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ADCS response to Working Together to Safeguard Children: changes to statutory guidance

1. Introduction

The Association of Directors of Children's Services Ltd. (ADCS) is the national leadership organisation in England for directors of children's services (DCSs) under the provisions of the Children Act (2004). The DCS acts as a single point of leadership and accountability for services for children and young people in a local area, including children's social care and education. ADCS welcomes the opportunity to comment on the latest iteration of the *Working Together to Safeguard Children* guidance.

In March 2016 the *Wood Review* concluded that the current system of local multi-agency safeguarding arrangements required reform and proposed a new model of collective accountability across local authorities (LAs), the police and health services (via clinical commissioning groups or CCGs). It also recommended a new system of local and national learning reviews to replace the existing serious case reviews (SCRs) and that the Department for Health should take the policy lead for child death reviews. Legislative provisions to support these recommendations were included in the *Children and Social Work Act (2017)*, consequently Working Together requires amendment.

2. Multiagency safeguarding arrangements

The Act replaces local safeguarding children boards (LSCBs) with new local arrangements to be led by three safeguarding partners. In recent years the health economy has grown increasingly complex at a local, regional and national level which potentially adds an extra layer of complexity in the development of new arrangements. The guidance would benefit from recognising this reality; greater clarity is similarly needed around LAs discharging some or all of their services and duties via a trust or alternative delivery model.

Each agency must identify a senior officer to lead on safeguarding matters, for LAs and the police this is relatively straightforward, however, CCGs are not necessarily coterminous with LA or police boundaries and in some larger, rural counties multiple CCGs are involved. How senior officers can take responsibility for and/or influence practice outside of their own locality if the new arrangements operate on a larger footprint is not covered here nor are any legal practicalities. Local partners will also be able to determine which 'relevant agencies' should be involved in the arrangements which could lead to further variability across the country.

The relevant agencies listed in the draft statutory instruments included in Annex A of the consultation document does not explicitly reference free schools, it would be helpful if this could be corrected. The Education and Skills Funding Agency is referenced but Regional Schools Commissioners (RSCs) are not. Their responsibilities include oversight of performance and governance in academies and free schools, it would be helpful if RSCs were listed as they too have a role in safeguarding children and young people.

ADCS members believe it is a missed opportunity not to name schools as an equal partner alongside LAs, the police and health given education settings typically have the greatest levels of contact with children and young people as a universal service. These reforms have the potential to refocus partnerships on the provision of early help and preventing issues from escalating, however, funding to do so is currently insufficient. Schools must be at the forefront of these efforts - by the time concerns come to the attention of the local authority (via a referral to children's social care), police (via a

callout) or health partners (via presentation at the GP or A&E) significant harm may have already occurred. If schools are not named as core partners then it is right that safeguarding expectations are clearly articulated in statutory guidance, including the requirement to be proactively engaged with their local safeguarding partnership.

In confirming the joint and equal responsibilities of the LA, health and the police in the new arrangements, it is hoped that more effective working will emerge. This, however, cannot be guaranteed so it is disappointing that the relative looseness of the "duty to cooperate" has not been addressed here. Agreement on the resourcing of these new arrangements must be reached locally yet funding has long been a sticking point with LAs typically meeting a larger proportion of LSCB's operational costs. The guidance states: "The three safeguarding partners may make payments towards…" ADCS believes this section should be strengthened, safeguarding is everybody's business therefore a fair and equitable division of responsibility and costs is required (although it is recognised that this will be a significant ask against a backdrop of year-on-year funding reductions across all public services, including local authorities).

The absence thus far of a nationally set, or locally agreed, outcomes framework will be a challenge in monitoring the impact of these reforms, the progress of each area or relative performance. Further information is also required about governance in light of greater flexibility to develop alternative arrangements involving different partners and operating over new or different footprints. In terms of accountability and inspection, if the three core partners – LAs, the police and CCGs – have primacy in determining local arrangements, will they all be held to account equally? Will these new arrangements be inspected jointly and what would the response to failure look like?

Whilst LSCBs have an independent chair, the updated Working Together draft states: "It will be a local decision how best to implement a robust system of independent scrutiny. Safeguarding partners should involve a person or persons who are independent," which again introduces further variability in local arrangements. There is little detail in the guidance about the expectations with regards to scrutiny and governance – is an impartial person required to attend meetings, for example, or might they just receive and/or review the partnership's annual report?

These arrangements, like LSCBs before them, cannot ensure the effectiveness of safeguarding arrangements across the local partnership because they do not have authority over the key agencies in relation to their child protection functions. ADCS has previously raised concerns about longstanding ESFA guidance suggesting lower level safeguarding concerns arising in academies and free schools should be referred to the relevant LSCB 'for investigation,' despite boards having no such powers or remit. The EFSA guidance must therefore be reviewed accordingly to accurately reflect these new arrangements.

ADCS is disappointed that the draft guidance does little to clarify the tensions that currently exist in determining the relationship between the local safeguarding arrangements (the LSCB as was) and a multitude of other local partnerships, including adult safeguarding boards, community safety partnerships, health and wellbeing boards (HWBs) and multiagency risk assessment conferences etc.

3. Local child safeguarding practice reviews

The guidance outlines a new system of national and local child safeguarding practice reviews (which will replace existing SCRs) and the establishment of a new National Child Safeguarding Practice Panel. Local partnerships will be responsible for: "identifying serious child safeguarding cases which raise issues of importance," and the commissioning of reviews. ADCS is concerned that "serious harm" could be confused with "significant harm" which could result in thousands of additional notifications for children subject to child protection plans or care proceedings being made. This wording should be clarified in the final version of the guidance for the avoidance of doubt.

The guidance states a concise investigation should be undertaken within five working days of known or suspected abuse or neglect of a local child, where death or serious harm has occurred. It may not always be possible to gather this information in five working days e.g. in the school holidays and/or

additional complexities may emerge as this process progresses. Once this exercise is complete any immediate learning points should be shared locally and the new national panel notified if a local child safeguarding practice review will be undertaken. The national panel will then consider this information and advise the local partnership whether they wish to challenge a decision not to initiate a local review or whether they intend to undertake a national child safeguarding practice review. The guidance states the national panel must observe the same timeframe i.e. five working days, but it does not specify how notifications will be dealt with, will the panel be convened each time a notification is received? Is this feasible given in excess of 160 serious case reviews are typically undertaken each year? The draft guidance also does not sufficiently address the duplication in efforts between the initiation of local and national learning reviews. If there is any delay at a national level, there is a risk a local review may well have started given the ambitious timeframe set out here - two to six months. This is both a poor use of public resources and may feel insensitive or confusing to grieving families.

The existence of other reviews in relation to the same child(ren) and family e.g. a domestic homicide review or a safeguarding adults review is briefly touched on. Whilst the draft states all those involved should work collaboratively, it would be helpful if more detail was provided on the interaction between these related activities and how learning from these different processes can usefully be brought together to improve practice.

It is disappointing that meeting the costs of this exercise is not addressed and ADCS suggests the guidance should explicitly state that local partners should manage these costs in a proportionate and equitable way. A new burdens assessment may also be required to assist with the fundamental redesign of local partnerships, to assist with the broader remit for undertaking learning reviews and servicing engagement with the new national panel.

Local learning reviews should be outcome driven to maximise learning opportunities and whilst the proposed criteria supports good practice reviews, ADCS believes there is a key role here for the national panel and/or the What Works Centre in Children's Social Care in the promotion of effective practice across the sector.

SCRs have been making recommendations of national government for some time, however, it is unclear how these proposals are systematically considered or acted upon in terms of influencing the development or review of national policies and guidance. It would be helpful if the national panel's role in responding to learning escalated up from local partnerships was covered here and how it will retain its independence if it is to be both funded and hosted by a government department.

4. National reviews

The 2017 Act provides for the establishment of a national Child Safeguarding Practice Review Panel which will be responsible for the commissioning of national learning reviews and supervising of reviewers. It is proposed the national panel will receive notification of all child safeguarding cases where a child has died or been seriously harmed, as well as copies of completed local learning reviews and annual reports published by local partnerships. The draft guidance suggests the panel will utilise these resources to identify any improvements either locally or nationally to safeguard and promote the welfare of children but there is little information about how this will be achieved nor the required expertise and experience of panel members to fulfil this role. Will the triennial reviews of SCRs continue under these new arrangements, for example, or will the What Works Centre play a central role in the timely dissemination of learning? This does not yet appear to be part of the new centre's emerging workplan.

ADCS believes national reviews should be intelligence driven (utilising the rich resources and learning we already have from existing reviews supplemented with research) to draw out common themes and lessons. ADCS suggests that the panel should consider cases which involve complex safeguarding matters, multiple children and young people and/or multiple perpetrators, as well as cases which may require changes to national legislation or guidance. ADCS believes national reports should be

conducted on a thematic basis so it is unlikely that this process will be completed within six months, particularly if criminal investigations or a coroner's inquest is also running in parallel.

It is difficult to understand how the expectations and wishes of the children and their families will be taken into account in this exercise, how national reviews will improve local practice nor how nationally appointed reviewers will capture local meaning and engage local organisations and practitioners in that learning. It is not clear in the draft guidance how a nationally commissioned and nationally supervised learning review will operate in practice nor how the costs of this activity will be met. At the moment it appears that plans for national reviews will be 'done to' the local area rather than a collaborative effort. The guidance implies the national panel will direct local partners to undertake certain actions e.g. a local learning review, but it is unclear from the information provided whether it has the power to do so. ADCS recognises that it may be more appropriate for further detail about the workings of the national panel and national learning reviews to be provided elsewhere and then linked to in the final version of Working Together, however, the information provided here is all that has been shared with safeguarding partners to date about how the new arrangements will work in practice.

ADCS believes DfE should clarify the framework within which nationally appointed reviewers will operate. Over-prescription is unhelpful in responding to complex and evolving scenarios but it is vital that the individuals undertaking national reviews are confident in their remit and fully conversant with systems and structures. It is disappointing that the Department has decided not to hold a list of accredited reviewers. ADCS believes this decision should be either reconsidered or the rational for reaching this position shared more widely. The SCR process can be very challenging for reviewers in that it requires a lot of skill to manage such a dynamic process. The quality of the reviewer is key to a successful review and ensuring this could be a key function of the national panel.

The intense media attention surrounding the publication of SCRs is dis-proportionate to the messaging that surrounds other types of reviews that are undertaken in equally tragic circumstances, such as domestic homicide reviews undertaken by community safety partnerships. ADCS is concerned that there is a risk that national reviews will heighten this attention further. Achieving a better balance in the public debate and designing a system which facilitates timely learning from good practice as well as learning from when things go wrong is key.

5. Child death reviews

Whilst the majority of child deaths do occur in medical settings, ADCS is concerned that the transfer of this process to the Department for Health risks the over medicalisation of this process which could limit opportunities for genuine learning. As previously expressed the multitude of health footprints do not reflect LA or police boundaries and this potentially adds a further layer of complexity which is not addressed here.

ADCS believes the draft guidance is overly focussed on health and does not make it clear how this process will feed data into Public Health England's public campaign planning process, the national panel's work nor the What Works Centre in Children's Social Care. There is very little, if any, value in epidemiological data that is confined to the child population of a single locality, whether a local authority, police or CCG area. Populations of up to one million people are required to elicit useful trends in data which strengthens the argument for at least some aspects of child death review arrangements to operate on a regional or a national level. Data on sudden deaths in infants are collated at a national level by the Office of National Statistics and aggregate findings are analysed by region, gender and so forth, replicating this model could offer a helpful tool in preventing serious harm or death via collaborative efforts across all public services and should be applied to all child deaths.

ADCS members believe reducing child mortality requires a public health approach where possible to identify significant recurrent contributory factors and a public health response to preventing child deaths. ADCS has previously suggested local HWBs should examine the findings of child death reviews in order to inform its local joint strategic needs assessment (JSNA), we maintain this view.

6. Contextual safeguarding

The inclusion of contextual safeguarding within this guidance is a step forward in recognising that harm, particularly in relation to adolescents, can happen outside of the family home and that practitioners require systems, resources and interventions that reflect these wider environmental factors in their assessments. Further detail about the practical implications of using contextual frameworks should be included in the guidance and it would be helpful if the different structural and procedural changes being consulted upon were similarly recognised here.

7. Transition arrangements

Transition arrangement present a number of challenges including the potential loss of LSCB staff and expertise as well as managing any ongoing serious case reviews (SCRs) instigated under the old arrangements. The 12-month grace period for SCRs is therefore welcome.

8. Other changes

One of the 'minor' changes listed under 'Appendix C' includes the removal of 'with their managers' from the assessment section of the guidance, this is a fairly significant amendment and ADCS believes this warrants further discussion about the drivers for this change and the potential implications this may have, not least with the sector regulator.

ADCS welcomed in principle many of the recommendations stemming from the *Wood Review*, including greater flexibility in designing local arrangements, however, the draft guidance lacks sufficient detail to assist local partnerships in understanding the interface between their work and the operations of the new national panel as well as its remit and power in influencing local practice and ultimately outcomes for children.

ADCS would welcome further discussions with the Department for Education to this end via our Families, Communities and Young People Policy Committee. Please contact Katy Block, ADCS Policy Officer, to this end via katy.block@adcs.org.uk