The Third Joint Chief Inspectors'

Safeguards Review

Survey of Chairpersons

of

Local Safeguarding Children Boards

December 2007

Index

Introduction	3
Summary report	4
Conclusions	6
Recommendations	7
Main report	8
Chairing of LSCBs	8
Structure of LSCBs	9
Funding and Resources	11
Influence and accountability	12
Priorities	14
The wider safeguarding agenda	16
Participation of children and young people in the work of LSCBs	16
Child Death Review Panels	17
Serious Case Reviews	17
Monitoring and evaluation	19
Appendix 1: LSCB respondents	20
Appendix 2: LSCB survey questionnaire	

Introduction

1. This report of the national survey of Local Children Safeguarding Boards (LSCB) in England was conducted by Ofsted between October and December 2007 to inform the third Joint Chief Inspectors' Safeguards Review, scheduled for publication in July 2008. It builds on the first national survey published in *Local Safeguarding Children Boards – A Review of Progress (DfES 2007)*. This survey collected updated information to help evaluate the extent of progress by LSCBs on implementing national guidance *Working Together to Safeguard Children 2006* and its associated regulations *The Local Safeguarding Children Boards Regulations 2006, Statutory Instrument 2006/90.*

2. Since 1 April 2006, LSCBs have replaced the former Area Child Protection Committees. They are required under the Children Act 2004 to act as the key statutory mechanism for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children in that locality, and for ensuring the effectiveness of what they do.

3. The primary functions of LSCBs are set out in section 14(1) of the Children Act 2004:
   - "To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established.
   - To ensure the effectiveness of what is done by each such person or body for those purposes."

4. The functions are expanded in more detail in *The Local Safeguarding Children Boards Regulations 2006*. The statutory guidance in *Working Together to Safeguard Children* that covers LSCBs, explains their role encompasses responsive work to protect particular children and young people at risk of significant harm, targeted work for children in need and vulnerable groups, and promoting the safety and welfare, for all children and young people living in their area. The guidance makes clear that LSCBs should not focus on preventive or proactive work if they judge their responsive child protection work to be ineffective.

5. While the LSCB has a role in co-ordinating and ensuring the effectiveness of the work of local individuals and organisations to safeguard and promote the welfare of children, it is not accountable for their operational work. All Board partners retain their own existing lines of accountability for safeguarding and promoting the welfare of children by their services. The LSCB does not have a power to direct other organisations.

6. The core membership of LSCBs is set out in section 13(3) of the Children Act 2004 as representatives of the local authority plus

partners who have a duty to cooperate in the establishment and operation of the LSCB. Guidance sets out other organisations that should be co-opted onto the LSCB as non-statutory partners, and still others that the LSCB will need to cooperate with in its work.

7. The DfES review carried out in 2006 found there was cause to be optimistic about the potential of LSCBs to make a difference arising from increased commitment and improved understanding of partners of the wider safeguarding agenda. Key recommendations to support further development of LSCBs included:
   - There needs to be clarity about the relationship between LSCBs and children's trusts. Good practice on chairing arrangements needs to be shared. Effective scrutiny by Elected Members should be encouraged.
   - Statutory partners have joint responsibility for LSCBs. This responsibility should be re-emphasised. Good practice on managing attendance and business should be shared more widely.
   - LSCBs need to be adequately resourced and to spend less time discussing budgets.
   - LSCBs need to know how well they are doing and what good looks like.
   - LSCBs need further help making the transition from an operational child protection board to a strategic safeguarding board. The time LSCBs spend writing and agreeing protocols should be reduced.
   - LSCBs should carry out Serious Case Reviews (SCRs) when required.

8. The report of this survey of LSCBs is based upon completed questionnaires received from 118 of 145 LSCBs. This is an increase on the 109 provided to the DfES in 2006. In addition, structured interviews were conducted by Ofsted with 19 chairpersons. The list of chairpersons who contributed to the survey is set out in Appendix 1. The questionnaire (Appendix 2) was informed by the recommendations identified above and addressed the following issues:
   - Chairing arrangements
   - LSCB structures
   - Membership
   - Funding arrangements
   - Influence and accountability
   - LSCB priorities
   - Capacity to influence the local safeguarding agenda
   - Participation of children and young people
   - Child death reviews
   - Serious Case reviews and
   - Evaluation and performance management

Summary report

9. Key findings of the survey are:
   Strengths
   a. The proportion of LSCBs with independent chairpersons has increased.

b. Lead Members are better informed about the LSCB and safeguarding issues in their area and there are encouraging examples of scrutiny.

c. The focus for nearly all LSCBs has shifted from predominantly child protection to include a wider safeguarding agenda. One in four LSCBs identified promotion of safeguarding awareness across agencies and improved arrangements to combat bullying as high priorities.

d. Child Death Overview Panels are established in several areas and there are good examples of sub regional collaboration between LSCBs. Nearly all expect to have arrangements in place by April 2008.

e. Where serious case reviews are well established, LSCBs can demonstrate their contribution to improvements in practice.

Weaknesses

f. Some LSCBs have yet to achieve the involvement of all statutory partners. Of the LSCBs who responded to the survey, nine have no representation from the youth offending service (YOS) and three are without representation from the children and family court advisory and support service (Cafcass).

g. Reorganisation and reconfiguration of services undermines the consistency and quality of agency representation at some LSCBs.

h. There is considerable variation in the financial resources allocated to LSCB work across the country and within regions, and several are experiencing budget pressures.

i. The majority of LSCBs remain predominantly concerned with operational and practical arrangements, particularly in relation to ensuring a safe workforce, establishing child death overview arrangements and securing effective interagency arrangements.

j. Consultation with young people is developing in most areas and is acknowledged as an area for improvement by most LSCBs. Where consultation is established, the concerns of children and young people over issues such as bullying become more prominent.

k. Just under a quarter of the LSCBs who responded to the survey have not undertaken a serious case review compared to five who have completed five or more

l. Challenges remain in securing better engagement and oversight of safeguarding arrangements for most groups of vulnerable children and young people and in particular those held in secure settings. Several LSCBs are at early stages of developing local strategic arrangements in response to local issues that for some include gang or violent street culture in their local areas.

m. Performance management and evaluation is an increasing part of all LSCB activity but continues to rely on national key performance indicators and on the local authority children's services data. There are good examples of peer review and sharing of toolkits between some areas.

Conclusions

10. More LSCBs demonstrate greater independence of chairing arrangements with an overall good level of engagement from their statutory and non-statutory partners. However this masks some significant failures by a few agencies to fulfil their duty to cooperate. Local councillors, particularly lead members, are better informed about the LSCB in their area and in a few areas there is good planned scrutiny of arrangements. LSCBs continue to be preoccupied in getting the structures and policies in place, and in implementing national guidance and standards.

11. The extent to which LSCBs exert their collective influence and the impact this has on local safeguarding arrangements is less consistent. The resources allocated to the LSCB are a tangible indicator of this. The variations in the level of involvement from agencies and the commitment of resources to the LSCB's work programme demonstrate that more progress on making safeguarding children and young people a priority is needed within these agencies.

12. All LSCBs need to demonstrate more clearly how they co-ordinate the planning and delivery of improved safeguarding arrangements that deliver better outcomes for all children in their area and improve the effectiveness of local services. Further, most LSCBs acknowledge the need to improve their arrangements for the participation of children and young people in planning. LSCBs are clearly consulted about the local children and young people's plan (CYPP) and routinely receive information about the performance of some key services in their areas, notably about statutory child protection. However, nearly all are yet to set themselves clear and measurable local performance measures to evaluate the impact of their work. With regard to ensuring that lessons are learnt, there is a wide variation in the experience and practice of LSCBs conducting serious case reviews. However, where the process of serious case reviews is well established, LSCB can demonstrate their contribution to improvements in practice.

13. An increased emphasis on the wider safeguarding agenda is evident across nearly all LSCBs whilst, rightly, maintaining a clear focus on child protection. Good progress is being made on setting up child death overview arrangements, including some good example of collaboration between areas. The priority afforded by most LSCBs to address specific needs of vulnerable groups in their areas, and in particular those who are in the criminal justice system or are asylum seekers, is at a low level overall.

Recommendations

1. All agencies that have a statutory duty to cooperate should ensure that they are fully compliant in respect of statutory membership of LSCBs by 1 September 2008.

2. All LSCBs should publish annual reports that include details of agency membership, the attendance achieved for each member, and the contribution made by the agency. This should include description of financial contribution and details of specific responsibilities and work that are undertaken in their capacity as a member of the LSCB.

Main Report

Chairing of LSCBs

14. It is the responsibility of the local authority (after consultation with LSCB members) to appoint a chairperson of the LSCB. The review in 2006 found that LSCB chairpersons had a range of 'day jobs'. This continues to be the case in 2007, although an increasing number of LSCBs, now just over a third, are appointing an independent chairperson as shown in Table 1.

Table 1 Findings of surveys conducted in 2006 and 2007

Chairperson	2006	2007
Local authority	70%	63%
Other statutory partners	2%	3%
Independent	28%	34%

15. The 2006 Review found that the Director of Children's Services (DCS) or another local authority employee chaired most LSCBs. There were concerns that some of the accountability arrangements might limit the LSCB's ability to challenge the Children's Trust and some LSCBs were struggling to demonstrate their "independent voice".

16. By 2007, the number of LSCBs chaired by a Chief Executive had reduced from eight to five LSCBs. The Chief Executives who were interviewed believe their chairing makes a difference to ensuring greater commitment from other agencies.

17. The proportion of LSCBs chaired by a DCS has reduced to 40% but remains the most frequent arrangement. A further 19% are chaired by a local authority officer at second tier of management or below. This raises questions regarding the independence and ability of the LSCB to hold all agencies to account for safeguarding arrangements. However, some chairpersons commented that the role of DCS and its wider remit and responsibility for children's services enhanced their capacity to Chairperson the LSCB effectively. This view was shared by some senior officers in partner agencies who chaired LSCBs and emphasised the importance of knowing local networks and processes in addressing local safeguarding arrangements.

18. The increase in proportion of independent chairpersons of LSCBs to 34% reflects a positive response to the conclusion of the DfES review that in light of the experience of LSCBs, '*the Government believes that, resources permitting, there are advantages in appointing independent Chairpersons to avoid conflicts of interest and provide independent scrutiny'*. Most independent chairpersons noted that their independent status equipped them better to establish clear understanding and

accountability about the LSCB's role and the individual member's responsibility.

19. At least four independent chairpersons chair more than one LSCB. Such arrangements can provide a wider perspective for LSCBs. However the survey found that in one case one Chairperson held chairing responsibility for four LSCBs. This does appear excessive and raises questions about capacity to deliver the heavy agenda of LSCBs.

20. All of the chairpersons contributing to the survey demonstrate clear and personal commitment to the role. Despite their differences in perspectives about the status of the chairperson, there is a widespread belief that having the right skill set and knowledge is more important than whether the chairperson is independent of all the member agencies. Overall, the survey found that there is still some way to go to achieve the crucial role of the chairperson as set out in Working Together, paragraph 3.50 that is to make certain that the Board operates effectively and secures an independent voice for the LSCB. This requires combination of independence and influence with skills and knowledge.

Structure of LSCBs

21. All of the LSCBs meet as a minimum of once every quarter with several having a more frequent schedule of bi-monthly, six weekly or monthly meetings.

22. LSCBs have established varying numbers of sub-groups or committees to carry forward specific tasks or responsibilities. The majority include performance monitoring and quality assurance, policy and procedures and training. Nearly all have additional subgroups to address specific safeguarding issues such as safety in sport, hidden harm etc A few have created groups with responsibility for publicity, information and promoting safeguarding awareness. Some of the LSCBs, particularly in the larger county areas, have created a small executive group with responsibility for coordinating and managing the work of a range of other groups, some of which had more local area based responsibilities for safeguarding, representation, commitment and engagement from statutory partners.

23. The Review in 2006 found that on the whole, statutory partners were demonstrating strong commitment to LSCBs. However, in a few areas, some statutory partners had not yet committed to their LSCB. All of the LSCBs who responded to the 2007 survey had secured membership from the local authority, district councils where appropriate, probation, police, NHS and Primary Care Trusts (PCT). However, nine LSCBs have no representation from the Youth Offending Service (YOS), eight have

no representation from Connexions and three have no representation from CAFCASS.

24. It is evident, from this survey that problems persist in a few areas in securing regular or consistent attendance at the appropriate level from all member agencies. Part of the difficulty arises from organisational changes and restructuring for some services such as Primary Care Trusts (PCTs), where there has been an amalgamation of Trusts or reallocation of an individual's workload or responsibilities. Other agencies have also been affected by organisational changes that impede LSCB attendance. For example in a few areas, the CAFCASS representative does not attend due to their span of responsibility.

25. The seniority of people involved on local area groups is occasionally an issue but this is less frequent than found in the 2006 review. Many LSCBs have been proactive in securing representation at a more senior level. Some LSCBs have introduced membership contracts that specify targets for attendance at LSCB meetings. Some chairpersons reported that they had met with the Chief Executive of each constituent agency on the LSCB to ensure there was a good understanding at a senior level regarding the role and remit of the LSCB.

26. The contribution of partner agencies to the delivery of the LSCB's business plans was viewed positively overall by chairpersons. However, the responsibility for leading key LSCB tasks continues to fall largely to local authorities. Even so, instances of other partners taking a lead role are increasing. For example, in Staffordshire the Head of Human Resources for Connexions led on safe recruitment work on behalf of the LSCB. In some areas, chairpersons noted concerns about levels of engagement which most frequently related to poor attendance, inadequate financial contribution and in a few areas to organisations not keeping the LSCB informed about relevant agency safeguarding incidents or issues.

27. Representation and participation on LSCBs by partners who have no statutory duty to cooperate with LSCB arrangements is inconsistent across areas. Of LSCBs who responded to the survey, more than 90% have representation from the voluntary and community services. Several LSCBs have a broad range of organisations associated with the work of the LSCB. This ranges from multi-faith organisations including Madrassehs through to work involving at least two premiership football clubs. One LSCB in the north of England reported that over 200 organisations or individuals contribute to the work of their LSCB.

28. The participation of learning organisations in the work of LSCBs is particularly variable, with state schools being represented on 89%, independent schools on 18% and further education colleges on 42% .

59% of LSCBs have representatives from early years services and a further 45% have representation from children's centres.

29. The contribution of public sector agencies is good overall. Participation on LSCBs by designated doctors and nurses is well established in nearly all areas. However, the survey found that twelve LSCBs have no designated doctor or nurse involvement in place. Furthermore, the local Multi-Agency Public Protection Arrangements (MAPPA) was represented on only 61% of LSCBs. Some LSCBs have involved their local Fire and Rescue Services in their LSCB. Most LSCBs have secured involvement from local Mental Health Trusts and adult social care services. 19 of the LSCBs had representation from the Crown Prosecution Service (CPS).

30. The membership of many LSCBs includes representation from national services which are located within their area. Members of the armed services are represented in 19 areas where there is a significant concentration of service personnel. Six have representation from immigration services, and three from national asylum support services. However, discussion with chairpersons revealed inconsistency in the effectiveness of this representation. Representation from prisons and secure centres is in place in 26 LSCBs and is perceived to be more effective. Examples include good senior management representation on LSCBs resulting in improved joint working arrangements with local children's services.

Funding and Resources

31. The Review team and DfES survey in 2006 found that the levels of resource available to LSCBs varied substantially between and within regions. This continues to be the case in 2007 and is clearly a significant issue for many LSCBs, with the situation deteriorating for some. In 2007, nearly all LSCBs expressed concerns about securing sufficient resources to undertake the range of work envisaged. However, since the survey was completed, DCSF and DH have announced specific funding for local authorities and the health service to cover the cost of child death review processes. Some chairpersons noted that budget pressures in almost all services are a significant factor leading some agencies to reduce their contribution to the LSCB, in a few cases unilaterally. A few chairpersons identified ongoing concerns about reaching a budget agreement in a timely manner and the waste of considerable time on this issue.

32. There are considerable variations in expenditure per capita of children under 18 years across LSCBs. The smallest expenditure in 2006/07 was £5,000, equivalent of 17 pence per child, although this LSCB plans to spend £19,648, equivalent to 68 pence per child, in 2007/08. The

biggest expenditure in 2006/07 was £393,857, equivalent to £1.58 although this LSCB planned to spend less, £366,605, in 2008/09. This is equivalent to £1.47 per child. Most LSCBs plan to spend more in 2007/08. Only 16% of LSCBs plan to spend the same or less in 2007/08.

33. The funding contribution of partner agencies is set out in Table 2. The largest contribution was made by local authority children's services. There were wide variations in the percentage contribution for all agencies, with that for local authority children's services ranging from 87% to 22.5%. The second largest contribution to LSCB budgets comes from PCTs with similar variations across the country ranging from over 45% down to 3.0%.

Table 2

Service	**% funding contribution**
Local authority Children's service	53.0%
Primary care trust	21.6%
Police	9.6%
District council	4.3%
NHS Trust	3.3%
Probation	2.7%
Connexions	2.2%
Youth offending service	2.0%
Cafcass	0.8%
Prisons	0.4%
Secure Training Centres	0.1%

34. The wide variation in the contribution from police services to LSCBs is a specific concern. The organisation of the police service in several large county areas means that several LSCBs have membership and financial contribution from the same police service. However, variations do not appear to clearly reflect variations in safeguarding needs between the areas. In one London borough, the police are the second largest contributor after the local authority at 29% whereas this falls to 2% in four other boroughs. Similarly within West Midlands, the contribution to local authorities varies from 2% to 24%.

35. Other statutory partners contribute relative small financial resources to the work of their LSCB, and in some cases make a contribution in kind. In some areas there is significant contribution from non-statutory partners. This ranges from culture and leisure services, safer community partnership, and local skills council through to non-statutory organisations. One London Borough has successfully negotiated a financial contribution from their local premiership football club.

36. LSCBs were asked to rank their highest cost of expenditure. The most frequent items identified were the costs of appointment of an

independent chairperson and LSCB business manager or coordinator, establishing child death review panels and increasing demands for training.

Influence and accountability

37. *Working Together* states that elected members should not be members of an LSCB. However, they should hold the local authority to account for the effective functioning of the LSCB and for the local authority's own contribution to the LSCB's work.

38. The Review in 2006 found some good examples of close scrutiny by the Lead Member. However, in other LSCBs Lead Members were not closely involved. Some LSCBs were distancing Lead Members, possibly because they had misinterpreted the lead member's role as set out in *Working Together* or because officers felt their members had little understanding of safeguarding children and child protection work. This prevented elected members from exercising their scrutiny role effectively.

39. By 2007, there is evidence of elected members taking a more informed interest in the work of LSCBs in their areas and of better and improving arrangements for ensuring that they are informed of safeguarding issues. These range from informal individual discussion through to formal and planned reporting and scrutiny of business. However, in seven areas there are no clear arrangements in place for keeping the Lead Member informed. In all these areas, the LSCB has an independent chairperson. Examples of the different types of involvement by Lead Members are set out below:
    - In Lancashire, the LSCB Chairperson (local authority officer) attends Children's Services Board and Children and Young People's Overview & Scrutiny Committee to provide updates and respond to questions on a regular basis.
    - In Leicester, Leicestershire and Rutland where there is an independent chairperson, the Lead Members are invited to attend the LSCB as observers, receive the minutes of all LSCB meetings and are regularly briefed in person by the respective Vice Chairpersons of the LSCB.
    - In Stoke on Trent, the LCSB independent Chairperson meets with the Lead Member after each board meeting.
    - In Somerset, the Lead member meets with the chairperson (Local authority officer) twice a year and attends one full board meeting each year.
    - In Stockport, there are quarterly Safeguarding Accountabilities Meetings that include the Chief Executive, Leader of Council, Executive Councilor for children and young people, and the chairperson of the LSCB. The DCS (LSCB chairperson) also meets weekly with Executive Councilor and safeguarding is a regular agenda item.

40. The position relating to contact between LSBC and local authority Chief Executives remains inconsistent. Whilst five Chief Executives are directly involved in the work of the LSCB through their role as

chairperson, the survey found that one in five chief executives have had no direct contact with their LSCB. However, most chief executives kept themselves appraised of the work of the LSCB through established reporting arrangements with the DCS.

41. All LSCBs have clear arrangements for reporting on their progress in implementing their business plans and contributing their views to strategic or governance bodies at the local level. Arrangements vary considerably across LSCBs. Most LSCBs report directly to the council's scrutiny committee and to the Children and Young People's Strategic Partnership or Children's Trust. Arrangements for reporting to governance bodies of partner agencies are routed via the relevant representative on the LSCB. Good practice is demonstrated in a few LSCBs, where arrangements are in place for the LSCB chairperson to report directly to the PCT governance body.

Priorities

42. LSCBs generally rely on the needs assessment carried out in relation to the Children and Young People Plan (CYPP) as a substantial source of information in assessing the extent of need in local areas for safeguarding children and young people. Overall, LSCBs are recipients rather than commissioners of information, and are reliant on the quality of information provided by the Children's Trust or strategic partnership. However, there are increasing examples of specific needs analysis work that has been commissioned. This includes Bristol's annual 'Catching in the Rye' and Portsmouth's scoping exercise with Barnardo's regarding the prevalence of sexual exploitation locally. Chairpersons interviewed for this survey expressed confidence in the capacity of local partnerships to determine where resources need to be directed to identify and support vulnerable children. Several identified good work being undertaken in relation to the identification of transient groups, including those seeking asylum, traveller communities, children living away from home and those who are not in mainstream education.

43. Most chairpersons who were interviewed provided examples of where evidence from serious case reviews or inspections, including Joint Area Reviews, had informed the priorities of the LSCB. Examples include work with a youth offending service to address concerns that emerged about the quality of safeguarding children and young people who are known to the criminal justice system.

44. The 2007 survey found a broad consistency across LSCBs in identifying their local priorities. LSCBs were asked to identify their top four priorities. The priorities identified and ranked by frequency across all LSCBs are set out in Table 3. Almost half of all LSCBs identified establishing a safe workforce practice among their top four priorities.

This indicates that LSCBs are increasingly concerned with the wider safeguarding agenda but remain pre-occupied with operational and procedural requirements.

Table 3

	Priority	**Frequency**
1	Establish a safe workforce practice	47%
2	Maintain effective child protection service	31%
3	Establish child death review panel	28%
4	Raise awareness of the wider safeguarding agenda	26%
5	Establish quality assurance and performance monitoring	26%
6	Increase effectiveness of LSCB	25%
7	Reduce incidence of bullying	23%
8	Reduce incidence of domestic violence	20%
9	Deliver training programme	18%
10	Review multi-agency safeguarding procedures	15%

45. The survey found that less than one in ten LSCBs had given high priority included targeted activities to safeguard specific vulnerable groups of children and young people among their top four priorities. Safeguarding looked after children and those in private fostering were identified as high priorities by less than 5% of LSCBs. Children or young people who are hidden such as asylum seekers, children in mental health settings or those placed in custody outside the areas featured as high priorities in less than 2% of LSCBs. However, several LSCBs reported significant concerns in their areas regarding gang culture and the use of knives and in at least one area a worrying trend of violent deaths. In these areas, the LSCBs recognize there is work to be done although all are at early stages.

46. Whilst arrangements to reduce the incidence of domestic violence are prioritised in many areas, it is less clear how the LSCB is influencing activity through its own direct work or its influence on local partnerships, including domestic violence forums and MAPPA. Although some areas report improving arrangements for identification and notification of incidents and delivering victim support services, it is unclear to what extent progress is being made on reducing incidents and providing timely support to children who witness or experience domestic violence. Identifying and working with perpetrators and ensuring appropriate emotional and psychological support for children experiencing domestic violence remains a challenge in nearly all areas.

47. Many LSCBs continue to spend a lot of time writing and agreeing policies and procedures. There are several examples where groups of LSCBs have joint procedures. In general, national guidance is seen to be helpful, particularly in relation to safe recruitment and describing wider agency roles and responsibilities - providing 'the meat on the bones'.

The wider safeguarding agenda

48. Most chairpersons expressed confidence in the commitment across agencies in extending the remit of LSCBs to embrace a wider safeguarding agenda. However, they also acknowledged that this is at an early stage of development and that they are yet to develop measures to demonstrate the impact of this work. Chairpersons noted that this shift had made a positive impact on the engagement of agencies and cited examples of more effective and relevant contributions from district councils, voluntary sector and the youth offending services. They are confident that *Every Child Matters* increasingly influences the safeguarding work in their areas. Several describe strengthening relationships with local Trusts and strategic partnerships in relation to work that includes the Common Assessment Framework, workforce planning and earlier intervention and preventative services as well as overseeing formal inter-agency child protection arrangements and access to services.

49. However, in a few areas, chairpersons were concerned that the roles and responsibilities of agencies and strategic partnerships had become less clear. Examples include persistent and significant differences between agencies in increasing the profile of safeguarding within their service and demonstrating clarity of accountabilities and relationships with the Children and Young People's Strategic Partnerships and Children's Trusts.

50. Whilst some LSCBs in the survey sample are planning significant amounts of work across all areas of activity in *Working Together*, others do not appear to plan activity beyond their core agency work for child protection. This may reflect a commitment to get child protection right before moving on to the wider agenda as required by *Working Together*.

Participation of children and young people in the work of LSCBs

51. Nearly all LSCBs acknowledged that involvement with children and young people is undeveloped and in need of improvement. Whilst arrangements for consulting with young people vary across areas, most LSCBs have undertaken consultation events with children and young people on specific safeguarding issues such as bullying, substance misuse and the experience of children who have attended child protection conferences. Significantly, where young people are consulted, clear themes emerge regarding their concerns about bullying and community safety. This contrasts with the organisational preoccupations that inevitably have been at the forefront of LSCB planning and activity.

52. Examples of good practice include:

- Staffordshire's local Children's Commissioner attends the LSCB to specifically represent the views of children and young people in the county.
- The LSCB in Medway worked with a young people's focus group to organise a series of participation events focussed on raising awareness of the board's work among young people.

Child Death Review Panels

53. Most LSCBs are making good progress in establishing child death overview arrangements in their areas with nine areas having a panel already in place at the time of the survey. Many LSCBs are collaborating on a sub-regional basis to set up child death overview arrangements. Almost all LSCBs are confident of establishing review arrangements by April 2008.

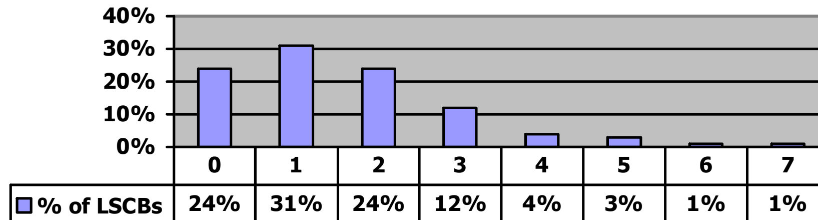
54. However, some LSCBs are concerned about securing adequate resources for providing an effective child review arrangement. Their concerns relate to the availability of paediatricians to contribute and securing appropriate forensic oversight. In a few areas with a small geographical area, there are concerns about access to paediatricians and capacity in neighbouring areas to support reciprocal arrangements. As noted above, the survey was carried out before the DCSF and DH announced resources to fund local authorities and the health system, respectively, to play their roles in the child death review processes from April 2008.

55. The involvement of coroners is inconsistent. Whilst there is keen interest from coroners to be consulted or involved in the development of the overview arrangements in some areas, in others there is a worrying absence of engagement.

Serious Case Reviews

56. The survey has identified considerable variations in the practice of LSCBs in commissioning serious case reviews in accordance with *Working Together 2006*. Whilst all LSCBs reported that they have relevant procedures in place, nearly one in four LSCBs has not commissioned a serious case review. Table 4 sets out the number of serious case reviews by frequency across LSCBs.

Table 4 Numbers of Serious Case Reviews commissioned by LSCBs



	0	1	2	3	4	5	6	7
% of LSCBs	24%	31%	24%	12%	4%	3%	1%	1%

57. A few areas use alternative arrangements such as Individual Management Reviews or a case file audit when they have decided that criteria for a serious case review as defined by *Working Together* are not met. Opinions varied among chairpersons on the effectiveness of such alternative processes. One view was that LCSBs tended to take a more 'conservative approach' to interpreting *Working Together* guidance due to resource implications and potential media interest in cases reviewed through these formal processes. Where alternative processes were established, there was confidence that lessons learned reviews are conducted well, have "buy-in" from all agencies and have been an effective way of promoting improvement in practice across agencies. However, others found that the alternative process lacked the rigour of reviews commissioned in line with *Working Together,* outcomes were weaker and that staff invested less in this alternative process. Many LSCBs plan to make further changes to their arrangements to introduce more rigour and objectivity. This includes the use of external or independent Chairpersons of Case Review Panels, additional use of external expertise on Individual Agency Reviews and independent authors for Overview Reports.

58. Themes identified by LSCBs from their serious case reviews include the familiar issues of sharing information and communication, importance of chronologies, clarity of planning and roles, overcoming hard to engage or resistant families and quality of assessment. Several also highlight difficulties in communication and planning intervention between adult or mental health services and core teams implementing child protection plans.

59. Nearly all LSCBs have processes in place for overseeing the implementation of action plans and ensuring that lessons are disseminated and learnt. Many chairpersons identified improvements in practice arising from action plans and noted the importance of formal arrangements for linking recommendations and action plans to training, strategic planning and performance monitoring. For example:

- Croydon audited against all SCR outcomes for past four years to ensure that all recommendations had been carried through. It commissioned full executive summaries and findings have been integrated into training. The Corporate

Parenting Panel has received summaries of SCRs to gain greater understanding of issues.

- In Leeds, following a serious case review, the National Children's Bureau was commissioned to undertake research on '*Hidden Harm, relating to the needs of children of drug users,* and this has informed new models of working.

- Somerset completed a ten-year study of serious case reviews undertaken since 1995 and has identified domestic violence and parents with substance misuse problems as thematic issues for further work.

Monitoring and evaluation

60. The Review in 2006 found that a small number of LSCBs were beginning to develop their own performance measures to evaluate the impact of their work on outcomes for children and young people, but many were reliant on social services performance data. The 2007 survey found that most LSCBs have established sub-committees to oversee performance evaluation and are receiving regular information about performance. However, this continues to rely heavily on national key performance indicators and overall, LSCBs have not yet developed measures for evaluating the local impact of their safeguarding arrangements. For example, chairpersons commented that they were working to develop local measures to evaluate the impact of domestic violence and preventative strategies. One in four LSCBs has prioritized the development of quality assurance and performance monitoring systems for this purpose.

61. Most LSCBs have conducted audits of service compliance, such as the national requirement for monitoring compliance with Section 11 of the Children Act 2004. Furthermore, most have introduced quality audits of front line practice within and across agencies. Where processes of quality audits of practice were in process, LSCBs could identify improvements in practice, recording and the quality of assessments as well as increased compliance with policy and procedure. An example of more innovative practice includes collaboration between Telford & Wrekin and Sunderland LSCBs to undertake peer reviews of their respective performance.

62. LSCBs were asked to identify their most important achievements to date. There was widespread consistency among LSCBs in identifying a successful transition from an ACPC to an LSCB as their most important achievement. The second most frequent achievement was the establishment of safeguarding awareness across member agencies and more widely within local communities. Many chairpersons who were interviewed reflected the view of most respondents to the survey that this provided a solid foundation for further developments.

Appendix 1: LSCB respondents

Barking and Dagenham
Barnsley
Bath & North East Somerset
Bedfordshire
Birmingham
Blackpool
Bracknell Forest
Brent
Bristol
Bromley
Bournemouth & Poole
Buckinghamshire
Bury
Calderdale
Cambridgeshire
Camden
Cheshire
City of Westminster
Cornwall & Isles of Scilly
Coventry
Croydon
Cumbria
Darlington
Derby
Derbyshire
Devon
Doncaster
Dorset
Dudley
Durham
Ealing
East Riding of Yorkshire
East Sussex
Enfield
Essex
Gateshead
Gloucestershire
Greenwich
Hackney & City of London
Halton
Hampshire
Haringey
Harrow
Hartlepool
Havering
Herefordshire
Hillingdon
Hounslow
Isle of Wight
Islington
Kensington and Chelsea
Kingston upon Hull
Kingston upon Thames
Knowsley
Lambeth
Lancashire
Leeds
Leicester, Leicestershire and Rutland
Lewisham
Lincolnshire
Luton
Manchester
Medway Towns
Merton
Newcastle upon Tyne
Norfolk
North East Lincolnshire
North Lincolnshire
North Somerset
Northumberland
Nottinghamshire
Oldham
Oxfordshire
Peterborough
Plymouth
Portsmouth
Reading
Redbridge
Richmond upon Thames
Rotherham
Salford
Sandwell
Sefton
Sheffield
Shropshire
Slough
Solihull
Somerset
South Gloucestershire
South Tees
South Tyneside
Southampton
Southend-on-Sea
St Helens
Staffordshire
Stockport
Stockton-on-Tees
Stoke-on-Trent
Suffolk
Sunderland
Surrey
Sutton
Swindon
Telford and Wrekin
Thurrock
Tower Hamlets
Trafford
Wakefield
Walsall
Wandsworth
Warwickshire
West Berkshire
West Sussex
Wigan
Windsor and Maidenhead
Wokingham
Wolverhampton
Worcestershire