Local Government Association response to the DfE consultation on changes to the statutory guidance 'Working Together to Safeguard Children', new 'child death review' guidance, and new regulations.

Date: 21 December 2017

Submission

About the Local Government Association (LGA)

The Local Government Association (LGA) is the national voice of local government. We work with councils to support, promote and improve local government.

We are a politically-led, cross party organisation which works on behalf of councils to ensure local government has a strong, credible voice with national government. We aim to influence and set the political agenda on the issues that matter to councils so they are able to deliver local solutions to national problems.

The LGA welcomes the opportunity to comment on the government's proposed changes to guidance to support the new system of multi-agency safeguarding arrangements established by the Children and Social Work Act 2017. The consultation, and subsequently this response, is arranged under three main areas:

- the replacement of Local Safeguarding Children Boards (LSCBs) with local safeguarding partners
- the establishment of a new national Child Safeguarding Practice Review Panel
- the transfer of responsibility for child death reviews from Local Safeguarding Children Boards to new Child Death Review Partners

The replacement of LSCBs

1. The LGA welcomes the principle of greater flexibility for local areas to design multi-arrangements that work best for their local circumstances, but we have long argued that this flexibility must be couched within a robust regulatory framework to ensure consistency of quality and effectiveness. Unfortunately, we believe that the provisions outlined in the consultation fall some way short of this ambition.

2. In particular, we believe that the guidance outlined under "leadership" (pg 78) is too permissive in allowing each safeguarding partner to identify a "senior officer" of their choosing to have responsibility for ensuring collaboration with these arrangements. We strongly believe that effective safeguarding relies on full commitment and leadership from the very top of an organisation, and that the importance of effective multi-agency arrangements is too great for this responsibility to be delegated. Within local authorities, while day to day leadership will likely come from the Director of Children's Services, we would expect that the final design of the new arrangements should be signed off by

18 Smith Square, London, SW1P 3HZ
Email info@local.gov.uk
Tel 020 7664 3000 Fax 020 7664 3030
www.local.gov.uk

the Chief Executive and Leader of the Council. We would expect the same arrangements to be in place in for senior engagement and sign off within health and the police.

3. This is further confused in the permissiveness granted for the new arrangements to work across LA boundaries whilst determining that there must be one LA representative in the triumvirate. This would effectively lead to one LA being held accountable for the safeguarding activity of another, despite the respective Director of Children's Services and Lead Member for Children's Services having no power to direct practice in that area.

4. We recognise that the Department has attempted to allay widespread concerns about the role of schools in the new arrangements by including a specific section on their role at page 81. However, we remain concerned that their exclusion from core partner status risks diminishing their role in the new multi-agency safeguarding arrangements. We are clear that a failure of schools to engage in local arrangements would create a hole in the system that could fundamentally compromise its effectiveness. Further, we are disappointed that the provisions outlined in the guidance still place the onus on the three core safeguarding partners to attempt to engage schools, rather than placing a clear duty on schools to play their part as full partners in line with the expectations on local authorities, health and the police. It is also unclear how regional school commissioners will be expected to collaborate with the new arrangements.

5. There is currently no process in place for national oversight of these arrangements, which *Working Together* expects to be designed and enacted without prior (or subsequent) scrutiny. We believe that effective multi-agency safeguarding is sufficiently important that more robust oversight is required, and propose that government provides funding for the development of a new multi-agency sector-led review process to robustly examine the effectiveness of local arrangements.

6. Unfortunately, we believe that the provisions within Working Together will do little to resolve the primary issues identified in the joint LGA / Research in Practice *Review of current arrangements for the operation of local safeguarding children boards (2015)*. This research identified four key themes in the debate around the effectiveness of LSCBs:

   a) a lack of clarity on the role and expectations of LSCBs;
   b) pressure on LSCB resources;
   c) the level of power and authority that LSCB have to exercise their responsibilities and in particular hold partners to account;
   d) the strong reliance on the individual skill and ability of LSCB Chairs.

7. We believe that these reforms represented the ideal opportunity to address these concerns in full. Instead, we are disappointed to find that the guidance does not appear to have been written with these issues in mind, and in many cases risks exacerbating them. We will address each of these issues in turn below.

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18 Smith Square, London, SW1P 3HZ
Email info@local.gov.uk
Tel 020 7664 3000 Fax 020 7664 3030
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Role and expectations

8. The LGA is clear that any reform of multi-agency safeguarding arrangements must be based on a clear understanding of what these arrangements are intended to achieve. While our 2015 research did not identify a single key "problem" with the current operation of local safeguarding children boards, it was clear that their gradual evolution over a number of years has led to some confusion over their core purpose.

9. In particular, we found that the key statutory duties placed on LSCBs had, in many cases, come under increasing pressure from a large number of competing, and at times very specific, national priorities, including "undertaking initiatives in relation to FGM" *(2011 Multi-Agency Practice Guidelines on FGM*), "taking accountability" for tackling faith based abuse (*2012 National Action Plan to Tackle Child Abuse Linked to Faith or Belief*), and producing and publishing detailed thresholds guidance (*Working Together to Safeguard Children, 2013 revision*).

10. In our response to the call for evidence supporting Alan Wood's review of LSCBs, we were clear that any reform to the current system should follow the principle of "form follows function", with a clearly articulated statement of purpose underpinning the arrangements that local areas are required to put in place.

11. *Working Together 2017* contains no such statement, and is in fact considerably weaker on the core purpose of LSCBs than its predecessor documents. Page 78 states *that "the purpose of these arrangements is to support and enable local agencies to work together in a system where: excellent practice is the norm; partner agencies hold each other to account effectively; there is early identification of 'new' safeguarding issues; learning is promoted and embedded; information is shared effectively; and the public can feel confident that children are protected from harm".*

12. These aims are extremely broad, and fall considerably short of a clearly articulated statement of purpose. They do nothing to resolve the debate of whether multi-agency arrangements should focus on core child protection or wider safeguarding issues for example, and it is difficult to conceive of any inspection or oversight regime that would be able to judge their effectiveness in ensuring that "the public can feel confident that children are protected from harm". In our response to Alan Wood's review in 2015, we expressed our concern that the increasing dilution of LSCB responsibilities risked undermining their core focus. Two years later, we now find ourselves unsure of what that core focus actually is.

13. We believe that this section of the guidance needs to be fundamentally reconsidered, in consultation with key stakeholders from across the sector.

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18 Smith Square, London, SW1P 3HZ
Email info@local.gov.uk
Tel 020 7664 3000 Fax 020 7664 3030
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Funding and resources

14. The LGA has long argued that arrangements for funding multi-agency safeguarding arrangements are not fit for purpose, with our 2014 analysis of LSCB budgets finding that local authorities on average provided 65% of their LSCBs budget. In some areas, this figure was over 80%. In these circumstances, it could become difficult to view the LSCB as a true partnership body, with the considerable disparity in resource commitment leading to arrangements that could be more accurately described as the local authority plus partners.

15. This situation had emerged despite *Working Together 2013* making it clear that members should share financial responsibility for the LSCB in such a way that a disproportionate burden does not fall on a small number of partner agencies. In our response to Alan Wood's review, we argued strongly that each core partner should be required to contribute to the funding of these arrangements in an equitable fashion, via a process to be laid out clearly in regulations.

16. Working Together 2017 does not include such a process and, as with the role and function of the new arrangements, the provisions have actually become weaker. Indeed, the two paragraphs contained at page 82 allow the three safeguarding partners to make payments towards the new arrangements but contain no such provisions for other relevant agencies, which have previously contributed financially to LSCBs across the country. This omission must be addressed as a matter of priority.

17. As in previous editions of *Working Together*, the consultation makes one limited reference to funding arrangements that *"should be equitable and proportionate"*. As outlined above, similar wording in previous editions has left the local authority to provide the majority of funding for multi-agency arrangements in the majority of local areas. With local authorities facing a £2 billion funding gap for children's services by 2020, their ability to regularly make up for the shortfall in partner agency contributions is likely to be considerably diminished in future and will soon become unsustainable. It is therefore vital that this issue is addressed to ensure that the new arrangements have access to the resources they need.

18. For example, the section on "dispute resolution" (pg 82) could include provision for local partnerships to seek arbitration, from DfE or elsewhere, in cases where equitable funding cannot be agreed between the three core safeguarding partners. However, this section is currently limited to a last recourse appeal to the Secretary of State where agencies are failing to meet their "statutory obligations". Since the statutory framework set by the *Children and Social Work Act 2017* is entirely permissive in respect of funding (*"the safeguarding partners…may make payments"),* such disputes would not be covered here.

19. We therefore urge government to make further provision for independent dispute resolution on obligations that fall beneath statutory obligations but are

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Tel 020 7664 3000 Fax 020 7664 3030
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expected under this guidance, such as the direction to ensure "equitable and proportionate" funding between partners.

The power to hold partners to account

20. The issue of whether LSCBs lack the "teeth" to hold partners to account, and particularly to compel them to act, has been a longstanding concern that is often referenced when commenting on their effectiveness (or otherwise). Our 2015 research found that only one in five LSCB Chairs surveyed thought they had the necessary powers to hold partner agencies to account. As Ofsted noted, also in 2015*, "LSCBs have limited authority and do not have powers to require agencies to act… There is no obligation on partner organisations to take account of the advice of the LSCB or to carry out any recommendations given by the LSCB".*

21. The fundamental reform of multi-agency safeguarding arrangements presents an opportunity to address this longstanding issue, and the welcome introduction of shared responsibility between health, the police and the local authority does have the potential to give the new arrangements more authority over those core agencies.

22. However, the guidance includes no provision for the three core partners to hold other relevant agencies to account, nor any route to escalate concerns where they are not fulfilling their obligations. Indeed, page 80 is clear that relevant agencies need only co-operate with the arrangements *"as far as they can do so consistently within the exercise of their other statutory functions".* In a period of considerably restricted funding across the public sector, it is not difficult to envisage a scenario where agencies could argue that full co-operation would lead to a drain on their resources that will limit their ability to fulfil other statutory functions.

23. We are particularly concerned about the implications that these reforms will have on the ability of local partnerships to fully engage schools in their work, particularly given the potential regulatory loophole quoted above. As the eyes and ears of local safeguarding systems, we remain extremely disappointed that schools are not listed as core partners and would, at the very least, expect robust guidance to ensure that they are fully engaged in these local arrangements as relevant agencies. The lack of direct reference to District Councils is also concerning given their key role in delivering many of the services that children and young people rely on, such as housing, and must be addressed in the final document.

24. We would urge government to look at the duties on other relevant agencies again. These must be strengthened to ensure full co-operation from all agencies, and the guidance should also include a clearer dispute resolution process that will give local multi-agency safeguarding arrangements the necessary teeth to hold all partners to account.

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The role of independent scrutiny

25. Our 2015 research highlighted significant benefits to the independent leadership and scrutiny provided by LSCB Chairs, but it also cautioned that their crucial role could sometimes place a disproportionate importance on their individual professional and interpersonal skills to draw together the full range of partners towards a shared goal. Where this worked well, the independent LSCB Chair acted as a powerful galvanising force for the local partnership, but placing such a strong emphasis on the ability of this single individual could prove too great a responsibility in some cases.

26. We therefore welcome the greater flexibility around what should constitute independent scrutiny, with Working Together 2017 simply stating that plans should include provision *"for scrutiny by an independent person"*. We believe that independent leadership can have considerable value when building local multi-agency partnerships, but we feel that the competence and ability of individual leaders remains the most important factor in ensuring their effectiveness. Indeed, in responding to our 2015 research LSCB Chairs themselves rated independence as the fourth most important skill the required to carry out their work effectively, with leadership skills emerging as the most important, followed by the ability to challenge others, and the ability to establish and maintain good relationships across agencies.

27. However, we do feel that robust independent scrutiny is important, and would welcome stronger guidance on some aspects of how this will be expected to operate. The only detailed requirement in the current draft is for independent scrutiny of the annual report, with all other scrutiny arrangements left entirely at the discretion of the three key partners. Taken at face value, this would allow local partnerships to limit independent scrutiny to a yearly comment on their annual report. We feel that this is insufficient, and would urge government to provide minimum standards on the process and timescales for independent scrutiny of these arrangements.

Child safeguarding practice reviews

28. During the passage of the Children and Social Work Bill, the LGA raised a number of concerns regarding the establishment of a National Panel for reviewing serious child safeguarding cases. In particular, we were keen for more clarity on how this process would interact with local reviews, and how government would ensure that learning from national reviews was effectively identified and disseminated at local level. We were assured that these issues would be addressed in subsequent guidance, and it is therefore extremely disappointing that Working Together offers considerable ambiguity on both these points. We feel it is essential that this guidance is revised to include considerably more detail on how this process will work in practice.

29. For example, *Working Together* requires local authorities to notify serious incidents to the Child Safeguarding Practice Review Panel within five working days, at which point the Panel will *"advise the safeguarding partners whether they intend to undertake a national child safeguarding practice review".* The

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guidance later states that this should happen *"within at least five working days of their decision",* but the document is silent on the timescales required to actually reach that decision, and on the process to be followed. Will the Panel be required to meet whenever a notification is received, for example, or will local areas be required to wait until the next scheduled meeting, which could presumably be some weeks away?

30. It is implied at various points in the guidance that the National Panel may direct local areas to undertake certain actions, but it is unclear whether they will actually have the power to do so. Page 94, for example, states that *"if they have views on whether a local review is appropriate, they should inform the safeguarding partners"* while page 87 requires local areas to inform the Panel of *"the name of any reviewer commissioned"* and page 92 requires local safeguarding partners to *"have regard to any comments the Panel or the Secretary of State may make with regard to publication".* This level of ambiguity is unhelpful in statutory guidance, and clarity on the precise powers of the Panel in relation to these issues would be welcome.

31. We do, however, strongly welcome the clear statement that *"reviews are not conducted to hold individuals or organisations to account. Learning must be at the heart of all reviews"*. While we are clear that failings and poor practice in relation to child protection must be always be identified, challenged and addressed, including in public where necessary, we have long argued that serious case reviews are not inquiries into who is culpable for a child coming to harm – those issues are decided elsewhere. The recognition of this fact in the guidance is therefore welcome, and we hope that this principle remains central to the work of national Child Safeguarding Review Panel.

32. We note that the criteria for undertaking local practice reviews has changed from the previous criteria for a serious case review, stating that local partners must now take the following into account:

    a) *Whether the case highlights or could highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified;*
    b) *Whether the case highlights or could highlight recurrent themes in the safeguarding and promotion of the welfare of children;*
    c) *Whether the case raises or may raise issues relating to the safeguarding and promotion of the welfare of children in institutional settings;*
    d) *Whether the case highlights or could highlight concerns regarding two or more agencies working together effectively to safeguard and promote the welfare of children;*
    e) *Whether the case is one which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate.*

    These criteria appear considerably broader than previously, and could potentially bring almost any case into scope. We would be interested in a further discussion to better understand the rationale for this decision.

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18 Smith Square, London, SW1P 3HZ
Email info@local.gov.uk
Tel 020 7664 3000 Fax 020 7664 3030
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33. We remain concerned that the guidance refers to the concept of "serious harm" throughout, which we believe risks confusion with the statutory definition of "significant harm" as outlined in the 1989 Children Act. It would be helpful if the guidance was clearer on the distinction between these two terms.

34. The guidance allows local partners five working days from receipt of a serious incident notification to conduct *"a concise investigative exercise to understand both the relevant circumstances and the involvement of local agencies"*. Our members report that this timescale is likely to be far too restrictive, with the cause of death not always certain at this point and issues such as school holidays or other complexities likely to add delay in many cases. A more realistic timescale, established in consultation with the sector, would be welcome.

35. The availability and quality of reviewers has been a long standing issue in relation to serious case reviews, and we are disappointed that the Department has not taken the opportunity to address this through the introduction of some form of accreditation or training programme. Indeed, the availability of high quality reviewers to undertake local practice reviews is likely to be exacerbated by the decision to establish a pool of reviewers to undertake national reviews. This risks creating a two tier system whereby the most able reviewers are expected to undertake national reviews, while local areas are left to pick from those who were not considered suitable for this national pool. We strongly believe that the government needs to do more to ensure the availability of high quality reviewers for all safeguarding practice reviews, not just those undertaken nationally.

Child death reviews

36. While we support much of the process outlined in the separate guidance related to the child death review process, we do feel that it could be made more user-friendly in parts. At 79 pages, the document is just 51 pages short of the entirety of *Working Together,* a document which outlines the entire basis for multi-agency safeguarding practice. We would urge government to consider whether any of this guidance could be summarised or shortened, to create a more accessible document better suited to busy local partnerships.

37. We would welcome a commitment to greater regional or national aggregation of data through the child death review process. Epidemiological data has limited use when confined to small populations within particular local areas, and it would be helpful to introduce new processes that allow this information to be analysed and reported on at far greater scale. It would also be helpful to understand how the child death review process will feed into broader national learning systems, such as the National Child Safeguarding Practice Review Panel, the various What Works Centres and campaigns run by organisations such as Public Health England.

38. There is limited reference in the guidance to the interaction between the child death overview panel (CDOP) and other local bodies, such as the new Multi-

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Tel 020 7664 3000 Fax 020 7664 3030
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Agency Safeguarding Arrangements, Corporate Parenting Panels and Health and Wellbeing Boards. We believe that the Health and Wellbeing Boards could play a particularly powerful role in using CDOP findings to inform local joint strategic needs analyses, and would urge government to give this relationship more prominence in the guidance.

39. Finally, we are concerned that the guidance is currently silent on how this process will be funded. In line with our previous comments in relation to multi-agency safeguarding arrangements, we feel it is essential that funding arrangements are clearly defined in this document.

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