Item **ADCS submission to Alan Wood's independent review of LSCBs (based on conversation between ADCS Council of Reference and Alan, held on 4 February 2016, and drawing upon ADCS's existing policy positions, where applicable)**

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Purpose **To inform Alan Wood's review**

The Association of Directors of Children's Services Ltd, (ADCS) is the professional association for directors of children's services and their senior management teams. Under the Children Act 2004, the DCS is the chief officer responsible for the discharge of local authority functions for children's education and social care. The DCS provides a clear and unambiguous line of professional accountability for children's services as well as being professionally responsible for the leadership, strategy and effectiveness of local authority children's services.

1.0 Introduction

1.1 What are the problems that this fundamental review is trying to solve? Firstly, there is perception that the impact and effectiveness of LSCBs needs to be improved. This is borne out to some extent by the outcomes of SIFs. What therefore would help to improve Boards' impact and effectiveness? Secondly, what do multi-agency safeguarding arrangements that are fit for the future look like?

1.2 Fundamental to the problem of perceived ineffectiveness of LSCBs is their purpose and how their functions are set out in regulation. Accountability is at the heart of both of these problems. We do need a mechanism for mutual accountability for achieving the shared purpose of protecting children and young people. But, LSCBs cannot ensure the effectiveness of the child protection arrangements because they do not have authority over the key agencies in relation to their child protection functions. If they had such authority it would interfere with the clarity of each agency's accountability for what they do to protect children. LSCBs can do a lot to encourage, cajole and scrutinise but any shift in the clarity of each agency's accountability for their work will lead to even further muddle.

1.3 In October 2015, ADCS published a policy position paper of LSCBs[1]. ADCS members believe that LSCB arrangements are not broken *per se*. The problem lies in how well the arrangements are understood and utilised by government, some local statutory partners, inspectorates and others. This poor understanding has led to a burgeoning of expectations, and appears to underlie Ofsted's reviews of LSCBs.

1.4 Child protection should be the **principal** focus and statutory objective of LSCBs. Government and inspectorates should recognise that Boards can and must prioritise this objective above all others. Beyond this core business, LSCBs have a wider remit, which includes preventative work to avoid harm being suffered, including for example the effectiveness of early help provided to children and families. The wider, preventative agenda of Boards is vitally important but the LSCB is probably not best placed to lead it without detracting from the achievement of the principal statutory objective of protecting children from harm.

[1] http://adcs.org.uk/assets/documentation/ADCS_Policy_Position_Paper_LSCBs_Oct_2015.pdf

2.0 Local Safeguarding Children Boards (LSCBs)

2.1 Mission creep

2.1.1 Effective LSCBs are in theory a tool in the armoury to aid system improvement by improving the practice of agencies' professionals. In reality however, there has been a dis-proportionate focus on the practice of the local authority's children's social care professionals. The attendant inspection regime amplifies this imbalance, exerting massive leverage on LAs and not much on any other agency. The LA's role, enshrined in statute as the lead agency in the multi-agency endeavour to safeguard and protect children, justifiably attracts most scrutiny. Although positively piloted, the jury remains firmly 'out' on the potential for the full roll out of multi-inspectorate Joint Target Area Inspections (JTAI) to improve the impact and effectiveness of local multi-agency arrangements.

2.1.2 Latterly the emergence of increasingly prevalent complex safeguarding issues (CSE, modern slavery, trafficking, radicalisation, increased understanding of the impact of domestic abuse on children and young people, FGM, faith-based abuse, so-called 'honour' violence, etc) have brought into even sharper relief the need for whole system partnership working, to safeguarding and protect people in communities. This necessarily requires a clearer understanding of how LSCBs relate to the plethora of other local partnerships, including LSABs, CSPs, local strategic leaders fora, HWBs, children's trust arrangements (where they still exist), MAPPA, MARAC etc.

2.1.3 In response to these complex safeguarding issues, burgeoning unrealistic expectations and requirements have been placed upon LSCBs explicitly and by default by the inspectorates and the government which is, essentially, the regulator of children's social care. . At the heart of this dissonance sits Paragraph 3.3 of *Working Together to Safeguard Children* (2015), which states:

"LSCBs do not commission or deliver direct frontline services……. While LSCBs do not have the power to direct other organisations they do have a role in making clear where improvement is needed. Each Board partner retains its own existing line of accountability for safeguarding."

2.1.4 Boards have on the whole become overly-involved with service design, service delivery and service development – these are important matters but they are operational. Boards do not, rightly, have the authority to task operational activity.

2.2 Footprint

There is a real tension here that is not easy to reconcile:

2.2.1 It is unsustainable and frankly unrealistic to expect police forces and other public service agencies operating on footprints larger than that of a LA, to have to support, contribute to the cost of funding, and secure senior personnel attendance at multiple LSCBs. This might suggest enlarging the footprint across which the LSCB operates

2.2.2 Pan Safeguarding Partnership arrangements, for example in Greater Manchester and in London, have successfully developed some conurbation-wide systems, but their overall impact could be said to have been limited.

2.2.3 The lack of coterminosity of public service boundaries presents a further dilemma to LSCBs in relation to engaging adequately with stakeholders' voices, which requires

sustained community–(or even neighbourhood)-rooted investment. This argues against enlarging the footprint across which the LSCB might operate.

2.3 Membership

2.3.1 There are legitimate concerns as to the seniority of people in membership of LSCB and whether they have authority to make decisions on behalf of the agency they represent. Moreover, their role on the Board and that in their home agency can sometimes fetter their objectivity when the Board attempts to monitor and challenge the effectiveness of the arrangements made by partner agencies, individually and collectively.

2.3.2 It is increasingly difficult to engage schools, indeed to find any entity outwith the LA that can be said to represent the 'non-maintained' schools sector. This difficulty will be magnified as the government drives the system towards achieving its ambition of 100% academisation.

2.4 Independent chair

2.4.1 Most in the sector have long accepted that the construct of 'independence' in this context is fudged. The true descriptor lies somewhere closer to a 'commissioned chair'. Whether independent or commissioned there is an explicit and helpful expectation that the chair will bring challenge as part of the role.

2.4.2 As an aside, it is interesting to note that HMRC regional offices, although not consistent, have since the establishment of the requirement to have an independent chair, said that the role is in effect a LA Officer role and as such the role-holder should be subject to PAYE and therefore on the LA's payroll. This is also true about chairs of Fostering Panels, etc.

2.4.3 Overall, ADCS members believe that independent chairs have largely been a good thing. We are however concerned that independent chairing has become an orthodoxy. The effectiveness of the chair comes down to the quality of the individual and not their independence *per se*. Currently there is great variation in standards amongst LSCB chairs. This must be addressed if the requirement to have an independent chair is to remain in place.

2.5 Multi-agency safeguarding arrangements that are fit for the future

2.5.1 Effective public services can only be delivered in partnership across agencies – the local authority, schools and colleges, police and the health economy engaging strategically with business leaders, voluntary and private sector providers in a locality. The local authority leads these partnerships on behalf of the citizens its elected members represent. It is not only the democratic legitimacy of the local authority that makes it best placed to lead local partnerships but it also has a fundamental role in co-ordinating services that impact upon the lives of its citizens. The local authority can best fulfil this leadership role because of its wide reach across almost all aspects of local public services (education, social care, leisure, housing, environment, public health, economic regeneration and so on).

2.5.2 It follows therefore that effective children's services can only be delivered in partnership – between the local authority, schools, police and the health economy in particular. The local authority not only leads this aspect of the local partnership, it carries 200 or more statutory duties and responsibilities with respect to promoting the safety, health, wellbeing and educational attainment of its children and young people. The Children Act

2004 and the statutory guidance on the role and responsibilities of the director of children's services (DCS), invest the single point of professional accountability in the role of the DCS. Whatever the future arrangements might look like, the statutory roles and responsibilities of the DCS and LMCS remain vitally important, each providing a clear single point of professional and political accountability respectively. These complementary roles remain crucial on the leadership of local multi-agency arrangements to safeguard and protect children and young people.

2.5.3 The commissioning, delivery, quality assurance and oversight of services for children and young people has become increasingly fragmented. The resulting action can be discordant and unconnected and has led to the creation of new demands and requirements on direct service providers which in turn impact upon the time they have to work directly with children, young people and their families.

2.5.4 Sitting alongside this fragmentation are too many partnerships with muddled operational responsibilities and confused governance arrangements leading to a lack of clarity about inter-dependencies. These, combined with the proliferation of multiple sub-groups (often established to respond to specific risks) working to a LSCB place too many demands on too many practitioners all of which detracts from the time that practitioners have to work with children and young people.

2.5.5 As noted above, there are some real tensions and no easy solutions to reforming LSCBs. It does however remain the view of ADCS that every top tier authority in England should be required to establish an inter-agency LSCB because the local authority must continue to hold the responsibility for ensuring that the arrangements made by itself and other local agencies (and service providers) are designed to benefit children, young people and families and are not predicated on the needs of a single organisation, agency or provider alone.

2.5.6 The revised principal purpose and statutory objective of a LSCB could be **to inform the coordination of what is done by each agency rather than to coordinate what is done for the purposes of protecting children in the area**. Reformed LSCBs could have a much smaller membership, which does not require representation from every agency, individual or body that has a duty to cooperate. Members could operate at a more strategic level and might for example, helpfully include academics (particularly helpful in local areas that have, or are forming teaching partnerships with their HEIs).

2.5.7 The preventative work of LSCBs in relation to safeguarding and promoting the welfare of children and young people might sit better within a locality's early help and safeguarding partnership arrangements.

2.5.8 The work of the LADO (investigating allegations) and the work on safety and welfare of children in private fostering is clearly the responsibility of LA children's services and could be de-coupled from the work of reformed LSCBs.

2.5.9 Multi-agency training does not need to be designed or delivered by a LSCB although practice intelligence should inform what is designed and delivered by partners.

3.0 Child Death Overview Panels (CDOPs)

3.1 There is very little, if any, value in epidemiological data that is confined to the child population of any LA however large its child population. Child populations of at least one million would be required to elicit useful trends in data.

3.2 In May 2014, RCPCH and NCB published a report entitled *Why Children Die?*[2]

- It found that many causes of child death disproportionately affect the disadvantaged and could be prevented through a combination of societal change, political engagement and improved training for children's healthcare professionals. The report made recommendations to reduce poverty and inequality; promote healthy pregnancy; create healthy safe communities; improve CAMHS; and, better training for healthcare staff.

3.3 Reducing child mortality therefore requires a public health approach to identify significant recurrent contributory factors and a public health response to preventing child deaths were there are modifiable factors which may have contributed to the death.

3.4 CDOPs should operate on at least a regional basis, taking a common approach and producing comparable datasets, in order to establish trends. Each local Health and Wellbeing Board (HWB) within the regional footprint should then examine the findings in order to inform its local JSNA. Thus, accountability arrangements for CDOP functions should sit with HWBs. This would bring the added advantage of HWBs explicitly focussing on children's health and wellbeing.

3.5 There may be an argument for CDOP arrangements to operate closer to national level like that of SUDI arrangements. SUDI – data on sudden unexpected/unexplained deaths in infants (deaths under 1 year of age where there are no pre-existing risk factors associated with sudden infant death syndrome - also referred to as 'cot death') are collated by ONS at a national level and aggregate findings are analysed by region, gender, etc.

4.0 Serious Case Reviews[3] (SCRs)

4.1 The term 'serious case review' is itself problematic. The pandemonium that ensues from media coverage of SCRs is dis-proportionate to the messaging that surrounds other types of reviews that are undertaken in equally tragic circumstances, such as DHRs, critical incident reviews in the health services and air accident industry. We need to achieve a better balance in the public debate and a system which facilitates learning from good practice as well as learning from when things go wrong.

4.2 The industry that has built up around SCRs, the associated costs, and the time taken to publish SCRs, even those that are not linked to criminal offence proceedings, are all serious barriers to learning. By the time of publication, practice and sometimes policy has already changed.

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[2] http://www.rcpch.ac.uk/index.php?q=child-health/standards-care/health-policy/child-mortality/child-mortality

[3] http://adcs.org.uk/safeguarding/article/serious-case-reviews-virtual-staff-college-report This suite of papers, published in July 2015 by the Virtual Staff College, provides the context for, and an overview of, materials which offers pointers to effective local management of the serious case review process, including an overview of the history of and rationale for SCRs and a brief exploration of some of the factors which make reviews of child protection practice and subsequent action to implement recommendations particularly challenging.

4.3 The notion that any amount of learning could eradicate the deaths of children at the hands of their parents/carers, is false. There is however no doubt that local safeguarding partnerships have a strong appetite to learn in order to improve practice that will contribute to minimising those deaths. But, learning must be local and timely in order to be effective.

4.4 It is hard to see how centralisation of SCRs could work or contribute to improving practice – how will learning garnered at a distance be embedded in local practice? The problems revealed by SCRs are overwhelmingly local and need local solutions. Done well locally SCRs can help change and influence local practice. The problems are in practice - individual, agency and collective. This is what the very thorough biennial reviews of SCRs have shown. If this process moves away from the local it will make it harder to capture local meaning and engage local organisations and practitioners in that learning and it could compound the barriers to developing relationship-based professional practice that safeguarding requires.

4.5 The proposed centralisation of the commissioning of SCRs will require a central register of approved (or accredited) SCR authors. To its credit, the DfE has in the past tried to expand the pool of SCR authors but it is unclear whether any of this 'new blood' ever made it into circulation within the system.

4.6 Several revisions to the statutory guidance *Working Together to Safeguard Children* have expanded the criteria which if met require a SCR to be initiated. Indeed, there has been an expectation within Ofsted and DfE that a serious incident notification (made to Ofsted) should almost always result in the initiation of a SCR. It is unclear what value serious incident notifications add over and above CDOP processes, SCRs etc.

4.7 Currently, between 160 and 180 SCRs p.a. are commissioned and, eventually, the majority are published. It is inconceivable that anything like this number of SCRs could be commissioned centrally; nor would it be appropriate to do so. The increased prevalence of complex safeguarding issues, all of which would fulfil the criteria for commissioning a SCR, will quickly cripple any centralised system. It follows therefore that if SCRs are to be centralised, that timely and lighter touch local learning reviews would need to take their place

4.8 Plainly there would therefore have to be a clearly defined set of 'triggers' identifiable in the short sharp local learning review that would escalate a local learning review up to a centrally commissioned SCR. There should also be a process by which a local area can request that a centrally commissioned SCR takes place.

4.9 What might those triggers be, and what might the circumstances be where a local area requests a centrally commissioned SCR? Broadly speaking, in both circumstances, they would be issues that would be best considered at a national level to test for example whether unintended consequences of policy are placing children at risk of serious harm, e.g. safeguarding assurance arrangements in academies and independent schools; significant harm or death of an electively home educated child (where parents/carers are not required to register with their LA). Or in circumstances where pressure needs to be brought to bear on practices that potentially have universal consequences for children.

4.10 LSCBs should be freed from constraint and choose whichever type of learning review methodology (and reviewer) they think is most likely to result in timely identification and dissemination of learning, depending on the circumstances of the case. It is important to recognise however, the interface with other processes too. For example, the requirements of a Coroner following the death of a child often amount to a review of the scale of a SCR.

4.11 Local learning reviews should have a clear focus on assessing and identifying learning for improving practice standards based on an ability to analyse the impact of practice within a more local context, for example, what happened on that day to affect the practice of an otherwise good practitioner. This learning should then inform, through the reformed LSCB, the coordination of what is done by each agency for what they do to protect children.

5.0 Conclusion

5.1 In commissioning this independent, fundamental review of LSCBs and associated arrangements from Alan Wood, the government is seeking, potentially, to re-shape local multi-agency safeguarding arrangements for the future.

5.2 There are unquestionably some difficulties with the present arrangements that should be addressed. In doing so however, it is helpful to reflect, briefly, on why Boards were established in first place:

- In 1974, the inquiry into the death of Maria Colwell chaired by Thomas Field-Fisher, QC, highlighted a serious lack of coordination among services responsible for child welfare. The Inquiry's report led to the development of Area Child Protection Committees (ACPCs) in England and Wales, which were established to coordinate local efforts to safeguard children at risk.
- In January 2003, Lord Laming published his report into the death of Victoria Climbie. It recommended and lead to arrangements to put those coordinated partnerships onto a stronger and statutory footing to give greater strength to those ways of working.
- In September 2003 the Green Paper *Every Child Matters* proposed the establishment of statutory LSCBs to replace ACPCs.
- In November 2004 *The Children Act 2004* was passed by Parliament enshrining in statute the requirement for every top tier local authority in England to establish a LSCB.