specialist staff, for example neonatologists, are under-represented at CDOPs. They also pointed to a problem with the area coverage of a CDOP. Examples were given showing how some areas had a higher number of deaths because they housed the regional specialist centre

²⁶ National Maternity Review- Better Births 2016 4.61; 4.63

for children or specific conditions affecting children for example a large rural county which had one specialist heart facility for children of surrounding counties too. But the deaths were reviewed by the children's home CDOP which could be a significant distance from the place of death. This created a real problem for learning and meant that medical specialists could not participate in the local review process easily. Some CDOPs have responded to this by having themed meetings, e.g. covering all neo-natal deaths once a year to supplement their regular sessions.

181. Local CDOPs are passionate about the work they do and the learning they identify from examining child deaths. They point to the work they are developing in supporting parents and families and the influence they have had on ensuring within hospital mothers who have lost a child are treated with sensitivity and are not left on maternity wards where others are awaiting the birth of their child. They gave me examples of local learning relating to death caused by the ingestion of lithium cell batteries and nappy sacks, and children who die after becoming entangled in blind cords citing these as leading to regional and national learning.

182. I am persuaded by the argument that child deaths need to be reviewed over a population size that gives a sufficient number of deaths to be analysed for patterns, themes and trends of death. Indeed in the North West, West Midlands, Dorchester and many other areas, regional gatherings of CDOPs provide a source of data and intelligence which when analysed leads to the identification of key issues relating to the deaths. We need to encourage this regionalisation and consideration should be given to establishing a national-regional model for CDOPs. A new National Network of Child Death Overview Panels held its second annual conference (grant aided by the Cheshire Coroner's Educational Fund) in February 2016 on a theme of investigating paediatric and neonatal deaths. The conference had several examples of local learning from CDOP reviews of death, was well supported in its aim to create a national oversight of CDOP learning. The organisers are planning a third conference in Birmingham in 2017. The NMR-BB report contains a proposal to establish a regional Maternity Clinical Network (12 exist currently) to share information and best practice. Perhaps these initiatives offer examples of the type of model that may more effectively oversee CDOPs.

183. The introduction of a national database has to be a priority for implementation. It will assist the collection of local information and the national analysis of child deaths. It will be able to support a regional structure of CDOPs with themed and consistent information and allow for greater uniformity in the categorisation and definition of the type of child death.

184. From within the NHS I have heard a clear preference that CDOPs should be hosted within its framework – that is the clear view of the consultant paediatricians and range of other clinicians I met with.

185. In the response to my questionnaire the majority said that child deaths should continue to be reviewed within local multi-agency arrangements. I agree with this but believe arrangements other than those overseeing child protection and safeguarding exist to provide that overview. Given the very small number of child deaths that relate to child protection and safeguarding I do not think it is axiomatic that CDOPs should sit within the framework of multi-agency arrangements for child protection and safeguarding.

186. It is however important to ensure that whatever structure hosts CDOPs it has a capacity to generate and promote both local learning and the inclusion of a non-medical voice in the review process to ensure a strong interest in the wider interests of children is maintained. A clear current in the responses we received was, given the overwhelming majority of child deaths had a medical or public health causation, for health and wellbeing arrangements and public health to play more of a leading role to be played in reviewing child deaths.

187. In my view, the Department for Education is not in the best position to provide the necessary support required for a specialist and technical oversight of this process. If Health have oversight of the policy the necessary specialists are likely to feel more ownership of the process. In these circumstances and given proposals in the NMR-BB I think that ownership of the arrangements for supporting CDOPs should move to the Department of Health.

Recommendations

30. That the national sponsor for CDOPs should move from the Department for Education to the Department of Health. It should consider how CDOPs can best be supported and sponsored within the arrangements of the NHS.
31. If the national study recommends the introduction of a national database for CDOPs, the Department of Health should consider expediting its introduction.
32. The Department of Health should determine how CDOPs can be organised on a regional basis with sub-regional structures to promote learning and dissemination. They should also give consideration to the membership of CDOP to ensure appropriate representation from both health and non-medical agencies.
33. In considering a common national standard for high quality serious incident investigations for child death the Health Safety Investigation

Branch of the NHS should consider the role CDOPs will play in this process.

34. The Department of Health should consider the role that Health and Wellbeing Boards and the Joint Strategic Needs Assessment play in dealing with child deaths and the role of a CDOP.

Expected impact of changes

188. If the recommendations in this report are accepted, I believe they pave the way for a fundamental reform of our system for protecting and safeguarding children. As a whole the recommendations provide for a more relevant, and in my view tougher, statutory framework. This new framework will:

- ensure the contributions made by the health service, the police and local government are better coordinated and deployed toward the objective of creating a safer, more consistent, national framework protecting and safeguarding children and young people;
- clarify and lay out the responsibilities, in ensuring effective multi-agency arrangements, of a lead chief officer in health, the police and local government;
- create a National Learning Framework overseen by a new independent body to promote higher quality inquiries into the tragic events which sometimes affect children and young people with a capacity to carry out a national inquiry; and
- create a more effective model of learning from the deaths of children.

189. The recommendations also offer the opportunity for local agencies to innovate in a less prescribed system. They will be able to determine the area and boundaries they will operate in, how they organise multi-agency staff and agencies to provide early support to children and young people within their families. If they choose to organise services in a particular way the test should not be about the models they employ but about the outcomes they achieve.

190. The move to a more permissive system is happening across the public services. As a result we are seeing the development of radical and innovative ideas having an earlier and bigger impact as the hard burden and bureaucracy necessary for following in a tick box fashion over detailed prescription is removed. We will see a practice based challenge to the protecting of job description boundaries, the tardiness of poor information sharing and the insistence on following processes which do not impact on the work done with children and families.

191. If we can balance a more effective statutory framework with the promotion of innovation at local level it will release resources to focus on the front line of practitioners engaging with children, young people and their families. We will see the outcomes of this in the development of more highly skilled practice leaders and practitioners using their professional skills and

judgement in casework as opposed to form filling and data collection. If we want to achieve a safer system to protect children, we must create the environment in which better skilled practitioners can practice and get on with the work of protecting children.

Summary of recommendations

Multi-agency arrangements for protecting children

1. To replace the existing statutory arrangements for LSCBs and introduce a new statutory framework for multi-agency arrangements for child protection.
2. To require all areas to move towards new multi-agency arrangements for protecting children within a prescribed period. Local areas/regions would need to establish a plan which would describe how services would:
 - meet the new statutory framework;
 - be coordinated;
 - be led by senior officials;
 - be evaluated for their effectiveness;
 - involve a role for independent scrutiny;
 - engage with children and young people; and
 - be held to account.

The existing legislative framework underpinning LSCBs should cease to operate as new arrangements come into being.

3. To require the three key agencies, namely health, police and local authorities, in an area they determine, to design multi-agency arrangements for protecting children, underpinned by a requirement to work together on the key strategic issues set out in this report and referenced in recommendation 2.
4. For new statutory arrangements to require health, local authorities and the police to make clear their leadership responsibility for multi-agency arrangements, to include the identification of a chief officer in each of the agencies to have responsibility and authority for ensuring full collaboration with those statutory arrangements.
5. For government to provide guidance on:
 - a. Drawing up a local proposal to provide strategic multi-agency arrangements to protect children.
 - b. The meaning of the terms Child Protection, Safeguarding and Wellbeing, clarifying the part of this spectrum to be covered in multi-agency statutory arrangements.
6. For government departments (Department of Health, Department for Education, the Department for Communities and Local Government and the Home Office) to provide a clear, joint statement explaining their commitment to multi-agency arrangements and explaining how all local partners will be supported and required to play a full and

committed role.

7. The Department for Education should review what approaches to early cross agency intervention and intelligence gathering to identify children and young people at risk are most effective, including considering whether the Multi-Agency Safeguarding Hubs model offers an effective approach.
8. NHS (England) should consider how their Accountability and Assurance Framework for safeguarding vulnerable people could be amended to place greater emphasis on how local health agencies fully participate in multi-agency practice.
9. Keeping Children Safe in Education should be reviewed to ensure it covers child protection and safeguarding issues in respect of unregistered school settings, independent schools and home education. There should also be clearer guidance on the role played by the police and the NHS in that process. Keeping Children Safe in Education should make clear what role, if any, academy chains will carry out in respect of child protection and safeguarding children.
10. The role of schools in providing early help to children and young people should be included in the Department for Education's review of the role of a local authority in education. This should include the role of the police and health services.
11. To consider whether the statutory guidance in relation to Directors of Children's Services and Lead Members is necessary in light of the new White Paper and recommendations made by this review.
12. To consider issuing new guidance on the responsibilities of a chief officer nominated by each of health, the police and local government to agree the multi-agency arrangements and processes in an area.
13. The Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Her Majesty's Inspectorate of Probation should review their inspection frameworks to ensure they focus on child protection practice without being burdensome on service providers. Their inspections should be proportionate and always assess the contribution the agency they inspect makes to successful multi-agency working.
14. There are too many separate inspections of local authority children's services: this is over burdensome, costly and needs urgent attention. In replacing the Single Inspection Framework (SIF), Ofsted should be encouraged to develop a model that is not burdensome, is unannounced, short in duration (five days), and focuses on the child protection practice. It should identify strengths and areas for development in the local authority.

15. The Joint Targeted Area Inspection (JTAI) should not replicate the inspection of the child protection front door. That should be a discrete inspection. The JTAI should concentrate on key themes in the life and experience of children and young people e.g. domestic violence, child sexual abuse, children with a disability, missing children, youth violence, gangs and neglect. In carrying out these thematic inspections the focus would be on the multi-agency approach and the outcomes for children achieved by it.
16. The review of an LSCB as part of the SIF should be discontinued at the earliest possible time.
17. For the Home Office and Departments of Communities and Local Government, Health, and Education to issue joint advice and guidance on the critical importance of effective and speedy sharing of information and data in relation to protecting and safeguarding children. This should focus on the expectation that unless there is specific legal impediment information must be shared.
18. To incentivise all applicants for devolution deals to include in their proposals arrangements for establishing multi-agency arrangements for protecting children.
19. Government departments should review the range of Boards and guidance (e.g. Health and Wellbeing Boards, Local Family Justice Boards, Community Safety Partnerships) with a view to reducing the burden, and therefore cost, on the health agencies, the police, local government and other agencies.

Serious Case Reviews

20. To emphasise in all national guidance that the main purpose of inquiring into an event is to improve the systems we provide to protect children.
21. To discontinue Serious Case Reviews, and to establish an independent body at national level to oversee a new national learning framework for inquiries into child deaths and cases where children have experienced serious harm.
22. For the Department for Education to set out the key tasks for the new body to determine. These should include:
 - the creation of a new national learning framework;
 - the process by which the notification of an event takes place;
 - the process for establishing a National Serious Case Inquiry (NSCI);
 - best practice guidance on delivering a proportionate approach at local level to conduct a Local Learning Inquiries (LLIs);
 - providing new guidance to cover best practice in undertaking

- single and multi-agency inquiries, including the importance of a rapid response and transparency in publicising how an area has learned for the event and what has changed in local practice; and
- advising how learning can be reported through existing local accountability structures so as to ensure transparency and promote learning.

23. Once established, the new body to carry out consultation on the introduction of this new model.
24. For the new body to be required to report to the Secretary of State, identifying the lessons for government from learning derived for LLIs and NSCIs.
25. On the creation of the new body, to end the national panel of independent experts on SCRs.
26. To require the new body to be responsible for overseeing a new model for learning from serious events affecting children.
27. To ensure that this model is driven by proportionate LLIs, whose reports should be published and sent to the national body.
28. To ensure the new body has the capacity to commission and or carry out NSCIs.
29. To amend as appropriate the legislative framework to introduce this new model of inquiry.

Child Death Overview Panels (CDOPs)

30. That the national sponsor for CDOPs should move from the Department for Education to the Department of Health. It should consider how CDOPs can best be supported and sponsored within the arrangements of the NHS.
31. If the national study recommends the introduction of a national database for CDOPs, the Department of Health should consider expediting its introduction.
32. The Department of Health should determine how CDOPs can be organised on a regional basis with sub-regional structures to promote learning and dissemination. They should also give consideration to the membership of CDOP to ensure appropriate representation from both health and non-medical agencies.
33. In considering a common national standard for high quality serious incident investigations for child death the Health Safety Investigation Branch of the NHS should consider the role CDOPs will play in this process.

34. The Department of Health should consider the role that Health and Wellbeing Boards and the Joint Strategic Needs Assessment play in dealing with child deaths and the role of a CDOP.

Annexes

Annex	Title
Annex A	Ministerial letter of appointment
Annex B	Review terms of reference
Annex C	Review governance
Annex D	Findings from the rapid research review – LSCBs
Annex E	Findings from the rapid research review – SCRs
Annex F	Cabinet Office Implementation Unit findings
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Annex J	Triennial Review
Annex K	List of meetings and events

Annex A: Ministerial letter of appointment



Rt Hon Nicky Morgan MP
Secretary of State

Sanctuary Buildings Great Smith Street Westminster London SW1P 3BT
tel: 0370 000 2288 www.education.gov.uk/help/contactus

Alan Wood
Alan.Wood@learningtrust.co.uk

16 December 2015

Dear Alan,

This letter is to invite you formally to lead a fundamental review of the role and functions of Local Safeguarding Children Boards (LSCBs) within the context of local strategic multi-agency working. This will include the child death review process, and consideration of how the intended centralisation of serious case reviews (SCRs) will work effectively at local level.

We want a robust local accountability system, one that adds real value, is better at identifying delivery problems early and putting them right and which is more effective in safeguarding children.

Evidence suggests, however, that too many LSCBs are currently ineffectual and that more radical reform is required. SCRs are too often inadequate – above all they fail to ask why things went wrong. That is why we have asked you to give clear recommendations on alternatives to inform potential legislative change.

Your appointment will take effect from 1 January 2016 and run until 31 March 2016. During the period of your appointment, you should be guided by the terms of reference included with this letter. A contract for your signature will follow.

We are both delighted to offer you this role and look forward very much to working with you over the coming months.

Nicky Morgan

RT HON NICKY MORGAN MP

*Yours ever,
Edward*

EDWARD TIMPSON MP

Annex B: Review terms of reference

REVIEW OF LOCAL SAFEGUARDING CHILDREN BOARD ROLE AND FUNCTIONS: TERMS OF REFERENCE

Aim

- To undertake a fundamental review of the role and function of Local Safeguarding Children Boards (LSCBs) within the context of local strategic multi-agency working, including the child death review process, and to consider how the intended centralisation of serious case reviews (SCRs) will work effectively at local level.

Objectives

- Examine the current role of LSCBs within the local authority multi-agency space, including a consideration of what multi-agency arrangements need to achieve locally, how that might best be achieved, and where accountability for ensuring the effectiveness of child protection arrangements should lie.
- Identify what success looks like and the factors that make LSCBs successful or unsuccessful, and consider whether alternative structures to the existing model might ultimately improve the outcomes for children and young people.
- Consider the impact on the role of LSCBs arising from centralisation of the SCR process and suggest how learning from SCRs in future can be effectively embedded in local practice.
- Consider how SCRs relate to other reviews, for example domestic homicide reviews.
- Identify what makes an effective Child Death Overview Panel (CDOP) and explore which body is best placed to review child deaths to ensure that CDOPs are managed and held to account effectively.

In working towards these objectives the reviewer will need to take into consideration:

- Relevant published research and reports, including the reports from the national panel of independent experts on serious case reviews.
- The findings from the LSCB projects currently being funded by the government to pilot different and innovative ways of working.
- Findings from the SCRs: Learning into Practice Project being funded by the

Innovation Programme and led by NSPCC and the Social Care Institute for Excellence.

- The triennial review of SCRs being carried out by the Universities of East Anglia and Warwick.

Scope and constraints

All options for the future of multi-agency working are open. The reviewer will take a view on what system (if any) would operate most effectively.

The government intends that the process of commissioning and publishing SCRs should be managed at national rather than local level. The reviewer should focus on identifying what issues may arise as a consequence of this change process, rather than on the details of how the centralisation process itself will operate.

The government is not proposing to withdraw the child death review process. The review will look at how well CDOPs work and propose measures to improve the learning from child death reviews.

Communications and Outputs

The reviewer will:

- Discuss the progress of the review of LSCBs at regular intervals with the overarching Project Board managed by DfE.
- Provide updates to the Child Protection Implementation Taskforce as required.
- Present interim findings to the Project Board in mid-February 2016.
- Send a written report to the Secretary of State for Education by the end of March 2016, including recommendations linked to the above objectives.

Annex C: Review Governance

A review of the role and functions of Local Safeguarding Children Boards (LSCBs) – Governance and reporting arrangements

Purpose: This review will explore key questions about the role and function of LSCBs within the context of local strategic multi-agency working, including the child death review process, and consider how the intended centralisation of serious case reviews will work effectively at local level. The review is scheduled to report at the end of March 2016.

- **Lead reviewer** - Alan Wood

Alan Wood has been appointed by the Secretary of State for Education and the Minister of State for Children and Families. Terms of reference have been set.

- **Project board**

Membership: Alan Wood (lead reviewer), Graham Archer (Chair, DfE), Isabelle Trowler, Penny Halnan (LAO, DfE), Stephanie Brivio (DfE), Felicity Winter (DfE), Hannah Smith (DfE), Steffan Jones (Cabinet Office), Jeremy Oppenheim (Home Office), Helen Alderton (No.10), Helen Walker (Department of Health)

Secretariat support: Helen Walker, Cynthia Davies, Derek Smale

Purpose: The Project Board will enable key people with interest in the policy around LSCBs to discuss the progress and direction of travel of the review with Alan, providing challenge and reshaping it as appropriate. The terms of reference and governance arrangements for the review set out that Alan is to discuss his progress with the Project Board at regular intervals.

- **Review Secretariat**

Membership: DfE team, led by Helen Walker

Purpose: The secretariat will liaise with and act as link between the Other Government Department (OGD) Working Group, Alan Wood and the Project Board. They will respond to policy/legal questions raised by Alan Wood, discuss and arrange travel, process appropriate expense claims, schedule meetings between Alan and key stakeholders, schedule Project Board meetings, take, write up and share notes at meetings.

- **Other Government Department (OGD) Working Group**

Membership: Mike McGrath (Communities and Local Government), Alan Bell (Health), Mark Walsh (Home Office), Mike Box (Home Office) Angela Colyer

(National Offender Management Service), Anne Gair (Ofsted), Paul D’Inverno (Ofsted), Cheryl de Freitas (Youth Justice Board), Bill Kerslake (Youth Justice Board)

Attendees from DfE: Felicity Winter, Helen Walker, Cynthia Davies, Ivan Wintringham, Derek Smale, and David Serrant

Purpose: To feed into and support the work of Alan Wood, and contribute views via the secretariat.

- **Ministers**

The secretariat will update Ministers at regular intervals throughout the review. These updates will follow project board meetings.

Meeting arrangements

- The secretariat will arrange an initial meeting with Alan Wood prior to the start of the review to discuss working arrangements.
- The secretariat will arrange a meeting between Minister Timpson and Alan Wood at an early stage of the review.
- Alan Wood and the secretariat will liaise weekly (and on an ad hoc basis).
- The project board will meet at three stages of the review; at the start, at the mid-point, and prior to the submission of the final report at the end of March 2016.
- The OGD group will meet every four-six weeks. Their views will be fed into the project board meetings via the secretariat.
- The secretariat and key members of the project board will liaise regularly in order to provide updates for Ministers and for the Child Protection Taskforce as required.

- **Conflict of Interest**

If, at any time, Alan Wood becomes aware of a professional or personal conflict of interest, he is to alert the DfE secretariat immediately, as per the terms of the appointment contract.

Annex D: Findings from the rapid research review – LSCBs

Findings from the rapid research review

This paper describes Local Safeguarding Children Boards (LSCB), their aims and activities. It then goes on to highlight some of the research evidence, it is a rapid review that serves to highlight some of the common themes ahead of the LSCB Review and should not be read as a comprehensive evidence review.

The Aims and Activities of LSCBs

LSCBs were established in 2006 to put the responsibility for safeguarding and promoting child welfare on a statutory basis. Each local authority must establish a LSCB, the main responsibilities of which, as set out in section 14 of the Children Act 2004, are to co-ordinate and quality-assure the safeguarding children activities of member agencies. LSCB functions include:

- developing policies and procedures for safeguarding and promoting welfare
- communicating and raising awareness
- monitoring and evaluation
- participating in planning and commissioning services and training
- collecting and analysing information in relation to child deaths
- conducting serious case reviews.

LSCBs aim to make sure member agencies work together to keep children and young people safe, hold one other to account and ensure safeguarding children remains high on the agenda across their region. Since their introduction, the nature and scope of their responsibilities have changed. *Working Together to Safeguard Children 2013* (WT 2013) added a number of significant responsibilities. These include oversight of early help arrangements, clarifying thresholds, and developing a local framework for learning and development.

LSCB Leadership and Membership

LSCB statutory members are local authorities, health services, police, probation, youth justice institutions and lay members. Other organisations, including schools and voluntary and community sector organisations should be involved in the LSCB as appropriate.

LSCB Chairs come from a range of professional backgrounds, predominantly social work or policing, and many chair a number of Boards. The Association of Independent LSCB Chairs lists 151 LSCBs, 146 in England. Some Chairs oversee more than one LSCB and there are currently 103 independent Chairs (Baginsky and Holmes, 2015). Chairs are now required to be independent whereas previously most LSCBs were chaired by a Director of Children's

Services (DCS) or an assistant director. Many of these had a professional background in education and very few Chairs in 2009 came from the police (France et al 2009).

Income and Expenditure of LSCBs

LSCBs are funded by their members. Member contributions vary, but local authorities contribute the most. Contributions pay for support staff and training (among other things). LSCBs also rely on in-kind contributions and the release of staff to attend meetings and to engage in their activities.

LSCBs provide details of their income and expenditure in their annual report. A small number of reports (n=10) were examined for this paper. Member contributions varied enormously; the highest total annual income was over £475,000 whilst the smallest was around £150,000. In most cases the local authorities contributed over 50% of the total; health partners were the next biggest contributors followed by the police. In two of the LSCBs examined income was generated from training and from annual membership.

In the 10 LSCBs reports examined, expenditure varied too. Salaries made up the biggest expenditure – in one LSCB over £285,000 was spent on staff. Business managers and administrators were the most cited roles; others include media manager, performance officer and workforce development manager. There were variations in the expenditure on chairs; £5,000 was the lowest amount paid, and £20,000 was the average, but in one LSCB £46,000 was paid in chair costs. In some cases it appears that the chair costs were included as general salaries.

In the 10 LSCBs reports examined, the expenditure on SCRs ranged from £15,000 to £40,000 (but in one LSCB the higher costs were for three SCRs). Training expenditure varied widely: the lowest spend was £5,000, the average was £30,000 and one LSCB spent £95,000 on training (this is one of the LSCBs that also got income from training). Other expenditure included staff and activities associated with the Child Death Overview Panel and Local Authority Designated Officer.

History - Area Child Protection Committees

In the early 2000s there was a shift from traditional child protection to a more all-encompassing safeguarding approach²⁷. This was influenced by the first Joint Chief Inspectors' safeguarding children report in 2002 and the Victoria Climbié Inquiry, and formalised in the Every Child Matters programme (Children Act 2004). A number of institutional changes were made including the abolition of Area Child Protection Committees (ACPCs), which were replaced by LSCBs. Previously, each area had a non-statutory ACPC but these were deemed to have performed poorly in some areas. Research found that their lack of statutory power limited their effectiveness (Chief Inspector of

²⁷ Safeguarding is a concept that is broader than child protection; it incorporates the wider aims of prevention whilst child protection is the process of protecting individual children identified as either suffering, or likely to suffer, significant harm.

Social Services et al., 2002). A number of other weaknesses were identified including the domination of children’s social care, variations in levels of representation and membership, structure and practice, poor leadership and insufficient resources (Chief Inspector of Social Services et al., 2002; Horwath and Glennie, 1999; Narducci, 2003; Ward et al., 2004).

Rapid Evidence Review

This section summarises some of the evidence on what LSCBs appear to be doing well and not so well and any apparent barriers and facilitators. The findings are drawn from a number of sources: an analysis of the inspection reports examined for this paper of LSCBs was undertaken for this paper²⁸ and a number of relevant research studies were reviewed. This is a rapid review that serves to highlight some of the common themes and should not be read as a comprehensive review of all the evidence. Overall the research findings are based on feedback from LSCB Chairs, partners and front line professionals. Whilst they point to good and bad practice and the facilitators of this, none of the studies offers a robust assessment of the effectiveness of LSCBs. It is also worth pointing out that some of the research quoted is quite old and may not reflect the current situation, particularly in light of the changes to departmental guidance.

Quality Assurance, Scrutiny and Challenge and Evidencing Outcomes

LSCBs are expected to carry out Section 11 audits²⁹ and interrogate the full range of local performance management information. This data should culminate in an annual report which gives an assessment of the effectiveness of local child protection arrangements. This annual report should directly inform the commissioning and delivery of wider services including health in the local area. Ofsted (2011) found that there was progress in the quality assurance work of LSCBs, in particular auditing activities and internal and external challenge. There is increasing acknowledgement amongst LSCB Chairs about the importance of monitoring and evaluating agencies’ performance (France et al 2010) and a growing need to review data requirements and performance frameworks (Munro and Lushey, 2012).

Inspection reports examined for this paper reveal repeatedly that many of the LSCBs judged to be “requiring improvement” or “inadequate” are failing to collect quality assurance data on the safeguarding activities of their partners, or where this is collected the systems are not sufficiently developed. Inspectors commented that they are unable to hold partners to account and the boards’ priorities are not based on local needs.

Conversely in the inspection reports examined for this paper of the LSCBs judged to be “good” it is noted that they undertake a range of monitoring and bespoke audits, including deep dives on specific issues (domestic violence, CSE etc.). Section 11 audits are conducted well and some feature peer

²⁸ Looking at a sample of reviews carried out up until 30 June 2015.

²⁹ A Section 11 Audit is designed to allow the LSCB to assure itself that members are fulfilling their responsibilities to safeguard children and promote their welfare.

review and challenge to identify gaps in agency safeguarding practice, policies or procedures. “Good” LSCBs demonstrate a culture of challenge and provide clear examples of where they hold partners to account. In LSCBs requiring improvements, examples of challenge were emerging but these were not sufficiently embedded. Inspectors commented that the robust performance management and quality assurance arrangements ensure that these LSCBs know their strengths and weaknesses. The Board’s priorities are carefully derived from the findings of multi-agency audits and other intelligence.

Effective challenge relies upon there being representatives of sufficient seniority who are able to make sure that the Boards’ decisions are actioned in their home departments (France et al., 2010).

A good LSCB should be able to clearly demonstrate the impact they make locally (Ofsted, 2011). Ofsted (2011) found that LSCBs were beginning to make arrangements to show that their activities had an impact on outcomes yet this was proving to be a difficult area for them to evidence. Similarly Baginsky and Holmes (2015) found that despite many references to data collection and analysis, there was very little information that could be quoted on outcomes. Inspection reports examined for this paper show that LSCBs struggled to provide evidence of how their work was improving outcomes for children, though they recognised this to be extremely important.

Input from Children and Young People

The Munro Review recommended a greater emphasis on child-centeredness and the development of a culture of listening and engaging with children. Engagement and consultation with children and young people by LSCBs was underdeveloped (France et al, 2010). This issue was mentioned often in the inspection reports examined for this paper. LSCBs were not engaging with and giving sufficient prominence to the views and experiences of children and young people to drive improvement in safeguarding practice. They need to develop the voice of the child and establish processes to ensure that partners learn from the experiences of children and young people. In good LSCBs there is a strong focus on the voice and influence of children and young people. A Student LSCB is an example of good practice highlighted by Baginsky and Holmes (2015) along with inviting young people to present to the board and involving them to peer review Section 11 audits. However, respondents in the same research noted that it would be helpful to explore what is being achieved by LSCBs in this area and how effective these types of activities are.

Training

LSCBs are responsible for ensuring that there are appropriate safeguarding training opportunities for people who work in children’s social care³⁰. Research (Carpenter et al, 2009) shows that multi-agency training is highly effective in helping professionals understand the respective roles, responsibilities and procedures of each agency involved in safeguarding children and in developing a shared understanding of assessment and decision-making practices. The opportunity to learn together is greatly valued; participants report increased confidence in working with colleagues from other agencies and experience increased mutual respect. Inspection reports examined for this paper reveal that ensuring the provision of training by LSCBs did not appear to be an issue, but in many cases they were not evaluating the training offer. Baginsky and Holmes (2015) found that multi-agency training was not being evaluated rigorously and systematically – particularly in terms of impact – because resources and expertise were not available to do so.

Serious Case Reviews (SCRs)

(See the other paper for a fuller discussion of SCRs). The evaluation of LSCBs in 2010 showed that the time and resources required to undertake SCRs inhibited capacity to move forward and fulfil other responsibilities. This is corroborated by Baginsky and Holmes (2015) who found that one of the biggest demands made on LSCBs (in terms of difficulty, and in some cases in terms of actual cost) comes from conducting SCRs. Participants at all stages of the research raised the significant resource challenges (financial and personnel time) associated with conducting SCRs, and a not insignificant number questioned whether they were even useful at all. The authors raise the questions “*whether this mechanism, designed to examine problems and learn from them, has now become a problem in itself – a mistaken endeavour which we need to learn from*” (Baginsky and Holmes, 2015).

Thresholds and Early Help

Oversight of early help arrangements and clarifying thresholds were added to the responsibilities of LSCBs in WT 2013. Analysis of the inspection reports examined for this paper showed that amongst some “inadequate” LSCBs, partners are not clear about their early help responsibilities and referral thresholds are not well understood. Amongst some of the LSCBs “requiring improvement”, progress around the development of early help is still at an early stage and more needs to be done to help workers understand the thresholds for access to children’s services and facilitate viable inter-agency lower level services. However, it was noted that in some “good” LSCBs that thresholds are understood, embedded and applied well by partner agencies. They are supported by an escalation policy that is well understood.

Facilitators/Barriers

³⁰ LSCBs are not required to provide training themselves, but evidence suggests that many do so.

Composition of the Board

The research by France et al (2010) found that LSCB Chairs provided strong leadership and that agency representation on Boards had been secured. They also found there was a greater sense of shared responsibility for child protection, as it was no longer seen as the sole concern of children's social care services. Partner engagement does vary; local authorities, police and probation are well-engaged whilst health partner engagement is more mixed (the recent reorganisation of the health sector is said to be creating a degree of confusion). Historically engaging schools has been problematic but the increased independence of schools is complicating issues further (Baginsky and Holmes, 2015). Inspectors found that in LSCBs "requiring improvement" schools were generally less engaged in the boards' work (Ofsted, 2015).

As well as ensuring the engagement of the relevant partners, research suggests that it is important that appropriate individuals are represented on the board. France et al (2010) found that representatives on LSCB Boards are largely of sufficient seniority to speak for their organisation with authority, commit their organisation on policy and practice matters and hold their organisation to account, although in some areas securing the right levels of seniority still needs to be addressed. However they also found that securing appropriate levels of attendance by board members in LSCB meetings remains a challenge. Changes in agency representation on the Board and the lack of continuity of Board membership can make it difficult to maintain a shared vision and to sustain progress and development. It can also limit the establishment of relationships and trust, effective networking and operation. Ofsted in 2011 however found that continuity of board membership had improved.

Evidence from Ofsted (2015) shows that good boards tend to be characterised by mature partnerships. Baginsky and Holmes (2015) highlighted the pivotal importance of LSCB Chairs "*the skills and qualities of the individual Chair is a vital element in determining Board effectiveness*". This is an issue that they feel poses some risk, in light of the limited amount of paid time available to Chairs.

There is wide variation in terms of how boards are structured. France et al (2010) found that small Boards lack enough members to be able to invest enough time to meet the LSCB role and remit, while large Boards become unwieldy and impersonal. The most effective size would seem to be between 20 and 25 members. Some have a large number of sub-groups who report to the main board whilst others have only a few sub-groups. There is no agreement within the research evidence about the best approach as the set up usually reflects the local circumstances.

Comparable Data Sets

Whilst data analysis is increasingly seen as important and carried out, France et al (2010) found that meaningful comparison and analysis of data could prove challenging due to definitional issues and variations in the quantity and quality of data collected by different agencies. They also identified a tendency towards judging performance in narrow terms (for example, whether assessments were completed within statutory timescales) without giving due consideration to qualitative analysis of the quality of the service response. At that time it was suggested that it would be very helpful if agreement could be reached about a shared data set that all agencies would be required to populate. This could then be analysed and converted into information so the data then attracted a wider meaning (see Moynihan, 2008). Without this in place, it was felt that there was limited information about how the work of the LSCB was affecting safeguarding outcomes and it was not possible to see how LSCBs would be able to take the lead on challenging and scrutinising practice, or to fulfil their strategic objectives, without these data (Baginsky and Holmes, 2015).

Broadened Remit and Clarity of Priorities

The 2010 evaluation into the effectiveness of LSCBs revealed that the most effective boards had been realistic about what they could achieve and had avoided taking on an overly ambitious remit (France et al, 2010). Ofsted (2015) in its annual review found that in good boards responsibilities have been clearly articulated. However, France et al (2010) found that LSCBs struggled to fulfil all their functions. The time and resources required to undertake Serious Case Reviews, in particular, inhibited capacity to move forward and fulfil other responsibilities. Similarly in the Baginsky and Holmes (2015) survey nearly all Chairs reported that the work of LSCBs had grown over the past two years, three quarters saying that this had been to a large extent. Views from the sector suggest there is a lack of clarity on the role and expectations of LSCBs, linked closely to this perceived increase of responsibilities together with the emergence of new strategic bodies whose work interacts with that of LSCBs. A survey by Munro and Lushey (2012) found that eighty four percent of Chairs agreed or strongly agreed that it would be helpful if central government clarified LSCBs' core priorities.

Funding/Resources

As seen earlier in this paper, LSCBs need to have sufficient resources to fulfil their roles; all partners' need to contribute and contributions vary enormously. France et al (2010) found that LSCBs spent considerable time negotiating and securing contributions towards the operation of LSCBs. The need for a funding formula and central government guidance on levels of funding from different partner agencies has been emphasised (France et al, 2010 and Munro and Lushey, 2012 and Baginsky and Holmes, 2015). France et al (2010) found that over half of boards reported that their budget was inadequate for their LSCB to function effectively. Baginsky and Holmes (2015) also found that funding pressures in member organisations, which can impede

both the individual agencies' safeguarding efforts and their contribution to the LSCB, were an area of concern. They also found that almost all the Chairs said that they routinely spend more time on their role than is remunerated; in a third of cases Chairs reported working twice as much as is paid for.

Accountability

LSCBs must ensure accountability of every agency for the quality of their contribution to child protection and safeguarding. However, they are not operationally accountable for the work of each agency, do not have the resources to support service delivery and have no authority to direct partner organisations to act. There is no obligation on partner organisations to take account of the advice of the LSCB or to carry out any of their recommendations. If LSCBs are to contribute to safeguarding children it is important that their recommendations are taken seriously and engender change (Munro and France, 2011).

France et al (2010) recommended that the implications of non-compliance with Board recommendations should be clarified and systems should be put in place to support the resolution of differences of opinion. Just under half of respondents to the Munro and Lushey (2012) survey felt that the introductions of sanctions against partner bodies for non-compliance would strengthen the role of the LSCB. Participants in the Baginsky and Holmes (2015) survey were clear that this perceived impotence risks undermining the effectiveness of Boards.

Some participants also felt that it seemed they were expected to take on an inspection function. This was not a role for which they were established and would seem to transform them into a local arm of Ofsted. They are, as everybody recognised, required to 'ensure the effectiveness of what is done by each such person or body for those purposes', but this is a phrase that is open to wide interpretation. Ofsted substantiates these views and issued a clear message in their social care report that "*the government must clarify and strengthen the role and responsibilities of LSCBs to ensure effective and robust oversight and action at a local level*" (Ofsted, 2015).

Independence

Linked to the issue of accountability is the issue of independence, particularly independence from the local authority. We have seen earlier that LSCBs rely heavily on local authorities to fund their activities. A number of the participants in the Baginsky and Holmes (2015) research recognised the tension between a desire to ensure the LSCB was (and was seen to be) truly independent of its corresponding local authority and the recognition that in most cases it was the local authority contributing the lion's share of resources, both financial and in-kind. According to Baginsky and Holmes (2015) "*this perpetuates the unhelpful perception that safeguarding is the sole responsibility of children's social care*".

Analysis of the inspection reports examined for this paper showed that there are a few examples where the inspectors feel that the LSCB has not been sufficiently independent from its key partners and has not adequately influenced the prioritisation of safeguarding children amongst other strategic fora or exerted challenge to other partners or organisations.

The 2010 evaluation (France et al) recommended that the Chief Executive's Office and Lead Members, through scrutiny committees, should be more central to the governance process to ensure that the Chair and the Board are held to account. They added that LSCBs need to clarify governance arrangements and separate out accountability from management. There were also those who were concerned that the role of the Chair was evolving in a way that would threaten its independence *"there are real questions to be answered about the recruitment of independent Chairs – should they become ministerial appointments like the one I hold as an independent member of the parole board for England and Wales. Because we are accountable to the Chief Executive this does compromise our independence though fits well with the localism agenda"*. (Baginsky and Holmes, 2015)

Other Strategic Partnerships

LSCBs are one structure amongst many that exist in local areas and there are a number of partnerships whose remits impact on LSCBs, including Health and Wellbeing Boards (HWBs), Community Safety Partnerships, Children and Young People Strategic Partnership Board, Local Safeguarding Adults Board, Children in Care Council and where they still exist, Children's Trusts.

Analysis of the inspection reports examined for this paper showed that amongst some requiring improvement and inadequate LSCBs, there is a need to improve communication with other strategic bodies; they do not have sufficient impact on other strategic partnerships and should increase their influence and effectiveness through improved strategic arrangements.

The demarcation of roles and responsibilities between LSCBs and Children's Trusts has not always been as clear as it should be (France et al, 2010). The picture is similar today; respondents struggled to reach a clear understanding of how these strategic bodies all related to each other and where the LSCB fitted. They were unclear about aspects of the relationships and about expectations of what the relationships should be. There is a need to establish clarity in terms of LSCBs' relationship with the other strategic bodies whose work interacts with that of LSCBs *"a key part of unpicking the confusion was for Chairs to meet to sort out respective responsibilities and accountabilities"* (Baginsky and Holmes, 2015).

It is relatively early days in the life of HWBs and most are still developing their way of working and are thinking through how the new board would dovetail with LSCBs. Easton et al (2012) found that LSCB chairs were involved in the Children's Trust/partnership board and the Shadow Health and Wellbeing Boards. Several local authorities had strengthened the communication between the LSCB and other bodies. Joint training, sharing data, presenting

at other boards were ways of understanding roles and responsibilities. People were supportive of cross-representation between the different partnerships. Some LSCBs have protocols in place between the LSCB, the safeguarding adults board, the HWB and the Community Safety Partnership to define responsibilities, relationships and priorities in order to improve clarity.

International Evidence

It has not been possible in the time to retrieve and review any international literature of relevance to LSCBs. There is very little detailed comparative research available on the similarities and differences between international child protection systems.

All parts of the UK have established structures to support child protection systems including LSCBs or Child Protection Committees (CPCs). There are differences in the extent to which these structures are applied or prioritised within local authorities. Since devolution Scotland has tended to adopt a less statutory approach than the other parts of the UK.

In 2011 the Welsh Assembly undertook an inquiry into LSCBs. They found evidence of weaknesses in joint working arrangements between LSCBs and other local partnerships; shortcomings in the current arrangements for funding LSCBs; a disconnect between the strategic work of LSCBs and the knowledge and awareness of front-line practitioners; variation across Wales in LSCBs' effectiveness to protect vulnerable groups of children; problems with information sharing across agencies; and a lack of meaningful participation by children and young people in the work of LSCBs.

The inquiry proposed a long list of recommendations. The government should issue guidance on: where accountability lies between partnerships for the range of issues along the safeguarding spectrum, on the focus of LSCBs and their role in holding other partnerships to account and the need to meaningfully involve children and young people. They should address the over-reliance on Social Services Departments and address current inconsistency in the use of terminology. They should promote a more collaborative approach between LSCBs, ensure that individual agencies and LSCBs prioritise awareness-raising of the role of LSCBs amongst frontline staff and review the financial and human resource costs associated with undertaking SCRs. The Welsh Government should consult on revised guidance on the information sharing responsibilities and duties of partner agencies and on a national funding formula for LSCBs.

Conclusions

In terms of effectiveness this paper found that:

- There is varied performance on LSCBs in data collection and scrutiny, their ability to challenge and evaluating their own performance.
- Input from children and young people is an area that appears to need progress.
- Training is provided but is not sufficiently evaluated.

- There are concerns about the resource pressure from carrying out SCRs.
- Early help responsibilities and referral thresholds are an issue in some LSCBs.

In terms of facilitators and barriers, this paper found:

- A good breadth of committed and active partners and the pivotal importance of LSCB Chairs are emphasised.
- The need for a national data set was highlighted, as this would help LSCBs monitor and evaluate their performance.
- On the one hand the review found that the most effective Boards had been realistic about what they could achieve and avoiding an overly ambitious remit but on the other some LSCBs are struggling with broadened remits and would welcome clarity from central government on their core priorities.
- Some LSCBs would welcome a nationally agreed formula for contributions.
- There is dissonance between the degree to which LSCBs are held accountable and the level of power and authority they have to exercise their responsibilities and in particular hold partners to account.
- The need for the LSCB to be sufficiently independent from its key partners (and in the main the LA) is an issue for some.
- Some LSCBs are working well with other strategic partnerships but clarity of how these strategic bodies all related to each other was wanted.

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Inspection Criteria:

- The Local Safeguarding Children Board (LSCB) complies with its statutory responsibilities in accordance with the Children Act 2004 and the Local Safeguarding Children Board Regulations 2006.
- The LSCB is able to provide evidence that it coordinates the work of statutory partners in helping, protecting and caring for children in its local area and there are mechanisms in place to monitor the effectiveness of those local arrangements.
- Multi-agency training in the protection and care of children is effective and evaluated regularly for impact on management and practice.
- The LSCB checks that policies and procedures in respect of thresholds for intervention are understood and operate effectively and identifies where there are areas for improvement.
- Challenge of practice between partners and casework auditing are rigorous and used to identify where improvements can be made in front-line performance and management oversight.
- Serious case reviews, management reviews and reviews of child deaths are used by the local authority and partners as opportunities for learning and feedback that drive improvement.
- The LSCB provides robust and rigorous evaluation and analysis of local performance that influence and inform the planning and delivery of high-quality services.

Annex E: Findings from the rapid research review – SCRs

Spotlight on Serious Case Reviews – a rapid review

This paper is a rapid review of existing evidence ahead of the Wood Review of the role and function of Local Safeguarding Children Boards (LSCBs). It sets out the role of LSCBs in relation to Serious Case Reviews (SCRs), their history, and some of the common themes highlighted in previous reports and research studies. It should not be read as a comprehensive evidence review.

What are SCRs?

Regulation 5(1) (e) and (2) of the Local Safeguarding Children Boards Regulations 2006 set out an LSCB's function in relation to SCRs, namely:

5(1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1)(e) a serious case is one where:

- (a) abuse or neglect of a child is known or suspected; and
- (b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

The history of SCRs

Working Together: a guide to arrangements for interagency co-operation for the protection of children was first published in 1986. The first revisions to this statutory guidance were published in 1988 on the same day as the publication of the Cleveland Inquiry, a public inquiry into events the previous year where concerns had been raised about inappropriate and possibly excessive intervention by health professionals and social workers into families on the basis of questionable evidence of sexual abuse.

Part Nine of *Working Together* introduced a system of 'case reviews' to be carried out by the senior management of relevant agencies under the auspices of Area Child Protection Committees, which were later replaced by LSCBs. Case reviews were introduced to try to avert the need for time consuming, expensive and high profile public inquiries, such as the Cleveland Inquiry.

Subsequent versions of *Working Together* added to and strengthened guidance on case reviews. The number of pages increased from four in the 1999 version to 15 in 2006 (by which time case reviews had become serious

case reviews) and again to 23 pages by 2010. These increases were at least in part in response to recommendations contained in the public inquiry carried out following the death of Victoria Climbié (Laming, 2003) and the report carried out by Lord Laming into '*The progress being made across the country to implement effective arrangements for safeguarding children*' (Laming, 2009), following the death of Peter Connelly.

The 2013 version of *Working Together* marked the first significant departure from the trend of evolving guidance since the 1991 guidance, radically reducing its length and specificity. SCRs were identified as one element within a wider framework of learning and improvement, and LSCBs were given increased freedom over the learning model used in carrying out SCRs.

Working Together (2013) also introduced the national panel of independent experts on SCRs, which was established to advise LSCBs on the initiation and publication of SCRs, and to report to Government their views of how the SCR system is working. *Working Together (2015)* provided a definition of 'serious harm' in response to comments made in the first report by the national panel that some LSCBs were '*failing to make rational decisions on what constitutes serious harm*'.

The number of SCRs

The number of SCRs initiated and published has continued to increase over recent years. Figures held by DfE show that there was a year on year increase from 2010-11 (53) to 2013-14 (131), although there was then a slight dip in 2014-15 (101). Over the same period, there was an increase in the number of SCRs published, from 12 in 2010-11 to 71 in 2013-14, with again a slight dip in 2014-15 (56). The increase in the number of SCRs published can be attributed to a change in government policy from June 2010, which required publication of all SCRs initiated from that point³¹.

Rapid Evidence Review

This section summarises some of the main issues associated with SCRs. The findings are drawn from a number of sources: an analysis of some LSCB inspection reports was undertaken for this paper³² and a number of relevant research studies were also reviewed. This is a rapid review that serves to highlight some of the common themes and should not be read as a

³¹ Whilst the numbers of SCRs initiated has increased, the first report of the national panel found that there is a deep reluctance in some instances to conduct SCRs (DfE, 2014). The panel found that some LSCBs are failing to make rational decisions on what constitutes serious harm and that confusion in this area is leading to unjustifiable decisions regarding whether SCR criteria have been met. In some circumstances LSCBs carry out alternative investigations (the panel has seen over 20 different types). The panel is not confident that the other types of review investigate failings with sufficient independence and might be produced to evade publication.

³² Looking at a sample of reviews carried out up until 30 June 2015.

comprehensive review of all the evidence.

SCRs have been the focus of a relatively small number of research studies. Research that is critical of SCRs and/or recommending improvements is the most easily found. Some of the research quoted is quite old and may not reflect the current situation, particularly in light of the changes to departmental guidance.

Good practice in SCRs

Ofsted (2011), in its report looking at good practice in LSCBs, found that LSCBs demonstrate good practice by:

- being proactive in ensuring that lessons are learned from SCRs and in disseminating information from SCR findings;
- ensuring that SCR recommendations are implemented, holding agencies to account for progressing their individual action plans;
- using SCR findings to drive improvement and to influence future plans;
- learning from the process of carrying out SCRs;
- understanding how implementing the findings of SCRs makes a difference to children, young people and their families;
- learning from ‘near misses’ and serious incidents that do not meet the criteria for SCRs.

Publication delays

SCRs have received criticism for the length of time it takes to complete them. Long delays might be the result of court processes and to some extent outside the control of the reviewers, but commentators (Rawlings et al 2014 and Sidebotham et al 2010) agree that for findings to have any impact on practice they need be disseminated quickly and any recommendations actioned as soon as possible. There has been a steady increase in the number of SCRs initiated and the percentage of SCRs being published within 12 months of being initiated between 2011-12 and 2013-14. However, figures from DfE suggest that only 23% of SCRs initiated in 2013/14 have since been published. The second report by the national panel suggested that briefer, more proportionate SCRs might reduce the long wait for the learning (DfE, 2015).

Recurrent findings and the focus of SCRs

Research suggest that SCRs often reach similar conclusions, repeatedly highlighting issues with interagency working, particularly around information sharing and the quality of recording and analysis of information (see Brandon et al 2010). The fact that these failures are repeated have led people to question whether we are learning anything from SCRs but Sidebotham et al (2010) make the point that although conclusions are repeated these are *“reminders that are needed about important issues”*.

In her review of child protection in England, Professor Eileen Munro argued

that SCRs provided descriptions of what happened in a case but fail to look at why the events occurred (Munro, 2011). Elsewhere, it has been suggested that SCRs need to provide a better understanding of what caused an individual in a case to behave the way that they did so that effort can be aimed at improving professional judgement (Dale and Mills, 2013). The organisational context, which for some agencies has involved major change resulting in disruption and discontinuity in staffing, also rarely featured in issues to be addressed (Rose and Barnes, 2008).

The variable quality of serious case reviews was highlighted as a potential barrier to learning by Ofsted (Ofsted, 2008; 2011) and continues to be highlighted as a concern in both reports from the national panel (DfE 2014; 2015). The panel identified a number of key problems in the quality of reports including: too much detail making it hard to read and hard to understand what happened; too much listing of what happened without asking why; a failure to look at human motivation and the impact of fear, overwork, timidity, wilful blindness and over optimism; reports that fail to centre on the child; and unclear, unfocussed recommendations.

SCR recommendations and policy and procedures put in place following an SCR

The study on the barriers to learning from SCRs found the numbers of recommendations that generate new policies and procedures overwhelming (Rawlings et al, 2014). Brandon et al (2011), in their analysis of recommendations from SCRs, suggested that *“LSCBs need to take responsibility for curbing this self-perpetuating cycle of a proliferation of recommendations and tasks and allow themselves to consider other ways of learning from serious case reviews. Recommendations may not be the best way to learn from these cases.”*

Brandon et al (2011) also note *“most recommendations concerned procedures and training. The route to grappling with practice complexities like engaging hard to reach families, was usually more training and the compliance with or creation of new or duplicate procedures. Fewer recommendations considered strengthening supervision and better staff support as ways of promoting professional judgement or supporting reflective practice”*. Devaney et al (2011) caution against SCRs increasing the prescription of practice and Rawlings et al (2014) concur: they suggest that there should be awareness that *“over-proceduralisation squeezes out professional practice, judgement and accountability and ownership of actions”*.

The development and implementation of policy and procedures following an SCR are often *“not proportionate or sensitive to the scale, locality and context of the case”*. (Rawlings et al, 2014). They add that policies and procedures *“... may not be sensitive to what is able to be actioned by practitioners with large workloads and who are already very busy”* and that policies and procedures take time to embed and too much change is *“destabilising and undermining and communication systems are currently ineffectual in ensuring*

that learning from SCRs informs practitioners within and across disciplines, agencies and sectors". They suggest that auditing the impact of, and embedding changes, needs to be given more attention and follow up learning and procedures to ensure corrective actions are implemented .

Clarity on the purpose of SCRs

Devaney et al (2011) state that, whilst the emphasis when SCRs were first introduced was on learning rather than holding organisations or individuals to account, and that they informed local rather than national practice, nowadays SCRs exist both to manage learning for professionals and are seen as part of public interest and political processes. Experience from the health sector suggests that these functions can have contradictory influences on review processes (Nicolini et al, 2011). Devaney et al (2011) agree and comment that *"the sense of being able to reflect on learning from a given situation does not always sit comfortably with the need to ensure that both individuals and institutions are held to account if their actions have fallen below the expected level"*. Respondents in Brandon et al (2014) expressed similar confusion about the competing aims of SCRs: *"the confusion was the perception of a dissonance between the systems learning approach and public statements from Ministers which were perceived to be more about blame than learning"*. The second report from the national panel reiterated that the point of publishing SCRs is not to punish but to learn, and they welcomed the reinstatement of the regular national analyses of SCRs as a means of ensuring that the SCR system has the impact intended (DfE, 2015).

Time and resources required for an SCR

The time and resources required to undertake SCRs inhibited the capacity of LSCBs to move forward and fulfil other responsibilities (France et al, 2010). Baginsky and Holmes (2015) concur: they report that one of the biggest demands made on LSCBs (in terms of difficulty, and in some cases in terms of actual cost) comes from conducting SCRs. Participants at all stages of the research highlighted the significant resource challenges (financial and personnel time) associated with conducting SCRs, and a not insignificant number questioned whether they were even useful at all. The second report from the national panel acknowledged that SCRs are costly and made it clear that a proportionate approach to carrying out the review needs to be adopted to enable the aims of the SCR to be met without incurring excessive cost or workload. The panel also urged DfE to act to ensure that LSCBs are adequately funded by local partners to support the SCR process; and that the Association of Independent LSCB Chairs (AILC) in turn receives adequate funding from DfE or member LSCBs (DfE, 2015).

Publication in full

On 10 June 2010, the Coalition Government announced that all SCRs initiated from that point onwards should be published in full unless there were compelling reasons relating to the welfare of children in the case for this not to happen. This was later reinforced in Working Together 2013, which stated

that *'final reports of SCRs **must be published**, including the LSCB's response to the review findings, in order to achieve **transparency**'*.

The study on the barriers to learning from SCRs highlighted concerns about publication in full amid concerns about transparency and confidentiality (Rawlings et al, 2014). Some respondents expressed concern that publication fuels the blame culture and may be promoting defensiveness and that this could undermine potential learning. The first report of the national panel reported positively that redaction is now rare (DfE, 2014). The second panel report reported anecdotal evidence from AILC that the publication of SCRs increasingly sees LSCBs challenged in new ways, for instance by professional bodies, threatened litigation from families and victims, or aggressive media attention. The panel recommended that DfE and AILC monitor the impact of the publication of SCRs and report to the panel any specific, verifiable instances of direct and serious consequences for individuals as a result of publication.

Clarity on what constitutes a good report

The first report of the national panel described the quality of SCRs (particularly those initiated before *Working Together 2013*) as *'disturbingly variable'*, and containing detail *'not relevant to learning'* which can make publication more difficult (DfE, 2014). Rawlings et al (2014) agree and find that *"reports are not accessible in terms of length and common language to make them meaningful and manageable to all users across different sectors, professions and agencies. Key themes and learning are not adequately identified nationally"*. They recommended that DfE give examples of what good SCRs look like (DfE, 2014) and likewise Brandon et al (2014) found that participants remained unsure about a number of matters... among these was the need for clarity about what constitutes a *'good report'* (including clear case examples). In the same research, respondents were also still unclear on how much flexibility there was to use the different methodologies.

Commissioning a review – skills and experience

Finding suitable authors with suitable experience is an issue for some LSCBs and some feel that it is often a case of who you know (Brandon et al 2014). Devaney et al (2011) proposed the appointment of external chairs *"to avoid relying on arbitrary system of informal contacts to find suitable people"*. Ensuring that participants and authors have the right skills is important. Munro and Lushey (2013) comment that *"the traditional SCR is much maligned but those doing them didn't have the skills and experience"*, they add that irrespective of model *"those involved need to have training, skills and competencies to fulfil their role"*.

Involvement of practitioners

A survey by the British Association of Social Workers (2012) reveals that the majority of social workers do not read SCRs. SCRs are criticised for containing irrelevant detail, jargon and acronyms which makes it hard for

people to read and learn from them (DfE, 2014). Several researchers comment that frontline practitioners need to be more actively engaged in the process of learning from the reviews rather than being passive recipients (Brandon et al (2010) and Sidebotham (2012)). The study on the barriers to learning from SCRs (Rawlings et al, 2014) also recommends that changes in policy and procedures be discussed and tested with frontline practitioners before roll-out.

Learning culture

Rawlings et al (2014) said that to assist with learning from SCRs key themes should be identified and there should be a national, themed repository of reports, with some targeting at different professions, practitioners and management roles, agencies and sectors. (NSPCC and the Association of Independent LSCB chairs have since initiated a national and themed repository of all SCRs.) Rawlings et al (2014) also listed a number of facilitators to improve the learning culture from SCRs:

- Capture learning from smaller incidents as well as major emergencies;
- The importance of learning should be recognised by senior leadership;
- Develop a stock of lessons learned for on-going incremental learning;
- Create a learning culture and an evidence-based process of learning;
- Discuss and test changes in policy and procedures frontline practitioners before roll-out and implementation.

International Comparisons

In the time available, it has not been possible to provide a comparative analysis of the systems operating elsewhere: comparative and reliable studies of different aspects of the child protection systems are rare. However, the UK experience of child protection ‘tragedies’ is not unique to this country]: *“in many countries child protection and child welfare has taken on a high political profile due in large measure to intense media coverage”* (Gilbert et al., 2011).

Each of the home nations have reworked the scope and approach to their reviews. The Welsh Government’s introduced the ‘Child Practice Review (CPR) model’³³, following an inspectorate report that concluded the SCR process had become ineffective in improving practice and inter-agency working. CPRs encompass both ‘concise’ and ‘comprehensive’ reviews with an emphasis on shared learning. Due to the limited number of CPRs completed to date there is no evaluation evidence on the quality or impact of the new CPRs. Messages from early implementation research are that there are high levels support and commitment for the CPR process. People felt the process involves more work but recognised the need to get the process right. There was recognition of the differing levels of quality in some aspects of the process and how delay has, on occasion, impacted upon quality, but it was felt that as more CPRs are completed the quality of the process would improve and awareness would increase. This would, in turn, have a positive

³³ The CPR process stemmed from the Care and Social Services Inspectorate Wales report published in October 2009: *improving Practice to Protect Children in Wales: An Examination of the Role of Serious Case Reviews*.

impact on the wider level of practice learning across Wales. Finally, stakeholders were keen to be part of the development of national dissemination of the findings (Cordis Bright, 2015).

In Northern Ireland, Case Management Review (CMR) processes are undertaken when non-accidental child deaths occur. Research by Devaney et al (2011) showed that the system does command professional support, but could be improved through greater attention to process issues and a stronger emphasis on translating learning into action. They state that the traditional approach can deliver: *“participants were able to identify how different CMRs resulted in important refinements and improvements in practice”*. There were, however, some suggestions to amend the process. For example:

- more options to review cases in different ways where appropriate
- appointment of external chairs
- initial training for chairs and panel and refresher training including a focus on the outcomes of CMRs (to avoid duplicate recommendations)
- ensure the involvement of relevant agencies, families and professionals
- the need to learn lessons, hampered by:
 - time taken to complete reviews,
 - recommendations – too many, lack specificity or achievability, failure to audit the implementation of recommendations
 - dissemination – generally lacking

Conclusion

This paper has looked at the good practice and facilitators of SCRs and presented the common criticisms of SCRs and barriers to their use.

The main criticisms:

- delays in publication;
- recurrent findings and describing what happened with insufficient focus on why things happened with a failure to understand human motivation;
- irrelevant information and unclear recommendations;
- policy and procedures put in place following the SCR are not appropriate, implemented or audited adequately;
- inability to action change following the learning.

The main barriers:

- time and resources to undertake the SCR;
- requirement to publish reports in full.

The main facilitators:

- the need for clarity on the purpose of SCRs;
- the need for clarity on what constitutes a good report;
- having the necessary skills and experience;
- involving practitioners.

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Annex F: Cabinet Office Implementation Unit findings

Cabinet Office Implementation Unit ‘deep dive’

The Implementation Unit (IU) was commissioned by the Child Protection Implementation Taskforce to support the independent review of LSCBs by collecting additional evidence on the enablers and barriers to effective multi-agency working to safeguard vulnerable children and how these relate to formal governance structures. This included a specific focus on:

1. the role of leadership;
2. the ability to translate strategic direction into operational delivery; and
3. how to operate effectively in a wider local multi-agency landscape.

The IU conducted 15 structured interviews with LSCB members - including LSCB Chairs and representatives from the police, education, health and Children's Services - from 11 boards across England.

The IU's findings closely mirrored those which emerged from meetings and our consultation. The IU found that successful boards were built on relationships of trust that had developed between key stakeholders over time, led by a strong Chair. Biggest challenges included variable commitment from agencies outside the local authority to local multi-agency working and difficulty in holding these agencies to account. The IU did not find evidence that the LSCB structure alone ensured effective multi-agency working.

Summary of findings

Several key areas were highlighted as being important enablers to achieving effective multi-agency working:

- Structure

Constructing a lean, high-level group of senior colleagues that are able to take decisions and set direction, was deemed important to success. This high level group could be supported by smaller sub-groups that write strategies and plan more detailed work.

Some boards also reported the benefits of co-membership on and coordination of work across, different local boards, with strong administration of these structures being highlighted as a success factor.

- Leadership

Opinions were divided around whether the LSCB should be chaired by the DCS or someone independent of the partner organisations. A key success factor, however, was that the Chair should have a sufficiently high level of

experience, knowledge and skills to stand on an equal footing with the senior leaders from partner agencies. Other requirements of a successful Chair were identified as:

- being open to challenge
- wanting to improve their service
- setting clear strategic direction
- investing time with partner agencies
- building trusting relationships

It was felt that these enabled boards to have greater success in getting things done in their area, despite the lack of formal 'levers' to ensure buy-in from partner agencies.

- Other factors

Other key features that were identified as being enablers for a successful multi-agency working were:

- achieving a strong sense of joint ownership of issues and actions with partner agencies
- using an evidence-based approach to set priorities, incorporating local and national research with the views of frontline professionals and young people.
- Creating an environment conducive to robust scrutiny and constructive challenge.

A number of factors that could limit the effectiveness of multi-agency working were identified. These barriers included:

- confusion around whether the board was required to deliver work, as well as hold organisations to account
- confusion around the interactions and overlap with other local boards
- difficulty in identifying appropriate representation from schools and the health sector
- the challenges faced by larger geographical areas or those with very different localities
- the lack of coterminosity with key services
- the burden on the local authority caused by children's social care taking the lead 'by default', and the difficulties arising when other agencies do not put in proportionate resource
- competing priorities of partner agencies, which could lead to poor resource and data contributions and engagement.
- the variability in the quality of independent Chairs across the country.
- concerns that inspections do not always accurately assess success.

Finally, while some LSCBs reported achieving success through excellent networking and relationships, some felt the duty on partner agencies to cooperate and contribute was too loose. Some stated that greater formal powers to commission partner agencies could improve safeguarding.

Annex G: Consultation analysis

Consultation Analysis

Total responses – 628

Total named responses – 433

Summary of Named Respondents to Consultation

Health

	Number of respondents
Health – CCG	33
NHS Trust	48
NHS England regional	3
Health – other	5
Total	89

LSCB

	Number of respondents
LSCB – Chair	47
LSCB – Board/business manager	21
LSCB – Lay member	7
LSCB – Training officer	6
LSCB – other	5
Total	86

Local authorities

	Number of respondents
Local authority – DCS	16
Local authority – public health	15
Local authority – CDOP	7
Local authority – other	40

	Number of respondents
Total	79

Other categories

Category	Number of respondents
Nursery	30
Voluntary and community	25
School	21
Private company	10
Police	8
Community rehabilitation company	7
Consultant	6
Individual	7
Fire Brigade	6
National probation service	6
SCR reviewer	7
Youth offending/youth justice	5
FE/sixth form college	5
District and borough council	4
Inspection agency	4
Professional association	4
Children's centre	2
Childminder	4
Coroner	2
Cafcass	2
Other	14

List of National Bodies Responding to the Consultation

(by submission)

- Association of Independent LSCB Chairs
- Association of Directors of Children's Services
- Home Office
- Local Government Association
- Ofsted
- Care Quality Commission
- Prisons and Probation Ombudsman
- HM Inspectorate of Probation
- Association of Directors of Adult Social Services
- Cafcass
- Children's Society

(by survey)

- Youth Justice Board for England and Wales (Safeguarding and Child Protection Manager)
- National Offender Management Service, Offender Management & Public Protection Group (Safeguarding Policy Lead)

Qs1 - Do LSCBs currently coordinate effectively what their partners do to safeguard children in their local area?

Total responses 628

Yes 62.5% (from this % there were 185 written comments)

No 19% (71)

Don't know 18.5% (39)

Some themes from the written responses that say that LSCBs are currently coordinating effectively

- There are clear systems in place through s11/s175 and audit process to co-ordinate and monitor effectiveness even across a large area, and arguably more opportunity for impact.
- LSCBs are able to bring together the range of agencies working with children and young people in an area. Through formal and informal discussion and agreement and challenge where necessary, at board, sub-committee and individual level, safeguarding activity can be effectively planned and coordinated.
- LSCBs hold each other to account, challenge each other and ensures safeguarding children remains a central focus and high on the agenda across the borough.

Some themes from the written responses that say that LSCBs do not coordinate effectively

- It's not consistent across partnerships.
- There is more emphasis in some agencies of single agency responsibilities rather than joint responsibilities. There's often a linear structure to safeguarding, despite it being everyone's responsibility.
- The breadth is not there, services such as the voluntary sector and probation services are often not included.
- LSCBs are limited in their ability to coordinate what partners do because the statutory function is held by the LA.
- LSCBs lack sufficient statutory powers to coordinate effectively.
- The wider partnership terrain is crowded and confused. Health and Wellbeing Boards, Children Partnerships, Prevent Boards and Community Safety Partnerships need either clearer demarcation or closer cohesion.
- Some LSCBs are too big and it is difficult to manage a culture that is the best fit for all areas.
- Of these more than 10 specifically cite the lack of accreditation or the closed nature of the current SCR author roster as a current difficulty.

Key Quotes

Cafcass

There is variation in performance between different LSCBs but generally the experience within Cafcass has been that LSCBs make little significant impact on local practice. LSCBs have expanded their scope beyond the core business of child protection into a multitude of safeguarding matters. Section 11 is one such example which has been subject to widespread 'mission-creep', morphing from being a proportionate check on arrangements into an increasingly elaborate and ineffective mechanism for evaluating practice. It absorbs huge amounts of resource too little, if any, benefit, that would be much better spent on the frontline.

Designated Nurse - CCG

The LSCB tries to do the above, but on occasions this is not achieved, e.g. locally ascertaining how the CCG holds the provider to account regarding safeguarding KPI's. Since reorganisation of the NHS and the implementation of the CCG's the NHS has become fragmented. Difficult to hold GP's to account –comes under NHSE. Commissioning is done in different places e.g. mental health, school nursing and HV formerly NHSE, now devolved to Local Authority etc. The Provider commissioning split has had an enormous impact on working together-brick walls have been erected between the services. If it is not in the contract you can't have it.

Designated Nurse - CCG

I sit on 3 LSCBs which sit in 3 LAs. This means I see the same multi-agency partners (particularly police, probation and health partners who serve the whole area) at each board and relevant sub-group. There is much repetition as a consequence. Effective co-ordination is variable across a very small geographic area. The word 'co-ordinate' is misleading and would lead someone to believe that we, as LSCB board members are conduits for multi information sharing and building relationships. This is not necessarily the case; relationships tend to be built outside the LSCBs and these are dependent on personalities and shared drivers and ambitions to get things done. So, the LSCBs are aware of what their partners do in their area rather than play an active co-ordination role. The statutory and relevant partners are members of the LSCB and they are aware of each other's role but this is not what I define 'co-ordination.'

Local Authority

Unfortunately it appears that LSCBs are limited in their ability to coordinate what partners do since the statutory function is solely held with the LA. Until the statutory function is held by leaders in police, health and education (complicated by academy system) the LSCBs impact to effect change will remain constrained. The constraints in being able to effectively coordinate are in part likely due to the complex structure of other governance arrangements such as the local adult safeguarding board, health and well-being board, community safety partnership board which frustrates the authority of the LSCB to 'coordinate'.

LSCB

LSCBs have an oversight of how effectively partners are working but they are not operational enough to be co-ordinating what they 'do'. This is down to the individual partners work. The LSCBs certainly put pressure on partners to perform better and make adjustments to their ways of working or to implement changes following serious case reviews. The LSCB is a system improver and driver, that attempts to hold organisations to account for their work, but they don't co-ordinate what individual organisations do on a day to day basis to safeguard children.

Qs2 - Do LSCBs currently ensure the effectiveness of what their partners do to safeguard children in their local area?

Total responses 628

Yes 52.8% (from this % there were 166 written comments)

No 21.7% (72)

Don't know 25.5% (47)

Key Analysis – the consultation responses from LSCB Chairs and Business Managers backs up the response from the LGA (see below) that they do ensure effectively but they were less confident that they could continue to do this well. The main reasons given were: lack of statutory power to compel agencies to act; partners' good will diminishing due to their own operational needs; and due to mission-creep the LSCBs remit and accountability has expanded beyond a level that LSCBs can cope with.

Some themes from the written responses that say that LSCBs do ensure effectively what their partners do to safeguard children

- They do this through a range of measures: through quality assurance groups where agency activity is assessed across the partnership and challenged where necessary; through Section 11 and multi-agency audits, as well as peer review and feedback from frontline practice; through learning from case reviews; and through quality assuring and delivery of training to agencies.
- LSCBs do ensure effectively but has been made difficult as the remit and accountability for LSCBs have expanded.
- Effective LSCBs tend to have good multi-agency data sets that provide relevant data around LSCB priorities. The analysis is provided to the Board timely for Boards to develop a good understanding of what's important to inform local needs.

Some themes from the written responses that say that LSCBs do not ensure effectively what their partners do to safeguard children

- LSCBs' remit is too big; the core function of monitoring effectiveness is not assisted by the plethora of ever competing demands.
- LSCBs are compromised by their proximity to the local authority senior teams and therefore their independence and ability to bring about change in failing children's social care services is limited.
- LSCBs cannot 'ensure'. They can seek assurance and challenge but ultimately each organisation is responsible for their own actions.
- LSCBs are less effective in holding individual partners to account for their actions. They lack sufficient statutory "teeth" to carry out this task and are dependent upon the effectiveness of the independent chair

which varies considerably from area to area.

Key Quotes

Named Professional for Safeguarding children

I have seen good and bad practice of this. Some Boards do this very well. On the whole I do not think that they get it right, there seems to be a lack of Section 11 audit review process of agencies. There seems to be an inconsistent focus on chasing action or gaps. Challenging partner agencies can often be difficult for some chairs. Depending on the chair's strength, the Board can grow a culture that is accepting, rather than challenging and questioning. Strong Business Managers and Chairs are critical; these roles should not be overlooked. The strength and culture of the Board is driven from these two roles. It is critical that they have a level of autonomy, independence and freedom to drive the Board agenda.

Former DCS of Local Authority

LSCBs cannot ensure the effectiveness of what partners do. They can comment on it, criticize what is done, challenge partners, hold partners to account in various ways but the LSCB does not have the authority to ensure a partner does something. That is the partner organisation's responsibility. If the LSCB became responsible it would have to have the authority, resources and accountability. It would become an operational organisation.

National Probation Service

Again, this is a mixed picture. Monitoring processes via Section 11 Audits need to be matched with robust challenge about how they match positive outcomes. Data collection needs to focus on how the processes impact on the children. LSCBs are very effective when there is a willingness to be transparent and open to constructive challenge. The less effective ones have poorer structures and business support. There needs to be structured and consistent alignments with other partnership priorities for example from Community Safety Partnerships, Health and Wellbeing Boards (responsible for Joint Strategic Needs Assessment), Safeguarding Adults etc. Currently there is significant overlap in the priorities/policy/delivery within these partnership structures (for example around Child Sexual Exploitation, Domestic Abuse) and a need for greater strategic coordination.

LGA

Our research found that Chairs were less confident in this aspect of their work. Although the overwhelming majority said they were doing so at least 'moderately well', with just under half reported to be doing this 'mostly very well' or 'completely', 14 per cent were said to be doing so 'poorly' or 'very poorly'. One issue that emerged frequently in the research was the potential for conflict between the priorities of Boards and those of partner agencies, sometimes leaving members to choose between following the wishes of the Board or the more formal demands of their employer. For example, the police were seen to be a highly engaged partner but one with a strong alternative chain of command. This meant the representatives not only received orders from their superiors, but they were subject to priorities other than those of the

Boards, all of which made it harder to hold them to account. In discussions with members of Boards it was evident that many faced similar dilemmas, often speaking of contributing to their LSCB's work or reporting to the Board rather than of owning the work or acting on the Board's behalf.

LSCB Chair

There are many examples of this- including conversations with front line staff to find out whether they can do their job properly, the establishment of the MASH model in many areas (in our area this includes CSE multi-agency hubs) the children's JSNA, the annual reports (which are improving since the yearly analysis from AILC which provides an outline/baseline) and the other examples of compliance with guidance referred to elsewhere in this response. Boundaries are always on the move, agencies are constantly being re structured, staff at all levels are changing so it is a process which has to be done and done again and that in itself is a challenge for all boards. My experience is that partners generally understand the importance of safeguarding and look to the board and other board members as a source of expertise and experience in a constantly changing environment.

Principal Social Worker, Local Authority

Boards provide a forum for discussion to allow all partners to identify and understand their role in the safeguarding processes. This clarity provides the foundation for effective safeguarding practice and understanding across the multi-agency partnership. Reviews of LSCBs carried out under the auspices of the SIF inspection framework would tend to suggest that they are not effective, along with the fact that, over and over again, SCRs carried out across the country come to the same conclusions, suggesting that lessons were not learnt and / or appropriate remedies were not put in place or sufficiently embedded. It could be argued that LSCBs have not been given the correct statutory power to ensure the effectiveness of what partners do to safeguard children; it could also be said that the expectations placed on LSCB are not achievable in the current context because (a) a lack of statutory powers resulting in an inability to compel partners to take any particular action and (b) the current economic climate and financial challenges facing the partners around the table are such that they are likely necessarily to threaten the quality and consistency of practice regardless of the effectiveness or otherwise of the LSCB: It would not really be fair to hold the LSCB solely accountable for "ensuring effectiveness" within this context.

Qs3 - Are formal multi-agency arrangements important in keeping children safe?

Total responses 628

Yes 97.7% (from this % there were 276 written comments)

No 1.4% (7)

Don't know 0.9% (2)

What did people say about the value of formal multi-agency arrangements?

In specific comments about formal multi-agency arrangements, four key themes emerged:

- They ensure that strategic joint working takes place and in a way which sets a positive example to operational partnerships.
- They provide a structure to share key information.
- They provide an authoritative forum in which individual agencies are held to account and where all parties are made aware of their child protection responsibilities.
- They ensure that child protection remains a relative priority for the agencies involved, particularly at a time of diminished resources.

Different sectors emphasised these points to varying degrees

- LSCBs and LAs were most likely to argue that formal arrangements ensured joint working took place, but all sectors cited this argument more frequently than others.
- Respondents from the health sector were most likely to refer to formal arrangements providing a platform for sharing key information. LSCBs and non-LSCB/LA/health organisations also cited this frequently, but this was less common in responses from LAs.
- LAs were significantly more likely to talk about formal arrangements holding agencies to account. This was also often referred to by non-LSCB/LA/health organisations, and somewhat less frequently by LSCBs and the health sector.
- A small number of respondents in each sector suggested that formal arrangements were necessary to ensure child protection remained a relative priority for individual agencies.

Other points made on formal multi-agency arrangements include:

- A number of respondents from non-LSCB/LA/health organisations said such arrangements were important to ensure child protection involved all agencies and was not dominated by particular services. Equally, some respondents said formal arrangements were also important for ensuring that lead individuals came to the fore.

Some non-LSCB/LA/health organisations and some LSCBs said formal arrangements were necessary to ensure there were independent voices in child protection arrangements.

Sector Responses

Answering 'Yes'

Early Years

"Yes yes yes!!! There needs to be more direction on which agency should take the lead though. All too often, there is confusion about who is co-ordinating the multiple agencies."

LSCB

"Lord Laming's comments that, "safeguarding cannot be done by one profession acting alone" remain as true as ever. This world has been transformed since 2005 and these gains must not be lost."

Local Authority

"Is this a trick question? Research and best practice clearly inform us multi-agency work is the only way to keep children safe."

"For those of us who've been around the block, there is no doubt in my mind that these formal statutory arrangements have brought agencies and kept them at the table... It is clear that we are in a much better place now than previously."

Answering 'No'

Early Years

"They should not be - if the child / vulnerable person is at the centre of the process this should be automatic."

"Multi-agency working is not possible within the constraints of each organisation and their own priorities. Serious case reviews always seem to highlight the fact that multi-agency working doesn't work. I think it would be better to be honest about this, and have more realistic expectations of what each organisation can and does do."

Health

"National structures and confidence in them would better support children and keep them safe. Multiagency audits can only go so far in showing service working together however as finances reduce this process will be become more a process and less about the children."

Local Authority

"It is staff, systems, and good practice that keep children safe. LSCBs should encourage partners to collaborate and use resource effectively to support children and families restoratively. There needs to be much more focus on learning and reflection, debate and dialogue, seeking solutions to complex problems, rather than blame."

School

“Much fuss is made of MA arrangements. However as a practitioner MA working is often a farce – it’s all about silo mentality and agencies worrying more about decreasing resources than putting children first.”

Qs4 - Should local multi-agency arrangements to safeguard children be reformed?

Total responses 628

Yes 54.9% (from this % there were 88 written comments)

No 16.2% (20)

Don't know 28.9% (41)

Some themes from the written responses in favour of reform

- LSCBs should be reformed but need to ensure that the strengths of the current model are not lost, such as local accountability which is an important component of effective LSCBs.
- There should be reform to arrangements for funding Boards, which are largely funded by local authorities and is unsustainable.
- The current role and remit for LSCB has increased, so LSCBs should be better resourced, Chairs should spend significantly more time than at present doing their job.
- LSCBs are responsible for assurance and coordination, but struggle to get key partners round the table; they don't have enough authority to demand changes. LSCBs statutory powers should be strengthened with regard to directions they provide.
- LSCBs need to incorporate *"the voice of the child"* into their work; young people should be better represented on Board.
- Should establish an analytical function within the LSCB which is multi-agency, would enable for more robust assessments of local practice and make it easier to identify the 'big picture'
- LSCBs should be independent of local authorities.
- Should reduce the number of LSCBs to a cluster or regional approach to have coterminous geographic boundaries in order to identify any systemic issues which may apply to more than a single area.
- The partnership landscape is too cluttered with CSPs, LSCBs, LSABs and HWBBs. They all risk duplication and evade responsibility of effort. The cost of attendance for agencies to all these meetings is considerable. Rationalising the partnership meeting structures would provide greater co-ordination and reduce duplication of effort.
- There should be a national overview around themes as they emerge with capacity to investigate across current area boundaries, with subsequent lessons learnt implemented locally.
- Should adopt a formal role for LSCBs chairs governance that links them into Ofsted on an ongoing basis, so that the Annual Report goes to Ofsted to critique and advice of shortfalls. This can be a mechanism for the influencing power of LSCB Chairs. This could address the current gap between Boards knowing what the issues are, and being able to resolve them and would effective as an approach, given the nature of the new multi-agency partnership inspection methodology.
- In the changing educational landscape, many agencies have reduced leverage with schools, especially academies to provide timely and

accurate information, and cannot easily verify what information is provided.

- Key agencies should have a statutory obligation to commit to LSCBs.

Key Quotes in support of reform

Local Authority

The boundary of what 'local' means should be carefully thought through with consideration to 'regional' multi-agency safeguarding arrangements. The statutory function should be held across partners and not solely with LAs and the relationship between the various governance arrangements requires substantial reform. There should be an ambition to dovetail reforms to LSCBs with upcoming multi-agency inspections so that inspections can more seamlessly lead to the sharing of multi-agency objectives and improvement plans. I wonder whether the alignment of multi-agency strategies in a regional area might be better achieved through having an overarching Family Safeguarding, Health and Well-being Board with a variety of more focused boards operating below, one of which would be specialising in Child Protection.

LSCB Chair

More focus on sub-regional collaboration; the current roles of LSCBs can often be done over a larger area. In particular, training, development of policies & procedures, and interventions in support of vulnerable young people (CSE, gangs, interventions, youth justice oversight). Some functions can also be aligned with SABs - but some still need to be based around the locality, the council footprint. Some elements, such as SCRs, need a wider look - not only centralising the commissioning (though the learning has to be local), but also reducing the numbers - maybe this comes up later in the survey.

LSCB Chair

However, success really depends on whether any reform can look clearly at what works well and builds on that. It is important to take account of the huge changes since LSCBs were established. These include management and accountability in education; commissioning and provision of health services; 'emerging' issues such as FGM, CSA and; Radicalisation. The role of Local Government and other key agencies such as the NHS as a direct provider has changed radically and while it remains the case that Commissioners are responsible for quality of provision, always, the fact is that governance has become increasingly complex and the current structure does not always reflect that fact.

LGA

Any reform of multi-agency safeguarding arrangements must be based on a clear understanding of what these arrangements are intended to achieve. While our research did not identify a single key "problem" with the current operation of local safeguarding children boards, it was clear that their gradual evolution over a number of years has led to some confusion over their core purpose. We remain concerned that the key statutory duties identified under

questions 1 and 2, above, are under increasing pressure from a vast number of competing, and at times very specific, national priorities, including "undertaking initiatives in relation to FGM" (2011 Multi-Agency Practice Guidelines on FGM), "taking accountability" for tackling faith based abuse (2012 National Action Plan to Tackle Child Abuse Linked to Faith or Belief), and producing and publishing detailed thresholds guidance (Working Together to Safeguard Children, 2013 revision). The establishment of other multi-agency partnerships with a similar focus, such as Health and Wellbeing Boards, and new bodies with responsibility for overseeing local safeguarding practice, such as Police and Crime Commissioners, have caused further confusion in some areas but provided opportunities for greater streamlining of LSCB priorities and joint working across agencies in others. We believe that any reform to the current system should follow the principle of "form follows function", with a clearly articulated statement of purpose underpinning the arrangements that local areas are required to put in place.

National Police Chiefs Council

Given the rising number of academies further consideration is required relating to the role of LSCBs and their capacity to influence and coordinate safeguarding activity across them. Schools are a key stakeholder in this area in terms of information sharing, identification of need and delivering prevention materials/ advice. It is extremely important that their activities are coordinated/ joined up with other local safeguarding partners.

Some themes from the written responses against reform

- Changes can be made to local safeguarding structures and processes but wholesale reform which will be costly and disruptive is not required. LSCBs need power to compel partners to comply with direction.
- Regional arrangements will affect local impact for LSCBs. LSCBs should continue to have a statutory framework as they will have no teeth without them; duty to cooperate is useful but needs a further statutory footing.
- In many areas the arrangements work well, so need no reform, in others less so, therefore a prescriptive model will not work. What partnerships need is clarity of outcomes and expectations, then local areas can work out the best way to achieve this, and be held accountable for what outcomes they achieve, not how they run their arrangements.
- There is some scope for improvement, successful multi-agency hubs have been embedded in many areas and are effective in promoting better sharing of information and expertise.
- Most LSCBs do a good job, but the control of the local authority is too strong for overall effectiveness. The Chair tends to be accountable to the local authority.

Qs5 - Should local multi-agency arrangements have protecting children as their principal focus?

Total responses 628

Yes 87.7% (from this % there were 276 written comments)

No 6.8% (7)

Don't know 5.5% (2)

Did respondents feel multi-agency arrangements should have a clear focus on child protection or be geared to a broader context?

- Around 60% of feedback comments spoke about ensuring that child protection is the clear focus of local arrangements. The remaining comments suggested that, while important, child protection work should be placed in the context of broader safeguarding and preventative measures and other local services.
- Nearly two thirds of LSCB and LA respondents said that child protection should be the principal focus, as did three quarters of responses from non-LSCB/LA/health organisations. However, only one quarter of comments from the health sector made this argument, with the remainder focusing on broader work local arrangements could fulfil.
- A small number of respondents from each sector, including from LSCBs themselves, stated that they felt new responsibilities had stretched LSCBs too thinly in recent years. However, an equal number of respondents in the LSCB sector said they believed LSCBs should expand further into broader remits.
- Respondents made suggestions on particular areas alongside child protection which multi-agency arrangements should focus on. LSCBs often promoted work on early intervention and whole family approaches. The health sector often stressed both early intervention and link-up with adult safeguarding. Respondents from LAs and non-LSCB/LA/health organisations also referred to these two areas of work in particular.

Sector Responses

LGA

"We are concerned that the increasing dilution of LSCB responsibilities risks undermining their core focus....Our research found that many LSCBs currently lack the necessary resources to undertake the growing workload expected of them and, at a time of growing financial pressure across the public sector, it is therefore right that these arrangements focus first and foremost on the central importance of co-ordinating and ensuring the effectiveness of child protection activity across the local partnership. However... we support the contention in Working Together 2013 that: "When this core business is secure... LSCBs should go beyond it to work to their wider remit."

Answering 'Yes'

NSPCC

"The concept of 'safeguarding' all, as opposed to 'protecting' a few, has been useful for many as a way of conceptualising and prioritising workload. However, with the increase in issues such as on-line grooming, child sexual

exploitation and radicalisation, the boundary has become so much more blurred as to where the safeguarding and protection concepts split. On that alone, I think that reforms are necessary to support priority areas of work and intervention, particularly given referral rates and workloads.”

LSCB

“The agenda is too large and only very experienced and mature chairs have the confidence to prioritise. Early help and CSE can devour LSCBs while neglect is getting less attention and that is where our most vulnerable children are.”

Local Authority

“Over the last few years the expectation of LSCBs as grown with no increase in legislative power or finances. The LSCB is not a mini Ofsted and should not be used as such. You need to be clear about its role and remit and that would really help us.”

LSCB

“LSCBs have been given increased responsibility but in an environment of significant resource reduction. Agencies also have reduced resources but increasing priorities. The role, function and responsibilities of LSCBs need to be significantly clarified and indeed realistic.”

Answering ‘No’

Local Authority

“That is a deficit model - the focus should be promoting wellbeing in its broadest sense... Most children are OK most of the time and I don't think it's appropriate to have outlier behaviour (neglect, abuse etc.) defining the way all services work.”

LSCB

“Protection issues don't generally arise as a surprise, their development can be seen in emerging difficulties or a problematic context before they become acute. Effective protection of children needs to start by addressing these emerging concerns.... [the high] threshold for child protection is only acceptable in a context where interventions at earlier points in the service delivery continuum are structured and formalised.”

Clinical Commissioning Group

“Supporting families should be the focus. Chaotic families and lifestyles don't always indicate a need to for child protection so we need to learn from families that do well and support families that don't by early intervention or parenting support.”

Qs6 – Should local multi-agency arrangements to safeguard children be a matter for local determination within a national framework?

Total responses 628

Yes – 70.8% (from this % there were 184 written comments)

No – 18.6% (62)

Don't know – 10.6% (25)

Did respondents feel that local multi-agency arrangements to safeguard children be a matter for local determination

- Yes to local discretion in areas that are working well.
- Yes but it requires better join-up between Children's Social Care and partners within LSCBs.
- Local needs should always drive action.
- Local plans should be approved centrally.
- The national framework should be about outcomes and scope not structure.
- Yes but the national framework should be mandatory (legislation).
- Needs better partnership working especially cross-LSCBs/ regionally.
- Yes but local determination needs clear governance and oversight.
- Yes depending on definition of local as the police force and other agencies boundaries are often wider than LSCBs/ LAs.
- Yes but the national framework should not be too rigid.
- The minimum standards of the national framework has to be very high.

Respondents answering No

- There should be a consistent model across the country, as it could lead to confusion.
- A national government diktat could dilute local safeguarding effectiveness.
- Permissiveness often leads to things/ processes ceasing to happen.
- There would be a risk that some areas fail to invest - i.e. lack of resources or geographical spread is too large.
- Local determination expertise is often not present at board level - need to develop national standards and legislation that is applicable for all levels of need.
- No to local determination as LSCBs often fail to see the wider picture.
- There should be regional determination.
- This could also be used as a means for some agencies to "hide" behind local determination as an excuse for under focussing on safeguarding.
- Children move across boundaries, and agencies work across boundaries, this needs a national arrangement.
- No to local determination as local authorities may decide not to prioritise as much as it should.
- if you don't have national rules provision will sink to the lowest denominator.

Key Quotes

LSCB Chair

There should be an element of local discretion, particularly in areas where safeguarding arrangements are seen to work well and could fit well with

additional freedoms and flexibilities given to high performing children's services areas. Given the vast differences in sizes of LSCBs / LAs, as well as in dynamics of population groups and demographics there could be scope for joining up LSCBs / working across broader areas. Decisions surrounding this should be made at a local level but with a clear direction, requirement and outcomes set out in a national framework. In some local authorities, devolution discussions are taking place across the LAs which adds more weight to similar discussions taking place across the LSCBs.

Voluntary Sector

While developing a true understanding of local needs was supported in principle by members, it was suggested that valuable resources were currently being used to develop almost identical procedures in each LSCB area. This was not felt to represent an efficient approach to providing guidance, especially where so much has already been made available from Government.

Qs7 Should local multi-agency arrangements to safeguard children include independent leadership?

Total responses 628

Yes – 72.7% (from this % there were 209 written comments)

No – 6.7% (13)

Don't know – 20.7% (44)

Yes responses

In comments about whether multi-agency arrangements should include independent leadership the following themes emerged:

- Provides effective **oversight** of practice and **resolves issues/brokers solutions**. Crucial in order to effectively **hold all agencies to account** in an open and transparent way. Ensures rigour and **scrutiny** and ensure **partner engagement**. **Clear voice and autonomy**. **Drives partner behaviours**. (YJB; other x21; LSCB x11; National Probation Service; Cafcass; National Police Chiefs Councils; LAs x15; CDOP x1; NOMS; Health x7 Police x6)
- **Removes politics** from decision-making. Avoids inter-agency conflict (Health x5; LSCB x2; other x5; LA x3)
- Promotes **inclusive approach**, and **fair and impartial challenge, objectivity, transparency and trust**. Critical friend. Non-partisan and avoids bias. **Joint solutions to shared problems**. Brings partners together. (CDOP x1; National Probation Service; other x21; LSCB x 28; Health x18, NOMS; LA x5)
- Should be independent of LA influence. Still very LA managed. Paid by LA. Hired and fired by LA. Accountability to Chief Executive of LA sets wrong tone. LA has more influence. As LA hosts LSCB this causes confusion as to distinction between them. Employment by LA compromises independence. LSCB Chair can become so aligned to DCS their independence is lost. Too embedded with social care partners. Separation from LA delivery functions is vital. Leadership should be accountable to the Board rather than the LA. (health x5; LSCB x1; other x8; LA x3; Police x1; British Association for the Study and Prevention of Child Abuse and Neglect)
- Important that independent leaders have: **Skills, knowledge, attributes and experience** of chair key / professional **competence and credibility**. Good understanding of local arrangements. Leadership requires real authority. Quality of Chair varies (YJB; LSCB x6; other x3; Cafcass; LA x4; Health x1)
- Maintain **public confidence** in the system; **public transparency**. (other x3; LSCB x2)
- Acts as a **balance to prevent the dominance** of any one partner or small

grouping. (YJB, other x2; LSCB x3; LA x1)

Other points made on independent leadership of multi-agency arrangements include:

- Provides strategic leadership (LA x1)
- All agencies have to be able to operate with autonomy and cooperation (Education x1)
- Ensures voice of child is considered both strategically and operationally (health x1)
- Can support a **focus on learning and improvement** that is supported by an objective overview of the issues presented (YJB)
- Question over independent chairs **powers should a serious dispute arise** (LA x1)
- **Breaks down silos** (other x1)
- Learning from Jay Report gets a few mentions supporting independent oversight (health x1)
- Elected members value role of independent chairs (LSCB x1)
- Provides focus on safeguarding issues (LA x1)
- Too difficult to provide leadership from within any of the agencies alongside day job (police x1)
- Necessary due to resource and demand pressures on agencies (LSCBs x4)
- Independent leadership managed centrally will risk alienation and reduced partnership (LA x1)
- Inspections have identified strong independent leadership as key (LSCB x2)
- Leadership is already in place across the relevant agencies (Cafcass)
- Independent view of agency performance is conducted through inspection arrangements (Cafcass)
- Statutory duties in place already ensure that safeguarding is the principal focus of multi-agency arrangements (Cafcass)

Suggestions:

Should be different chairs for Safeguarding Adult Boards (SAB)

Needs to be a swift mechanism to respond where independent leadership is insufficient (x2)

A triumvirate would be best to ensure rigorous analysis and performance (health x1)

Separation from local councils

Use similar structure to MAPPA SMB is used

Nationally employed chairs working at local level with focus on good practice development and learning rather than external scrutiny and judgement

Role of Chief Executive of LA should be considered in leading arrangements (Cafcass)

Regionally based functions (British Association for the Study and Prevention of Child Abuse and Neglect)

Independent leadership implies something additional, with underlying statutory powers. Need statutory powers (other x5; National Probation Service)

National framework to develop recruitment guidelines or a benchmark of standards for independent leaders. Role and hours/days and payment contracted would benefit from a review and standardisation. National professional development programmes or training. National job description and annual appraisal required. Paid by national body. Arrangements for appointment could be subject to ministerial endorsement. External monitoring and supervision of leadership. Open recruitment process. Greater national coordination, accountability and clarity of expectations of leaders. Evaluation of required skills set and effectiveness of leaders. Recruited by DfE (LSCB x9; LA x4; other x2; National Probation Service).

Independent leadership should have a maximum time in office (2-3years). Chairs should be moved regularly to avoid becoming too settled in accepting local 'norms'. (other x2; LA x1)

Health and police also to take ownership of the Board and Chair

LSCB Chair should be answerable to a larger area board

Leadership could come from regional independent leaders

No responses

In comments about whether multi-agency arrangements should include independent leadership the following themes emerged:

- **LA ends up being accountable as lead agency/CEO.** Leadership should

sit within the leadership of the chief executive and other senior leaders.
(LSCB x2; other x2)

- Local multi-agency arrangements require leadership from within. Independent leadership lacks local and frontline understanding. Independent chair is **not embedded day-to-day in local networks** and does not have the local network that a DCS or CCG chief executive or local police commander would have. This network can get things done and ensure agencies play their part. Leverage on agencies is across a variety of forums and structures such as Health and Well-being Boards. (other x5)

Other points made on independent leadership of multi-agency arrangements include:

- Some functions could have **rotating multi-agency chairs** (LA x2)
- No independent chair if local arrangements have **dedicated staff, specific roles and funding** (LA x2)
- Too little expertise. Too much margin for error for multi/single agency to be locally. (LA x1)
- Independent scrutiny rather than leadership (health x1)
- Leadership must come from statutory organisations (health x1)

Don't know responses

There was nothing new that was not covered by the Yes and No responses.

Blank responses (i.e. respondent did not complete Yes/No/Don't Know box)

- Structure arrangements differently, for example police authority areas or for a sub-region (LSCB x1)
- Ofsted do role of independent leadership (other x1)
- DCS should be linked into arrangements – i.e. independent with clear accountabilities and oversight into DCS (other X1)

Quotes:

Answering 'Yes'

LSCB

“Too ready to understand the difficulties rather than look at arrangements from the perspective of a vulnerable child”

Youth Justice Board

“Acts as a balance to prevent the dominance of any one partner” YJB

NHS

“Keeps everyone focused on what matters: the children and young people”

LSCB

“Independent leadership is crucial otherwise local arrangements can look inwards and continually reinforce current ways of thinking and acting”

LSCB

“The research and move in 2015 to recommend that SAB’s in the Care Act should have independent chairs is testament to avoiding the claim that the board is only the vehicle of the LA”

Answering ‘No’

LSCB

“Ultimately the LA ends up being accountable as the lead agency”

Clinical Commissioning Group

“Independent scrutiny rather than leadership.”

Individual

“Good leadership is more important than whether it is independent or not”

Don’t know Quote

Local Authority

“This should be a matter for local determination – with being held to account for outcomes, not structures and ways of delivery”

Qs8 Is it clear who should lead local multi-agency arrangements to safeguard children?

Total responses 628

Yes – 49.2% (from this % there were 154 written comments)

No – 35.7% (70)

Don't know – 15.1% (32)

Did respondents feel that it was clear who was responsible for leading arrangements at present?

- In all sectors, a majority of comments about current arrangements suggested respondents had a clear impression of who led on local safeguarding. Many consultees in particular referred to the latest Working Together guidance as a clear source of information.
- Comments from different sectors suggested that non-LSCB/LA/health organisations felt least clear about who led arrangements, with around one third of responses saying they did not feel there was a clear lead at present. Those in LAs and the health sector were least likely to respond in this way (around one in six comments).
- There was apparent disagreement in all sectors amongst those who felt confident that a lead was in place, specifically about who this lead actually was. In the LSCB sector, respondents who said a clear lead was currently in place were equally as likely to name this as the local authority as the LSCB. Many called for a clearer distinction between the current roles of LSCBs and LAs. All other sectors - and in particular LAs themselves - were much more likely to name the LA as the lead for current safeguarding arrangements, though many voices still disputed this.

What views did respondents have on who should lead arrangements in future?

- Many from across sectors commented on how they would like to see lead arrangements change. LSCBs tended to promote a clearer leadership role for their own Boards. However a number also suggested that LAs should in fact be appointed as the clear lead.
- All other sectors had tended to identify LAs as safeguarding leads at present. However, the health sector was unique in strongly suggesting that the arrangements should be rebalanced in future in favour of a clearer leadership role for LSCBs.
- A number of respondents from all sectors, but particularly from non-LSCB/LA/health organisations, emphasised that arrangements should ensure no single agency becomes the lead or dominant agency. Occasional suggestions of other lead agencies included the police and health sectors, Health and Wellbeing Boards and Police and Crime Commissioners.

- Other advice was given on ensuring clear awareness of who leads in this area, including local decision making over safeguarding arrangements and clarifying relationships with other local Boards.

Sector Responses

LSCB

“Working Together 2015 is clear on this, as are all of my Board members.”

“This should remain with the local authority. There is a clear line of accountability through the DCS/ Chief Exec/ and sufficient infrastructure to support Board Managers/ staff who are otherwise completely separate from any personnel support.”

“Currently, without real authority, LSCBs do not have true leadership and influence over partner agencies.”

“Yes, I think it is clear but I’m not convinced that all professionals will be clear about this issue.”

Local Authority

“The LSCB for the local area should clearly lead the multi-agency arrangements.”

Police

“There is a conflict here between the DCS and the independent chair and each see themselves as being the lead. This needs confirmation nationally.”

Shared leadership across police, health and LA, rather than just the LA

- *This may sound like an over simplistic answer, but leadership, accountability and ownership of local multi-agency arrangements must be shared by the statutory partners, namely police, local authorities, NHS, probation service. The actual individual who is the designated leader of local partnership is less important than establishing the above principle of shared leadership, and testing this vigorously via inspections and other means. (anonymous response – Yes answer to Q8)*
- *Leadership in the Local Authority is clear. The role of the independent LSCB chair is also clear. Accountability in other key services, e.g. Police and health providers, is less clear. (Local Authority – No answer to Q8)*
- *It should be shared with distributed leadership across statutory partners. Currently most partners look to the council for that leadership*

which extends to a financial 'shoring up' when unexpected expenditure occurs. A national benchmark for partner's contributions should be considered. (LSCB Chair – No answer to Q8)

- *I believe it is clear that the statutory partners must take a joint leadership role but am aware that in some areas, this is not always the case and LA partners dominate. (CCG – Don't know answer to Q8)*

Qs9 Should multi-agency arrangements be structured to reflect population size and how different public agencies organise themselves?

Total responses 628

Yes – 60.5% (from this % there were 143 written comments)

No – 16.2% (57)

Don't know – 23.4% (54)

Did respondents support reform to multi-agency boundaries, and on what grounds?

- The majority of feedback comments from all sectors supported some reform of the boundaries within which multi-agency arrangements operate. This was particularly the case within the health sector (supported by around three quarters of comments) but least in the LSCB sector, where just over half of comments suggested some reform was desirable.
- Respondents differed on the appropriate basis for such reorganisation. Some comments from those who supported reorganisation said both a population basis and a focus on aligning with local service boundaries should be considered, but a significant number felt that only one of the two was appropriate. In all sectors, there were voices in support of each approach but neither emerged as significantly more popular than the other.
- Many comments promoted a reorganisation that was instead focused on need. Respondents from outside the LSCB sector were more likely to comment in favour of such a needs-based approach than to explicitly endorse either a population reorganisation or one around local service boundaries. Such references to need were least common in the LSCB sector but most common amongst LAs, with almost half of authorities' supportive comments promoting such a focus.
- More specifically, comments on need from all sectors tended to emphasise the demography of particular areas, with deprivation levels often cited in particular.

What arguments did respondents make against reorganisation?

- The most common argument against reorganisation in all sectors was that this would be unworkable in practice. This included views that disruption would harm child protection and that larger multi-agency areas would reduce local authority engagement and create new problems of local service overlap. Some respondents, in particular some LSCBs, expressed concern that sparsely populated areas would be detrimentally affected by population-based reorganisation.
- A smaller number of comments critical of reorganisation felt that it would be unnecessary, often because cooperative arrangements had already been put in place, or that boundaries should be irrelevant if professionals have a child-focused approach.

Sector Responses

For reorganisation

LSCB

“Both population size and coterminosity are real challenges with large LAs or Counties having several meetings attended by a small number of, for example, NHS Commissioners and Providers, stretched across several LSCBs and now SABs.”

“The focus should be structured to reflect the demographics of the population so that the diversity and varying safeguarding challenges are recognised.”

Local Authority

“There is no doubt that government regions and LA configuration needs to be more flexible to enable us to better safeguard children and I would welcome alternative structural arrangements.”

“Essential given the vast range in council size and different configurations.”

NHS

“London [has] 32 LSCBs – too many, too confusing and highly unsafe. Boards need to be restructured around populations that work.”

Against reorganisation

Local Authority

“Current arrangements for multi-agency working through the LSCBs are ‘good enough’. There are a myriad of ways of dividing up regions and services and all have significant drawbacks as well as some positives. It is highly unlikely that reconfiguring local arrangements will create any benefits which are not outweighed by the disadvantages and/or by the loss of productivity whilst the changes were taking place. It is also the case that the already complex safeguarding landscape is becoming increasingly fragmented and therefore extending the geographical remit of LSCBs would also significantly extend their task at a time when their remit is already growing.”

LSCB

“I consider the arrangements can be delivered on any basis provided we have clarity on who does what, how the arrangements are expected to work and who are the arrangements are accountable to.”

“The partner that contributes by far the most to an LSCB is children's services. If the LSCB is required to ensure the effectiveness of services this will be difficult when it covers more than one council area. At the moment the effectiveness of LSCBs is judged by the quality of council services to a much greater degree than it is for, say police or health services.”

Qs10 Will the centralisation of serious case reviews create an opportunity for a different approach to local learning from serious incidents involving children?

Total responses 628

Yes – 46.8% (from this % there were 116 written comments)

No – 13.9% (54)

Don't know – 39.3% (126)

Themes from the written responses

If said yes

- More than 20 specifically state they cannot answer the question without further information on what centralisation will entail.
- More than ten specifically state the current system is flawed.
- Opinion was divided as to whether centralisation would improve or undermine - more than 20 see the opportunity for improved learning, identification of best practice and/or greater transparency and more than 20 see centralisation detracting from local learning and/or accountability.
- Another 30 acknowledge the benefit of centralisation only if changes are owned and understood locally and/or an emphasis on local learning is maintained.
- More than 20 people identify aspects of current arrangements that should be 'fixed' - rather than go down the centralisation route. These include; imposing shorter SCR timescales; ensuring tighter terms of reference; improving the skills of LSCB members; increasing support from the centre; imposing a preferred model (Welsh Model is mentioned twice as a valuable way of releasing resources from SCRs to enable the LSCB to do other work); strengthening the role of the chair; improving the quality and availability of SCR authors.
- Of these more than 10 specifically cite the lack of accreditation or the closed nature of the current SCR author roster as a current difficulty.

Sector responses

LSCB chairs were evenly split between 'yes' and 'no' on this question with 'don't know' being the most popular ticked response.

Regardless of the box ticked the written responses were focused overwhelmingly on the importance of localism, flexibility, embedding learning locally and local ownership. The fact that there is much good already in the current system was recognised, along with the need for SMARTer SCR processes and greater local accountability.

One Chair strongly felt that the whole review process had been prejudged and was concerned that it was about 'how and not whether' SCRs should be centralised.

A minority of responses specifically stated that the key difficulty with current arrangements relates to authors being unaccredited and/or chairs not having enough power.

Other LSCB members responses were similarly evenly split between 'yes' and 'no' with the more popular response being 'don't know'. As with the Chairs' written responses, there was overwhelming concern at the potential loss of local ownership and learning.

The lack of availability of SCR authors and their accreditation, together with the resource intensive nature of current arrangements, were even more markedly highlighted than in the Chair's responses.

DCSs ticking 'yes' were in a minority with 'no' and 'don't know' being equally the more popular responses. The minority in favour saw the benefit of greater consistency and an external perspective with centralisation. However, there was a strong sense amongst the 'nos' and 'don't knows' that the system would become even more bureaucratic and driven by central government's political agendas. The loss of local buy in and accountability were key concerns. Amongst the 'no's and 'don't knows' the alternative solutions to centralisation offered were accreditation of authors, a full review of current DHR/SCR/SAR etc. arrangements and a proper systematic information sharing (aka CONTACTPOINT).

Amongst **other LA** responses 'don't know' was the most popular response, with 'yes' and 'no' being equally split. The key issues were again the importance of localism, the danger of over-bureaucratisation and the need to enhance/maintain local skills.

Of the responses from others

Anons 51% yes, 36% don't know and 13% no, with proportionately fewer written comments than other responses. Written comments reflect those elsewhere – the importance of local learning being a key theme – with one don't know saying case audits were more valuable than SCRs in this respect.

SCR authors Yes (3) and don't know (4) were the most popular responses with only one ticking no. Another offered comments only that could be taken as a no due to the level of concern expressed. Those that replied yes recognised the potential for circumnavigating local political pressures and opportunities for learning. Caveats included making chairs properly independent and ensuring continued flexibility on methodology. Amongst no's and don't knows were concerns at loss of author expertise and how cumbersome a centralised system would be.

Nursery and pre-school 60% said yes but written comments were generic re the potential for greater learning and prevention. 'Nos' and 'don't knows' recognised the danger of losing local perspective and impetus.

Schools were equally split between yes and don't know – but written comments were generic and brief - about the potential for greater learning or losing local ownership and buy in.

Police 70% said yes with the potential for greater learning and action at national level clearly recognised. However, the nos and don't knows thought

the solution was better information sharing and stronger national guidance. **Coroners** were equally split. One was concerned that coroners might be unwilling to disclose information for national SCRs in the way they do to local partners at the moment – the trust would be lost.

NHS and other health 55% said yes with the opportunity for greater transparency, independence, shared learning and consistent quality of SCRs – given a guarantee of SMARTer, more holistic approaches and flexibility. Amongst the nos and don't knows was a concern one methodology would be allowed to dominate; that accreditation of authors and greater powers for authors' to challenge agencies were the real solutions.

The decision to delegate decisions about how serious case reviews are conducted has fostered chaos and inefficiency. We share the independent panel of experts' concerns around variable quality, timeframes and a lack of focus. The proliferation of new 'systems models', many of which lack rigour, has exacerbated the situation.

I would worry about some of the granularity of reviews being lost if being governed nationally.

We believe that issues with the current serious case review process run deeper than a question of central vs local, with fundamental questions to be asked on their effectiveness as a learning tool as opposed to a method for apportioning blame.

Centralisation of serious case reviews is an opportunity to ensure that all SCRs are led by appropriately trained and supported reviewers. Currently there are no training requirements, nor on-going support and development opportunities for those commissioning or conducting reviews. The knowledge base about effective SCRs is not systematically drawn on, leaving idiosyncratic approaches based on personal experience as the norm. Further work is needed to professionalize the activity of reviewing, including a national accreditation scheme, CPD requirements etc.

Qs11 Should local areas be able to request a centralised serious case review body to undertake other types of learning review?

Total responses 628

Yes – 62.2% (from this % there were 126 written comments)

No – 12.0% (44)

Don't know – 25.8% (59)

- This would be in keeping with the Welsh model that currently works well.
- Concern over which model of SCR is used with a need to allow choice (Don't proscribe SCIE).
- How would we ensure this process is quick so that dissemination of learning isn't further delayed?
- How would such an approach mesh with other arrangements – coronial, justice proceedings?
- How would this be different to Ofsted's thematic reviews?
- Would resourcing come from the centre (otherwise local budgets might be severely hit?).

Qs12 Should review arrangements be designed to avoid overlap between different types of review (e.g. serious case reviews and domestic homicide reviews)?

Total responses 628

Yes – 69.5% (from this % there were 165 written comments)

No – 13.0% (37)

Don't know – 17.5% (31)

- Respondents take overlap to be a negative thing and agree - too much duplication currently.
- Get scoping and terms of reference right to avoid duplication.
- Have joint reviews based on 'think family' core.
- Someone needs to synchronise all relevant review processes.
- DHR process is too long and inflexible.
- Coroner's process needs to be properly aligned.
- Overlap sometimes needed to see whole picture.

Qs13 (a) Should child deaths continue to be reviewed within local multi-agency arrangements? (b) If not, where should they be reviewed?

Total responses 628

Yes – 67.9% (from this % there were 140 written comments)

No – 15.1% (67)

Don't know – 17.1% (38)

Themes from the written responses

- Strong sense that local multi-agency approach is vital and should remain if learning is to be identified – and that current arrangements work well in some areas.
- However, a strong minority feel CDOPs do not belong with LSCBs - with over 20 respondents specifically suggesting it is primarily an area for public health or H&WB – as the majority of deaths are medical related. (However a smaller number suggest arrangements be made coterminous with police authorities, LAs, LSCBs, the tertiary hospital network)
- Over 20 specifically say national arrangements are flawed and/or a stronger standardised system for analysing data (or a national database) is needed to identify trends or make comparisons. DfE is not 'driving' CDOPs forward and DoH would be better placed to lead. A move to thematic national analysis could lighten the load on local Boards.
- More than 20 would like to see sub regional or specifically London wide arrangements. Existing arrangements do not allow for proper epidemiological study as the samples are too small.
- One response suggests the National Network of CDOPs could drive forward the agenda if strengthened.
- A similar number thinks CDOPs works well in the LSCB setting and a move to Health would risk input from the Rapid Response arrangements being lost. If CDOPs becomes 'medicalised' there is a risk that safeguarding insights would be lost.
- Of those that feel CDOPs works well in the LSCB context there is evidence of synergy i.e. CDOPs findings on co-sleeping morbidity feeding into LSCB safe sleeping campaigns.

Any dilution of the multi-agency approach would be likely to reinforce the medical model which is exactly what the Child Death review process is so successful in challenging and which it was brought in to do so.

They add value where themes are identified and they are shared across the partnership. Within CDOP there is a heavy medical focus. Multi-agency engagement enables challenge and can offer an alternative view.

I personally feel that the child death review process should come under the responsibility of the Department of Health as the majority of

learning and recommendations are health related and relevant to public health. I understand why the process was initially under the remit of DfE as the panels have a safeguarding remit but 7 years into the process it is evident from local and national data that only a very small percentage of children that die were subject of a child protection plan, statutory order or serious case review.

Qs14 Should child death review arrangements cover a local minimum population size?

Total responses 628

Yes – 36.1% (from this % there were 86 written comments)

No – 21.9% (43)

Don't know – 42.0% (71)

Themes from the written responses

- More than ten said they did not understand the relevance of the question.
- More than 20 said actually effective national data collection is the issue - you don't need to tinker with minimum pop size – just rationalise national data collection.
- Less than ten said getting people with proper skills and knowledge to do the work quickly and effectively would allow current arrangements to work well.
- Less than ten specifically said local nuances would be lost if you have a minimum population base.
- Manchester, North Tyne, Sheffield, Black Country and Bristol - covering populations around 500K - these arrangements seem to work.
- Less than ten said the level of risk/number of deaths should be the base – not a min pop approach.

Responses by sector

Health 87 responded of which 47% said yes, 32% said don't know and 21% said no. Of the written responses, regardless of the ticked response, there is almost uniform recognition that individual CDOPs do not currently typically operate on a scale that provides meaningful data or trends. Coterminosity is also needed. Suggestions on coterminosity include LAs, NHS Trusts and the tertiary hospital network, with current arrangements in Sheffield (with 1 children's hospital, 1 CDOP and 1 neo natal service) and Derby/Derbyshire working well. Amongst the nos and don't knows concerns about introducing a minimum population size include a loss of local expertise and focus; the diminution of the Rapid Response role and the resource demands that come with wider geographical coverage. Reform of current arrangements to improve consistency of data, timeliness and use of findings from wider audits are alternative suggestions to introducing a min pop size.

CDOPs panel members 15 responded to Q14. Of those the answers were

Yes 53% No 33% Don't know 13%. Again almost uniform recognition that individual CDOPs do not currently typically operate on a scale that provides meaningful data or trends. Beyond a general agreement on the minimum population size there also is a clear sense that coterminosity is needed. Suggestions on coterminosity include LAs, NHS Trusts and sub regional LSCB groupings, with current groupings in Manchester/ North West and Coventry/Solihull/Warwickshire being cited as having good current arrangements.

LSCB Chairs 38 responded to Q14. 63% said yes, 18% said no and 16% said don't know. Of the written responses there was strong recognition of the need to work with a large enough data population to allow meaningful analysis and learning. Concerns about coterminosity and the benefits of a sub-regional model are repeated.

There needs to be a critical mass to enable transparent reporting to be anonymised sufficiently and to make any data analysis statistically meaningful but aligning with local geographical areas and with organisational boundaries enables learning to lead to developments more easily.

My gut feeling is that the data needs to be contextualised within a national picture that identifies trends, themes and patterns. The geography is only relevant when the analysis identifies it as being a contributory factor. This might best be measured nationally.

In child deaths knowing the detail is imperative otherwise important info gets lost.

Moving to a wider geographical base would necessitate a very different kind of panel focusing more on surveillance and less on individual learning from deaths. One reason to move to larger geographical units is the larger numbers of deaths providing more effective surveillance. There is however a significant opportunity to improve on data collection within the existing model.

Currently CDOPs have a statutory duty for the review of deaths of children resident in their area. This is an illogical approach. The example I give is of a CDOP who has a major children hospital in its area. This children's hospital takes patients from all over the country and has one specialist department with many 'avoidable deaths'. The local CDOP does not see the whole picture since it only review the few deaths of the children who are resident in their locality. CDOPs should have a statutory duty to review deaths of children by geographical area AS WELL as by residence. It is only in this manner that patterns of deaths can be picked up.

Annex H: LSCB innovation projects

DfE-funded LSCB innovation projects

The DfE-funded innovation projects have been exploring a variety of different ways of working. A primary theme which has been tested is how LSCBs work with other strategic bodies, such as Safeguarding Adults Boards, health and wellbeing boards and community safety partnerships. Others have trialled working across more than one LSCB area, while others have focussed on particular issues such as child sexual exploitation and performance management.

In some cases, projects are still underway or reflective or evaluative thinking is still to take place. The following findings are those which have been shared with DfE to date.

LSCB Innovation Projects – initial findings

Collaboration with other LSCBs – Most of the projects evidenced collaborative working with other LSCBs. For some this collaborative working was a key component of the project, whilst for others no activities have taken place yet, though there are plans to share the project findings with LSCBs more widely, once the findings have been analysed in more detail at the end of the project.

Learning – Many different areas of learning were reported. These included topics such as staff confidence, relationships of the LSCB with the local community, inadequacies in data collection, effective ways to monitor the provision of services to certain groups, how to disseminate findings at local and regional level, how to make agencies and services more effective and efficient, and how to capture data that demonstrates the impact of work on the overarching objective of protecting children.

Cost savings – A minority of the projects reported that identifying more efficient ways of working had directly resulted in cost savings.

Obstacles faced – In striving to implement innovative ways of working, some areas reported that progress was limited by the extent to which the LSCBs could require agencies to take action to improve ways of working. Others reported that the lack of data collection in certain areas prevented definitive analysis of the issues being faced.

Link with other policies – A number of the projects reported that their activities and early findings aligned well with local / regional work around neglect and domestic violence, and local / regional moves to improve the effectiveness of LSCBs, sector led improvement and work to prepare for Ofsted reviews.

Next steps – Some projects have reported looking to share their findings

regionally and nationally, and in some cases, extend the projects and offer certain aspects of them (e.g. guidance documents, networking / training opportunities) with other LSCBs.

Innovation projects

LSCB (lead LSCB in bold)	Project
Wolverhampton (with Birmingham, Coventry, Dudley, Herefordshire, Sandwell, Shropshire, Solihull, Staffordshire, Stoke on Trent, Telford and Wrekin, Walsall, Warwickshire and Worcestershire)	<p>Improve the effectiveness of the commissioning and delivering of children's safeguarding training by developing a joint framework for training, safeguarding procedures and performance management arrangements.</p> <p>Develop a shared understanding of the competencies that staff require, a consistent standard of implementing and evaluating the impact of training, and share in-house training across areas to ensure funds are used more effectively.</p>
Hartlepool (with Stockton-on-Tees, Middlesbrough and Redcar and Cleveland)	To test the development and implementation of a joint performance management framework and data-sharing and audit activity across the LSCBs.
Wakefield	Testing the implementation and effectiveness of streamlining the existing broad range of strategic partnerships. Clarifying lines of accountability and ownership of key issues, such as child sexual exploitation, domestic violence and abuse, mental health, substance misuse and others.
Stockport	To test a project focusing on alignment of the LSCB and adult safeguarding board, underpinned by clearer joint working between children and adult services and strengthened transitions processes (for young people approaching transition to adult services).
Norfolk (with Peterborough and Cambridgeshire)	To test a joint project exploring risk factors relating to the Eastern European community. The work includes CSE and trafficking issues.
Haringey and Enfield	To test a joint approach across two LSCBs with alignment of data analysis. Further, to explore potential cost-savings and pilot models for shared accountability (CSE, gang membership and missing children).

LSCB (lead LSCB in bold)	Project
Camden	<p>To develop an evidence-based framework for an enhanced Section 11 panel with an audit approach, to better identify strengths and weaknesses in the work of partners and in frontline practice, support improvement and evidence impact.</p> <p>Aim to build on experience and incorporate opportunities to learn from other partners' work through development of a 'learning system' and development of a robust performance management framework that includes risks, protective factors and includes joint working across boards.</p>
Waltham Forest	<p>To test the effectiveness of bringing a 'Think Family' approach to the work of the strategic partnership boards (i.e. the LSCB), Safeguarding Adult Board, Community Safety Partnership and Health and Wellbeing Board – testing efficiencies and reducing duplication</p>
Yorkshire & Humber	<p>Developing and implementing a regional approach to improvement of business planning and action plans, based upon peer challenge across up to 10 LSCBs.</p>
Bedfordshire	<p>Project focusing on the voice of children and young people, with a particular focus on CSE. Developing a team of supported young inspectors to carry out field visits to monitor and feed-back on the performance of local services.</p> <p>Facilitating workshops with young people from areas of higher deprivation to identify issues identified by young people and ensuring these influence planning and decision making at a local level. Identify any issue 'hotspots', e.g. for CSE. Incorporate findings into planning for provision of help and support programmes.</p>
Bexley	<p>Project to test the streamlining of the LSCB functions and membership, and trialling the introduction of a multi-agency learning hub that will provide the Board with more detailed analysis of, and subsequent evidence-based recommendations to improve, frontline multi-agency practice.</p>

Annex I: Learning into Practice Project

Learning into Practice: improving the quality and use of SCRs

Executive summary

What do we need in order to improve the quality and use of SCRs? Findings from the Learning into Practice Project

Providing the best services for children and families requires ongoing learning and improvement. The Learning into Practice Project (LiPP) has been based on the idea that SCRs are potentially a valuable source of learning for improvement, but are not yet fulfilling this potential. It has developed and tested a number of ways to optimise the quality of SCRs, and the impact they have on practice at local and national levels.

The project was undertaken between March 2015 and March 2016 by a partnership comprising NSPCC and the Social Care Institute for Excellence, working with a range of stakeholders across the safeguarding sector. Since December 2015 there have been a number of changes to the SCR 'landscape': the Government announced its intention to centralise the SCR process, a fundamental review of the role and function of LSCBS and plans to establish a What Works Centre for child protection. The final three months of the project have therefore included considering and consulting on how the work of the project could inform these forthcoming policy developments. This document summarises the main messages from the LiP project, suggesting how the work can be taken forward in the emerging new landscape.

The four LiPP work streams suggest that to improve the quality and use of SCRs, we need:

1. A common framework for commissioning and conducting reviews

How could this be achieved? Drawing together principles of good practice in case reviews to establish a consistent and robust framework. The common framework should avoid prescription and accommodate a variety of models, and support proportionate and innovative approaches. To support the national collation and sharing of findings from SCRs, the quality framework needs to include developing a common structure for presenting findings from reviews and in the longer term a common, high level category scheme.

LiPP contributions: Covering the whole SCR process, the LiPP SCR Quality Markers provide a consistent and robust framework for reviews. They are based predominantly on established principles of effective reviews and investigation as well as SCR practice experience and expertise, and ethical considerations. They enable dialogue by the commissioners about how to achieve quality in reviews.

Who should take this forward? A national body could use the SCR Quality Markers for the SCRs they commission. Local organisations could use the Quality Markers for commissioning local reviews. The national body and/or

What Works Centre could run training for commissioners in using the Quality Markers.

2. An adequately skilled workforce of reviewers

How could this be achieved? Establishing a national training programme for lead reviewers and the requirement for accreditation and on-going continuing professional development (CPD).

LiPP contributions: The LiPP suite of master classes provides an introduction to some key areas of expertise required. The Quality Markers provide an outline of all areas that need to be covered and summarise the existing knowledge base about quality.

Who should take this forward? The national body and/or What Works Centre could establish a training curriculum, programme and accreditation process and coordinate activities to support on-going CPD.

3. Timely access to practical learning from all SCRs

How could this be achieved? Establishing the routine collation of findings from reviews as they are completed, highlighting the types of practice problems and their causes. This would need to be made available in a number of ways. This could include giving direct access to a central data base, the production of topic briefings on priority areas, and regular newsletters.

LiPP contributions: Through the LiP project a new approach to collating findings across multiple reviews has been developed. This focuses on practice issues and their causes. New ways of presenting this analysis have also been created. This includes the mapping of issues across a care pathway and summarising these in briefings for local senior managers and leaders.

Who should take this forward? The What Works Centre could conduct this type of collation and analysis on an on-going basis, and develop related products for dissemination.

4. Strategic infrastructure to support improvements in multi-agency safeguarding

How could this be achieved? Establishing a strategic multi-agency forum that brings together leadership bodies from all agencies involved in safeguarding, as well as professional bodies representing the diverse workforces involved. This might be akin to a national safeguarding children board. It could enable the strategic direction and improvement work of such bodies to be routinely informed by the findings from SCRs.

LiPP contributions: The LiP project brought together an 'Alliance' of multi-agency strategic and leadership bodies, creating a forum for discussion about their potential, longer-term role.

Who should take this forward? It is less clear how this strategic infrastructure should be taken forward, including where its mandate would best come from, how governance would work and who could most effectively

service and support its activity. Any future arrangements will need to balance the group's aim of providing national sector-led leadership and support to the agencies involved in multi-agency child safeguarding with the need for clear channels of communication with Government.

Overall learning from the project suggests that to improve the quality and use of SCRs, we need to:

1. Place SCRs in a wider organisational improvement framework

A key observation of this project has been that, whilst there is consensus that we need to use the findings of SCRs, there is also a view that this can feed a 'deficit' model of practice. Although some SCRs do identify good practice, by their nature they tend to highlight difficulties and weaknesses in practice. Here, the children's safeguarding field may be able to learn from other sectors. Other fields have fostered a positive framing of learning from incidents and errors by placing reviews into a broader field of activity focused on organisational safety. Adopting an equivalent framework would highlight SCRs as one of many sources of learning and improvement about multi-agency safeguarding. It would focus attention on the development of a safety culture across agencies involved in safeguarding, in which people at all levels play a vital role in establishing systems and ways of working that make it less likely that things can go wrong as well as identifying and building on strengths. It would support a mature response to tragedies, that includes being always mindful that cases with bad outcomes may not be representative of wider practice.

2. Take a 'whole system' approach to improving SCRs and their impact

Undertaking the project has supported a 'whole-system' approach to improving SCRs, emphasising the inter-relationship between the quality of SCRs and their ability to influence practice. It has been clear in particular that the usefulness of collation of national findings depends on the quality of the reports that are being collated, which in turn depends on the knowledge and skills of those who write them. It will therefore be important for there to be ongoing dialogue between a body responsible for collating SCR findings, the lead reviewers who produce SCRs and those who train and support lead reviewers.

Annex J: Triennial Review

NSPCC and SCIE

Triennial Review of Serious Case Reviews 2011-2014

The Department for Education commissioned Triennial Review of Serious Case Reviews 2011-2014 research project commenced in April 2015 and was completed on 31 March 2016.

The Triennial Analysis of Serious Case Reviews builds on the learning from the last four Biennial analyses undertaken by the same team (Brandon et al, 2008; 2009; 2010; 2012), whilst also embarking on new approaches to both the analysis and the dissemination of findings and learning. It provides accessible learning for practitioners and policy makers from the themes emerging from the three years in question (2011-2014), as well as setting this learning within the context of wider themes and trends identified in SCRs from 2003-2014.

Downloadable user-friendly summaries of findings for practitioners have been co-produced with the organisation Research in Practice. The Triennial Review also extends the analysis of SCR recommendations and action plans undertaken for the most recent Biennial Analysis (Brandon et al, 2012) in line with the specific recommendation from the first annual report of the National Panel of Independent Experts on SCRs.

The aims of the triennial review are:

- To provide child protection professionals and others working in these areas with evidence of key issues and challenges in cases where children have died, or have been seriously injured and there are concerns about how agencies have worked together;
- To provide the Government with evidence of what is really changing as a result of their reforms, and to identify areas where further change may be required to support organisations to learn from SCRs and keep children safe.

The objectives of the triennial review are:

- To analyse data (both quantitative and qualitative) from the DfE held child protection database (CPD) and SCR overview reports with an incident date between 1 April 2011 and 31 March 2014;
- To identify common themes and trends across all 2011-2014 reports;
- To draw out implications for policy makers and practitioners;
- To provide the key findings in a series of accessible, user friendly summaries for professionals on the field;
- To set the themes identified in the context of wider themes and trends identified in SCRs from 2003-2014;

- To review recommendations made in SCRs (in the main study period) and how they have been implemented, analysing the extent to which SCR authors clearly define and address recommendations, and the ways in which the implementation of recommendations is driven and monitored by LSCBs. An accessible summary of findings will be produced for LSCBs.

Annex K: List of meetings and events

List of meetings and events – January-March 2016

Name(s)	Organisation and Background
Nicky Morgan	Secretary of State for Education
Edward Timpson	Minister of State for Children and Families
Karen Bradley	Minister for Preventing Abuse, Exploitation and Crime
Baroness Kennedy	Chair of the Royal College of Paediatrics and Child Health working group on sudden unexpected death in infancy.
Lord Laming	Independent expert and author of the Victoria Climbié Inquiry.
Jon Rouse	Director General, Department of Health
Cabinet Office	Implementation Unit
Home Office DfE	Radicalisation and extremism
Home Office	Domestic Homicide Reviews Public Protection Unit and Head of Interpersonal Violence Team
DfE	City Deals
Helen Hipkiss	Head of Safeguarding, NHS England
Eustace DeSousa	Public Health England
Charlotte Piper Nicola Underdown	The Centre of Excellence for Information Sharing
Professor Eileen Munro	Independent expert and author of the Munro review of child protection: a child-centred system
Dr Mary Baginsky Dez Holmes	Research in Practice
DfE	Safeguarding in Schools School and Local Authority Frameworks
Maggie Blyth	LSCB Chair Oxfordshire
Simon Bailey	National Police Chiefs' Council lead for Child Protection, and Norfolk Police Chief Constable

Name(s)	Organisation and Background
Paul D’Inverno	Ofsted, National lead for Child Protection
Jim Taylor Charlotte Ramsden Andrew Lightfoot	Manchester City Deal
Peter Wanless Nick Dann Elizabeth Clarke Alice Miles	National Panel of Independent Experts on SCRs
Anton Florek Ruth Lloyd	Anton Florek - Chief Executive, Virtual Staff College Ruth Lloyd – Virtual Staff College, project manages research
Mark Rogers	SOLACE President and Children’s lead, and Chief Executive of Birmingham City Council
Nick Dann	Head of International Development for Chief Inspector, Air Accidents Investigation Branch
Alexis Jay	Independent expert and author of Independent Inquiry into Child Sexual Exploitation in Rotherham (1997 – 2013)
Andrew Howe Jenny Selway Dagmar Zeuner	Public Health London representatives
Stephen Rimmer	Metropolitan Police
Professor Jenny Kurinczuk Gareth James Tina Strack Jenny Mooney	Health representatives
Jim Gamble	City and Hackney LSCB Chair
David Jones Alex Walters Simon Westwood	Association of Independent LSCB Chairs
Helen Johnston Richard Green	Cafcass
Jackie Cornish	National Clinical Director for Children, Young People and the Transition to Adulthood in the NHS
NSPCC and SCIE representatives	Learning into Practice Project
NAO	NAO study on Child Protection

Annex K (continued): List of meetings and events

Name(s)	Organisation and Background
Department of Health	Equity and Community Development Safeguarding Children and Tackling Violence
Caroline Tapster	Local Government Association
Isabelle Trowler	Chief Social Worker for Children and Families
Anne Longfield	Children's Commissioner
Sarah Caton	Association of Directors of Children's Services
Professor Marian Brandon Dr Peter Sidebotham Dr Catherine Powell Wendy Rose	Triennial review research team and triennial review advisory group members
Jacky Tiotto Jane Shuttleworth	Jacky Tiotto DCS Bexley Council Jane Shuttleworth LSCB Chair Bexley
Mike Cooke Clive Grimshaw Alison Renouf	London Safeguarding Children Board
Stephen Dorrell	NHS Confederation Chair
David Lloyd Sue Mountstevens	Police and Crime Commissioners
Ian Dean Cllr David Simmonds Cllr Richard Watts	Local Government Association
Olivia Pinkney	Deputy Chief Constable of Sussex Police
Mike Veale	Chief Constable of Wiltshire Police
Richard Morris	Cafcass
Mike Leaf Nisar Mir Sakthi Karunanithi	Public Health Lancashire
Nicholas Rheinberg	Senior Coroner for Cheshire

Annex K (continued): List of meetings and events

Name(s)	Organisation and Background
James Fraser Karen Luyt	NHS – CDOPs and child death reviews
Dr Geoff Debelle	Child Protection Officer, Royal College of Paediatrics and Child Health
Charlie Taylor	Leading independent review of the Youth Justice System
Officials	Department of Health - CDOP/Maternal Health leads
Home Office	Director for extremism and radicalisation of young people.
Dr Mike Durkin	NHS England
Dorset	Group of CDOP and LSCB Chairs
Charities Group	Forum of Chief Executives (NSPCC; Barnardo's; Children's Society, Children England)
	Group of SCR Reviewers
	Group of Local Authority Designated Officers
West Midlands	Group of LSCB Chairs, lay members of LSCBs, LSCB innovation project leads and CDOP Chairs/leads
Bradford	Group of LSCB Chairs
Cheshire	Group of LSCB and CDOP Chairs
Young people	Group of young people through The Participation People in Wandsworth
Young people	Cafcass Young People Board for young people who have been through the care system.
Young people	Part of Young Hackney's Hackney Youth Parliament meeting.
Two round table meetings	Arranged by Association of Independent LSCB Chairs
Event	Learning into Practice: Improving the quality and use of serious case reviews
End of Project Conference	Learning into Practice: Improving the quality and use of serious case reviews
David Niven	LSCB chair and podcast interviewer
Jane Ellison	Parliamentary Under Secretary of State for Public Health
Professor John Drew	Former Chief Executive of the Youth Justice Board for England and Wales

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