Wood Report

Sector expert review of new multi-agency safeguarding arrangements

May 2021

Contents

FOREWORD

The Children and Social Work Act 2017 reformed the framework supporting the delivery of multi-agency services to protect and safeguard children. Regulations for implementing these changes required all local authority areas in England to have adopted new arrangements by no later than September 2019. The legislation abolished local safeguarding children boards (LSCBs) and introduced the concept of three statutory safeguarding partners - local government, the police and health services. In December 2019, I was appointed to review the implementation of new arrangements.

I would like to thank all those local partnerships, organisations and individuals who gave me their time, ideas and experience of operating the new arrangements. I am also grateful to the cross-Whitehall Safeguarding Children Reform Implementation Board (SCRIB) and the national facilitators who work with each of the statutory partner organisations advising and influencing their day-to-day practice and operation. I am very grateful to the newly formed the Association of Safeguarding Partners (tASP) for organising a number of events for me to work in national workshops with over 150 safeguarding colleagues.

I liaised with organisations, that had undertaken work in this area, for example - Kantar Public's behavioural insights work for the DfE on multi-agency safeguarding; the work of the police on their national vulnerability knowledge and practice programme[1]; the work on Covid and the experience of children's social care by the National Institute for Health Research (NIHR) policy research unit in health and social care workforce at Kings College London[2], and the final report of the National Children's Bureau (NCB)[3] on safeguarding early adopters.

The past year is notable for the very significant and new challenges faced by those we trust to protect and safeguard children. The coronavirus has changed utterly the way colleagues have had to organise and deliver their work; their response has been commendable.

To liaise with new national organisations and to deepen contact with universal providers like schools, GP practices and local police child protection teams, colleagues have developed new and innovative approaches - many of which are likely to be embedded in the new ways of working that will flow through and beyond this pandemic. It is truly impressive to see how at local level determination and imagination have characterised the many ways colleagues have worked to continue to protect and safeguard children through better and more efficient multi-agency working.

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[1] National Police Vulnerability Action Plan 2018-21. College of Policing and The National Police Chiefs' Council.
[2] Managing through COVID-19: the experiences of children social care in 15 English local authorities, NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute Kings College London July 2020
[3] Safeguarding Early Adopters Developing the learning on multi-agency safeguarding arrangements, National Children's Bureau August 2019

This January saw the launch of the independent review of children's social care[4]. Led by Josh MacAlister the review will consider the needs, experiences and outcomes of the children supported by social care. The terms of reference of the review are broad and include a commitment to investigate how the police and health services roles, responsibilities and accountabilities interact with children social care and will recommend improvements to how they work together. Much of that territory is covered in this report - which will be formally submitted as evidence to the care review. I believe the ideas, evidence and recommendations in this report will allow the care review to consider the variety of ways in which children social care services work in partnership with colleagues in the health and police services, as well as all of those working together to protect and safeguard children from schools through to voluntary organisations. Together these colleagues are seeking to put children first to ensure they are safe.

I have seen evidence that our local multi-agency partnerships are striving to do the best they can to ensure focused, proactive and child centred models of safeguarding for children. I think we can see change for the better happening, but we are at the very early stages of the implementation. More must be done to enhance and develop the support and encouragement provided to the thousands of police officers, social workers, health professionals, teachers and parents for without them children would not be protected and safeguarded. I believe their work will be enhanced if the recommendations of this review are taken forward.

Sir Alan Wood CBE

February 2021

[4] Terms of reference for the independent review of children's social care: a bold and broad approach to support a fundamental review of children's experiences. DfE January 2021

EXECUTIVE SUMMARY

1. This report has focused on the key factors that underpin the successful implementation of the new multi-agency arrangements to safeguard children. These factors determine whether or not the arrangements will take us forward onto new ground in the way we plan, deliver, and assess the quality of provision and practice of our key staff. It is evident that although we are just 17 months beyond the implementation date of the new arrangements there are grounds for optimism and belief that change is happening, improvement in practice is beginning to embed, and is impacting on outcomes for children.

2. The many examples I include in the report illustrate the way in which safeguarding partners have grasped the opportunities provided in the legislation to introduce new, and adapt existing, arrangements to safeguard children. While we have some way to go to fully embed the reforms, progress this far is encouraging. Additional support, advice and guidance is needed to encourage and motivate safeguarding partners to maximise the potential within the statutory powers they now have to provide new ways of improving the quality of services to, and outcomes for, children.

3. Resources for protecting children are under much stress. The recruitment and retention of safeguarding professionals remains a challenge across the three statutory agencies. The pandemic has meant that resources to fund activity have been stretched even further and partnerships in many areas report the challenges they face to ensure safeguarding children is prioritised as finances are limited. The work of the ADCS on safeguarding pressures[5] emphasises the need for funding to be at a level which allows Ministers and local leaders to be confident that the cost of the work of protecting children is itself protected and improved. The report estimates a current shortfall in children's social care budgets of £824 million.

4. A central factor underpinning better, and more effective local multi-agency working is the role played by central government departments. While support to local areas has been forthcoming and thoughtful, it can and must do more to ensure the next phase of implementing the reforms quickens the pace and widens the depth and breadth of improvement and change at local level. Whitehall departments need to demonstrate more effectively a culture of joined up working to support local implementation of the new arrangements to support their full potential to further improve the safeguarding of children.

5. In particular there needs to be a specific and sharp step up in the support and encouragement provided by central government to embed a consistent and deep understanding of the role of the three statutory safeguarding partners. While I saw some very impressive evidence of the effectiveness of this triumvirate, there are too many

[5] Safeguarding Pressures Phase 7, The Association of Directors of Children Services Ltd, February 2021

examples of not too much change from the LSCB arrangements - “old wine in new bottles” is the term I have borrowed to describe this. The whole purpose and ethos of the new arrangements will stand or fall on the effective implementation of this new model of local decision making and accountability.

6. Ministers and senior officials in central government departments must send clear and focused messages to the statutory partners in a way that demonstrates that central government itself has a joined-up culture in supporting the reforms. That is not the case now, consequently a message on the importance of this role is not being embedded sufficiently at local level. The proposed reorganisation of Clinical Commissioning Groups (CCGs) into Integrated Care Services will be a major change and a test of cross-Whitehall planning to the way health services are arranged. It will impact directly on the new multi-agency arrangements. This will be a test for joined up Whitehall multi-agency planning to ensure those designing the change implement the government’s ambition for the new arrangements especially the role and seniority of the statutory safeguarding partner from health.

7. A key issue in this review has been the importance of *accountability and judgement* of the quality of service being provided by local agencies. I have seen creative models of scrutiny and independent assurance being implemented locally. I have also heard a clear and serious voice from agencies on the need for greater assurance, they believe they are doing the best they can but would be keen to see a national perspective on their work.

8. There is a palpable need for national inspectorates and regulators to develop a model that can provide an analysis on how things are impacting on children and what characterises best practice. There is no plan currently for a joint approach to provide such a picture. This is a serious gap. I have suggested in the report a framework for bringing together the quality work of national regulators and local leadership in a model that can provide for Ministers and the public a clear statement of assurance about how children are being protected and safeguarded.

9. I would hope that before we enter into 2022 the national inspectorates would have undertaken a range of activity - whether through the Joint Targeted Area Inspections (JTAI) or other mechanism, that allows them to offer Ministers and the public an early judgement on the impact on outcomes for children of the decisions taken by statutory safeguarding partners.

10. Implementation of the reforms has seen the development of a wide range of new approaches to engaging relevant agencies and other partners in safeguarding children. Some have said a focus on three safeguarding partners has created a sense of other agencies being ‘removed from the table’ of decision making. I saw sufficient evidence of how safeguarding partners have ensured full engagement of relevant agencies in their arrangements in a way that ensures their opinions on all strategic issues can be raised to lead me to the view that this is possible in all areas.

11. A specific issue has been raised about the engagement of *schools* and other educational partners. Some partnerships are saying schools do not get involved others saying schools are ‘kept out’. This report demonstrates there is clear evidence and example of how successful engagement has been possible in most areas. However, more can and should be done to ensure head teachers and designated leads in schools can work more effectively with the local arrangements and where possible feed in a consensual view from the broad range of schools in any area. The point on consistency across England was described to me by the representative of the National Association of Headteachers (NAHT).

12. One area of education that needs urgent attention is children who are in an unregistered school setting or receiving home education - there is some anecdotal evidence of an increase in the latter during the pandemic before the closure of schools. DfE needs to ensure its guidance to local authorities and safeguarding partners is up to date and contains additional guidance of managing children in these settings.

13. Safeguarding partners have introduced a wide range of new measures to ensure *independent scrutiny* and challenge of the new arrangements. This includes peer challenge, Independent scrutineers, commissioned external reviews, engagement of children and young people, annual assurance statements by external agencies, engaging lay members and the use of local authority scrutiny and health and wellbeing committees. We need to draw together a secure evidence base for the impact of independent challenge and scrutiny on the outcomes for children.

14. One area where there is a deficit is the independent scrutiny of the impact on practice of the collective decisions and actions of the three formal safeguarding partners (the Chief Executive of a local authority, Chief Constable and Chief Operating Officer of the CCG). This is an area that attention needs to be turned to and is something in the first instance that the national inspectorates should form a judgement on.

BACKGROUND

15. The Children and Social Work Act 2017 ('the Act') created a new framework for the oversight and delivery of the services providing multi-agency arrangements for protecting and safeguarding children. The purpose of the legislation in respect to this activity was to improve joint work at the local level to safeguard children and enable better learning at the local and national levels to improve practice in child protection.

16. The provisions of the Act amended the safeguarding provisions in the Children Act 2004. The Act provided for the abolition of Local Safeguarding Children Boards and set out new requirements for the safeguarding partners to make arrangements, they and any relevant agencies considered appropriate, to work together in exercising their functions. This included arrangements for the safeguarding partners to work together to identify and respond to the needs of children in their area.

17. The Act created three safeguarding partners, in relation to a local authority area in England these partners are:

- the local authority.
- a clinical commissioning group for an area any part of which falls within the local authority area.
- the chief officer of police for a police area any part of which falls within the local authority area.

18. Guidance in *Working Together* [6], chapter three, is very clear as to the *leadership role* to be played by the statutory safeguarding partners. It states that, "Strong leadership is critical for the new arrangements to be effective in bringing together the various organisations and agencies." In conducting my review, I have used this guidance to measure the extent to which the triumvirate of statutory partners have been able to demonstrate they are compliant with its advice.

19. The Act also created the role of a relevant agency. *Working Together* defines these as organisations and agencies whose involvement the safeguarding partners consider is required to safeguard and promote the welfare of local children. Local arrangements need to engage these bodies to work in a collaborative way to provide targeted support to children and families as appropriate. *Working Together* offers clear advice on how the statutory safeguarding partners can ensure relevant agencies are fully engaged and consulted about the local arrangements so as to effectively safeguard children. This category includes schools, colleges, GPs, probation services and providers

[6] Working Together to Safeguard Children- A guide to inter-agency working to safeguard and promote the welfare of children DfE 2018.

of childcare. A full list is laid out in the Relevant Agencies Schedule of The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018.

20. Safeguarding partners must make arrangements to identify serious child safeguarding cases and commission and oversee local child safeguarding practice reviews where they consider it appropriate to do so. They have a specific duty to ensure these are commissioned, progressed and result in clear recommendations for action. Working Together sets out the very specific responsibilities the safeguarding partners have.

21. Statutory government guidance allowed safeguarding partners up to 12 months to agree the new multi-agency arrangements, and three months to implement the changes. This set a final deadline date for the beginning of implementation of 29 September 2019. Many areas introduced their new arrangements well before this deadline. Once agreed by the safeguarding partners, the arrangements had to be set out and published. Safeguarding partners were required to provide DfE with a link to where the arrangements had been published.

22. Once the arrangements have been published and implemented, the LSCB for the local area had a period of up to 12 months to complete and publish outstanding Serious Case Reviews (SCRs) by 29 September 2020, after which date, they were to be replaced by child safeguarding practice reviews (CSPRs).

23. In the Spring of 2018 the Department for Education, Department of Health and Social Care and the Home Office announced a programme to support **early adopters** of new and innovative approaches to setting up multi-agency safeguarding and produce learning which could be shared across other areas. The NCB was appointed to oversee this programme which covered 17 areas of the country, involving 39 local authorities. The NCB produced its final report in August 2019. This concluded that, “Taken as a whole, the learning of the early adopters demonstrates the potential for, and value in, moving towards arrangements which are increasingly efficient, equitable, responsive, and *dynamic*.”

24. I organised my review in two phases. Phase one was to meet as many organisations, agencies and individuals as possible to identify some key hypotheses to look at in depth during phase two. I produced my phase one report in July 2020, and this is attached as Appendix 3. The report identified five themes to be looked at in further detail. These were:

- Structural issues of the new arrangements;
- Leadership of the arrangements;
- The impact of the new arrangements on practice; and
- New models of independence and scrutiny.

The fifth area was the support being provided by central government departments to the implementation of the reforms. I cover each of these areas in the report.

25. I met Ministers, conducted a wide range of discussion with a range of agencies and organisations, received detailed notes on their progress from a wide range of areas, carried out a 16-question survey and received responses covering 132 areas. I also spoke at a webinar with over 150 safeguarding partners, independent scrutineers and partnership managers, addressed the National Police webinar and read a wide range of literature and reports on the progress of the implementation of new arrangements. Finally, as part of my research, I addressed webinars for the London and Yorkshire and Humberside area to consider in detail the themes laid out in my initial report.

ASSESSMENT OF THE NEW ARRANGEMENTS BY SAFEGUARDING PARTNERS

26. I have seen some good examples of how the new arrangements are being implemented but I do have some concerns about the way in which they are being carried out. In particular weaknesses in the role of safeguarding partners and how independent scrutiny and challenge is not being utilised. I was not of course reviewing the child protection practice in those areas. My focus was on the strengths and weaknesses of the programme of implementation and whether areas were themselves looking for evidence of the impact of the new arrangements on operational practice. The independent chair of the Birmingham Senior Leadership Assembly expressed my view of the overall picture of implementing the reforms when she described implementation of reform in the area as, “A journey of progress.”

The survey

27. I conducted a survey with safeguarding partners which asked 16 questions, Appendix 2. I received 117 responses from the 132 multi-agency safeguarding partner areas. Headline findings of the survey provide good evidence that the reforms introduced by the Children and Social Work Act 2017 are beginning to have an impact. This includes 90% of respondents saying that to some or a significant degree the reforms were having a positive impact on multi-agency strategic decision making. In terms of the impact of the reforms on practice, 61% said they had evidence of a greater focus on multi-agency practice at operational level, 13% were gathering evidence of the impact and 26% had not begun to gather evidence.

28. Just over half of the respondents would like to see additional guidance from central government to assist them in carrying out their responsibilities and duties as statutory partners. Overall, these findings are encouraging given the short period of time since September 2019, when all local areas became safeguarding partner areas, and the ongoing challenge of the pandemic.

The challenges that were identified by the statutory safeguarding partners

29. Safeguarding partners were asked in the survey what were the three biggest challenges they faced in their area. There was a wide range of replies, some covered cross-agency strategic challenges others were more narrowly focused on the challenge from the perspective of a single partner. Below is a snapshot of the most frequent challenges mentioned in replies to the question:

- The disparity in size of the three partners means it is prohibitive for the police to engage at the level dictated by *Working Together*.
- The small size of the local authority means a small cadre of officers are often representing many areas and find themselves in both task group and scrutiny roles which reduces the independence of the arrangements.
- Fewer relevant agencies are proactively engaged with the arrangements compared to the time of the LSCB, anecdotally suggesting that they only have to comply with directions from the partnership:
    - *COVID-19 planning.*
    - *Developing safeguarding arrangements across different geographical footprints and the tension in developing a consistent health and police approach verses localised safeguarding.*
    - *Challenges around resources (not just funding) but developing skills and expectations.*
    - *Developing and maintaining a cohesive, robust, collaborative approach to Contextual Safeguarding.*
    - *Mental Health issues around stress and anxiety of COVID19 and the associated consequences of the virus – impact on children, young people, parents and families.*
    - *Domestic Abuse and the impact on children and young people.*

30. When asked in the survey if there were any additional issues partners thought needed to be explored about the operation and impact of the new arrangements the following issues were identified:

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    - *We observe that the threshold descriptions have more ambiguity than we imagined and some feedback from the Child Safeguarding Practice Review Panel (the Panel) has added some confusion.*
    - *The arrangements seem to exclude the judiciary and some of our local concerns relate to court ordered actions such as contact and in care at home.*
    - *The complexity of working across complex geographical footprints.*
    - *Scrutineer role: other than funding this has caused the most discussion in partnership arrangements in terms of what this could look like.*
    - *Equality of partnership: ability of LA to let go of leading and holding responsibility for safeguarding.*
    - *Virtual working as a partnership in terms of virtual meetings.*
    - *Online training – how are other partnership adapting to these new working arrangements.*
    - *How strategic leads have engaged with the wider partnership (particularly schools and health partners) in terms of feeling included in safeguarding arrangements.*
    - *Engagement with elected members.*

I have commented on these points in this report.

Evidence of a difference between the new arrangements with the LSCB arrangements

31. I asked a sample of five multi-agency safeguarding areas to give examples of the difference between their current arrangements and the previous LSCB by identifying whether they felt they were doing things they could not have done as an LSCB. Many partnerships told me that they believe they are now more clearly focused on safeguarding and child protection within the range of issues impacting on children compared with the much broader overview of LSCBs.

32. The replies I received confirmed that a great deal of thought has gone into structuring of the new arrangements to deal with the challenges and difficulties faced in the previous arrangements of the LSCB. Key points made by the safeguarding partners point to a reduction in bureaucracy; greater understanding of key challenges facing the safeguarding partners; greater sharing of responsibility and decision making between the three safeguarding partners; a heightened focus on assurance and challenge; and a focus on practice as opposed to process. I include some examples below; their full responses are laid out in Appendix 4 (i).

- The merger has resulted in greater understanding of key themes and their implications for both adult and children's safeguarding.

- The development of the hubs was an excellent example of enhanced partnership working, with both partners from health and the police being involved in design and delivery, including the shared use of premises and local facilities.

- Our new structure has strengthened relationships between the three areas, which has directly resulted in more proactive and open discussions. The Statutory Safeguarding Partners have acknowledged that the partnership feels less defensive than it used to when challenged by an Independent LSCB Chair. Partners feel responsible, therefore have a more pro-active approach to making it a success. This is a significant cultural change, especially across three Local Authority areas.

- Greater cohesion across a wider footprint, with subgroups on Quality Assurance and Education working more closely together, building on work of the already joint subgroups on Policies and Procedures and Learning and Organisational Development.

- Challenge and assurance are becoming stronger, as there is greater transparency about local arrangements.

- The professional experience and expertise of the multi-agency training pool has been strengthened by the collaborative approach across the whole partnership area.

- The opportunity is now open for us to broaden the collective approach by forming a group comprising Chairs of Children and Adult Safeguarding, Chairs of Health and Wellbeing Boards, Community Safety Partnerships and Corporate Parenting Boards, as well as senior Public Health representatives.

- There is a more open and collaborative approach to the way the Board operates. It has supported a greater understanding of the role each of the partner organisations play.

- More decisions are being made and are more fluid and timelier, including reporting and awareness of real-time issues and actions.

- In contrast, Executive meetings now meet quarterly, with a shorter agenda and much greater clarity around expectations. Attendees are the core partners only, with meetings providing an opportunity for discussion of key facts and issues, dynamic decision making and robust challenge where appropriate.

Early signs of impact on safeguarding practice

33. In our survey we asked safeguarding partners if they had gathered evidence that suggested the new arrangements have led to a greater focus on multi-agency practice at operational level, 61% said they had evidence of a greater focus, 13% were gathering evidence of the impact and 26% had not begun to gather evidence. It is very important to assess the impact of change on the day-to-day work of colleagues from all agencies in the field. The impact on practice is a critical test the reforms must pass.

34. I was encouraged to hear about and read the evidence provided by a large number of areas keen to share examples of the impact the changes had made to their arrangements on the work of their front-line colleagues. A range of comments made by safeguarding partners is outlined below (full details are in Appendix 4 (ii)):

- Evidence has been gathered in a wider range of areas, such as multi-agency data, voices of children and young people, ongoing multi-agency auditing and identification of multi-agency workforce development needs that will support enhanced practice.
- Whilst we have always operated within the 15-day timescale for completion of reports to the Panel, the prompt feedback and increased flexibilities in relation to child practice reviews is enabling us to share more widely the immediate learning.

- Improved communication between adult and children services and cross-working in areas for example domestic abuse, exploitation and transitional safeguarding.
- Complex strategy meetings that now take place involving numerous partners and the operational activity that is then driven from this is a good example of the closer operational working relationships across the partnership.
- We, as Statutory Partners, are gaining a deeper insight into our local practice than ever before, leading to a better understanding about the issues concerning front line staff on the ground.
- Although we are in the early stages, the workstreams very much include a focus on practice at an operational level. This includes seeking the views of practitioners in relation to their views of what is working well as part of specific areas of work and what support they feel would help in developing their practice. These views can be triangulated with the views of children, young people and their families, the outcome of audit work and performance data to provide assurance of the effectiveness of multi-agency practice.
- There has also been considerable multi-agency working with a child focus (Vulnerable Children Multi-Agency Group) where strategic and operational leaders are able to share information and modify processes quickly to meet the needs of children and families.

The impact of structural change

35. The new safeguarding arrangements allow a great deal of flexibility not only in setting out the geographical areas to be covered, but also the agencies to be involved in planning and delivering a multi-agency approach to protecting children. A small number of areas have agreed to work across geographical and administrative boundaries. Good examples of this approach can be seen in the examples below (full details are in Appendix 4 (iii)):

The Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership covers eight CCGs, three local authorities and one police constabulary. The partnership has developed a strong structure and assurance process. The work of the partnership is supported by the Lancashire and South Cumbria NHS Integrated Care System model which is followed by the eight CCGs and ensure consistency of high-quality safeguarding practice by NHS staff within the wider safeguarding partnership.

The Greater Manchester Safeguarding Alliance (GMSA) is a partnership of the 10 local safeguarding partnerships in the Greater Manchester Combined Authority area. Its purpose is to achieve excellent safeguarding practice and outcomes for children across the 10 partnerships by:

- agreeing a shared understanding of excellent safeguarding practice;
- creating a shared culture of collaboration, curiosity and challenge;

- utilising a strengths and evidence approach to scrutiny; and
- suggesting improvement to the quality and consistency of practice.

The **Derby and Derbyshire Safeguarding Children Partnership** covers two local authorities, two CCGs and the constabulary for the area. The partnership is led by a Chief Offices Group - including the two lead members - which directs and scrutinises the work of an executive board charged with assuring high quality coordinated services to protect and safeguard children, through its subgroups, which are voluntarily merging across the two authority areas, where appropriate.

The impact of ongoing change to area administrative boundaries

36. There is a significant challenge flowing from the planning and introduction of structural change within the health service, e.g. the reorganisation of CCGs into NHS integrated care services (ICS). This issue is now of the highest importance with proposals made by NHS England to replace all CCGs with a smaller number of ICS in the health service by April 2022. ICS will directly commission a wide range of local primary care services that affect children which will present key challenges for local safeguarding partners. It will be essential for clear guidance to be given to ICS about the role of the safeguarding partner and the ICS role in local safeguarding partnerships.

37. Issues of reorganisation and the structural changes also impact within police areas. A consequence of this that has been reported to me in my discussions with organisations and agencies, is the loss of a very senior focus on child protection at the level of official taking up the statutory safeguarding partner role. It is reported that as a result of area reorganisation of police command structures, and the aggregation of CCGs and introduction of new ICS, an outcome is that an officer at third or fourth tier is delegated to be the safeguarding partner. These colleagues are then attending meetings without the power of authority and accountability laid out in *Working Together*. As a consequence, the leadership is left to the local authority safeguarding partner seemingly in direct conflict with statutory requirements.

38. Although organisational and structural changes may well be inevitable, as organisations position themselves to deal with new challenges, there should be a requirement that discussion about such changes must include consideration of the role of the organisations' safeguarding partner for an area. This is an important issue for the civil service advice and guidance to those planning structural and organisational change. Planners must ensure that colleagues designing and leading such changes are cognisant with the need to protect and enhance the safeguarding partner role. The majority of safeguarding partners I spoke to wanted to see more consideration given to how current cross-central government sponsored changes support and encourage the integration of additional multi-agency arrangements with those introduced to protect and safeguard children at local and regional level.

39. New safeguarding challenges have arisen following increased concern about the safety and protection of children and how to respond to threats such as serious violence, criminal and sexual exploitation and child trafficking. This has led to new central government initiatives with a range of funding pots and the creation of new overarching multi-agency partnerships. It is not clear that the new initiatives have been considered in relation to the new multi-agency arrangements for protecting and safeguarding children. I have looked at academic thinking on this issue e.g. the RSA's report, Learning Cross Public Sector Innovation (2017)[7] on lessons for leading local cross public sector innovations and the principles identified by the NCB in their report on early adopters. Both of these refer to the importance of linking multi-agency work across initiatives.

40. Safeguarding partners have said, while welcoming the focus, that they have found it difficult to navigate all of these initiatives and wanted to see more thought given to how the new multi-agency arrangements could be used more effectively to introduce new initiatives in respect of children and young people as the statutory partner model provides an existing senior leadership framework for their effective introduction and coherence with existing provision. As an immediate step it would be helpful if the national facilitators and the SCRIB Board could be consulted on new plans.

Elected politicians and appointed officials

41. Elected Mayors, Police and Crime Commissioners, council leaders, councillors and chairs of NHS boards have a crucial role to play in supporting and funding multi-agency arrangements for protecting children. No guidance or advice has been provided by central government on the role to be played by these office holders. There are good examples of engagement and scrutiny of the performance of the arrangements, but this is not consistent and in some areas the role played by these officials is minor. Safeguarding partners claimed that the lack of guidance has led to confusion and some conflict between agencies - for example unilateral decisions being taken on reducing funding or staffing support and a clash of priorities in planning.

42. Statutory guidance is provided for the lead elected member for children services in a local authority area. This lays out clearly the strategic role played by the lead member in overseeing the delivery and performance of children services. I believe it would be helpful if advice were provided for other elected officials or if the guidance for lead members was extended to cover them. In particular, the regional role of elected mayors and PCCs might offer the possibility considering whether there is merit in them providing a regional coordinating and convening role in organising multi-agency arrangements for protecting children.

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[7] Royal Society of Arts-Transforming Together; Leading for People and Place. An inquiry into leading innovation in public sector partnerships-by Joan Munro, Ian Burbidge and Jack Robson September 2017

COVID-19

43. The impact of the pandemic was mentioned by the overwhelming number of groups and organisations I met. In general terms I was encouraged by the determination of partners to use the flexibility and new opportunities offered by the reforms to develop new, more effective ways of improving and developing systems and processes designed to protect and safeguard children. An example of this is the evidence identified by the NIHR research in July 2020 on how children's social care in fifteen local authorities had responded to COVID-19. This points to improvements in multi-agency working including closer working relationships between local authorities and the health service; improved engagement with schools, general practitioners and paediatricians at meetings and child protection conferences; and improved understanding of one another's professional responsibilities.

44. I was told in a number of areas how safeguarding partners responded to the pandemic by heightening their focus on the operational arrangements to finely prioritising those most at risk, expediting decision-making about keeping children safe and supporting children for whom they were making new placements in fostering or residential care.

45. Various police reports on the significant increase in domestic abuse has been experienced in many local areas over the time of the pandemic. This has alerted statutory partners to the need for more timely and focused interventions to ensure the protection and safeguarding of children is given urgent prioritisation and has been remarked on as a key indicator of better strategic working across the police, health and local government.

46. The ADCS (Safeguarding Pressures Phase 7) Report identified that local area leadership prior to, and during the COVID-19 pandemic was positive. This was helped by a strengthened partnership collaboration, especially through the three statutory partners and between social care and schools. It also found that virtual case conferences and meetings had led to an increase in participation by professionals, including GPs. It explained how partnership working and greater asset-based approaches to the pandemic had been enabling, with communities and agencies coming together to use what they have to best effect.

47. Comments in response to our survey question on COVID-19 included:

- *Through initial lockdown Strategic leads met on a weekly basis to review how agencies were working together to address safeguarding arrangements for children and young people.*
- *Multi-agency meetings were developed to ensure those most vulnerable and not attending school were regularly seen and supported.*

- *Strategic Lead discussions saw services pull together and support each other where required – for example, as pressures increased on Children's Services, school staff identified their most vulnerable students and, along with the Local Authorities most vulnerable students, undertook home visits to ensure the children were seen. Police Officers were made available to support any difficult to reach families.*

- *Police Strategic Leads regularly shared the levels of domestic abuse and missing children to ensure a coordinated response was in place.*

- *Police response - we have worked differently due to Covid and are now utilising technology to work more effectively. We are using less time driving and are able to spend more time working which has given us the ability to safeguard children quicker. In addition to this, we have helped to formulate and bring in recovery plans in line with schools closing.*

48. The following quote is representative of many others I received, "As soon as we faced a lock-down situation, the Statutory Safeguarding Partners and other key health organisation colleagues initiated a twice weekly COVID-19 Partnership meeting. This has enabled those with the ability to make decisions to problem solve issues as they arise in a coordinated way. We have been able to compare data, discuss emerging risks and are in the process of determining what the impact of lockdown, and its relaxation, will be on our families. Discussions have included the sharing and agreement of business continuity and changes in working practices, impact of mental health issues, temporary changes to child death processes and agreement and swift production of communication materials for practitioners and communities."

LEADERSHIP OF THE MULTI-AGENCY ARRANGEMENTS

The role and purpose of a statutory safeguarding partner

The safeguarding partner

49. Although I touched on this earlier in the report, it was a key theme in the second phase of my review and one I will explore in more detail here. A safeguarding partner is defined under the Children Act 2004 (as amended by the Children and Social Work Act 2017) as:

- the local authority;
- a clinical commissioning group for an area any part of which falls within the local authority area; and
- the chief officer of police for an area any part of which falls within the local authority area.

50. The three safeguarding partners have equal and joint responsibility for local safeguarding arrangements. The seniority of each of these posts within their own agency allows them to consider issues, outside the brief of services designed to protect and safeguard children, that have a direct implication on those services - e.g. youth crime, adult mental health services, drug and alcohol misuse, domestic abuse, housing, and public health.

51. *Working Together* states clearly who the lead representatives for safeguarding partners are:

- It is important therefore that the lead representative from each of the three safeguarding partners plays an active role. The lead representatives for safeguarding partners are ***the local authority chief executive, the accountable officer of a clinical commissioning group, and a chief officer of police.***
- All three safeguarding partners have ***equal and joint responsibility for local safeguarding*** arrangements. In situations that require a clear, single point of leadership, all three safeguarding partners should decide who would take the lead on issues that arise.
- Should the lead representatives ***delegate their functions they remain accountable for any actions or decisions taken on behalf of their agency***. If delegated, it is the responsibility of the lead representative to

identify and nominate a senior officer in their agency to have responsibility and authority for ensuring full participation with these arrangements.

- The representatives, ***or those they delegate authority*** to, should be able to***:***
    - ***Speak with authority*** for the safeguarding partner they represent.
    - ***Take decisions on behalf of their organisation*** or agency and commit them on policy, resourcing and practice matters.
    - ***Hold their own organisation or agency to account*** on how effectively they participate and implement the local arrangements.

52. The leadership role of the safeguarding partner is, therefore, based firmly on the notions of **authority to act and the accountability for action taken**. Its purpose is to remove the blockages, bureaucracy and organisational self-interest that bar the route to the effective and efficient delivery and practice of multi-agency services to protect and safeguard children. The safeguarding partner holds to account both the agency they represent and the collective partnership for their performance in protecting and safeguarding children.

53. In conducting this review, I have used this guidance to consider the extent to which the triumvirate of statutory partners have been able to demonstrate they are compliant with its advice.

Delegation to a deputy

54. In answer to the survey question as to whether the statutory safeguarding partner roles had been delegated, 100% replied it had been. In cases where this critical role is delegated to a deputy, they must be in a position to ensure the three tasks above can be delivered on.

55. It is clear in some organisations the delegate statutory partner is not in a position to commit their organisation or hold it to account. This occurs in cases where the actual attendee is at the level of a head of service as opposed to a Director or Chief Officer. In these circumstances it is not likely that the individual is able to carry out their role in the manner envisaged in the guidance. A number of comments were made about the level of delegation from the level of chief constable.

56. The expectation of many safeguarding partners is that the delegated rank should be specified as assistant chief constable or commander level. It is reported that often the delegated representative is at superintendent level. This is five steps below the chief constable in the police hierarchy. It is unlikely that an officer at that level can take decisions which commit the polices service to an action.

57. Where a statutory safeguarding partner delegates their responsibility to a deputy there is often not a sufficiently clear process for how their deputy is held to account or how the partner ensures they are in a position to support or challenge the deputy. There is room to question whether delegation is taking place and monitored in a way that is reflective of statutory guidance. It would empower safeguarding partners if it were recorded formally in their meetings that they are acting with the explicit authority of the statutory safeguarding partner to deliver on the three tasks set out in *Working Together*.

58. Two examples illustrate the difficulty encountered when delegation is not well organised. The first one is on **funding**. A number of deputy safeguarding partners have expressed concern that funding for the arrangements is not being shared in line with guidelines in *Working Together*. In some cases, one organisation has unilaterally reduced their financial contribution. The matter has not been resolved because the individual deputy partners cannot agree. In these cases, the matter has not been escalated to the formal statutory partner and a stalemate exists.

59. Elsewhere in this report I comment on a specific funding issue in Greater London which relates to a fixed budget level being introduced on local police services by the Mayor's Office for Police and Crime to the dismay of many health and local government statutory safeguarding partners.

60. The second example relates to **data sharing**. I met the deputy safeguarding partners in a large county. I was very impressed by the evidence the partners shared about their strategic decision making which underpinned their new arrangements. The focused agendas they worked through and the examples of committing their agency to the decisions taken. When I asked about data sharing agreements it became clear there was a problem. The issue was that the police deputy could not agree to the sharing protocol as the Chief Constable said it was a matter reserved for the police. The matter had not been escalated for a decision to the formal statutory partners and therefore was unresolved.

61. Both of these cases, and other comments I have received, suggest that the escalation process is not working sufficiently well at safeguarding partner level and that the role of an independent scrutineer/chair is not always being used to bring the three safeguarding partners together to resolve the issues which cannot be agreed on. If the three statutory partners are not able to even agree a joint budget for the funding of the arrangements or a data sharing protocol, it raises a question as to how much priority they are giving to ensuring strategic decisions are made to effectively deliver services to children and families.

62. *Working Together* states that strong leadership is critical for the new arrangements to be effective in bringing agencies together and that is why the lead representatives, i.e. the local authority chief executive, the accountable officer of the CCG and the chief officer of police, should play an active role. It was not always clear to

me that this was happening, and it is less likely to if the formal safeguarding partners do not meet together to discuss partnership business at all.

63. This is a crucial point. If the individual safeguarding partners hold to account their own deputy but do not meet with the other two partners to determine key strategic issues like quality of practice, outcomes for children, finance and data sharing, it would seem that in those areas the model is not operating as it is intended to.

64. A number of colleagues have suggested that delegation takes place because the formal safeguarding partner cannot be drawn into frequent safeguarding partners meetings on operational issues and that is why delegation makes sense. This is a misunderstanding of the role. The function of the statutory safeguarding partner is not to be involved in operational issues. It is the strategic decisions they should be dealing with which underpin and ensure multi-agency practice leaders can focus on the operational issues.

65. This is a particular challenge for some constabularies where one chief constable is responsible for an area containing several safeguarding partnerships. However, the chief constable retains responsibility for ensuring effective multi-agency safeguarding arrangements are in place. If there is a scheme of delegation to a deputy it has to ensure an officer of the level of seniority allowing them to commit their service and hold it to account for its contribution to the arrangements.

66. In my report of 2016, I identified (para 69) [8] the key strategic issues statutory partners would need to focus on. They were:

- 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.

[8] Wood Report-Review of the role of Local Safeguarding Children Boards-DfE March 2016

- 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.

67. It was evident, from some of the agendas for safeguarding partner meetings that were shared with me, that a good deal of the time was given to the sort of operational leadership issues that would be perhaps more effectively dealt with by a cross agency practice leadership body - and would not ordinarily be put to safeguarding partners to determine.

Advice, support and professional development for safeguarding partners

68. I had a very productive meeting with representatives of the Society of Local Authority Chief Executives (SOLACE) to discuss the role of the local authority chief executive in the new arrangements. Comments made at the meeting by chief executives include:

> "*There is a greater sense of accountability among safeguarding partners- but it's still the local authority which is leading."*
>
> *"Ofsted still assume the local authority is responsible for all multi-agency operations, so we have to be clear that we lead the partnership."*
>
> *"There is an inequality of leadership because local authorities experience of child protection goes back 50 or more years and health and the police don't have the same history*."

Similar points were made by a number of DCS I heard from, they were concerned that colleagues from the police and health services were trying to stray into local authority decision making which is a core part of their statutory role.

69. Very different messages can be heard from within the police and health service. Comments were made about the local authority "*dominating the agenda*" and "*not recognising the experience and skill of police or health staff and processes*."

70. General support and administration is provided to support the safeguarding partnership, often this is a continuation of the business support manager from the LSCB. I have seen great industry carried out by business managers and their contribution is highly valued by partnership boards. Professional advice and guidance to the lead representative safeguarding partner tends to be provided by one of their deputies or specialist directors. It is in that sense unidimensional support and understandably is likely to lean toward a partisan view. Whether this support is sufficient to promote a partnership approach to remedying challenges, as envisaged in *Working Together*, is a moot point.

71. In one area I visited, the business manager observed that with LSCBs she had only one person to support, now she has to provide the support to three partners at three separate meetings. It was clear that she had no opportunity to provide support to meetings of the formal safeguarding partners as they did not take place, therefore there was no clear or structured opportunity for the three partners to meet together as it was all delegated to their deputies.

72. There is a good case to consider the role of professional support to the safeguarding partners. Providing support in the form of a cross partnership performance (e.g. prioritisation, analysis, data, intelligence gathering and interpretation, performance management and quality assurance) in a way which would focus the safeguarding partners on their cross-agency role and cross-agency decision making.

73. A professional advisor with the ability to provide that cross-sector perspective would significantly add value and impact to the specialist advice available in each of the partner agencies; provide a process to mitigate against single agency decision making and provide a clear focus for the strategic decisions necessary to underpin and ensure effective multi-agency working.

The case for additional guidance

74. A number of local statutory partners have pointed to what they see as an anomaly in terms of national advice-the existence of the statutory guidance for a DCS (covering the wide remit of their roles including child protection and safeguarding) and lead member but nothing similar for a statutory partner role. Of course, in local government the statutory partner role is more than the DCS and involves the chief executive and elected politicians.

75. I think there is a clear and unambiguous case for developing formal guidance for the three statutory safeguarding partners. This is a significant lacuna in our intelligence and knowledge about the way in which the new multi-agency arrangements are being introduced and the objective assessment of the impact they are having on children and families.

76. There is little guidance from the NHS in its Safeguarding Accountability and Assurance Framework[9]. It has three references to the new multi-agency arrangements on their role and function, these are descriptive only.

77. On the issue of the strong leadership to be provided by a health safeguarding partner it states, in the section on multi-agency arrangements, that, "*designated professionals and local providers should ensure appropriate representation in the new partnership arrangements*." This framework does not quote the guidance in Working

[9] Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding and Assurance Framework-NHS England-Updated August 2019.

Together that the lead representative for health is the accountable officer of a clinical commissioning group nor the requirement that the representative must be able speak with authority for their organisation, to take decisions on behalf of their organisation and commit them on policy resourcing and practice matters, and to hold their organisation to account on how effectively they participate and implement the new arrangements.

78. I could not find any advice from MHCLG, DfE or Home Office. It does not necessarily require full blown statutory guidance, but it should be comprehensive and be issued with the full support of Ministers. This would allow the work of statutory partners to be considered - by the public and regulators - against a reasonable national standard. This should be in a form that is clearly cross-Whitehall and not from the one department alone. This is an anomaly that needs to be remedied as soon as is practical.

79. The sometimes bewildering and ever-growing map of local multi-agency arrangements could well be more effectively navigated if the critical leadership role of the local safeguarding partners were underpinned in guidance, better understood by central government departments and made more use of. Instead I am told of duplication, more bureaucracy, conflicting decision making and confusing advice to the operational front line as one central government proposal on multi-agency working together follows another.

80. Greater connection with the local safeguarding partners will significantly improve the channels of influence and persuasion available to SCRIB and central government generally in relation to local safeguarding partnerships. It would create a feedback mechanism that would provide timely information exchange and a wider understanding of how the new arrangements are settling in. There is no central hub of intelligence as to who they are, what skills or training needs they have, how they can become a power for promoting change and disseminate national policy. Indeed there is not even one agreed national register/data bank of who the statutory partners are. The DfE has the only list I am aware of and that is not complete.

81. As a matter of priority, a formal list of local statutory partners should be set up, and then maintained by the three facilitators, to be used as a key interface for sharing good practice, intelligence and data sharing as well as a conduit for advice and guidance between government departments and local statutory safeguarding partners.

Professional development

82. The introduction of the post of Director of Children Services was supported by the provision by the DfE of an extensive national professional development programme. This was implemented through the National College of Leadership and subsequently the Staff College. It was delivered against a leadership framework developed by the National College, it said, *"…the framework describes the underpinning leadership attributes, knowledge and skills which are required of DCSs in order for them to understand and manage better the complexity and accountability of the role and be highly inspirational*

and effective leaders." The programme ran between 2010 and 2013 when funding was withdrawn[10].

83. Currently the DfE fund a consortium led by the Staff College to provide a programme of professional development for an aspirant and serving DCS. This comes to an end in March 2022. There is no national advice or guidance on the professional development or training support for safeguarding partners. The role of safeguarding partner is an entirely new one which for the first time places a statutory duty on the three key agencies. While some attention is given to the role of safeguarding partner in individual national organisations, there is scant evidence of it featuring in national training programmes and absolutely no guidance or professional development for the executive role the three safeguarding partners are required to undertake.

84. Over the last six years NHS England has provided a national safeguarding executive training programme. This does not include specific training for a safeguarding partner. NHS England is in discussion with its provider of leadership training to include this aspect in their programme. This will not be sufficient if it is restricted to health safeguarding partners.

85. A cohesive programme, such as the framework above, involving safeguarding partners from each of the agencies would be a very important addition to the support provided to safeguarding partners and is likely to promote a joint vision allowing them to take decisions which account for the unique position of each agency and allow for acceptable, agreed outcomes.

86. I believe more needs to be done in central government to promote and demonstrate a shared agreement cross-Whitehall about the authority and responsibility of this role. I question whether the safeguarding partner role can be fully realised without additional guidance or advice. The Act provides for the Secretary of State to give advice to safeguarding partners in connection with functions conferred on them by the Act (sections 16E-16J). In my view the advice on what this entails in *Working Together* is not sufficient, and experience of operating the new arrangements have highlighted the need for more specific guidance on the strong leadership role to be played by the statutory safeguarding partners.

87. Statutory guidance from 2013 is provided for the roles of Director of Children Services and the lead member for children services. It is out of date and in need of major revision to reflect the fundamental changes which have taken place since its introduction. There is no guidance equivalent to this for a statutory safeguarding partner. This gap

[10]National Leadership Qualities Framework for Directors of Children's Services: National College of Leadership March 2010

needs to be closed by the provision of new guidance which adequately covers the unique and combined responsibilities of the three statutory safeguarding partners.

Funding

88. It is clear that for most, if not, all areas are facing a major challenge in ensuring that sufficient funding is available to maintain and develop the services they provide to protect and safeguard children. Financial pressures are regularly reported on by the police and NHS agencies. The impact across local government is described in the ADCS Safeguarding Pressures report which examined data from 129 local authority areas covering 89% of England's children. The report calculates that the financial gap in the cost of funding services for children is in excess of £820 million.

89. The delivery cost of providing child protection and safeguarding services incurred by each of the statutory safeguarding partners is subject to their organisation's budgetary arrangements. The funding of multi-agency arrangements is becoming a far more contested issue than hitherto, it is an issue increasingly raised with me by local partners.

90. Funding of multi-agency arrangements, in the context of this review, is essentially about the contribution made to ensure the strategic decision-making process is in place to maintain their coordination and leadership role. The funding needed will cover, for example, the actual cost of supporting the arrangements, for resourcing agreed initiatives and priorities, learning from serious incidents or events and promoting multi-agency operational working.

91. Chapter three paragraph 37 of *Working Together* states, *"The safeguarding partners should agree the level of funding secured from each partner, which should be equitable and proportionate, and any contributions from each relevant agency, to support the local arrangements. The funding should be transparent to children and families in the area, and sufficient to cover all elements of the arrangements, including the cost of local child safeguarding practice reviews"*.

92. There is a specific funding issue which affects some police services which I have already mentioned. This tends to be in areas where one police authority administration covers a number of local authority boundaries and CCG areas.

93. This point is illustrated most clearly in the case of the Metropolitan Police in London. There are 32 local authorities in London (excluding the City of London). Each is of a different population size with varied demographic characteristics and social conditions. The financial contribution to each multi-agency arrangement area in London is the responsibility of the Commissioner of Police of the Metropolis but in practice is set by the Mayor's Office for Policing and Crime. Currently this is £5,000 for each Borough, which is a sum that has not changed for many years. While there may also be some in kind cost attributed to an area, this is likely to be the same case for the local authorities

and CCGs in London and is unlikely to bring the total police contribution to an equitable level.

94. This approach sits in direct conflict with the role of a statutory safeguarding partner and the specific guidance set out in chapter three of Working Together. The fixing of the financial contribution that the police make means there is no room for discursive attempts to set a reasonable budget. *Working Together* requires the statutory safeguarding partners to agree a level of funding that is equitable and proportionate. When any agency makes a unilateral decision as to its contribution to a shared expectation it damages the concept of joint working and partnership. In some areas CCGs operate in a similar manner, leaving safeguarding business support units to negotiate directly with health provider agencies.

95. In London it is a matter of concern for the safeguarding partners. A number of independent chairs have commented that it limits the full potential of the police statutory safeguarding partner to play a full and equal role in upholding the multi-agency arrangements for local areas of London.

96. This is a matter that needs to be considered and remedied by the Home Office and the Department of Health and Social Care in discussion with Police and Crime Commissioners and partner government departments. For two reasons I would not recommend that central government should set out a national formula for funding local multi-agency arrangements.

97. First the needs and circumstances of each area are very different and second, ensuring that local arrangements are appropriately funded is one of the key tasks of the three safeguarding partners. Central government should reaffirm advice to statutory partners that funding has to be agreed by them - and not be left in limbo with their delegates - and then commit the funding agreed.

98. It is unacceptable, in my view, that in some areas the three safeguarding partners cannot agree how to fund their arrangements. It is a failure of the most senior officers in each of the three agencies and is something that central government needs to respond to. Central government departments could lead the way by agreeing that the funding provided nationally to support implementation, including the cost of the national facilitators, is jointly funded by them.

Involvement of children and young people

99. I asked those local areas I met, and through our survey, whether any new arrangements had been made to ensure the voice of children and young people is considered by the statutory safeguarding partners, 50% said they had and 50% said they had not. Of the latter, group respondents were keen to stress that they felt that their existing arrangements were strong with a number of participation and engagement

groups firmly established. In the NHS a key learning issue in their system leaders programme is promoting the voice of the child.

100. Findings in the NCB report on early adopters identified the work undertaken in Calderdale and Tameside as examples of good practice of engaging children and young people in in planning community events. Tameside created a challenge panel to discuss their 'Voice of the Child 'strategy. Hertfordshire had well developed arrangements for engaging with children in care but wanted to do more to involve young people, for example in the development of their strategies for neglect and engaging with parents.

101. Most of the areas I spoke to were able to point to their work of engaging young people and wanted to do more to improve engagement. In a webinar of 100 delegates organised by tASP, I received very many examples of the importance and variety of models of engaging children and the great lengths partnerships took to reflect this in improving safeguarding practice.

102. I question whether the purpose of engaging children to talk about multi-agency systems is always clear. In direct work with children safeguarding professionals should always ensure children's views are sought to cover issues about statutory intervention; the type of placement to be made; whether siblings will be split up; a decision to move a placement at no notice; a change of school; changing a social worker; whether or not to have a health check; and such like decision making.

103. To be clear about the impact local partnerships expect to achieve by engaging children and young people in discussion about the multi-agency system, they need to ask themselves:

- what outcomes are we trying to achieve when asking children to share their experiences of the multi-agency safeguarding system?

- will it make a difference to the outcome of children's experience of the multi-agency system, if so why and what is it about them sharing their experiences that enables change at that level?

- do we accept that children's engagement can and should lead to a change in the way the system operates and will allow them the opportunity to influence and change decisions made by safeguarding professionals about their lives?

- are we doing it because even though it will not directly change things from the system's perspective, it helps leaders and those operating at a strategic (and frontline) level to be connected to why this work is so important to the ultimate goal of safeguarding children?

- are we doing it because we think it makes children feel more involved and that is worthwhile even if it does not really make a difference to how strategic decisions re safeguarding are made?

104. It is only by being straightforward both with children and ourselves about why we want to hear directly from them, or why we don't, that any engagement can be truly authentic and meaningful.

105. Engaging children is a critically important thing to do especially in direct work, but we need a better understanding of what influence or impact a child or children can have on the wider system of multi-agency arrangements and strategic decision making by virtue of their engagement. Without this clarity there is a danger that we will disappoint children and snag their expectations.

Yearly Report

106. The safeguarding partners must publish a report at least once in every 12-month period. The report must comment on:

> (a) what the safeguarding partners and relevant agencies for the local authority area have done as a result of the arrangements, and
>
> (b) how effective the arrangements have been in practice.

This will include:

- evidence of the impact of the work of the safeguarding partners and relevant agencies, including training, on outcomes for children and families;
- an analysis of any areas where there has been little or no evidence of progress on agreed priorities;
- a record of decisions and actions taken by the partners in the report's period to implement the recommendations of any local and national child safeguarding practice reviews; and
- ways in which the partners have sought and utilised feedback from children and families to inform their work and influence service provision.

107. The DfE carried out a high-level internal assessment of the initial plans drawn up by safeguarding partners - *'Multi-agency Safeguarding Arrangements: High Level Snapshot of Plans July-August 2019'*[11]. This identified key facts about compliance with the guidance provided by the DfE.

[11] Multiagency Safeguarding Arrangements: High Level Snapshot of Plans July-August 2019

108. A copy of all subsequent reports should be sent to the Child Safeguarding Practice Review Panel and the What Works for Children's Social Care (WWCSC). Both organisations were not up and running at the time of the set-up plans but will now receive the yearly reports going forward. However, there is no specific task allocated to either organisation other than to receive the reports. The organisations have developed a high-level memorandum of understanding which includes how they will deal with the reports and draw information from them to inform wider work and learning.

109. In their joint assessment of yearly reports for 2019/2012 the Panel and WWCSC undertook a desktop review of 68 reports with a deep dive analysis of 19 of them. This detailed report assessed reports for evidence of compliance with the guidance in Working Together. They found 11 (16%) were evidenced, 36 (56%) were partially evidenced and 19 (28%) were not evidenced. I have seen a draft of the report, it identifies six areas for development. They are:

1. Safeguarding Partnership reports need to provide evidence of the added value and impact of new arrangements rather than describing governance structures.
2. There is a need for a more systematic approach to the evidencing of impact.
3. The need for partners to set out the evidence base behind their actions and decision making as well as how they will evaluate activity.
4. To set out more clearly the partnership's learning and improvement cycle and to evaluate its overall impact.
5. Develop guidance to support partnerships in measuring the impact of training and the dissemination of learning.
6. For partnerships to have clearer guidance about the expectations in reporting on the effectiveness of early help, looked after children and care leavers.

110. The report gives examples of the positive practice it identified and suggestions for specific activities of development partnerships might consider. It concluded with this overall assessment of progress:

> "*Given the degree of variation in approach, there would be benefit in the three national advisers working with partnerships, the Panel, and WWCSC to consider the key areas for development in our report and develop practice guidance for Safeguarding Partnership Yearly Reports. The practice guidance would also set out the ways in which the yearly reports would be used by the Panel and WWCCSC to inform learning and evidence-based improvement*."

I would add to the findings the need to ensure the yearly report is approved by the safeguarding partners as their statement of assurance about the multi-agency system, see below.

111. The SCRIB should provide a brief explaining what they would like to see included in the analyses and sampling undertaken by WWCSC and Panel and work with both

[12] Analysis of Safeguarding Partners Yearly Reports 2019-20 Overview Report. The Child Safeguarding Practice Review Panel and What Works for Children Social Care- February 2021

organisations to ensure key issues of challenge and interest about the work and impact on children's outcomes of the safeguarding partners can be identified and promoted.

112. In some areas, for example Bradford, the three safeguarding partners produce their yearly report as a statement of assurance about the safeguarding work and systems overseen by the partners. Alongside this, there is a statement from the independent chair commenting on the statement to provide an objective view of the assurance made in the plan. In this way the safeguarding partners are making a transparent statement about the evidence they have used to give the public an assurance that they are doing all in their power to ensure all that is possible is being done to protect and safeguard children. I think this is a very effective way of the safeguarding partners offering an assurance publicly, showing that it has been independently and objectively scrutinised and making for a clear base of accountability.

113. Central government should encourage all areas to adopt an open and transparent approach to independent scrutiny of, and comment on, the yearly report. The requirement for yearly report should be seen as the public statement by the three statutory partners of their joint safeguarding assurance. A record of their assessment of the work and impact of the multi-agency arrangements with proposals for change and improvement where necessary.

114. An interesting approach is the model used in the Republic of Ireland under the Children First Act 2015. There it has focused the attention of the leaders of the relevant public services on the safety of their child protection arrangements, as all organisations providing relevant services to children and families must have a Child Safeguarding Statement in place. This approach is being taken in Bromley where the Independent Chair and the safeguarding partners are considering introducing a statement of safeguarding assurance.

115. In line with Working Together the yearly report should be subject to a covering statement by an independent scrutineer. However as pointed out in the research by tASP, *'Some Independent Scrutineers scrutinise Annual Reports written by the LSCP [local safeguarding children partnership], others write the LSCP Annual Report themselves as a Scrutiny Report, and others both write their own Report and contribute to and scrutinise the LSCP Annual Report'*[13].

116. The yearly report should be seen as the agreed statement of the three formal safeguarding partners. The fact it that had been subject to independent scrutiny is a significant step in assuring the public and ministers that safeguarding children was actively overseen and led by the most senior of officials in the three key agencies providing support to children.

[13] Independent Scrutiny of Local Safeguarding Children Partnerships (LSCP) Arrangements, Discussion Report January 2021 tASP.

RELEVANT AGENCIES

117. Working Together identifies which organisations safeguarding partners should work with to safeguard and promote the welfare of children and families. It also makes clear that the partners can identify any agency they deem appropriate to be a statutory partner. I received a great deal of comment about the engagement of relevant agencies. In the survey we asked if the safeguarding partners had considered inviting any relevant agencies to become members of their executive decision-making safeguarding partners group. Of the replies, 60% said they had, and 37% said they had not, 3% did not know (!). This indicates significant effort has gone into fulfilling responsibilities safeguarding partners have to engaging and consulting relevant agencies.

Schools

118. The issue of engaging with schools was a point raised regularly by respondents. It is expected that the safeguarding partners for an area will designate all schools and colleges, including early years, as relevant agencies. Keeping Children Safe in Education 2020[14] lays out how schools should deal with children about whom they are concerned. It explains the responsibilities of teachers, designated staff, headteachers and governors. It explains how schools can engage with the new multi-agency arrangements and stresses how important it is that schools and colleges understand their role in them. Emphasis is placed on Governing bodies, proprietors and their senior leadership teams, especially their designated safeguarding leads, making themselves aware of and following their local arrangements.

119. When the safeguarding partners set out their published arrangements, they make clear which organisations and agencies they will be working with and some explain how they will work with schools and other educational partners. Generally, from what I have seen safeguarding partners encourage all schools in their local area to be fully engaged, involved and included in safeguarding arrangements.

120. Most seek to achieve the active engagement with individual institutions in a meaningful way. From the internal multi-agency safeguarding arrangements high level snapshot of plans - DfE (July-August 2019) of the first annual reports provided by each multi-agency area, practice examples from Essex, Brent and Stockport illustrated the detailed work which has gone into consulting and engaging schools and other agencies.

121. The number of schools covered within multi-agency areas varies widely-from 50 in some areas to over 500 in others. This covers all types of school, special, community, academy, church, voluntary, voluntary-aided, free and public. This is then filtered by

[14] Keeping children safe in education-Statutory guidance for schools and colleges on safeguarding children and safer recruitment. DfE 2020

nursery, primary, secondary, post 16 and special delineations. The complexity of engaging with several hundred schools requires a detailed network of representation. There is no command-and-control lever for schools, seeking a collective or consensual view of headteachers and governors on safeguarding and child protection issues is not always possible. The common factor is that all children live in an area of a local authority which has responsibility for protecting and safeguarding all children in all schools.

122. Examples of how arrangements for working with relevant agencies-including schools - are made is laid out in the annual report prepared by the safeguarding partners and include models like these below:

> ***Staffordshire*** *"Linking with school and education settings via the designated safeguarding leads network has begun to demonstrate an increased awareness of thresholds and ability to articulate safeguarding concerns more effectively.*
>
> *Termly face to face contact with over 400 schools across Staffordshire advising and sharing guidance, using rapid review learning for case discussion and threshold awareness. The engagement with schools is an area for development."*
>
> ***South-East region Safeguarding Partnership*** *"Throughout the transition discussions, we were very clear that the voice of schools needed to be retained as a strong presence and influence in our future arrangements. We were disappointed that schools/education had not been named as a Statutory Safeguarding Partner and determined that the importance of this universal service in safeguarding was not overlooked. In one of our areas there was already an Education Engagement Group in operation, made up of a selection of Headteachers from all sectors, Early Years and Further Education providers and key Local Authority colleagues. We have now replicated this in all three areas, and these groups are vital to ensure that issues specific to the school/education community have a voice and can be escalated for discussion by the Statutory Safeguarding Partners. These groups have been responsible for raising the issue of online safety, the impact of the (local) Festival on local pupils (and being a conduit for organisers to speak directly with schools), taking forward recommendations from Serious Case Reviews and sharing good practice."*
>
> ***Derby/Derbyshire*** *"Underpinning our arrangements is a stakeholders group, which will meet twice a year. This will comprise all 'relevant agencies', who are already participant members of relevant subgroups. The wider stakeholder group provides the opportunity for everyone to join together twice a year, on an equal footing, to identify strengths and areas for improvement and drive forward identified improvements across the Partnership, whilst informing the Business Plan and the Annual Report."*

123. An argument is made for schools to become a fourth statutory safeguarding partner. In my opinion this view is not consistent with the responsibilities and duties laid out for statutory safeguarding partners. A sole representative from one school cannot speak with authority for all schools; commit all schools to a specific decision; or hold all schools to account for their action. Schools therefore do not have a duty or responsibility for taking decisions on the strategic issues that lie within the statutory safeguarding partners' role.

124. There are very many models of how schools are actively engaged and involved in the local safeguarding arrangements. In other areas it is not so evident and headteachers and schools do not feel engaged. This point on consistency across England was emphasised to me by the representative of the National Association of Headteachers (NAHT) I met, she told me of reports she had received from schools that felt they were not being engaged with and her view was that if one area can do this successfully so others should be able to.

125. It is essential that schools, along with other agencies, are fully consulted on these strategic issues, thus I think it is imperative that multi-agency plans should include a clear description of how they specifically involve, consult, and engage schools along with other relevant agencies in discussing the strategic issues relating to the multi-agency arrangements. I am pleased therefore that the DfE has invited statutory partners, working with their schools, to submit bids for funding innovative models for engaging schools in multi-agency arrangements.

Children not in a registered school

126. The education of children other that at school (children missing from education, children receiving education at home, and children attending unregistered schools, yeshivas, and similar organisations) was raised as an issue of concern by those I consulted. While accepting that not all the children in these settings were at risk, too many face potential risks as the local partners were not able to get information from those running the institutions. They have no legal power to visit and enquire about a child.

127. Some authorities, like the London Borough of Hackney have campaigned on this issue for many years and have in place systems for checking up on children but these are not comprehensive and rely on voluntary cooperation of proprietors and parents.

128. In the case of children missing education, statutory guidance for local authorities (DfE 2016)[15] does not contain sufficient detailed advice about children not in a registered

[15] Children missing education-Statutory guidance for local authorities and advice for other groups on helping children who are missing education get back into it, DfE 2016.

school or receiving home education. The DfE has been considering this matter for somewhile and is in regular contact with local authorities.

129. There is now a pressing need for further advice and guidance from central government on dealing with this issue and for safeguarding partners to have access to specific powers and responsibilities to allow them to take the steps necessary to protect and safeguard children who are not in a registered school. This guidance was due for renewal before September 2019. This does not seem to have happened as the guidance is not up to date with the reforms to multi-agency arrangements for safeguarding children.

LOCAL LEARNING FROM SERIOUS INCIDENTS

130. The work of the Child Safeguarding Practice Review Panel (CSPRP) and the development of local learning were not part of the terms of reference for this review. However, it is the responsibility of the safeguarding partners to make arrangements to identify and review serious child safeguarding cases which, in their view, raises issues of importance to their area. I wanted to look at how safeguarding partners were implementing learning arrangements. I discussed this with the Panel and decided to include a question in the survey which could be shared with them to support their work nationally with safeguarding partners.

131. The survey asked a question about new multi-agency models of learning from serious incidents and events and the feedback areas had received from the Panel. It is clear, from the responses to the survey and the comments made at meetings and webinars, that a wide range of new models of local learning have been implemented. A number of areas have adopted models developed by another partnership. This cross fertilisation is to be welcomed and indicates that areas are working together to share best practice. Overall respondents were positive about the feedback they received from the Panel and guidance they had received.

132. The richness of the replies we received is evident from the selection below, the full comments are included in Appendix 4 (v):

Local learning reviews

- Guidance from the panel has helped inform improvements to rapid review reports.
- We are creating a process to collate individual examples evidencing how day-to-day practice has been influenced/changed as a result of this learning. A Learning Briefing is developed following all Rapid Reviews (whether they then become CSPRs or not). This learning is disseminated to professionals in the partnership by the members of the LLS.
- We carry out learning reviews regularly and use a model based on the Welsh model.
- The learning from serious incidents is incorporated into the performance management framework which combines learning and improvement from CSPRs, rapid reviews, audit programs which in turn inform the learning and workforce development program.
- A format for the Rapid Review Report has been developed and refined and the NSCP Development Manager is responsible for drafting the report following the panel. The report is signed off by named decision makers for each of the safeguarding partners before submission to the National CSPR Panel.
- We aim to ensure that the terms of reference and methodology are appropriate to the individual case under review. I think this is an area where further guidance to Independent Authors would be of benefit.

CSPRP feedback comments

- We have found panel feedback supportive with our concerns and would welcome further clarity on thresholds for national reviews as we perceive we may be overburdening them with cases which are of lower national importance.

- Guidance from the panel has helped inform improvements to rapid review reports.
- The Partnership has received feedback from the Panel which has been supportive of the conclusions drawn by the Rapid Reviews undertaken to date. In some cases this has included support or guidance as to the focus of any subsequent CSPR.
- National panel feedback has generally been positive and supportive of our approach and response to learning from rapid reviews. This has assured partners that we are taking the right approach to complete effective Rapid Reviews.

133. It would be helpful to all safeguarding partnerships if the Panel collated and presented a good practice guide of the wide range of models being operated by partnerships and identified the key characteristics that underpinned models of effective learning.

INDEPENDENCE AND SCRUTINY

134. We need to have a coherent and compelling argument for the need and impact of independent scrutiny. One that can evidence the differences between it and self-assessment or internal peer challenge.

135. Working Together states that scrutiny should be objective, act as a constructive critical friend and promote reflection to drive continuous improvement. It says, *"the role of independent scrutiny is to provide assurance in judging the effectiveness of multi-agency arrangements to safeguard and promote the welfare of all children in a local area, including arrangements to identify and review serious child safeguarding cases".*

136. The arrangements made about the type and model of independent scrutiny is to be agreed by the safeguarding partners. Among other matters, it should consider and judge whether the safeguarding partners are providing strong leadership; assessing if the systems at safeguarding children are effective; and if the yearly report has been subject to independent scrutiny.

137. In the survey of statutory safeguarding partners, we asked about the model the area had adopted for independent scrutiny of the arrangements. The replies were:

Local authority scrutiny approaches	3%
Peer/Regional Review	3%
Independent Chair	37%
External independent assessment/review	23%
Other	37%

138. The NCB report on Safeguarding Early Adopters identified a wide range of new approaches that have been adopted following the abolition of LSCBs. The report points out that whatever form independent scrutiny takes it should be focused on *activity leading to improved outcomes for children* and build on existing good practice. This message has been received by partnerships, but we need to see more evidence that the wide range of activity undertaken has a clear focus on the advice from the NCB and Working Together. To comply with this advice, it seems obvious that the scrutineer must consider whether the leadership of the safeguarding partnership has clearly identified what outcomes they are seeking.

139. A key challenge for scrutineers is to determine what they scrutinise and why. Is scrutiny a review of an activity or services or is it a diagnostic analysis of what impact a service is having? Is something being scrutinised because it is 'next in line' or because there is a question about its effectiveness? Can scrutiny trace a line between decisions taken by safeguarding partners and outcomes for children and improvements in multi-agency practice? Does the scrutineer's independence offer them a *carte blanche* to look at issues and actions they think will give evidence of impact of services on

children and families? Is there evidence to show that the lessons from learning reviews are being implemented across the partnership and as a consequence practice is improving?

140. I have been impressed by some models of scrutiny and independent challenge to safeguarding partners that I have seen. This includes holding them accountable as a group for the work of the multi-agency arrangements; holding discussion with staff to assess the impact of the new arrangements on their work; leading small reviews of service areas; and making recommendations for improvement.

141. I have also seen a lack of real scrutiny or independent challenge to the work of the safeguarding partners with too much attention focused on reviewing services or processes as opposed to identifying the impact on outcomes for children.

142. One area that does not seem to have had sufficient focus from scrutiny is the **performance of the three statutory safeguarding partners** and the effectiveness of their strong leadership. The safeguarding partners have full control and decision making over the multi-agency arrangements. They are accountable for all of the decisions taken by the partnership and are expected to have a direct line to frontline practice. Together they shape and control the practice of safeguarding children in their area. It is imperative therefore that what they do as a team is accountable and held up for scrutiny.

143. When their functions are delegated to deputies, I have seen little evidence to show if independent scrutiny has challenged the accountability arrangements between the partner and their deputy or the impact of the joint leadership of the three statutory partners.

144. Assessing the effectiveness of the strong leadership could and should be spelled out in Working Together as an essential component of independent scrutiny. I understand the point that it is perhaps a little early in the implementation cycle to forensically assess the impact safeguarding partners are having on practice, but their "strong leadership" is a fundamental necessity for the effective functioning of the new arrangements to drive improvement in multi-agency practice. This is why I believe it is something that must be looked at in detail and reported on by the independent scrutiny process and, as I argue elsewhere in this report, by the national inspectorates and regulators.

145. The University of Bedfordshire has begun a project to assess the lessons learned from using the Six Steps Model for independent scrutiny of safeguarding developed by Professor Jenny Pearce OBE. This programme is being used by a number of the multi-agency safeguarding partnerships.

146. The model offers a coherent framework for scrutinising the work overseen by the safeguarding partners. It focuses on looking at how the LSCP leads are engaged with safeguarding children planning and implementation, how effectively are relevant agencies engaged and how children and young people are engaged. It also looks at

whether there is an effective quality and assurance process in place, if there is a process for identifying and investigating learning from local and national case reviews and if there is an active programme of multi-agency safeguarding training. This is supported by a set of criteria against which the quality of work in each of these dimensions can be assessed.

147. The Association of Safeguarding partners (TASP) commissioned a survey and held webinars on the use and role of independent scrutiny. The findings of this work have been published. It includes a series of questions for independent scrutineers-and others to consider including, ”*Do we need agreed benchmarks for effective scrutiny of safeguarding practice to measure standards against?”*

148. I argue that there must be some form of inspection-judgement-assurance of the use of independent scrutiny in multi-agency safeguarding. This will need to be measured against a set of criteria with a focus on whether or not it has impacted on better outcomes for children and families. This research also identified partnerships that had appointed scrutineers who were also chairs of the adult safeguarding boards and other relevant bodies e.g. Health and wellbeing board, community safety partnerships thus creating a model of joined-up scrutiny.

149. Working Together could say more about independent scrutiny. It could suggest how to link it to outcomes for children and how it can assess the quality of strong leadership by the safeguarding partners. More work needs to be done to collate and test the available evidence such that good practice can be promulgated cross the sector. There is a case for a national benchmark of the characteristics of independent scrutiny of the arrangements for safeguarding children based on the good examples of how it can be seen to impact on the practice of professionals and outcomes for children. I think this may be a better way of spreading good practice as opposed to central government issuing a standard framework prescribing a specific model or method of scrutiny.

150. Working together makes clear that independent scrutiny is part of a wider system which includes the independent inspectorates’ single assessment of the individual safeguarding partners and the Joint Targeted Area Inspections (*Working Together* para 31). Currently, this wider system does not exist. If a decision is taken to undertake a thematic inspection of the impact of the new arrangements, the value added by independent scrutiny must be considered within that process.

151. A wide range of models of scrutiny and independent challenge have been adopted by safeguarding partners. Because this is such an important aspect of assessing-and assuring-the quality of provision made by safeguarding partners, I have included in Appendix 5 a large sample of the descriptions provided to the review.

152. It is encouraging to see a number of areas have identified the work they are doing to involve children and young people in the process of scrutiny. Below I have selected some examples which demonstrate the variety of approaches, the full comments are in Appendix 4 (iv).

- *"an independent chair is charged with providing the safeguarding partners with assurance that the new arrangements are working effectively for children and families as well as practitioners …and will consider how well safeguarding partners are providing strong leadership*."
- *"…an independent chair provides scrutiny and challenge to the Executive Board and the Chief Officer Group and has been vested with the authority to identify and ensure that agencies respond positively and work to address areas of practice requiring development*."
- *"The three safeguarding partners commissioned an independent reviewer to undertake an evaluation of the new arrangements and the work of the safeguarding partnership."*
- *"Key tasks of our independent scrutineer are to seek assurance in judging the effectiveness of the new multi-agency arrangements to safeguard children and assess whether the three safeguarding partners are fulfilling their statutory obligations. "*

- *"We commissioned an independent scrutineer to scrutinise the partnership arrangements and assess how well it is fulfilling its duty to safeguard children and young people and ensure the voice of the child is represented and heard throughout the arrangements."*
- *"We have appointed an Independent scrutineer to work with the Strategic Leaders, and an associate scrutineer to assist with more operational analysis and review."*
- *"We have appointed an Independent Child safeguarding Commissioner (ICSC) with the authority to coordinate the independent scrutiny of the local child safeguarding arrangements. The ICSC is fundamentally independent to local safeguarding partners and relevant agencies."*

INSPECTION AND ASSURANCE

153. I met the joint inspectorates (Ofsted, CQC, HMIP, HMICFRS) to discuss inspection of the new arrangements. Colleagues indicated they had not yet developed a full proposal to offer a holistic judgement on the impact of the statutory safeguarding partners and the new multi-agency arrangements on the quality of outcomes for children. As of yet no request has been made by central government to the inspectorates to carry out a thematic review of the impact of the new arrangements. In single agency inspections of local authority children services, health arrangements for protecting children or inspection of police services only partial coverage of this issue is possible.

154. Immediately prior to the introduction of the new arrangements, a thematic inspection of child abuse in families spoke of the need for closer working relations between the police, local government, and health. However, it made no detailed reference to the nascent role of statutory safeguarding partners or independent scrutiny of the new multi-agency safeguarding arrangements.

155. A principal purpose of the reforms was to ensure lead practitioners were not being deflected from their engagement with children and families as a consequence of servicing and supporting complex and bureaucratic processes and repetitive meetings. We need to know if this has resulted in better outcomes for children.

156. Essentially, it is not evident how the three statutory partner organisations (as a group) are held accountable for their contribution to delivering an effective and coherent contribution to the new arrangements. This lacuna seems to be particularly clear in respect of health where no specific agency or regulatory body has the overall responsibility to judge the health service contribution to multi-agency arrangements for safeguarding children.

157. The CCG outcomes indicator set is used by NHS England when undertaking their annual assessment of the effectiveness of CCGs. The set focuses on clinical and medical measures. In addition, it assesses how CCGs work with others (including their local Health and Wellbeing Boards) to improve quality and outcomes for patients. It makes no reference to local multi-agency arrangements to safeguarding children or the fact that the chief accountability officer of the CCG is the statutory safeguarding partner for these arrangements.

158. The CQC regulates health providers and carries out Children Looked After and Safeguarding Inspections (CLAS) of services provided by primary medical health services, acute hospitals, mental health trusts (including child and adolescent mental health services), and community services (to include health visiting, school nursing, child and adolescent sexual health and substance misuse services). It also contributes to multi-agency child protection inspections with other inspectorates. These inspections provide an assessment of how police, probation, health, and children's social care work together to help and protect children.

159. In respect of local government and the police, Ofsted and HMICFRS do cover some of this, and can rase issues with other inspectorates if they have an issue of concern. I do not think this is sufficient and it is an important issue to look at further. There is a case for the national inspectorates to be asked to introduce arrangements which look at accountability for these services and judge their impact on outcomes for children. This would allow central government to be better informed about the effective implementation of the new multi-agency arrangements. Any such change, however, should be undertaken *without* putting significant additional burdens on providers.

160. Ministers and their government departments need to receive advice and guidance on the impact of the arrangements on casework and decision making so as to form a view about the safety of the new system. Safeguarding partners and colleagues across the sector (police, health and local government) also make clear their support for a model of assessment. One that can help them and policy makers to consider if further change or amendment is necessary to help drive further improvement to protect children.

161. In my view it must be sensible that the new multi-agency arrangements should be subject to national evaluation. I think this can be done without introducing new legislation- perhaps by using the current JTAI arrangements to look at a sample of areas, or a commissioned joint agency thematic inspection. Using existing guidance, inspectors from the three relevant inspectorates could then assess the impact of the new process of statutory partner decision making on the safety, wellbeing and outcomes for children. This could be done in partnership with selected statutory partners and a thematic, focused assessment could be carried out in England, the results providing evidence of both what the current position is and whether a more formal process would be feasible and helpful.

162. Inspectors must look at practice to be able to form an assurance and a judgement about the safety and effectiveness of the new multi-agency system. The key areas to consider include:

- the impact of the changes on outcomes for children;
- how effectively is the new arrangement promoting learning;
- how is scrutiny and independent challenge adding value;
- how effective are the safeguarding partners in working together especially where they have delegated their authority.

163. It should be possible to put together a programme of thematic reviews seeking to identify how effective the changes have been in helping (or hindering) good practice with children and families. Initially this process should be led by the three relevant inspectorates Ofsted, CQC and HMICFRS in partnership with peers so that a comprehensive picture can be gathered on the impact of this new safeguarding partner role.

164. Following discussion with the three inspectorates the outline terms of reference for the review could be drafted by the SCRIB, with the review framework and process manual drawn together by the inspectorates in discussion with a pool of statutory partners.

SUPPORT TO SAFEGUARDING PARTNERS FROM WHITEHALL

165. The breadth of change implied by the new arrangements is extensive. Each area has reviewed and reconsidered its multi-agency arrangements and designed an approach in line with new duties and responsibilities. The ambition of ministers to see sustained improvement in multi-agency safeguarding practice has been clearly stated. To be effectively implemented the safeguarding reforms need equally ambitious support from central government departments. At the centre, government departments do not demonstrate a joined up or united approach to implementation.

166. There are still too many issues which are dealt with by one department, this results in conflicting or confused advice. There needs to be more evidence that permanent secretaries and their deputies cross-Whitehall have created and encourage a joined-up culture of working with local safeguarding partners and actively promote the new arrangements through joint departmental advice on guidance to safeguarding partners.

167. Support is currently provided to local safeguarding partnerships by a cross Whitehall team-the Safeguarding Children Reform Implementation Board (SCRIB). This Board has representatives from the Home Office, DfE and DHSC, the leads for each department are at Deputy Director level there is also a representative from NHS England, the Police and the ADCS. The SCRIB has created an operational group which works closely on day-to-day issues that impact on the implementation of the reforms at local level.

168. There has been a level of support to safeguarding partners for the introduction of the new arrangements overseen by the SCRIB - for example, the national facilitators appointed to work with areas on developing their new multi-agency arrangements, these have been helpful but not been sufficient in my view.

169. In my phase one report I commented on and made recommendations about the role to be played by SCRIB. This group sits in a position of national leadership on the implementation of the multi-agency arrangements reform programme. This leadership should be made explicit through the actions it takes and the decisions it makes. The SCRIB needs to have a more authoritative, influential role across government departments which work to safeguard children. I suggested two changes should be considered.

170. First the group should have a direct reporting line to the permanent secretary of each government department involved in the reform programme. Second, the group needed to have a small set of clear deliverables designed to support and foment the necessary decisions to ensure the effective implementation of the new reforms. Having considered this issue further I think the membership, role and functions of the SCRIB should be reviewed to ensure it has senior representation with a direct line of report to the relevant permanent secretaries.

171. It is essential in my view to ensure that a fourth government department - the Ministry of Housing Communities and Local Government and Communities (MHCLG) makes a full contribution to a remodelled SCRIB. This department has a critical role to play in the wider local government contribution to safeguarding and in local government politics including elected city and metro mayors. The role of local government in safeguarding children goes way beyond the remit of a children services department and that is why the safeguarding partner for the local authority is its chief executive. Increasingly initiatives from central government impacting on children cover a wide range of local government services, mental health, serious youth crime, domestic abuse, county lines and so on. The MHCLG has a key role in these initiatives, it needs therefore to be within the SCRIB helping to support the implementation of the reforms and the role to be played by chief executives.

172. Support provided to local partnerships by the national facilitators has developed well in the Police service. For local government and health support has been withdrawn for very valid reasons, despite some sterling efforts by individuals. This has meant changes and gaps in the support which are now being addressed. It is essential that facilitators understand the strategic nature of this work is a key requirement for success.

173. Sector specialist knowledge is essential but not sufficient. Facilitators must have experience and understanding of the dynamics and processes of how the entirety of the local health service, or a local authority system operates, how cross agency decisions are taken, how chief officers provide leadership and scrutiny and how stubborn problems can be remedied, e.g. funding, data sharing, seniority of representation at safeguarding partner level.

174. Working to SCRIB, emphasising a joined-up culture, the national facilitators should provide cross government information, advice, guidance, and evidence of progress with implementing the reforms. They should work to a focused framework of priority objectives, identified by SCRIB from feedback from safeguarding partners. The facilitators are a very important point of contact, but their work needs to be equal across the three partners and I am encouraged to learn that from April the team is likely to be at full compliment. They must work as a team, supporting areas to overcome challenges and identifying good practice to share with others. This is what we expect at local level when we talk about the three safeguarding partners as a team with equal responsibility for the new arrangements.

175. Recently, those currently in the facilitator role made a number of suggestions for improving support for implementation. These included the integration of the three key government departments' approach to safeguarding children; the creation of a clear vision for the SCRIB; and the rapid establishment of strong relationships with local safeguarding partnerships. I think these are helpful and sensible proposals.

176. Examples of where the SCRIB and the facilitators could be more prominent in providing clear advice, guidance and decision making include:

- ensuring that changes to the area structure e.g. the consideration administrative boundary changes, have full regard to protecting the role and seniority of the safeguarding partner, particularly in regard to changes made by a local constabulary and CCGs-where there is some evidence that change has led to less senior representation;
- giving clear advice about resources provided for multi-agency safeguarding arrangements when CCGs merge into integrated care systems (ICS). This issue is now of the highest importance with proposals made by NHS England to replace all CCGs with a smaller number of ICS in the health service by April 2022. ICS will directly commission all local primary care services and that has key challenges for local safeguarding partners;
- advising on issues that exist in areas where one constabulary oversees activity in several local authority areas and sets the same level of funding or imposes a fixed financial contribution on each partnership;
- advising of a clear national view and setting out clear expectations on an issue e.g. GPs requesting payment for providing reports required by child protection processes - as is the case of some GPs which is subject to consideration by the courts;
- illustrating and further emphasising the advice laid out in Working Together - e.g. the key area being the authority and accountability of statutory safeguarding partners and their delegates;
- clarifying the expected interface of multi-agency arrangements for safeguarding with new initiatives by central government - e.g. most recently on serious youth violence and violence reduction; and
- coordinating information and evidence about the impact on multi agency arrangements for safeguarding children by threat factors such as COVID-19 to establish a national picture and the gathering of good practice.

177. More joined up activity on safeguarding children undertaken in central government will provide greater clarity for safeguarding partners and assist them in their discussions, joint endeavours, and activity to improve the work they undertake to safeguard children.

178. If the multi-agency arrangements are to be successful, additional support for bedding in change for improvement will be a great help and it should be put in place quickly. This can take a number of forms. Just over half of the respondents to our survey would like to see additional guidance from central government to assist them in carrying out their responsibilities as a statutory strategic partner. This view was also expressed by the Society of Local Authority Chief Executives and many of the groups and organisations I met. Providing additional joined up Whitehall guidance will send a strong message to local partnerships about the criticality of the three safeguarding partners also acting jointly.

179. As I mention above a number of safeguarding partners have raised how important it is to deal with the cross over with the statutory guidance for Directors of Children

Services and Lead members in local authorities (April 2013)[16]. This guidance is dated, does not take account of the new multi-agency arrangements for safeguarding children particularly not the role of the three safeguarding partners - the local authority chief executive, the local chief constable and the chief operating officer for the clinical commissioning group (or their successor in the putative ICS). It is as an anomaly that needs to be reconciled now to be consistent with the new arrangements.

[16] Directors of children's services: roles and responsibilities-Statutory guidance for local authorities with responsibility for education and children's social services functions. DfE 2013

OTHER KEY ISSUES

Information and data sharing

180. Despite cross-government statements and guidance on the need to improve how health, the police, education and local government share data and information, this is still a problem remarked on in reports by inspectorates, learning reviews, the Office for the Children's Commissioner and by individual statutory partners in local areas. It was also raised in this review by a number of areas.

181. How can we help hard pressed, stressed professionals to feel empowered to ask for and share information and to inculcate an attitude of sharing and openness in those who control the data and information? We need to promote the behaviour and general notion of the need to protect a child will nearly always trump the withholding of information. Sharing is a positive characteristic of effective cross agency cooperation. In my experience one of the most disappointing factors is that often when shared, the information deemed to have been strictly confidential and not to be shared, is often anodyne and basic.

182. Kantar Public has been commissioned by the SCRIB to work on identifying how behavioural insights can be used to support changes in behaviour. The lessons from this will be an important resource for safeguarding partnerships to consider.

183. Changing human behaviour is influenced by a range of factors including that of senior civil servants and ministers. People take a lead from the behaviour of those with power. It is encouraging that a recent joint letter to statutory partners encouraging a more effective approach to serious violence was signed by the three relevant ministers, previous letters to safeguarding partners had only been signed by one or two of the relevant Ministers. This was commented on at local level with people surprised that all relevant ministers were not signatories. Unless all central government departments working on the multi-agency arrangements speak with a united, core message - the problem of poor data and information sharing will continue to hold back improvement and learning and will not be able to challenge effectively silo practice at local level.

184. The 2018/19 annual report of the national Child Safeguarding Practice Review Panel (published 4 March 2020)[17] identified a need, *"to move beyond the legislative and procedural, to the technological and the behavioural, and forensically explore how we can develop our multi-agency and multi-disciplinary practice in routine ways, and at critical points, which strengthens information sharing, risk- assessment and decision making."*. It argued that a fresh approach was needed to respond to dealing with these critically important features of child protection practice.

[17] Corporate report Child Safeguarding Practice Review Panel: annual report 2018 to 2019 (March 2020)

185. The report accepted the importance of pursuing technological solutions as a critical component of improving information and data sharing but called for a new focus on the human factors that influenced the process of information sharing arguing that the, "*Complexity of practice requires sophisticated conversation, hard wired into the DNA of our child protection practitioners*."

186. As part of its work on multi-agency arrangements Kantar[18] identified that local area leaders were describing the absence of a coherent, comprehensive cross-agency capability to analyse information and intelligence held by partners and relevant agencies to move efficiently from referral to analysis to action both at strategic level to identify persistent issues in the system's framework as well as at case work level. Kantar's report will be published in spring 2021. This will provide advice that local safeguarding partnerships should access to review and refresh their data and information sharing practice, behaviours, and protocols to overcome blockages and move to a higher level of effectiveness in providing intelligence and quality data analysis to safeguarding partners and their front-line staff.

Child Death Reviews - (CDR)

187. I was not asked to look at the implementation of reforms to the arrangements for CDR. Responsibility for child death review policy was transferred from the DfE to the DHSC in 2017 following the recommendation made in the Wood report of 2016. However, a number of respondents did raise the issue and asked why the arrangements for CDR were not being reviewed. A number of comments were made, both positively and negatively, about the CDR changes. I am not sure what plans the DHSC/NHS may have to review or assess the new CDR arrangement, but they should work with the DfE given local authorities are joint child death review partners. It would seem sensible for such a process to be undertaken to identify good practice and to see if any additional support is necessary to aid implementation. I advised those who raised this issue with me that I would bring it to attention in this report.

[18] Kantar-DfE Multi-Agency Safeguarding-Case Study Overview 2020 at a Webinar

CONCLUSION

188. If the recommendations in this report are accepted and introduced, I believe they will build decisively on the progress made thus far in implementing the new arrangements for multi-agency safeguarding. They will:

- Provide additional support to the three lead representative safeguarding partners to act with the full authority of their role as laid out in legislation and Working Together;
- Establish clear accountability arrangements for the effective delegation of functions of the safeguarding partner;
- Provide a higher level of joined up support and engagement from Whitehall for the implementation of the safeguarding reforms;
- Create a national register of safeguarding partners to provide an effective feedback relationship between them, local safeguarding partnerships and Whitehall; and
- Ensure that future organisational or administrative changes proposed by central government, such as the transition of CCGs to ICS in Health, take full account of the central importance of the new arrangements and the leadership role of safeguarding partners in any multi-agency model affecting children.

189. There is a need to ensure that the impact of the new arrangements is tested by external judgement and assessment of national inspectorates and regulators. This is essential to provide an assurance for all that the new multi-agency system is focused on ensuring better outcomes for children and improvements in safeguarding practice.

190. The yearly report provided by safeguarding partners should become a statement of assurance by the safeguarding partners allowing a framework for accountability and assessment of their impact on the safeguarding system.

191. The recommendations offer the opportunity for safeguarding partners to make more effective use of independent scrutiny and challenge. In particular of the way the three partners work as a leadership team influencing and shaping services to improve outcomes for children. The dissemination of effective practice in scrutiny will benefit from a joint SCRIB and tASP good practice guide showing how scrutiny can draw a link between the decisions of safeguarding partners outcomes for children.

192. If we can balance new guidance with continuing to encourage and support innovation at local level, it will encourage greater focus on engaging with children, young people, and their families. We will see the outcome of this in the development of more highly skilled practice leaders and practitioners using their professional skills and judgement in direct work with children.

193. Everything that is done by safeguarding partners and practitioners in multi-agency arrangements must contribute to delivering better outcomes for children and to

a safer system to protect them. Building on what we have achieved thus far will achieve that outcome.

RECOMMENDATIONS

In order to have any impact on the effectiveness of the implementation of the reforms, these recommendations should be considered and, where possible, acted on within the next 12 months.

Central Government

1. Current cross-government reform implementation governance must be strengthened. The membership, role and functions of the internal governance board (SCRIB) should be reviewed to ensure it has a senior representation with a direct line of report to the relevant permanent secretaries and includes full representation from the MHCLG. A set of objectives for the national facilitators' should emphasise their team role and all advice and guidance provided for local safeguarding partnerships should be cross government.

2. As a matter of priority, a formal list of local statutory partners should be set up, and then maintained by the three facilitators, to be used as a key interface for intelligence and data sharing as well as a conduit for advice and guidance between government departments and local statutory safeguarding partners.

Advice and guidance

3. Government should arrange for new and additional guidance - to be provided through the most convenient route - for safeguarding partners. The advice should focus on the "strong leadership role" of the safeguarding partner expanding on the outline in Working Together 2018. It should cover:
   - accountability and authority when the role has been delegated;
   - the role to be played by the safeguarding partners in situations where each has delegated their role;
   - escalation of issues and disputes resolution;
   - ensuring an agreed data and information protocol is agreed by the safeguarding partners;
   - a formal yearly statement of assurance in the yearly report; and
   - how the work of the safeguarding partners is subject to independent scrutiny and /or challenge.

4. The *Statutory guidance on the roles and responsibilities of the Director of Children services and the Lead Member for Children Services (April 2013)* should be reconsidered in light of the role of the safeguarding partner and new statutory multi-agency arrangements for safeguarding children.

5. Government should ensure guidance is provided on the importance of considering the impact of change on multi-agency safeguarding arrangements to those in central government departments planning or publicising geographical and organisational changes to the boundaries of police, CCG and local government

areas. This should focus on ensuring that the status and role of the statutory safeguarding partner is protected in the new plans.

6. Consideration should be given to the commissioning of a national development framework for statutory safeguarding partners.

7. All central government communication about multi-agency child safeguarding arrangements should be joint departmental advice and shared with each of the safeguarding partners for an area.

Funding

8. The section on multi-agency funding for safeguarding partnerships in Working Together should be revised to more clearly identify the functions that funding should cover in a partnership and to clarify the process areas where policing and health boundaries cover several multi - agency safeguarding arrangements.

9. Advice should be given to CCGs, Police Commissioners and local government to ensure that they fund cross area multi-agency arrangements by allocating an appropriate sum for each area within a partnership. Consideration should be given to how the principal that the three safeguarding partners have the responsibility for agreeing the funding for their area is maintained in constabulary areas that cover more than one multi-agency safeguarding partnership.

Children missing education

10. Government should ensure additional guidance and advice is provided for statutory partners-including updating guidance for children missing education - and consider if further powers for safeguarding partners are needed to ensure they can take steps to ensure children in a non-registered school fall in scope to the safeguarding arrangements.

City and metro mayors and PCCs

11. Consideration should be given to the role played in multi-agency safeguarding by elected Mayors and Police and Crime Commissioners. The regional scope of their brief should be reviewed to consider how they can best support the arrangements across their area.

Evaluation and dissemination of emerging practice

12. Government should invest in a suitable platform for the dissemination of good practice in delivering multi-agency safeguarding for children including a specific study on the impact of multi-agency safeguarding partnerships to identify any specific and added value contribution they are making to outcomes for children.

13. The SCRIB and national facilitators should work with others including the Association of Safeguarding Partners to produce a best practice guide on the role of independent challenge and scrutiny, giving specific attention to:

    - how scrutineers should assess the effectiveness of the strong leadership by the safeguarding partners, and

    - the involvement of children and young people in the scrutiny process.

14. Government should work with the National Child Safeguarding Review Panel and the WWCSC. to provide a formal brief for the analysis of yearly reports.

The Joint Inspectorates (JI) Ofsted, HMIP, HMICFRS and CQC

15. The JI should consider whether the JTAI model, or an alternative process, can be utilised to assess and form a judgement on the impact of decision making and planning by the statutory safeguarding partners on the quality of safeguarding practice and outcomes for children and young people.

16. The JI should consider the role independent scrutiny plays in the multi-agency arrangements and identify whether or not it has an impact on the quality of safeguarding practice and the outcomes for children.

Local safeguarding partnerships

17. Local safeguarding partners should satisfy themselves that the level of support, analysis and intelligence they require to conduct their business effectively and efficiently is provided. The role of business manager should be reviewed to consider whether it is meeting the needs of the safeguarding partners to carry out their strong leadership role in line with guidance in Working Together.

The Office for the Children's Commissioner

18. The OCC should consider undertaking a project to identify the impact on outcomes for children of engaging children and young people in the multi-agency safeguarding arrangements.

The Child Safeguarding Practice Review Panel (CSPRP)

19. The CSPRP should consider how it can most effectively disseminate the variety and range of models of local child safeguarding practice review and to share issues of national learning from local reviews.

NHS England (NHSE)

20. NHS England should ensure that the planning framework for the replacement of CCGs by Integrated Care Systems includes clear and explicit advice about the appointment to the lead representative role as the statutory safeguarding partner is consistent with existing legislation and guidance.

21. NHS England and the SCRIB should consider if and when an assessment of the new Child Death Review (CDR) arrangements might take place and advise the multi-agency sector accordingly.

Appendix 1: Terms of reference for the review

SPECIFICATION – MULTI-AGENCY SAFEGUARDING REFORM – SECTOR EXPERT SERVICES

Context

Following the *Wood Review 2016* into the effectiveness of Local Safeguarding Children Boards (LSCBs), the government introduced legislation through the Children and Social Work Act 2017 to reshape the way in which local agencies work together to safeguard and promote the welfare of children.

From the commencement of the legislation on June 29, 2018 - local authorities, police and clinical commissioning groups came under a joint and equal duty to make arrangements to safeguard and promote the welfare of children in their area. All local safeguarding plans are now published.

The next phase of the reform is implementation. New multi-agency safeguarding arrangements must be implemented by 29 September 2019. However, we recognise that this will be an evolutionary process whereby local areas will continue to adapt their plans as new learning and approaches are disseminated. Consequently, there is still work to do to support local areas with implementation and share learning on what is working well across the different multi-agency safeguarding partnerships from now and over the coming months.

Purpose

The purpose of the Sector Expert will be twofold:

- to provide additional support to local areas to implement their new multi-agency safeguarding arrangements on specific topics such as independent scrutiny or using data to improve local safeguarding arrangements. They will also identify local areas that may be in need of additional support that is more systemic and liaise with the police and health facilitators, already in post, to manage the support offered locally; and

- to look at how far the new arrangements are addressing the key issues as outlined in the *Wood Review 2016* and the criteria set out in *Working Together to Safeguard Children 2018.* While doing so they will identify the key innovations and areas of promising practice, as realised in local areas, and help share learning in relation to this and specific themes such as; working with schools, independent scrutiny, and shared accountability. As part of this, they need to be clear what the evidence base is for identifying the practice as ‘promising’. They will produce a report which will identify what has changed in how local areas work together to draw up safeguarding arrangements since the *Wood Review 2016,* and make reflections regarding the quality of these arrangements.

The Sector Expert will be expected to work closely with the Health and Police Facilitators, currently in post until March 2020, who work across their respective networks to gather intelligence on the ground, identify and find solutions to problems with the implementation of plans as they emerge and understand how different parts of the system work (for example Integrated Care Systems/Primary Care Networks). They will be required to work with the wide pool of professionals operating in this space, including the National Network of Designated Health Professionals and link in with the Children's Commissioner as appropriate.

Responsibilities:

- work with the cross-Whitehall multi-agency safeguarding reform implementation working group to identify areas that would benefit from additional support, alongside facilitators in health and police, to improve their safeguarding arrangements. This will be addressed at the relevant multi-agency safeguarding reform reporting group;

- build on the work already undertaken by the National Children's Bureau via the Early Adopters programme to identify key themes and areas where we have seen the most promising innovation across the country;

- to look at where there are still areas of weakness and those issues that remain difficult to resolve, to understand more about why this is and how it can be unblocked;

- identify areas with strong plans and extract useful learning that could be shared with other local areas from these;

- identify opportunities for children and young people to feed into the process;

- support and deliver seminars/learning events on findings; and

- to produce a report which will identify what has changed in how local areas work together to draw up safeguarding arrangements since the *Wood Review 2016 and* make reflections regarding the quality of these arrangements.

Appendix 2: - The Survey

SECTOR EXPERT REVIEW OF MULTI-AGENCY ARRANGEMENTS FOR PROTECTING CHILDREN

Survey for safeguarding partners

Please identify the job title/seniority of the statutory safeguarding partner for (and named deputy of each statutory partner if that arrangement has been made).
• Health
• Local Authority
• Police

If the role is delegated, please provide a sentence on how accountability to the named statutory safeguarding partner is arranged.

How have the statutory partners agreed to fund the new arrangements? Does this mark a difference from previous funding arrangements?

How do your multi-agency safeguarding arrangements interface with other multi-agency partnerships e.g. domestic violence, serious violence, trafficking, drug abuse.

At this early stage in the development of new arrangements have you gathered evidence that suggests they are having a positive impact on multi-agency strategic decision making.

As statutory partners what would you say the three biggest challenges facing multi-agency safeguarding work in your area are?

Has the boundary or scope of your multi-agency safeguarding arrangements changed from the model laid out in your initial plan? If so, briefly describe the change.

Are there any issues you think need to be examined closely about the operation and impact of the new arrangements not covered in this survey? Please identify them below

Have you invited any of your relevant agencies to become a member of your decision-making statutory partners group? Please identify which agencies and how they represent their stakeholders.

How are elected /representative officials (e.g. councillors, mayors, police and crime commissioners, NHS Board Chairs) involved with your multi-agency safeguarding arrangements?

Would a joint Whitehall code of guidance for statutory safeguarding partners assist you to carry out your responsibilities and duties as a statutory partner? *

☐ Yes

☐ No

At this early stage in the development of new arrangements have you gathered evidence that suggests the new arrangements have led to a greater focus on multi-agency practice at operational level?

Have you made any new arrangements to ensure the voice of children and young people is considered by statutory partners?

If you have agreed a new multi-agency model of local learning from serious incidents, please provide a short description in the space below.

If you received feedback from the panel, please explain below how it was helpful

How do you propose to evaluate the outcomes of the changes you have implemented for your area? *

What model has your area adopted for independent scrutiny of your arrangements?

*

- External independent assessment/review
- Local authority scrutiny processes
- Independent chair of the statutory partners meeting. (If an independent chair has been appointed was that person the chair of the former LSCB?)
- Peer/Regional review
- Other

The COVID virus has had a significant impact on delivering services to children. Have the new arrangements improved your ability to work to protect children? If so please describe how.

Appendix 3: Interim report

Sector Expert Review of multi-agency arrangements for protecting children

Phase One Report.

Sir Alan Wood CBE

7 July 2020.

Introduction

Despite the coronavirus situation I have managed to gather sufficient opinion, information and help to be able to identify a workplan for phase 2 of this review. I am tentatively planning to resume face to face contacts as from early September. The purpose of these will be to test the hypotheses drawn from phase 1 of the review. The hypotheses are structured in four blocks, I comment on each below. In each block I hope to evidence early promise of good practice and areas where more may need to be done to assist change. We have delayed the sending out of a survey to statutory partners and we will do so in phase 2. I suggest the survey is focused on the four sections identified below.

1. Structural

The new arrangements in the Children and Social Work Act allow a great deal of flexibility in setting out the geographical areas to be covered and the agencies to be involved in planning and delivering a multi-agency approach to protecting children. A small number of areas have agreed to work across geographical and administrative boundaries.

Recently new initiatives and challenges have arisen following increased concern about the safety and protection of children - e.g. serious violence, criminal and sexual exploitation, trafficking. This has led to new central government initiatives and a range of funding pots and the creation of new overarching multi-agency partnerships.

Despite some examples of good practice, it is not clear that the new multi-agency arrangements have always been involved in or are working sufficiently closely with these new developments. I have looked at academic thinking on this issue e.g. the RSA's report, Learning Cross Public Sector Innovation (2017) on lessons for leading local cross public sector innovations and the principles identified by the NCB in their report on early adopters.

I propose to look at this issue in discussion with the sector about:

- Multiple area partnerships-cross LA/health/Police boundaries;
- Engagement with key relevant agencies-especially schools;

- What role is being played by elected regional Mayors and Police and Crime Commissioners;

- Examining interface with other multi-agency arrangements - e.g. Violence Reduction Units; Knife crime, Health and Wellbeing Boards; Adult Safeguarding Boards;

- How central government could further incentivise new models of multi-agency working at local level;

- Consider how current cross-central government working supports and encourages implementation of the multi-agency arrangements at local and regional level.

2. Leadership

Leadership is often described as the things that top leaders do! The idea of the three statutory partners is to ensure leadership at the highest level of the three organisations (health, Police, and local government) take equal responsibility for the delivery of the new multi-agency arrangements. While the legislation allows the actual statutory partner to delegate their role to a nominated person of senior level, this does not remove from the statutory partner the duties imposed by the Act. I have identified some confusion here and the accountability of the nominated statutory partner to the actual statutory partner is not always evident or acknowledged. I have also seen evidence, for example in Tameside, of how the delegation works effectively and the nominated statutory partners are holding the nominated partners to account-for example by use of an independent scrutineer.

The distinct difference between the strategic leadership role of statutory partners and the practice leadership role of senior staff has been grasped in some areas, it is not evident in others. Leadership has to operate at all levels and is, to one degree or another, required in all posts delivering or arranging services to protect children. The absolutely critical point is that the statutory partner should be accountable for their organisation's strategic contribution to multi-agency arrangements and for ensuring they make decisions which commit their organisation to the decisions, once taken, of the partnership.

I want to look at this by considering issues such as:

- The issue of accountability and legality of the actual v nominated statutory partners;

- The issues statutory partners focus on in their formal meetings;

- The authority and accountability of the statutory partner and their ability to commit their organisation to the delivery of agreed multi-agency arrangements plans (not just finance);

- Decision making by statutory partners;
- Development and training for senior staff;
- Cross-agency workforce development plans;
- National cross-government guidance for statutory partners;
- The role of Lead members and elected politicians.

3. Impact on practice

I have seen some clear evidence of the impact of the new arrangements on practice, for example the evidence of impact where former inadequate Local Safeguarding Children Boards (LSCBs) have transformed into well supported and focused multi-agency arrangements, an example of this is in Lambeth. I have seen where learning from serious events is focused and transmitted quickly through the new arrangements. I want to look at this in more detail and to identify key principles underpinning good practice. This will include working with Kantar Public on their behavioural insights research, the WWCSC in its search for good multi-agency arrangements practice, the evaluation sub-group of the cross-Whitehall safeguarding reform board, considering reports and other documents such as the recent joint inspectorate thematic inspection of inter-familial child sexual abuse.

I have not been asked to specifically consider the model of local learning from serious events or the role and support provided locally by the national Child Safeguarding Practice Review Panel. However, this issue has been raised by local safeguarding partners and learning is a key issue for multi-agency arrangements locally. I have discussed these issues with some of the groups I have met and if helpful, would be willing to look in a bit more detail at the issue.

Issues I will look for include:

- Examples of the difference between current arrangements and things safeguarding partners feel they could/did not do as an LSCB;
- Views of practitioners;
- Development of support for practice leaders;
- Case studies;
- Improved methods/models of learning for serious events;
- Evidence of listening to the view of children/families;

- Information and data sharing;

- The use of cross-agency performance management plans for continuous improvement and use of data.

4. Independence and scrutiny

A number of imaginative approaches have been developed to ensure independent scrutiny of the new arrangements. There is also evidence of more peer review, for example in Hertfordshire and the eastern region, and challenge of the outcomes of the new multi-agency arrangements. There is also some evidence that suggests there is some “old wine in new bottles” taking place, with little change-for example I was told in one area ‘the only thing we have changed is the LSCB has become the LSC Partnership’. Of course, if an area already had high quality multi-agency arrangements in place it may well be the case that little needed to change, however the suggestion that one word being substituted for another is probably hyperbole but, in some cases, may not be!

In discussion with the sector I will look at evidence on:

- Forms and roles of independent scrutiny, particularly the extent of involvement of an external factor;

- Peer led scrutiny;

- Engagement of politicians, police committees and NHS Boards in scrutinising multi-agency arrangements;

- How internal accountability is arranged within each statutory agency for its contribution to the multi-agency arrangements;

- How the views users and children have been incorporated in the process of scrutiny;

- The overall impact of independent scrutiny on multi-agency arrangements.

National support to the development of multi-agency arrangements

I am clear that the settling in of these new multi-agency arrangements requires time and deeper cross-agency working to promote new ways of thinking, planning, assessing, and delivering high quality services. For this to happen, and for it to be successful, I am convinced that more needs to be done by central government departments to support and foment the further development of improvement in multi-agency working at local level.

Information and data sharing

An example of this is with data and information sharing. Despite several cross-government statements and legislation about the need to improve how health, education and local government share data and information, this is still a problem remarked on in reports by inspectorates, learning reviews, the Office for the Children's Commissioner and by individual statutory partners in local areas. It was disappointing that a recent joint letter to statutory partners encouraging a more effective approach to data sharing was signed only by two ministers. This was commented on at local level with people surprised that all relevant ministers were not signatories. Unless all central government departments working on the multi-agency arrangements speak with a core message - the problem of poor data and information sharing will continue to hold back improvement and learning and will not be able to challenge "silo practice" at local level.

Targeted support

The extent of change implied by the new arrangements is quite extensive. We are expecting each area to review and reconsider its multi-agency arrangements and design new approaches in line with new duties and responsibilities. There has been a level of support for the introduction of the new arrangements in each of the statutory partners - for example, the national leads appointed to work with areas on developing their engagement with the new multi-agency arrangements, but these have not been sufficiently extensive in my view.

The support seems very well developed in the Police service, in local government the focus has been on the DCS and in health illness has, despite some sterling effort by individuals, meant changes and gaps in the support. Recruitment to the two vacant posts is underway. It is essential that the strategic nature of this work is a key requirement of candidates. It is not enough to have sector specialist knowledge alone. These two national leads must have experience and understanding of the dynamics of how the entirety of the local health service, or a local authority system operates, how cross agency decisions are taken, how chief officers provide leadership and scrutiny and how stubborn problems can be remedied.

A number of local statutory partners have pointed to what they see as an anomaly in terms of national advice-the existence of the statutory guidance for a DCS and lead member but nothing similar for a statutory partner role, and of course, in local government the statutory partner role is more than the DCS and involves the chief executive and elected politicians. I think there is a clear and unambiguous case for developing statutory guidance for the three statutory safeguarding partners. This is a significant lacuna in our intelligence and knowledge about the way in which the new multi-agency arrangements are being introduced and the objective assessment of the impact they are having on children and families. There is a need for the joint inspectorates to develop a practice improvement focused review on the role of the statutory partners in promoting improvement in practice, so as to promote best practice and aid improvement where necessary.

Inspection of multi-agency arrangements

Inspectorates have not yet been in a position to inspect thematically or otherwise the way in which statutory partners and the new multi-agency arrangements are impacting on the quality of service. The issue is not regularly covered in single inspections of local authority children service, health arrangements for protecting children or inspection of police services. A recent thematic inspection of child abuse in families spoke of the need for closer working relations between the police, local government and health but made no detailed reference to the role of statutory safeguarding partners or independent scrutiny of the new multi-agency safeguarding arrangements. In a similar vein, the latest NHS guidance on training for leadership staff in protecting children makes no specific reference to the statutory partner role.

Essentially, it is not evident how the three statutory partner organisations are held accountable for their contribution to delivering an effective and coherent contribution to the new arrangements. In my view this lacuna is particularly clear in respect of health where no specific agency or regulatory body has a responsibility to judge accountability of providers in this area. In respect of local government and the police Ofsted and HMICFRS do cover some of this but as yet it is not specifically identified. I think this is an important issue to look at further and there may well be a case for the national inspectorates to be asked to introduce arrangements which look at accountability for these services and judge their effectiveness. This would allow central government to be better informed about the effective implementation of the new multi-agency arrangements. Any such change, however, should be undertaken without putting significant additional burdens on providers.

I will consider:

- The need to further define accountability and responsibility of the role of statutory partners, by providing national guidance equivalent to that provided for a DCS and lead member;

- The continuation and expansion of the resource for national lead for each statutory agency;

- Joint inspectorate planning re the new arrangements;

- Cross-Whitehall join up in providing advice and guidance on multi-agency arrangements;

- The role of the Ministry of Housing, Communities and Local Government in respect of advice to chief executives and the statutory partner role.

Support for Statutory Partners-the cross-Whitehall safeguarding implementation reform board

There is a pressing issue that needs to be considered now. The cross-Whitehall group sits in a position of leadership of the implementation of the multi-agency arrangements reform programme. This leadership should be made explicit. Two changes should be considered. First the group needs to have a clear reporting line to the permanent secretary of each government department involved in the reform programme. Second, the group needs to have a small set of clear deliverables which are designed to support and foment the necessary changes to ensure the effective implementation of the new reforms. Working to the cross-Whitehall group, the national leads can then provide information, advice, guidance, and evidence of progress with implementing the reforms within a focused framework of priority objectives.

There is, in my view, a very strong case for the cross-Whitehall safeguarding implementation reform board to build on the current model of national leads for statutory partners by seeking a small pool of funding to establish, for a period of 18-24 months, a nationally coordinated team providing support, advice, guidance and direction to statutory partners. A resource which can offer training and development, troubleshoot local issues, and provide regular and focused advice to central government departments and national agencies.

There is a significant gap in the channels of influence and persuasion available to central government in relation to the statutory partners. There is no central hub of intelligence about who they are, what skills or training needs they have, how they can become a power for promoting change and disseminate national policy, indeed we do not even have a national register/data bank of who the statutory partners are. As a matter of priority, a contact list of local statutory partners should be set up and maintained and be used as a key interface for intelligence and data sharing as well as a conduit for advice and guidance between government departments and local statutory leaders. An empowered group of statutory partners may well have helped significantly in dealing with the impact of coronavirus on children and families nationally. As I say in my first hypothesis the bewildering map of local multi-agency arrangements could well be effectively navigated if the role of local statutory partners was better understood and made more use of. If the multi-agency arrangements are to be successful, this support to bedding in change for improvement will be a great help if it can be put in place quickly. And, perhaps a more dynamic and sharper name for the cross Whitehall group may assist communication with the multi-agency world. When I asked a number of sector leaders about the group it was not known about and its title gave little clue to its role.

Finance

I do not propose to look in detail at issues to do with finance and resourcing. This is because channels already exist for agencies to raise the issue of overall resourcing for the day-to-day services that directly provide the multi-agency operations. The system is

facing very significant additional demands and the level of referrals and the need for services is, in many areas, increasing dramatically. This will need attention. The funding of multi-agency arrangements, in the context of this review, is essentially about the contribution made to ensure the strategic decision-making process is in place to maintain their coordination and leadership role. The funding needed will cover, for example, the actual cost of supporting the arrangements, for resourcing agreed initiatives and priorities, learning from serious incidents or events, and promoting multi-agency operational working. The delivery costs incurred by each partner are subject to their organisation's budgetary arrangements. If the three statutory partners are not able to agree a joint budget for the funding of the arrangements it probably raises a question as to how much priority is being given to ensuring strategic operational decisions are made to effectively deliver services to children and families. Central government could set an example by agreeing that the funding needed to provide central government support from key departments (DfE, Health, Home Office and MHCLG) to the implementation of the new arrangements over the next two years is equally shared between departments.

Annual report

The new arrangements provide for each new multi area arrangement to provide at least a yearly report on their work. The report is to be sent to the What Works for Children Social Care and the National Safeguarding Review Panel. There is no guidance or regulation covering what these two bodies should do with the reports. As it stands there is no clarity as to what either body is planning to do, if anything, on receipt of the reports. This potentially devalues the principal purpose for production of the reports and without a feedback loop, local areas may well set little priority producing it. This is an issue the cross-Whitehall group should consider and provide advice on to local areas. Given the impact of the coronavirus on prioritising critical work with service users, the first report may well be delayed. Information on the first year of operation could be collated via a survey asking a small number of questions about progress on implementation and examples of good practice and any challenges. This survey could then be evaluated and presented to the cross Whitehall group. We are planning a survey as part of phase 2 of the work and this could cover such an approach.

Recommendations

I believe the recommendations could be implemented within the next three months. If they are, they will give a very sharp boost to the implementation of the new multi-agency arrangements.

1. A national contact list/register of local statutory partners should be drawn up and maintained as a priority task.

2. The two vacant national lead posts should be filled as a matter of urgency. Consideration should be given to appointing a small team of national leads with one coordinator/leader to operate for two years.

3. Legal advice should be shared across government departments on the accountability of statutory partners and the issue of nominating individuals to act in their stead. It is not clear that an agreed, common, understanding exists cross government on this very important role.

4. The role (and name) of the cross Whitehall safeguarding group should be strengthened and formalised. In terms of accountability its reporting line should be to the permanent secretaries of government departments and a clear set of objectives set for it work and ensuring a clear focus on supporting local delivery groups and shaping the work of the national lead advisers.

5. The timescale for local areas to provide a yearly plan on the effectiveness of their multi-agency arrangements should be considered in light of the coronavirus and arrangements for an extension put in place if requested by an area. Advice on what the cross-Whitehall group expects the National Safeguarding Review Panel and the WWCSC to do on receipt of the local multi-agency arrangements annual reports.

6. Discussion should be held with the relevant inspectorates to consider the role inspection can play in assessing leadership in the new multi area arrangements in particular the role of the Statutory Partners and independent scrutiny and the impact they are having on the delivery of effective multi-agency arrangements to protect children.

Conclusion

I am very positive about what I have seen and heard thus far about the development of multi-agency arrangements. There are encouraging signs of change and improvement and some indication of areas that need attention to focus hearts and minds at local level. I think it is urgent for more work to be done now, cross-Whitehall, to sharpen the national drive and support needed to ensure successful implementation of the new legislation at local level.

I will restart physical meetings with the multi-agency arrangements sector as part of phase 2 in September. Prior to that I will continue to hold discussion with colleagues cross the multi-agency arrangements sector and maintain liaison with the remaining national leads and colleagues of the cross-Whitehall group.

I would be grateful for observations on the suggestion I have made regarding a new national lead arrangement to support and develop statutory partners.

I have identified four blocks to look in depth at aspects of multi-agency arrangements, are these sufficient and do they cover key issues for the cross Whitehall group?

I propose to produce a final draft report by the end of December 2020. Is this in line with your thinking and planning?

Sir Alan Wood CBE

07 07 20

Appendix 4: Observations made by safeguarding partners on implementation of the new arrangements

4.i Differences when compared with the LSCB

Area 1

- *The rationale for merging the safeguarding partnerships was to strengthen focus on key themes that were of relevance to safeguarding both adults and children e.g. domestic abuse, neglect, exploitation. The merger has resulted in greater understanding of key themes and their implications for both adult and children's safeguarding.*
- *Strengthening a joined-up approach to domestic abuse, a review of MARAC arrangements and improved systems and processes with regard to high-risk victims and their families was undertaken following a partnership wide review of MARAC. (The partnership is working on measuring outcomes when these arrangements have embedded).*
- *The level of partnership cooperation and collaboration, and the role of the safeguarding partnership in coordinating the consultation and development work, marked a significant step forward in the co-production of the new front door model.*
- *The development of the hubs was an excellent example of enhanced partnership working, with both partners from health and the police being involved in design and delivery, including the shared use of premises and local facilities.*

Area 2

- *The key difference with our new partnership is merger of three previous LSCB areas, who each had their own Board and local sub-groups. There was a history of working across boundary for some statutory requirements with two shared subgroups. However, the three Boards ran completely separately from each other, despite having the same LSCB Chair.*
- *Over the past year of implementation, there has been a greater focus on ensuring that the subgroups, particularly the locality based Independent Scrutiny and Impact Groups (ISIG) have appropriate representation, focus, terms of reference and an understanding of the skills and requirements of the group members.*
- *Our new structure has strengthened relationships between the three areas, which has directly resulted in more proactive and open discussions. The Statutory Safeguarding Partners have acknowledged that the partnership feels less defensive than it used to when challenged by an Independent LSCB Chair. Partners feel responsible, therefore have a more pro-active approach to making it a success. This is a significant cultural change, especially across three Local Authority areas.*

Area 3

Since the merger in September 2019 the following positive differences are evident:

- *Greater cohesion across a wider footprint, with subgroups on Quality Assurance and Education working more closely together, building on work of the already joint*

subgroups on Policies and Procedures and Learning and Organisational Development;

- *The single Partnership website is bringing together sources of information from practitioners and members of the public;*
- *Challenge and assurance are becoming stronger, as there is greater transparency about local arrangements;*
- *There is more effective use of time by major partners – Health and Police – who are able to devote more time to direct subgroup work than previously;*
- *The professional experience and expertise of the multi-agency training pool has been strengthened by the collaborative approach across the whole partnership area;*
- *The opportunity is now open for us to broaden the collective approach by forming a group comprising Chairs of Children and Adult Safeguarding, Chairs of Health and Wellbeing Boards, Community Safety Partnerships and Corporate Parenting Boards, as well as senior Public Health representatives.*

Area 4

- *The new LSCB is a more focussed group with a reduced membership.*
- *There is a lot less bureaucracy & paperwork. Agenda items are focused on the core business of safeguarding.*
- *There is a more open and collaborative approach to the way the Board operates. It has supported a greater understanding of the role each of the partner organisations play.*
- *Stripping back of a range of sub-groups which the partnership felt were ineffective and didn't add value and /or were duplication.*
- *More decisions are being made and are more fluid and timelier, including reporting and awareness of real-time issues and actions.*
- *The Board is supported by a multi-agency Partnership. The Partnership is seeking assurance from the Board for the direction of travel and decisions required.*

Area 5

- *Previously, LSCB meetings felt too `dry', with a focus on producing and reading reports, proving difficult to provide an evidence base to understand how we were improving outcomes for our communities.*
- *There was a lack of connection between the attendees of the LSCB and the operational frontline staff within each organisation. It was difficult to understand and disseminate key messages throughout the partnership, without diluting the content or finding it hard to measure the effectiveness of performance. There was a larger, more disparate, group of people attending LSCB's, whose focus and ability to make decisions on behalf of their organisations was sometimes unclear. It could be difficult to see any correlation between the meeting structure and positive changes to our most vulnerable.*
- *In contrast, Executive meetings now meet quarterly, with a shorter agenda and much greater clarity around expectations. Attendees are the core partners only, with meetings providing an opportunity for discussion of key facts and issues, dynamic decision making and robust challenge where appropriate. An example of this would be the work we have recently started with Research in Practice –*

Tackling Child Exploitation. We know that there is an issue of exploitation within one area but were lacking the support to evidence this. A decision was made within the partnership to apply for funding, which was successful, and work is progressing (COVID-19 excepting); key findings will be discussed at the Executive meetings regularly with the ability to support the work via our own organisations. Previously, this process would have taken a great deal of time longer to get agreement, with the findings being shared at a far later date. The ability to make quick time decisions now is far greater, in order to change practice for the positive.

4.ii Signs of impact on practice

Lewisham

- Yes – local safeguarding children partnership (LSCP) multi-agency arrangements have led to identification of Strategic Safeguarding Priorities, which have led to a wide range of multi-agency activity focusing on the efficacy of systems and multi-agency approaches in providing effective safeguarding practice and positive outcomes for children, young people and families. Evidence has been gathered in a wider range of areas, such as multi-agency data, voices of children and young people, ongoing multi-agency auditing and identification of multi-agency workforce development needs that will support enhanced practice.

Cheshire West and Chester

- The partnership welcomes the new structure around serious incident notifications and rapid review panels. Whilst we have always operated within the 15-day timescale for completion of reports to the Panel, the prompt feedback and increased flexibilities in relation to child practice reviews is enabling us to share more widely the immediate learning.

Shropshire

- Yes. Improved communication between adult and children services and cross-working in areas for example domestic abuse, exploitation and transitional safeguarding. Incorporating the Community Safety Partnership has bought a wider focus on safeguarding looking at key strategies to ensure wider prevention of safeguarding and crime. Complex strategy meetings that now take place involving numerous partners and the operational activity that is then driven from this is a good example of the closer operational working relationships across the partnership.

Haringey

- As a result of Covid-19 there has been a major focus on maintaining an effective multi-agency safeguarding system during the pandemic.
- We, as Statutory Partners, are gaining a deeper insight into our local practice than ever before, leading to a better understanding about the issues concerning front line staff on the ground. We also have increased collaboration including joint campaigns, information sharing and support for each other's roles in tackling the many issues the pandemic presents to the Haringey Safeguarding Children Partnership.

Lambeth

- There is some evidence that this is the case. For example, the Multi-agency Service Provision meetings which were set up by the partnership in response to

COVID facilitated discussion and shared problem-solving between leaders within partner agencies that directly and quickly influenced operation and service delivery.

Oldham

- The services already had a great focus on multi agency practice so this has further re-affirmed this operational practice. There is greater focus at an operational level but possibly that this comes in relations to themes (Domestic abuse, CSE etc). This has been demonstrated from peer reviews, the development of staff and the uplift of our MASH teams. The new learning hub approach will further support the focus on the effectiveness of multi-agency practice.

North Tyneside

- Our published plan outlined our intent to listen to frontline staff, and bring our arrangements closer to the frontline, so that we are learning from those who know best what the challenges are and what works. Although we are in the early stages, the workstreams very much include a focus on practice at an operational level. This includes seeking the views of practitioners in relation to their views of what is working well as part of specific areas of work and what support they feel would help in developing their practice. These views can be triangulated with the views of children, young people and their families, the outcome of audit work and performance data to provide assurance of the effectiveness of multi-agency practice.

Wiltshire

- Even as an early adopter, our Partnership is in early stages with limited evidence in change in frontline practice at this early stage although commitment to work in new ways at operational and strategic level is evident. It is evident that even with genuine commitments to practice differently and more effectively from what was an ok LSCB, change in behaviour and outcomes is taking longer to deliver than first envisaged. We reviewed our arrangements in January 2020 and reset some of our commitments – especially one to be more impactful on front line practice. Covid has somewhat slowed that ambition but it remains our key focus.

Rotherham

- The impact of the current pandemic has put on hold the specific gathering of evidence. However what has happened is that children per se have had considerable focus on multi-agency work.
- Relationships have improved as understanding of roles across all children services has increased. In addition during this period Rotherham has had safeguarding inspections from CQC and Ofsted recently completed a Focused Assurance Visit to Children's Services. CQC most certainly focused on multi-agency working. The new arrangement has meant that at an early stage the LA is

working operationally within Urgent and Emergency Care Centre to support front line staff's improvement journey. There has also been considerable multi-agency working with a child focus (Vulnerable Children Multi-Agency Group) where strategic and operational leaders are able to share information and modify processes quickly to meet the needs of children and families.

4.iii The impact of structural change

Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership covers eight CCGs, three local authorities and one police constabulary. This partnership has an experienced independent scrutineer. The partnership has developed a strong structure and assurance process. A key achievement is a comprehensive guide for staff - 'Working Well With Children and Families in Lancashire.' This guide along with the documents that support it:

- cover the values underpinning the work of all those (police, health and children social care) who work with children in Lancashire;
- establish and promote the principles underpinning the partnerships Assurance Framework;
- Confirmation of the effective performance management within partner organisations; and
- identified the three priorities for cross agency focus (Neglect, Exploitation and Domestic Abuse).

The work of the partnership is supported by the Lancashire and South Cumbria NHS Integrated Care System model which is followed by the eight CCGs and ensure consistency of high quality safeguarding practice by NHS staff within the wider safeguarding partnership.

The Greater Manchester Safeguarding Alliance (GMSA) is a partnership of the 10 local safeguarding partnerships in the Greater Manchester Combined Authority area. A new way of working is being tested in 2021. The purpose of the GMSA is to achieve excellent safeguarding practice and outcomes for children across the 10 partnerships by:

- agreeing a shared understanding of excellent safeguarding practice;
- creating a shared culture of collaboration, curiosity and challenge;
- utilising a strengths and evidence approach to scrutiny; and
- suggesting improvement to the quality and consistency of practice.

The Alliance is an approach and a way of working which involves a number of events. There is a Safeguarding Alliance Leadership Group comprising Chief Executives and CCG Chief Officers from each of the 10 local partnerships and senior representation from Greater Manchester Police. A series of Community of Practice events involving representatives from the 10 partnerships are planned. Events will be facilitated by an Independent Scrutineer who will work with the partnerships to develop agreed standards, analyse available evidence and identify where a Greater Manchester approach will add

value to local plans for improvement. Greater Manchester plans will be agreed through the Leadership Group.

The GMSA has been carefully crafted and informed by learning from other Greater Manchester work. For example the Community of Practice approach developed through the DfE funded scale and spread innovation programme, the GM Complex Safeguarding Peer Review process and the development of GM Care Leavers standards. Emerging evidence from elsewhere has also been considered. For example, some GM partnerships have adapted the Bexley Learning Hub model and this model also informed the GMSA.

This is a collaborative approach with an emphasis on improvement through reflection and analysis and exploring where action using the “power of 10” can add value.

The new **Derby and Derbyshire Safeguarding Children Partnership** covers two local authorities, two CCGs and the constabulary for the area. The partnership is led by a Chief Offices Group - including the two lead members - which directs and scrutinises the work of an executive board charged with assuring high quality coordinated services to protect and safeguard children, through its subgroups, which are voluntarily merging across the two authority areas, where appropriate. Both the COG and executive board have the same independent chair. The independent chair has identified a number of outcomes, which indicate the partnership has improved the leadership and scrutiny of safeguarding arrangements, developed the coordination and impact of work across the safeguarding partnership and minimised duplication of effort. This includes focused involvement of young people in safeguarding, more effective dissemination and transparency of learning from serious incidents, robust inter agency challenge and strengthening of the professional expertise and experience, through a cross-partnership collaborative approach. The Partnership team is clear that it supports the *Safeguarding Partnership*, not the individual agencies, and receives equal funding from *all* the statutory partners. This approach has shown its worth during the pandemic, with effective cross-agency working to identify and protect vulnerable children.

4.iv Models of scrutiny and the use of independent challenge

Safeguarding Partnership in the South East - We initially recruited two external independent scrutineers but found that this resource did not prove to be as advantageous as the partnership anticipated. On reflection, we have acknowledged that these were new roles, and our expectations were maybe not as clear as we had originally thought. We therefore have agreed that the Designated Professional for Safeguarding will assume the role of independence within the partnership. The role of the Designated Professional for Safeguarding is employed by, but independent from, the Clinical Commissioning Group, but to add clarity and further independence, a matrix management system will be set up to allow the postholder to report to a senior manager outside of the statutory agencies. There will be times during the year where the partnership will need to look for a further level of external scrutiny to demonstrate complete impartiality on specific pieces of work, e.g. large multi-agency audits, peer review. These will be decided and agreed as they arise, and the partnership will seek the most appropriate independent level of input for the specific task. This ensures that the local area maintains the integrity of its collective and resourceful approach to scrutiny and impact, whilst assuring a 'fresh eyes' approach to our work when required.

Safeguarding Partnership in the North West - an independent chair is charged with providing the safeguarding partners and the Greater Manchester Standards Board "…with assurance that the new arrangements are working effectively for children and families as well as practitioners …and will consider how well safeguarding partners are providing strong leadership."

Derby/Derbyshire Safeguarding Children Partnership - an independent chair provides scrutiny and challenge "to the Executive Board and the Chief Officer Group and has been vested with the authority to identify and ensure that agencies respond positively and work to address areas of practice requiring development."

Safeguarding Partnership in the South West - an independent Scrutiny Coordinator provides support and facilitation of assurance activity across the partnership. This is a wide role that includes facilitation and developing existing scrutiny activity, provides training for scrutineers, identifies areas of practice for review, and ensures all activity includes the voice of children, young people and their families.

The three safeguarding partners of the **Southend Safeguarding Partnership commissioned** an independent reviewer to undertake an evaluation of the new arrangements and the work of the safeguarding partnership - these cover both children and adults. The report stated, *"The review found evidence of significant progress in developing the partnership, its effectiveness and relationships over the past two years."* In a specific comment on the leadership of safeguarding and work across other multi agency boards the report stated that, "The strategic leadership group appears to be effective, and the recent addition of the Chair of the violence and vulnerability group is a positive step in strengthening cross-strategic partnership co-ordination and planning.

Liaison with other boards, such as the Health and Wellbeing Board, about common priorities and themes, looking at forward planning of joint projects and learning events increases knowledge sharing and reduce duplication between boards."

Camden Safeguarding Children Board has an independent scrutineer who is joint chair of the partnership and works closely with the three safeguarding partners. Key tasks of the scrutineer are to:

- Seek assurance in judging the effectiveness of the new multi-agency arrangements to safeguard children in.
- Assess whether the three safeguarding partners are fulfilling their statutory obligations.
- Act as critical friend, in order to scrutinise performance management, audit and ensure quality assurance mechanisms are effective.
- Arbitrate when there is disagreement between the three statutory safeguarding partners.

The independent scrutineer tests the effectiveness of practice in Camden by asking and considering,

- Do the multi-agency safeguarding arrangements have a clear line of sight on single agency and multi-agency safeguarding practice?
- Do the arrangements encourage reflection and learning from practice?
- What evidence is there that the arrangements have a positive impact on the lives of children and front-line practice?

North Yorkshire

Within North Yorkshire, we have commissioned an independent scrutineer who also chairs our NYSCP Executive and Strategic Partnership Group in addition to the following tasks:

- Scrutinise the partnership arrangements and assess how well the safeguarding partnership is fulfilling its duty to safeguard children and young people in North Yorkshire.
- Publish an Annual Scrutiny Report on how well the partnership is operating and provide constructive challenge for continued improvement.
- Scrutinise the multi-agency audit activity undertaken within the partnership.
- Ensure the voice of the child is represented and heard throughout the NYSCP work and arrangements.

Nottingham

We have appointed an Independent scrutineer to work with the Strategic Leaders, and an associate scrutineer to assist with more operational analysis and review. This had been for a fixed period and has been beneficial to developing the scrutineer function. Going forward it is likely that this post will amalgamate into a single independent scrutineer.

Anonymous

The SCP retained an Independent Chair, whom was the chair of the former LSCB. The Independent Chair holds the chair role for the Board, Steering and Planning meetings. The Independent Chair acts as a constructive critical friend, promotes reflection to drive continuous improvement and fulfils the role of the Independent Scrutineer. In addition, two Lay Members play a critical role in the partnership. The Lay Members act as further independent insight, on behalf of the public, into the work of agencies and of the partnership. As well as acting as critical friends at Board meetings, providing additional challenge and scrutiny, the Lay Members have undertaken a number of key tasks including taking a lead role in the development of a Children's Pledge through a series of art workshops, participation in multi-agency workshops examining how agencies can respond to the problem of Modern Slavery and county lines activity, provided an audit role for section 11 and become a standing member of the SCP Case Review Group.

Bristol

The BCSSP has worked regionally on an independent process of assurance working on a model supporting peer reviewers, plans were started but have not progressed because of Covid challenges and access to agencies. A Scrutiny and Assurance framework has been produced which maps the Partnership work against the Six Steps of Independent Scrutiny (adapted from J. Pearce model).

Barnet

We have commissioned an independent organisation to undertake an annual visit, speaking to a range of partners and hearing their reflections. They will give a presentation with their findings and write a report which shape our priorities. We also have an independent chair of the Learning and Thematic Review Group, which considers serious safeguarding cases.

Oxfordshire

The local independent scrutiny is fulfilled in a range of ways:

- Through the appointment of an Independent Chair to provide external scrutiny and challenge.
- By establishing a reciprocal arrangement with Hampshire to scrutinise each other's reviewing arrangements.
- Through the two lay members who are independent members of the OSCB.
- Through Oxfordshire County Council's Performance Scrutiny Committee which receives the OSCB Annual Report, the Performance, Audit and Quality Assurance

Annual Report and the CSPR Annual Report. The Committee also scrutinises child safeguarding practice reviews at the point of publication.
- Alongside Thames Valley Police's Service Improvement Programme, which undertakes thematic and geographic reviews, a Recommendations Panel is being established, which will oversee the implementation of recommendations from child safeguarding practice reviews and other similar reviews.
- Through the CCG's Quality Committee, Executive and Governing Body meetings where safeguarding board annual reports, child death review annual report and briefings on issues and emerging themes are presented for scrutiny and discussion. Oxfordshire CCG also provides a quarterly assurance report for NHS England as part of the external scrutiny and assurance framework for the NHS. MASA representation ensures feedback to health trusts. The health partners safeguarding group receives safeguarding assurance reports.

City & Hackney

The independent scrutiny of our local arrangements engages a number of mechanisms. The Safeguarding partners commission external consultants to undertake independent evaluation of practice and they have appointed an Independent Child Safeguarding Commissioner (ICSC) previously the chair of the City and Hackney Safeguarding Children Board.

- The ICSC being given authority to coordinate the independent scrutiny of the local child safeguarding arrangements. The ICSC is fundamentally independent to local safeguarding partners and relevant agencies. The ICSC has significant experience of operating at a senior level in the strategic coordination of multi-agency services to safeguard and promote the welfare of children.
- The ICSC provides independent leadership (through engagement, commentary and lobbying) in respect of local matters relevant to the safeguarding of children and young people.
- The ICSC holds both safeguarding partners and relevant agencies to account for their effectiveness in safeguarding children and young people. This will ensure ongoing alignment with the existing statutory arrangements for safeguarding adult boards.
- The ICSC chairs the CHSCP Strategic Leadership Team to ensure fundamental independence is built into the oversight of statutory safeguarding partners. As part of these arrangements, the ICSC holds safeguarding partners to account via oversight of the CHSCP's risk register and operational risk register.
- The ICSC also chairs the CHSCP Executive to both facilitate meetings and hold relevant agencies to account in the context of their effectiveness and their performance against defined priorities set by safeguarding partners.
- The ICSC chairs the Case Review Group to ensure fundamentally independent decision making in respect of the commissioning and progress of reviews. Safeguarding partners delegate this decision-making function to the ICSC and ratify any decisions made.
- A Senior Professional Advisor (SPA) appointed by safeguarding partners and working on behalf of the ICSC to lead the CHSCP support team.
- The SPA chairing the Quality Assurance Group and being responsible for the delivery of the CHSCP's Learning and Improvement Framework (including a

recently launched online self-assessment tool to oversee the meeting of minimum standards by safeguarding partners and relevant agencies).

- The ICSC providing an objective and independent assessment of the effectiveness of the safeguarding arrangements as part of an annual reporting cycle, in addition to independently evaluating the annual report of safeguarding partners.
- The ICSC being engaged in resolving operational disputes through the CHSCP's escalation process.

4.v Local learning reviews

- Guidance from the panel has helped inform improvements to rapid review reports.

- Learning from serious incidents is captured through reporting on case reviews to the Quality Assurance subgroup, near misses and national reviews are considered for thematic learning. Action plans and audits are part of the cycle of learning and improvement. The Learning and Policy Group has oversight of training needs and commissioning. During COVID the group agreed a model of virtual learning.

- For the published review SCR D this took the form of a toolkit with briefing notes on best practice, case learning and recommendations, supported by a trainer's presentation and guidance on delivering virtual training. Partners were asked to deliver training to their own agencies, and report on training success and outcomes. Learning is also reflected in basic and advanced safeguarding training delivered by the partnership (virtually).

- The partnership has undertaken reviews of models dependent upon the circumstances of the situation in order that this can cover a variety of circumstances and potential learning opportunities.

- We carry out learning reviews regularly and use a model based on the Welsh model.

- For every serious incident notification by the local authority, a Rapid Review is undertaken. Learning Briefings are developed following every Rapid Review (regardless of whether develops into a CSPR or not). Every briefing is disseminated across the partnership by member of the Local Learning Review Subgroup (LLS). We are creating a process to collate individual examples evidencing how day-to-day practice has been influenced/changed as a result of this learning. A Learning Briefing is developed following all Rapid Reviews (whether they then become CSPRs or not). This learning is disseminated to professionals in the partnership by the members of the LLS.
- The learning from serious incidents is incorporated into the performance management framework which combines learning and improvement from CSPRs, rapid reviews, audit programs which in turn inform the learning and workforce development program. A new system for undertaking Rapid Reviews was quickly devised and implemented and this has proved to be very effective. The work is coordinated by the NSCP Development Manager, requests for information are sent out to organisations to gather information about their involvement with the family. The Designated Nurse collates information on behalf of all health providers, and this has proved invaluable. The safeguarding partners and any relevant agencies with significant involvement meet as a panel to consider the information. A format for the Rapid Review Report has been developed and refined and the NSCP Development Manager is responsible for drafting the report following the panel. The report is signed off by named decision makers for each of the safeguarding partners before submission to the National CSPR Panel.

- We have commissioned LCSPRs. We aim to ensure that the terms of reference and methodology are appropriate to the individual case under review. I think this is an area where further guidance to Independent Authors would be of benefit in ensuring that they provide focussed reports with recommendations that are clear and capable of being implemented.

- We have adopted a solution focused approach to address thematic issues that have been identified consistently in reviews. This is in its early stages and we are currently testing it out on the theme of strengthening multi-agency information sharing.

- The statutory guidance has been used to inform a North and South of Tyne Learning and Improvement Framework which contains, for example, flow charts on rapid reviews and the establishment of an agreed procurement process to commission Independent Child Safeguarding Practice Reviews.

CSPRP feedback comments

- We have found panel feedback supportive with our concerns and would welcome further clarity on thresholds for national reviews as we perceive we may be overburdening them with cases which are of lower national importance.

- Guidance from the panel has helped inform improvements to rapid review reports.

- The National Panel has responded to our Rapid Review Reports. That feedback, along with attending conferences around Rapid Reviews and CSPRs (run by The National Panel) has allowed us to create an even more robust process that clearly sets out areas of concern and learning, informing Terms of Reference for a review and also ensuring learning is available during the review and robustly addressed.

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