

## Introduction

1. The framework for safeguarding children has changed considerably since the second *Safeguarding children* (2005) report was published. The Every Child Matters: Change for Children programme is well established and promotes five major outcomes for children: being healthy; staying safe; enjoying and achieving; making a positive contribution; and achieving economic well-being. Joint inspections assess how well agencies work together to improve these outcomes. The provisions of the Children Act 2004 are now largely in force and are significantly changing the way children's services are delivered at local level. The National Service Framework for Children, Young People and Maternity Services (2004) is also promoting greater recognition of safeguarding children in the NHS.

2. The key features of the current safeguarding children framework are:

- the duty to cooperate to improve the well-being of children and young people
- the duty for the key agencies that work with children to make arrangements to safeguard and promote the welfare of children and young people
- the replacement of non-statutory area child protection committees with Local Safeguarding Children Boards (LSCBs) to coordinate and monitor safeguarding at a strategic level in local areas
- the appointment of local directors of children's services and the establishment of multi-agency children's trusts
- the development of a children and young people's plan in every area, with at least annual evaluation by partner organisations
- the planned introduction of a new scheme for vetting people whose jobs bring them into contact with children.

3. This chapter considers to what extent all aspects of this framework are in place, what effect it has had on outcomes for children and young people and what improvements are still needed. It also considers other aspects of safeguarding arrangements that have an impact on children and young people, including multi-agency public protection arrangements.

## Local Safeguarding Children Boards

4. The Children Act 2004 established LSCBs as a statutory requirement. They replaced the former area child protection committees, which were non-statutory bodies, on 1 April 2006. LSCBs are the principal mechanism in each of the 150 local authority areas in England for agreeing how the relevant agencies will work together to safeguard and promote the welfare of children. LSCBs' primary functions are:

'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.'<sup>8</sup>

5. The statutory guidance in *Working together to safeguard children* explains that the LSCB's role includes: carrying out responsive work to protect particular children and young people; being proactive in working for children in need and vulnerable groups; and promoting the safety and welfare of all children and young people living in their area.<sup>9</sup> The guidance indicates that LSCBs have a specific focus on the staying safe outcome, but children's trusts have the wider responsibility for planning and delivering services. LSCBs contribute to commissioning and delivery through the children and young people's plan and the children's trust. Local areas have flexibility to extend the functions of their LSCB provided that this does not reduce the LSCB's ability to perform its core functions effectively. The guidance also states that LSCBs should focus initially on their responsive child protection work if they judge it to be in need of improvement.

6. As part of the targeted inspection work for this review, Ofsted carried out a survey of LSCBs.<sup>10</sup> This followed up the (then) Department for Education and Skills' (DfES) own national survey of the progress made by LSCBs in 2006.<sup>11</sup> The findings of the Ofsted survey are based on 118 questionnaire responses and 19 structured interviews with LSCB chairs.<sup>12</sup> This section also draws on evidence from other inspection work and a Healthcare Commission audit of LSCBs.<sup>13</sup>

### Structure, membership and participation

7. The 2007 survey shows that LSCBs are appointing more independent chairpersons (34% of LSCBs surveyed) and fewer directors of children's services as chairpersons, although the latter remains the most common

arrangement (40%) (figure 1). While this demonstrates a greater element of independence, there remains a heavy reliance on local authorities for chairing LSCBs.

**Figure 1: Findings of surveys conducted in 2006 (DfES) and 2007 (Ofsted)**

Chairperson	2006	2007
Directors of Children's Services	48%	40%
Independent	17%	34%
Other local authority officer	34%	23%
Other statutory partners	1%	3%

Sources: DfES 2006 and Ofsted 2007.

8. This is important in enhancing LSCBs' independence and capacity to influence local safeguarding arrangements. Local councillors, especially lead members, are better informed about the LSCB and safeguarding issues in their area. There are examples of robust and regular overview of LSCBs' work, which enables councillors to hold their local agencies to account for the effectiveness of their work (see examples below). In other areas, contact between councillors and LSCBs is more informal and less regular.

**Examples of the effective overview of LSCBs' work**

In Stockport, quarterly safeguarding accountabilities meetings are held that include the chief executive, leader of council, executive councillor for children and young people, and the chairperson of the LSCB. The Director of Children's Services (LSCB chairperson) also meets weekly with executive councillors and safeguarding is a regular agenda item.

Telford and Wrekin and Sunderland LSCBs collaborate to carry out peer reviews of their respective performance.

9. The survey results show that problems persist in a few areas in securing regular or consistent attendance at a sufficiently senior level from all member agencies with a duty to cooperate.<sup>14</sup> This has partly arisen from organisational changes and the restructuring of certain local services. All the LSCBs that responded to the 2007 survey had secured membership from the local authority, district councils where appropriate, probation, police and PCT. Probation inspections show that the local probation board was always part of, and often a full

and effective partner in, the LSCB. However, eight LSCBs have no representation from Connexions; three have no representation from Cafcass;<sup>15</sup> and nine have no Youth Offending Service representation.

10. The Healthcare Commission audit of LSCBs shows that there has been an increase in NHS trust membership and in the seniority of trust representatives compared with the former Area Child Protection Committees. The Ofsted survey found representation from prisons and secure training centres on 26 LSCBs, covering nearly all areas where these establishments exist. LSCBs perceived their contribution to be reasonably effective. However, it is questionable whether the seniority of representatives from some youth offender institutions is sufficient to raise the profile within LSCBs of safeguarding children in these establishments.

11. Representation on and participation in LSCBs by partners that are not named in the Act as Board partners varies considerably. The survey found that more than 90% of LSCBs have representation from voluntary and community services. However, the participation of education establishments was found to be particularly variable, with state schools being represented on 89%, independent schools on 18% and further education (FE) colleges on 42%. The CPS, which prosecutes people accused of an offence, encourages CPS Areas to work with LSCBs, but they were represented on only 19 LSCBs (16%). However, the majority of CPS Areas have engaged to some extent with LSCBs, although contact varies considerably from attendance at the meetings, or links via other agencies or meetings, to the provision of named points of contact only. The armed forces are represented in 19 areas where there is a significant concentration of services. Chairpersons consistently described their contribution as being focused on operational rather than strategic issues.

12. Like the DfES survey in 2006, the 2007 Ofsted survey also found that the levels of resources available to LSCBs varied substantially. Nearly all LSCBs noted concerns about securing sufficient financial resources and staffing to carry out the range of work planned. However, since the survey was completed, the Department for Children, Schools and Families (DCSF) and Department of Health (DH) have announced additional funding for local authorities and the health service to cover the cost of child death review processes. The survey also found wide and unexplained variations in the funding contributions of partner agencies

between LSCBs. For example, the organisation of the police service means that several LSCBs have membership and financial contribution from the same police force. However, variations in financial contributions provided by the same force to different LSCBs do not appear to be based on clear assessments of the needs of children and young people in these areas. Overall, local authorities, PCTs and police services provide the largest percentage of financial contributions to LSCBs.

### Priorities

13. Since the DfES survey in 2006, nearly all LSCBs have started to be involved in a wider range of safeguarding activities, instead of focusing largely on child protection. One in four LSCBs which responded to the survey identified raising awareness of the wider safeguarding agenda between agencies and improving arrangements to combat bullying as high priorities (figure 2). Nonetheless, the majority of LSCBs continue to be concerned principally with operational and procedural arrangements for safe workforce practice and child protection and with implementing national guidance and standards. In this respect, LSCBs are making good progress on setting up child death overview arrangements. All but one expected to have child death review panels in place by the deadline of April 2008.

Figure 2: LSCBs' local priorities

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

Source: Ofsted, LSCB survey 2007.

14. One in five LSCBs identified reducing the incidence of domestic violence as a priority. However, there is little demonstrable evidence of LSCB impact in this area, either through direct work or through partnerships such as domestic violence forums and multi-agency risk assessment conferences (MARAC). Some areas report that arrangements for identifying and notifying incidents and providing victim support services are improving. However, few LSCBs have developed measures to monitor the incidence and timeliness of support to children who witness or experience domestic violence. Nearly all areas face challenges in developing adequate provision for working with perpetrators and in providing emotional and psychological support for children who experience domestic violence.

15. Despite the emphasis on safeguarding vulnerable groups in the guidance to LSCBs, fewer than one in 10 have given high priority to targeted activities to safeguard specific vulnerable groups. These include: looked after children; those in private fostering arrangements; asylum-seeking children in the community and in short-term holding centres and immigration removal centres; children in mental health settings; and those in secure settings, especially when placed outside their area. In addition, while nearly all LSCBs are working with their local Crime Reduction and Disorder Partnership to coordinate safeguarding arrangements for children and young people (see paragraph 89), most are at an early stage of developing strategies or practice guidance to respond to locally identified issues such as gang or violent street culture.

### Impact

16. The 2007 survey found that LSCBs' processes for measuring their impact are still at an early stage of development. Very few LSCBs have set themselves measurable success criteria or targets that are distinct from national or key performance indicators. Most are dependent on local authority children's services data, which provides limited information on the wider safeguarding agenda. Most LSCBs also acknowledge that they need to consult more regularly with children and young people to ensure that policy and service delivery reflect their views wherever possible. Where consultation has taken place, LSCBs have subsequently given greater emphasis in their priorities to the concerns of children and young people on issues such as bullying and community safety.

17. In terms of learning the lessons from practice, there is unacceptably wide variation in both the frequency and effectiveness of serious case reviews. One in four LSCBs has not yet carried out a serious case review while five have carried out five or more. This is not wholly consistent with the number of serious incidents or deaths of children between areas. This is considered in more detail in the section on serious case reviews in Chapter 4.

## The duty to cooperate: strategic partnership working

18. Good partnership working between all the relevant agencies is a precondition for safeguarding children and for ensuring that their needs are recognised and met. The Children Act 2004 recognised this principle by establishing a statutory duty to cooperate to promote the well-being of children.

19. Strategic partnerships to safeguard and promote the welfare of children and young people have been established in all areas through the Children and Young People's Strategic Partnerships (CYPSP) and subsequently through children's trusts.<sup>16</sup> All areas have produced children and young people's plans and are reviewing them at least annually.<sup>17</sup> The plans are underpinned by strong adherence to the principles of Every Child Matters and a clear focus on each of its five outcome areas. In nearly all areas, these are leading to more effective targeting and better coordinated service provision for children and young people

20. However, some LSCB chairpersons expressed concern that the roles and responsibilities of the children's trust, strategic partnerships and LSCBs in determining safeguarding policy and procedure had become less clear. LSCBs have a key role in the strategic coordination of safeguarding activity, yet some found that this responsibility duplicated that of the local CYPSP and the children's trust.

21. Children's trusts are now established in all areas. However, the quality of partner relationships and the extent of different agencies' involvement have been inconsistent between areas. Government guidance indicates that each area should determine its own arrangements. Unsurprisingly, there are therefore considerable variations in organisational structures and functions. Some are fully integrated children's services

trusts while others exist solely for commissioning. Nearly all are at too early a stage to make judgements about their effectiveness.

22. Cooperation across agencies is generally good, with many examples of involvement of the voluntary sector and community and faith groups. There is less involvement of the private and independent sectors. Many services, such as the police, health services, education and social care services, have long experience of making links with other agencies and working together at operational level to safeguard children. There are also examples of a good approach to partnership working by individual agencies.

23. At a strategic level, the introduction in June 2006 of the 'Children and Young People: CPS policy on prosecuting criminal cases involving children and young people as victims and witnesses' and in April 2008 the violence against women strategy, support the CPS in fulfilling one of the main features of its role in safeguarding – that of safeguarding children as victims and witnesses. It also supports the partnership approach. CPS community engagement strategy is now more tailored to secure benefits in service delivery. At a local level, this is reflected by involvement with domestic violence forums, support groups for victims and witnesses, and schools, for example as part of the school citizenship programme.

24. There is greater integration of services particularly between health and children's services. Examples include jointly provided services for children with learning difficulties and/or disabilities and children's centres. Most areas are developing joint commissioning arrangements for services for all children in need through their children's trust. However, most areas have established joint commissioning and effective contract monitoring arrangements for placements for looked after children. Access for children and young people and their families to preventive services that address different levels of need is increasing through commissioned provision from a wide range of statutory, voluntary and independent agencies.

25. However, the development of services through joint working, especially preventive services, is inhibited by the wide range of funding streams and the fact that much funding is time-limited. Two examples illustrate this. First, social worker posts were established in prisons where children are held in 2005. Their remit was to promote the welfare of children in custody and to make links

with relevant local authorities concerning the welfare of looked after children and care leavers. Initial funding was provided for a year. Each year since then there has been a debate about who should fund the posts and funding has been provided only on a 12-month basis. The potential for developing these posts, which had started to achieve positive results, has therefore been constrained. Second, youth inclusion programmes, established in 2000, aimed to divert children aged eight to 17 from involvement in crime or anti-social behaviour and from entering the criminal justice system. The programmes focus on learning new skills, taking part in activities with others and getting help with education and careers. An independent evaluation of the first three years commissioned by the YJB showed that the programmes were having a positive impact on reducing offending. However, uncertainties about funding have caused gaps in service provision and restricted its continued development.

26. Inspections also highlighted common areas where improvement in strategic partnership working is needed:

- more widespread information-sharing and better use of data to identify gaps in service provision and poor performance
- the need to ensure that joint services are planned and provided across the full range of vulnerable groups of children.

### Multi-agency public protection arrangements

27. MAPPA were introduced to assess and manage the behaviour of sexual and violent offenders.<sup>18</sup> To be managed under MAPPA, offenders must have been convicted of or cautioned for a relevant offence.<sup>19</sup> The legislation requires the police, prison and probation services to act jointly as the 'Responsible Authority' in each of the 42 local Criminal Justice Board (CJB) areas of England and Wales. It also requires a range of agencies and organisations to cooperate with the Responsible Authority in the assessment and management of risk. These include health, local authorities with housing, education and social services responsibilities, YOTs, Jobcentre Plus and electronic monitoring services, which monitor convicted offenders. Some CPS areas are also involved with MAPPA.

28. In addition, the Responsible Authority is required to

keep the MAPPA under review and make any necessary changes. Each MAPPA area has a strategic management board to carry out the MAPPA's reviewing and monitoring functions. The MAPPA guidance strongly recommends that strategic management boards include representatives from bodies with a key duty to cooperate. It also recommends that representatives should have sufficient seniority to contribute to developing and maintaining strong and effective inter-agency public protection procedures and protocols on behalf of their agency.

29. Joint area reviews (JARs) found effective operational arrangements between MAPPA and children's social care services for identifying and protecting children and young people who may be exposed to risk by the release of an offender into the community. In some areas joint working at a strategic level was less apparent. Although LSCBs are generally represented on MAPPA strategic management boards, the role of the LSCB in monitoring the impact of MAPPA on outcomes for children and young people and the coordination of children protection processes with offender management programmes in the area is not always evident or well-understood.

30. The police are well-engaged and meeting their statutory responsibilities under MAPPA. Between 2002–03 and 2005–06 there was a 39% increase in number of category 1 registered sexual offenders.<sup>20</sup> This significant and rapid increase in demand resulted in workload and capacity problems for the service. Recent programmed inspections found that forces had taken action to tackle this through comprehensive staffing reviews and increases in staffing levels. Nonetheless, forces need to develop a sophisticated understanding of demand that goes beyond caseload and build the capacity and capability to respond proactively to future challenges and demands in this area.

31. Probation services are fully involved with MAPPA, but there is a lack of clarity about the role, function and responsibilities of YOTs in these arrangements. Not all YOTs were linked into the MAPPA strategic management boards. In addition, case managers were often unclear about how the system worked, how to refer cases to it and what their responsibilities were for ensuring effective assessment and communication. As a consequence, numerous cases were recorded by YOTs in MAPPA category 1 without being referred to the MAPPA Panel for consideration.

32. Arrangements in prisons for the overall management of young people who are subject to MAPPA while they are in custody are generally efficient and well-managed. These young people are often a risk to themselves as well as to others. Young people convicted of certain offences are vulnerable to bullying and victimisation and the nature of the offence may indicate that they have experienced child abuse, while difficulties coping with the length of their sentence can put them at risk of self-harm. However, MAPPA is not regarded as an integral part of safeguarding arrangements or included as part of the remit of the safeguarding committee in all youth offender institutions. Also, attendance at MAPPA reviews in the community by prison staff varies and is often affected by the distance from the prison and staffing capacity. Attendance by representatives from the smaller girls' units, which have higher staffing levels and fewer cases, tends to be more regular.

### Safe recruitment and vetting

**'Recognise that staff and carers are important in children's lives. People working with children and young people must be the right people, properly recruited and checked.'**

**'Where appropriate, involve children and young people in choosing staff and carers.'**<sup>21</sup>

33. The second *Safeguarding children* (2005) report raised concerns about vetting practices both during staff recruitment and for staff who have been in post for some time. Following the *Bichard Inquiry Report*, the Government is introducing a new scheme for vetting people whose activities bring them into contact with children and vulnerable adults.<sup>22,23</sup> The revised scheme is more robust, particularly with regard to barring unsuitable adults from working with children. Its implementation is expected to be phased in from autumn 2008. Its key aims are:

- to provide employers with a more effective and streamlined vetting service for potential employees
- to bar unsuitable adults from working, or seeking to work, with children and vulnerable adults at the earliest opportunity.

34. JARs judged recruitment vetting practices for centrally employed staff to be adequate or better in nearly all local

authorities. There is now much greater awareness of the need for and importance of CRB checking. Checking for new recruits is well-established in children's services and robust arrangements exist for checking contract staff in nearly all local authority areas. However, weaknesses in recruitment practices remain in some services, for example in the timeliness of checks on people who apply for approval as adopters resulting in delays in decision-making by adoption panels. Inspectors of YOTs were also concerned to note a few cases where staff were inappropriately allowed to take up their duties before CRB clearance had come through. In addition, there were widespread concerns from inspections about the extent to which agencies had undertaken checks on staff who were in place before the CRB was established in 2002 and who have remained in the same post. Similar concerns arise about staff who had been CRB checked on appointment but who have not been re-checked after three years. While this is not mandatory, it is accepted good practice.

35. There is a high level of compliance in NHS trusts, as assessed by trusts themselves, with the core standard for ensuring that all appropriate initial employment checks are carried out. In 2006–07, 377 trusts were compliant, while only 10 did not comply and seven could not give sufficient assurance of compliance. Nonetheless, the Healthcare Commission believes there is still much to be done to improve checking of existing staff who have remained in the same post for some time or who move jobs within an organisation. In a survey of maternity services in 2008, 30 trusts out of 148 (20%) reported all staff having had a CRB check, and 36% reported having over 70% of staff checked. Fifteen trusts (10%) reported fewer than 30% of maternity staff having received CRB checks. Good practice is for all staff to be checked every three years, although this is not mandatory. Fewer than 7% of trusts reported over 80% of staff having been checked in the past three years. Thirteen per cent reported that fewer than 25% of staff underwent CRB checks in the last three years.

36. In the police service, officers in specific posts should be subject to internal checks over and above enhanced CRB and security checks. Five out of 43 forces needed to improve arrangements to ensure that these additional internal checks were routinely carried out for holders of specialist posts in the forces' Child Abuse Investigation Units.

37. For secure settings, inspections found that vetting

procedures in three of the four secure training centres were robust but were inconsistently applied by the fourth centre. While all inspected youth offender institutions were checking new staff, the HM Prison Service (HMPS) did not require the checking of existing staff and only one establishment was carrying out retrospective checks. Only six out of the 14 establishments had 90% or more of their staff CRB cleared for working with young people. Three establishments only had around half of their staff CRB cleared. This is of particular concern in closed institutions where staff who may not have been vetted are permitted to carry out procedures such as strip-searching and restraint on vulnerable children and young people. In youth offender institutions, where there is a mixed population of children under the age of 18 and young adults aged between 18 and 21 who are managed on separate sites, staff who usually work with young adults and who are not required to undergo vetting procedures are sometimes cross-deployed to work with children.

38. The UK Border Agency has five short-term holding facilities at Heathrow airport. These account for a significant proportion of short-term immigration detention. One removals holding room mainly holds those being removed after they have spent some time in the UK. The remaining four facilities largely cater for those who have just arrived and are being questioned or have been refused entry (see paragraph 230). Staff are often dealing with very vulnerable unaccompanied minors and distressed children with their families. Detainees are regularly held there for more than 18 hours, and inspection evidence highlighted the case of a child who had been detained for 24 hours. All custody staff had undergone at least standard CRB checks. All those employed since a new contract was agreed had been cleared to the enhanced level and retrospective checking was being carried out on remaining staff. About a third of staff were yet to be cleared to the higher level.

## Conclusions

39. **LSCBs** are in place with more independent chairpersons and better reporting arrangements than when they were first established in 2006. They are beginning to focus on a wider safeguarding role in addition to child protection. A survey carried out in 2007 shows the following:

- Some statutory partners are not yet involved in the work of LSCBs in all areas; these include Connexions services, Cafcass and the Youth Offending Service.

- Few LSCBs are giving high priority to targeted activities to safeguard specific vulnerable groups; these include looked after children, those in private fostering arrangements, asylum-seeking children in the community and in short-term holding centres and immigration removal centres, children in mental health settings, and those in secure settings, especially when placed outside their area.
- LSCBs are not yet in a position to demonstrate the impact of their work, since few have set themselves measures of their impact on safeguarding.

40. **Strategic partnerships** for delivering services to safeguard and promote the welfare of children are established in all areas. Agencies work together better to safeguard children than they did in 2005. Every Child Matters is providing a cohesive framework for joint working. There are several areas for improvement:

- Joint commissioning of services for all children in need is under-developed.
- The time-limited nature of some funding arrangements constrains the development of joint services. Examples include social worker posts in prisons and youth inclusion programmes, which have achieved positive results.
- The extent to which relevant agencies work together to safeguard children and young people through local MAPPA to manage the risks posed by sexual and violent offenders varies. For example, MAPPA are not represented on all LSCBs; there is a lack of clarity about the role, function and responsibilities of YOTs in MAPPA; and prison staff attendance at MAPPA reviews in the community varies.

41. There is now much greater awareness of the need for and importance of **CRB checking** for staff whose jobs bring them into contact with children. Agencies comply well overall with requirements for CRB checking for new recruits. However, there are continuing concerns about:

- the extent to which checks are carried out or updated on staff who have been in post since before the requirement for CRB checks was established in 2002; this particularly applies to staff in NHS trusts and youth offender institutions
- re-checking of staff who have been CRB checked on appointment but who have not been re-checked after three years, which is accepted good practice.

## Recommendations

### All agencies

- All agencies that have a statutory duty to cooperate on safeguarding children (local authorities, district councils, police, PCTs, NHS trusts, Connexions, probation, Youth Offending Service, Cafcass, secure training centres and prisons) should ensure that they are fully compliant in respect of statutory membership of LSCBs by 1 September 2008.<sup>24</sup>

### Government

- The DCSF, the Home Office and the Ministry of Justice should clarify the roles, functions and responsibilities of agencies contributing to multi-agency public protection arrangements (MAPPAs) and ensure that relevant agencies meet them fully.

### Local Safeguarding Children Boards

- LSCBs should ensure that robust quality assurance processes are in place to monitor compliance by relevant agencies within their area with requirements to support safe recruitment practices. These processes should include regular audits of vetting practice and random sampling of compliance with CRB checks.