C4EO Desk Study Review of Effective LSCB Practice

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A Desk Study Review of Effective LSCB Practice

Contents:

1. Summary

This paper identifies the good and most effective practice that is currently taking place within strongly performing LSCBs. The key points drawn from a range of sources (see methodology) are:

- The independent Chair should be experienced, have a track record in partnership working and have good knowledge of and worked in, at least one area of children's services at a senior level; he/she should represent the Board on other key partnerships or ensure the links are in place
- Mechanisms must be in place to ensure children and young people's views and experiences are reflected in the LSCB's policies and actions
- Highly performing LSCBs are routinely undertaking single and multi-agency audits of their performance. A range of audit tools and toolkits are available for auditing purposes; some LSCBs prefer to develop their own. Performance or Quality Assurance sub-groups are widely used to assist the Board.
- Effective LSCBs embrace challenge and scrutiny and employ a variety of methods to do this including, external review, lay members, one agency scrutinising another agency using, eg, a Scrutiny Calendar; peer review is used and currently new resources are being developed to help LSCBs take advantage of this approach
- Collaboration and sharing practice between chairs is greatly valued by LSCB chairs. The Association of Independent Chairs plays an important role in providing the means for chairs to do this, through its active regional network.
- Successful LSCBs report that they are incorporating learning from audits into their training programmes; also, there is an appetite now for evaluating the impact of training on outcomes for children and young people. Some toolkits/ methodologies are available to help to do this.
- Effective LSCBs are taking a prominent role in their areas in leading the development of CSE strategies. Boards have been instrumental in setting up multi-agency hubs and teams to improve information sharing, inter-agency responses to CSE and the identification of young people at risk of sexual exploitation.

2. Introduction

This short review seeks to identify what good and effective practice currently exists within strongly performing LSCBs in order that other LSCBs may share and benefit from their experience. It highlights:

- The approaches used by LSCBs to review their performance, including the tools that are commonly used
- The qualities, attributes and skills of an effective independent LSCB chair
- How practice and knowledge is shared between chairs
- Useful resources available for LSCB chairs, including organisations and websites

We would like to thank those LSCB Chairs and professionals who were prepared to share their knowledge and experiences in order to contribute to this review.

3. Context

The Children Act 2004 made it a statutory requirement that LSCBs must be established in all children's services authorities. *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children published in March 2013* updated previous guidance which included every LSCB having an *independent* chair who can hold all agencies to account.

England's 148 Local Safeguarding Children Boards are responsible for ensuring that the key agencies involved in safeguarding children work effectively together in safeguarding and promoting the welfare of children at the local level. *Working Together* sets out the statutory role and functions of the independent LSCB Chair**.** Chapter 3 sets out the local safeguarding children boards responsibilities and requirements.

Review and Inspection Framework for LSCBs.

In 2013, Ofsted introduced the new 'single' framework, which incorporates four previously separate inspections of protection, care, adoption and fostering, alongside a review of local safeguarding children boards (LSCBs). These inspections, including *reviews* of LSCBs began in November 2013. All 152 local authorities in England and the associated LSCBs will be inspected within three years, with some having an 'integrated' inspection from April 2015.

Ofsted sets out that the primary aim of the new inspection and review of LSCBs is to ensure that the experiences and outcomes of vulnerable children, young people and their families are at the very heart of help, protection and care offered to them by their local authority.

Between 20 and 25 local authorities, around one in six of all top-tier authorities in England, are due to be inspected in the 19-month period between April 2015 and November 2016. Those targeted will primarily be authorities where Ofsted is returning following a previous "inadequate" rating, as well as those where other inspectorates have concerns.

The Ofsted gradings for review of LSCBs are:
An **outstanding** LSCB is highly influential in improving the care and protection of children. Their evaluation of performance is exceptional and helps the local authority and its partners to understand the difference that services make and where they need to improve. The LSCB creates and fosters an effective learning culture.

An LSCB that is **good** coordinates the activity of statutory partners and monitors the effectiveness of local arrangements. Multi-agency training in the protection and care of children is effective and evaluated regularly for impact. The LSCB provides robust and rigorous evaluation and analysis of local performance that identifies areas for improvement and influences the planning and delivery of high-quality services.

At the time of writing, 34 LSCBs have been reviewed under the new framework; less than a third of these received a “good” rating.

4. Methodology

The findings of this review have drawn on:

- A search of the literature available on the effectiveness of LSCBs which includes reviews highlighting good practice
- Relevant legislation, organisations and websites
- Ofsted ‘Single’ framework inspection reports (rated “good” and “outstanding”) undertaken since November 2013)
- Telephone interviews with a selection of independent chairs, whose LSCBs have been rated “good” or “outstanding”, and experienced individuals knowledgeable about this area.

5. An effective independent LSCB Chair

Working Together set out the role of the LSCB chair, who:

- Should be independent and hold agencies to account
- Should work closely with all LSCB partners, particularly the DCS
- Must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area
- Should have access to training and development opportunities, including peer networking

Key, skills and qualities of an effective chair:

- Chairs are more likely to be effective if they are respected and experienced. That experience should include having a track record of partnership working as an effective LSCB needs the "sign up" of all partners.
- The independent nature of the Chair means they can demonstrate that they are non-partisan as they are not employed by any of the Board agencies. This means scrutiny and challenge can be seen as objective as he/she is clearly not responsible for any aspect of service delivery.
- There was no consensus as to whether it was an advantage or not for the Chair to live, or have lived in the geographical area covered by the Board. Some felt it was an advantage because they had knowledge of the culture and issues in the area, others felt that this was a disadvantage as it counteracted the benefits of independence. However, all agreed it was important for the Chair to make it his/her business to get to know they key issues of the area, through talking to senior personnel and front line staff in the relevant agencies.
- Experience of children's services at a senior level, from whatever agency(ies) is important in order to secure the strategic attendance of agency representatives of sufficient seniority to commit resources. This experience gives them the confidence to relate to and challenge performance issues with senior colleagues from other agencies. An effective chair will have the respect and trust of the other agencies and therefore, actions will be carried through. These points were endorsed by *Oxfordshire, Cambridgeshire, Staffordshire* and *Bradford*.
- A number of Chairs interviewed felt that if good leadership was modelled at the top of an organisation, then that good practice would filter down to the front line and the independent Chair should also model that behaviour. *Portsmouth*

partners value strong leadership of the Board, which enables them to take full responsibility for the contribution and role of their individual agencies.

- It's important that the Chair has a good relationship with the DCS. Meeting regularly with DCS, Chief Executive and Lead member is very beneficial. The Chief Executive of the local authority demonstrating commitment to the LSCB was also considered very helpful by a number of LSCB Chairs.

- *Swindon, Sheffield* and *Newham* all cited good chairing skills with the ability to facilitate discussion well as key skills**.** This is coupled with ensuring meetings are well-planned, papers targeted with clear recommendations; learning is summarised at the end of items and making sure the Board members understand what decisions they have taken and making sure actions are followed through.

Relationships with relevant partnerships

An important element of the Chair's role is to ensure there are key links and communication channels to other partnerships that overlap with the business of the LSCB. Some examples are:

The Chair of the *East Sussex* Safeguarding Children Board is a member of the executive board of 'THRIVE' (an early help programme) and has played a significant role in developing this agenda and the interface between early help and statutory children's social care.

In *Hampshire, Newham and Staffordshire*, there are strong links between the LSCB, Health & Wellbeing Board and Children's Trust. The work of the respective Boards is demarcated well, with effective links, communication and synchronisation between them and their work plans. In areas where there are Improvement Boards, there also needs to be good communication with a clarity of the respective roles, perhaps through the LSCB receiving regular progress reports from the Improvement Board as in Cambridgeshire.

Another example of key relationships is the link with Clinical Commissioning Groups. In *Sheffield*, the Chair has established relationships between the Sheffield SCB and the CCGs and in Staffordshire, the Chair has contributed to health contracts issued by CCG, ensuring child safeguarding is a priority.

The Chair of *Sefton* LSCB explained that in order to address his concern regarding the engagement of schools, twilight sessions were run, 5 or 6 times a year and the attendance at the sessions increased from 30-40 representatives to begin with, to 200. The sessions have covered thresholds, guns and gangs, CSE and the role of schools in these issues. One of the benefits has been a re-working of the way S.11 audits are carried out in the area.

Many Chairs have ensured there are links with the local Adult Safeguarding Boards, often by the Chair being a member, eg in *Swindon*; other appropriate links are with the Corporate Parenting Board (as in *Cambridgeshire*) and to the 0-19 partnership and planning arrangements in the area as in *Staffordshire*.

In *Cumbria,* the Chair has been able to appoint a Deputy-Chair; this has proved particularly useful as the Chair lives some distance from the LSCB. The Deputy Chair, who is a member of the Board, has the Chair's full authority is able to maintain a local presence and represent the Chair at various meetings. This arrangement gives provides extra capacity and resource and works very well.

Listening to children and young people

The Chair of Newham LSCB explained how he was approaching this in two different ways; firstly, by talking to those children and young people who experience services and, secondly, from a wider group of young people. This particular LSCB has a sub-committee of around 20 children and young people which has been in operation for 6 months. The young people use mechanisms such as social media to elicit views from a wider group. This helps to inform the Board's discussions on evaluating and developing safeguarding services. The Chair felt putting this mechanism in place was particularly important post-Rotherham, so the Board could reassure itself that agencies are not failing in this regard.

In *Leeds*, the Board has, together with a local College, supported the development of a Student LSCB which comprises young people who not only undertake their own activities but also challenge the Board. For example, the young people have recently completed a review of the Complaints Procedures of all the LSCB partner agencies which has led to a decision to accept their proposals for change to the procedures; in addition, they have designed and run, on behalf of the LSCBs in the region and West Yorkshire Police, an internet based e-safety campaign. The College gives "credits" as part of their course(s) to young people involved in the Student Board and it has become a rolling programme for the students, mixing new students with those already having experience. The young people sometimes attend Board meetings, to present papers and as one means of auditing how it operates.

Other strategies used by Chairs include:
-in *Oxfordshire,* having effective links with the Children in Care Council and actively seeking the views of looked after children;
-In *Bradford,* the Board has established its own "Youth Fusion" sub-group in partnership with the voluntary sector. Young people have undertaken work to improve information about services and 'how to keep safe', and took part in Safeguarding Week;

-In *Staffordshire*, the Board supported and endorsed the implementation of the *My Journey; My Voice* toolkit in response to identifying that the views of children were not visible in plans. The toolkit has now been rolled out, and there has been a 53% increase in the wishes and feelings of the child being reflected in child protection plans.;
In *North Yorkshire*, the NYSCB is described as a listening Board that takes account of the views of practitioners and young people to develop the work of the Board. An example of this is how young people have reviewed the Board's website to improve its appeal to young people. This includes links to videos and E-safety material to inform young people on their choices in risk-taking behaviours. In *East Sussex*, the lay members on the Board have led on developing communications between the ESSCB and the community, agencies and young people. Working directly with young people, they have also revised and refreshed the ESSCB website which has experienced a three-fold increase in the number of hits.
-In *Oxfordshire*, the views of children and young people have informed business planning and priority setting, for example, at the annual OSCB development day.

6. Reviewing LSCB Performance

LSCB Chairs are commonly using the Ofsted Standards in *Working Together* as a broad performance framework within which their own approach is developed. Other performance and audit tools and methods were revealed in the literature search or highlighted by Chairs or cited in inspection/review reports.

The Chair of *Newham* LSCB explained how he ensured that multi-agency datasets, on a quarterly cycle come to the Board. The dataset that comes from the MASH process provides some of the cross-fertilisation that is needed when the Board considers its performance collectively. The Board has a Performance sub-committee whose role is to look at the data in detail then highlight issues for Board. The Board firstly examines the highlighted areas that need attention then secondly, has an open discussion of the data as a whole. He feels that this is a good tool for the Chair as the sub-committee has the role of streamlining the debate. This process gives a quantitative base, the Board then tries to match this qualitatively, eg, by examining a sample of multi-agency audits and section 11 reports.

Suffolk LSCB has developed an audit tool, designed to facilitate 'self-auditing' by organisations and teams within the local authority and Safeguarding Children Board partners. It identifies generic standards that derive from Section 11 responsibilities, and which apply in broad terms to the local authority and all Suffolk SCB partner agencies. More recently, this has been developed further in partnership with neighbouring Norfolk LSCB.
http://www.suffolkscb.org.uk/about-us/learning-and-improvement-group/

A Quality Assurance Framework for SE Region LSCBs has been developed in collaboration and on behalf of LSCBs in the *South East*. It is based on a number of overarching principles agreed within the region. The components of the Framework comprise the four building blocks of quantitative information, qualitative audits, involvement of children and young people and the involvement of front line staff. In the *Isle of Wight*, the Board uses the framework and for example, because of the data collected, it highlighted the increase in child protection plans and the impact this was having on services. In addition, the *Isle of Wight Board* undertakes 4 multi-agency audits per year, based on themes, with data and information coming from staff surveys interviews with parents, etc.
http://southamptonlscb.co.uk/wp-content/uploads/2012/10/Quality-Assurance-Framework-for-South-East-LSCBs1

Bradford Safeguarding Children Board has instituted a programme of single agency audits which is supported by thematic multi-agency Challenge Panels. Inspectors have reported that good quality, innovative practice is evident in the individual consideration given to how a particular Challenge Panel operates. For example, in October 2013, a panel looked in depth at inter-agency practice with four disabled children, involving their parents and carers, and identifying appropriate improvements to raise practice standards.
www.bradford-scb.org.uk

In Leeds, the LSCB Performance Management System and is made up of 3 components:

1. Monitoring partner compliance with the statutory requirement to have effective safeguarding arrangements in place (Section 11)

2. A Performance Management Framework which collates data from across the partnership about safeguarding activity. This was established in 2011 and has been refreshed to include measures from the national Children's Safeguarding Information Performance Framework. It is based on an 'Outcomes Based Accountability' approach, asking three questions (How much did we do? How well did we do it? and Did it make a difference? A series of scorecards have been developed which summarise performance across the priority areas for the Board.

3. A multi-agency Quality Assurance and Audit Programme which is designed to provide much more information about the quality of the work being undertaken and its impact on outcomes for individual children and young people.

This system complements and feeds into the *Leeds* Framework for Learning and Improvement which helps to promote a culture of continuous improvement across the partnership
.http://www.leedslscb.org.uk/LSCB/media/Images/pdfs/6_Performance-Scorecards-2013_14

Reading and Suffolk LSCBs are examples of a thorough approach where multi-agency audits aim to be reflective in approach so learning is taken on board. In *Reading*, following scrutiny of available data, it was identified that a very high number of referrals were being received by children's social care. The Board commissioned the Quality Assurance sub group to look at thresholds and a multi-agency audit took place involving 30 practitioners who brought cases to discuss where they felt thresholds had been inappropriately applied. Following the audit, it appeared that thresholds were sound but issues were picked up around understanding, about the quality of referrals, not seeking consent from families and about incorrect use of the Emergency Duty Team (EDT) to make referrals. A short-term 'task and finish' group was instigated to look at referrals and over a six-month period they reviewed the whole process. A toolkit for practitioners was developed to help with the referral process.
http://www.ofsted.gov.uk/resources/good-practice-local-safeguarding-children-boards

The LSCB Ofsted Good Practice Guide (2011) reported that some LSCBs are starting to place a greater emphasis on assessing the impact of changes put in place following audits on children and young people and their families. In *Halton,* the LSCB's Scrutiny and Performance Management sub group, focused on identifying indicators that measure the impact of the LSCB on outcomes for young people rather than outputs. The sub group also worked with commissioned services to ensure an outcome, rather than output, focused approach. For example, a service working with sexually exploited young people had initially identified the number of young people they would be working with during the year as an outcome for their service, however, taking a more outcome-focused approach, they agreed to report to the Board on the impact their service has had on these young people by looking at whether and/or how they continue to be involved in sexual exploitation.

The LSCB Chair for *Bury* explained how she undertakes "one to ones" with every Board member using a proforma which has been developed for the purpose. The conversations address for example: what do you see as the strengths of the LSCB? What do you see as are the areas we need to develop? What do you feel you have personally achieved for the Board in the last year? What would you like to achieve in the next year, both for your organisation and for the LSCB? How do you see the

relationships on the LSCB and what are the strengths and weaknesses of these? All the information is collated into a composite and provides a rich source of information for the Board to discuss. As a result of the success of this approach, the Chair is using the same format with the other Boards she chairs.
http://www.safeguardingburychildren.org/CHttpHandler.ashx?id=15455&p=0

7. Useful Tools

The Association of Independent LSCB Chairs has a number of active workstreams developing resources to assist Chairs in their roles. One of these workstreams is *Measuring LSCB Effectiveness* section and two resources highlighted are:

(1) What makes an effective LSCB? A presentation by Ofsted outlining the Inspectorate's expectations on LSCBs, together with suggestions on the lines of enquiry LSCBs should consider, to elicit evidence of the effectiveness of local practice: http://www.lscbchairs.org.uk/Measuring_LSCB_Effectiveness

(2) Improving local safeguarding outcomes: Developing a strategic quality assurance framework to safeguard children has been produced by the pan-London Safeguarding Children Board with Local Government Improvement and Development. Of particular interest is that the approach is based on principles from Outcomes-Based Accountability. It is a framework comprising a number of key elements, within which agencies and partnerships develop their own content, priorities and pace. It contains suggestions and examples of what the content might look like, but is not prescriptive and does not contain 'targets'. It is for individual agencies and partnerships to determine what is right for them, based on their own analysis of evidence. The primary focus of this framework is on the 'child protection' end of the safeguarding continuum, although relevant reference is made to the broader picture issues affecting child safety.
http://www.lscbchairs.org.uk/sitedata/files/Improving_local_safeguarding.pdf

Within the private Members area of the Association's website there are more effectiveness tools and practice, provided by LSCB chairs to share. Also in development as part of this workstream is a resource entitled "Facets of Effectiveness" (available from the Association).
http://www.lscbchairs.org.uk/

West Midlands Children's Services Performance Datapack
This regional performance report and datapack brings together a range of

intelligence across children's services in the West Midlands. It brings together data for each of the 14 local authorities showing how they compare to their statistical neighbours and the West Midlands and England averages. As well as key measures selected to provide an overview, there is also information about inspection judgements of provision for children and young people; the latest available public health benchmarking and a scorecard showing current performance against the 2014/15 West Midlands Improvement Plan for Children's Services.
http://www.westmidlandsiep.gov.uk/index.php?page=900

Self Assessment and Improvement tool (SAIT) for Local Safeguarding Children Boards (LSCBs). The development of this self assessment and improvement tool for LSCBs was commissioned by the Care and Social Services Inspectorate in Wales. It became the standard self assessment and improvement tool for all Welsh LSCBs. SAIT builds on development work undertaken by Tony Morrison and Jan Horwath with LSCBs in England and Wales and, prior to their introduction, ACPCs. It draws on the literature and the authors' experience of key factors that contribute to effective multidisciplinary partnerships. It is based on five key dimensions:

1. Establishing the Board's strategic direction
2. Establishing effective governance
3. Building capacity
4. Delivering outputs
5. Improving safeguarding outcomes for children

Using this tool, LSCB members rate their performance in each of these domains in relation to LSCBs' statutory duties (HM Government 2006) and then propose actions to address areas of weakness. The Care and Social Services Inspectorate of Wales published its findings from a national joint inspection of Local Safeguarding Children Boards (LSCBs) (2011). The inspection evaluated the effectiveness of LSCBs using the framework of the self-assessment and improvement tool.
In 2010, the *Tameside* Safeguarding Children Board adopted a comprehensive approach to quality assurance, called the 'TSCB Quality Assurance Approach (QAA)' which was influenced by the SAIT.
The evaluation: http://wales.gov.uk/docs/cssiw/report/111004overviewen.pdf
The SAIT: http://wales.gov.uk/docs/cssiw/publications/101012saittoolen.pdf

What are the key questions for audit of child protection systems and decision-making?

This briefing paper published by C4EO highlighted some local practice and tools for assessing performance of child protection systems including LSCBs. Of particular

relevance is the Welsh SAIT (outlined in the previous section) and the *Suffolk* LSCB Self audit tool.
http://archive.c4eo.org.uk/themes/safeguarding/files/safeguarding_briefing_2.pdf

Improving local safeguarding outcomes: developing a safeguarding quality assurance framework to safeguard children.
This was developed by Local Government Improvement and Development and the London Safeguarding Board and published in 2011. The framework comprises a number of key elements, within which agencies and partnerships develop their own content, priorities and pace. It contains suggestions and examples of what the content might look like, but is not prescriptive and does not contain 'targets'. It is for individual agencies and partnerships to determine what is right for them, based on their own analysis of evidence.

It is aimed at strategic partnerships and individual organisations with safeguarding children responsibilities. It has been designed to help those with leadership, senior management or scrutiny responsibility for the safeguarding of children to gain a better understanding of how safe children are in their services and communities e.g. LSCBs). The elements and principles of the framework can also be applied throughout all levels of all organisations that make a contribution to the safeguarding of children (including frontline practice) so that each level of the organisation can self-assess whether it is being effective in keeping children safe).
http://www.local.gov.uk/c/document_library/get_file?uuid=d9dfea72-4fe2-4498-9124-db3e42ecc7b2

Safeguarding through audit: a guide to auditing case review recommendations.
This resource pack is designed to help LSCBs audit the recommendations of serious case reviews. It is an updated version of a pack that was first published by the NSPCC in 2004. The pack is not an evaluation tool. It focuses on whether agencies are carrying out their work according to policies, procedures and standards set by the LSCB, to which member agencies have signed up. It does not provide the means to examine outcomes for children and families. However, the recommendations from SCRs arise from a detailed examination of inter-agency practice, and link to policies, procedures and standards which are based on established best practice. It is therefore considered reasonable to take the view that robust action to implement the learning from SCRs will improve outcomes for the children and families for whom LSCB member agencies have responsibility.
http://www.nspcc.org.uk/Inform/trainingandconsultancy/consultancy/supportingproductsandresources/safeguarding_through_audit_pdf_wdf70186.pdf

Sheffield Safeguarding Evaluation Programme

Sheffield LSCB has developed a safeguarding evaluation programme to consider how effectively organisations are embedding safeguarding practices and integrated working into the delivery of their services. A variety of measures have been employed for the evaluation:

• Self-audit: developed to capture information on safeguarding practices among local organisations. It covers safeguarding policies and procedures; information sharing; recording incidents of concern; recruitment of staff and volunteers; training; and safer employment.

• Questionnaires for professionals, volunteers and members of the public: questionnaires are anonymous and ask about experiences of safeguarding; early intervention and integrated working; whether or not they feel confident responding to issues of concern; and what they perceive to be local priorities.

• Case-file review: via a sample of cases being reviewed by the LSCB for evidence of good practice in safeguarding and early intervention.

• Consultation with people who use services: asking parents and carers if they are prepared to talk to someone from the safeguarding children board about their experience of the services they received.

http://www.nfer.ac.uk/publications/LSGL01/LSGL01.pdf

LSCB Challenge and Improvement Tool , 2008

The Tool reflects the six key principles of good governance:

(1) LSCB purpose and intended outcomes; (2) LSCB strategic and operational performance including clear functions, roles and relationships with other partnerships; (3) LSCB values and behaviour; (4) decision-making and managing risk; (5) developing capacity and capability of LSCB, and (6) engaging stakeholders and ensuring accountability.

The Tool presents a set of good governance principles for which participants are asked to express agreement or disagreement on a 6-point scale. A total score can be calculated and compared at a later date following appropriate action. The process is not intended to be prescriptive; it should build on good practice and be used as a guide for better working. This tool is not designed to be either an assessment or just a 'tick-box' exercise, ideally it should be used as an opportunity for group discussion and members should take collective ownership of the issues and priorities identified for future action. The process also aims to help LSCBs monitor their progress.

http://webarchive.nationalarchives.gov.uk/20130401151715/http://www.education.gov.uk/publications/eOrderingDownload/DCSF-00581-2008.pdf

Canary in the Cage – lead indicators and their use LSCBs and their partner agencies. Childhood Wellbeing Research Centre, Working paper 6, Mike Pinnock, 2011

This brief report summarises the views of a number of professionals, involved in managing and overseeing local child protection arrangements, on the value of including a set of 'lead indicators' within local performance management arrangements. This brief study found widespread agreement that carefully selected lead indicators could serve a useful purpose in alerting managers to emerging conditions in the operations of a local safeguarding system that, if left unattended, might compromise its future capacity to safeguard children and young people. The idea of lead indicators was seen as a useful classification and in particular, gave purpose and meaning to the measurement of process -something they believed had been overlooked in the desire to report progress on outcomes. Lead indicators were also seen as a useful feature of the formal risk management processes both within partner agencies and at the actual LSCB itself.
http://www.cwrc.ac.uk/projects/documents/Lead_Indicators_report_revised_for_website_Sept_11_WP_No_6.pdf

Related to the above, *Hampshire* LSCB implements a tracking process to identify any cumulative patterns arising from concerns reported by schools and has also introduced a multi-agency balanced scorecard to monitor and evaluate performance on safeguarding indicators across the partnership.

Eastern Region *Making a Difference* toolkit: LSCB Performance Management Toolkit, 2013

This toolkit was produced through the Eastern Region Children's Improvement Programme. Its premise is that performance management is a systematic, intelligence-based approach to managing and improving people, resources, processes and activities to achieve objectives, within a learning and improvement culture where individual services and the workforce can align their own priorities and actions to accomplish the organisation's objectives. It is argued that this can only succeed if there is access to robust, timely evidence and data. The toolkit provides support to achieve this. This section is part of broader toolkit and contains help sheets, guidance, examples, reference documents and challenge questions.
http://www.nwsli.co.uk/download-file/89

The *Swindon* LSCB undertakes a range of monitoring and bespoke audits, including deep dives on domestic violence and neglect and children subject to child protection plans for a second or subsequent time. It also undertakes case file audits and commissioned a 'deep case dive' in October 2013 into the multi-agency responses to work to protect children living with domestic violence.

Section 11 Toolkits

Staffordshire and Stoke LSCBs have developed a joint Section11 Toolkit which is used to help agencies complete and monitor progress against standards set by their Boards. In *Staffordshire*, the Board effectively challenges partners, and this has influenced developing practice such as the safeguarding improvements made by the Youth Offender's Institution in Staffordshire.

In Sheffield, compliance with Section11 is monitored every 3 years using a self-assessment toolkit. Following completion of the toolkit, organisations produce an action plan outlining those areas where additional work is needed to ensure full compliance with the requirements of Section11 (where needed). Progress with implementing action plans is monitored and reported to the Executive Board .https://www.safeguardingsheffieldchildren.org.uk/welcome/sheffield-safeguarding-children-board/sscb-information/s11-audit.html

The London Safeguarding Children Board has a range of resources on its website, including audit tools.

Pan London Section 11 Audit Tools. This self-assessment tool aims to assess the effectiveness of the arrangements for safeguarding children at a strategic level. Each agency or organisation must ensure that any statements made within the tool are supported with evidence. It is anticipated that assessment of compliance with arrangements at operational service level will have been undertaken to support statements in this self-assessment. Wherever possible, evidence of impact on improving outcomes for children should be identified. The tool assesses each agency/organisation against 8 standards based on the requirements of Section11. Throughout the self-assessment, consideration must be given to evidencing improved outcomes for children young people and their families as a result of the arrangements.
http://www.londonscb.gov.uk/audit_tools/

In addition:
- audit tool forms used by Barking *and Dagenham* for children with complex needs, for early intervention, for children subject to a child protection plan, for referral to children's social care, Assessment 47 enquiry and a multi-agency review form.
-notes and presentation from a *Serious Case Review workshop*, 2013
-notes and presentations from a *development day* for LSCB chairs
-Social care *threshold* guidance notes
- good practice with contributions from *London Boroughs* on annual reports, induction pack for members, for example.
-*West Midlands* Directory of Services and Practice (2010)
http://www.londonscb.gov.uk/resources_for_lscbs/

SCIE Learning together to safeguard children: a 'systems' model for case reviews

The model provides a method for getting to the bottom of professional practice and exploring why actions or decisions that later turned out to be mistaken, or to have led to an unwanted outcome, seemed to those involved, to be the sensible thing to do at the time. The answers can generate new ideas about how to improve practice and so help keep children safe.

In response to demand from LSCBs for more flexibility to the potential use of Learning Together, SCIE worked with the pool of accredited reviewers and commissioning boards to test out a whole range of possible applications of the model. The sliding scale of options now includes 'reflective audits', 'focused' and 'speed' reviews as well as the standard full version described above. A core set of principles and analytic tools unifies this whole range of learning activity.
This is referred to as the 'methodological heart' of the Learning Together model.

Following the multi-agency case audits that have taken place over recent years, the *Devon* Safeguarding Children Board has updated the process to reflect the SCIE Learning Together systems methodology. Referred to by SCIE as the *Devon 'speed' model*, it maintains all the core elements of the full Learning Together review process, but conducts them in an intensive fashion, over a one-week period.
http://www.scie.org.uk/publications/reports/report68.pdf

8. Challenge and Scrutiny

Holding Board members to account by scrutinising and challenging Board members on the performance of their agencies is a key role of the independent chair.

Ofsted's Good Practice Guide (2011) (http://www.ofsted.gov.uk/resources/good-practice-local-safeguarding-children-boards) reports that where practice is good, inspectors have found that LSCBs have become an effective arena for inter-agency professional challenge:

In *Hartlepool*, the level of professional challenge, both within the LSCB and internally at the Children's Trust board meetings, and in governance and safeguarding children committees, is good. The Board and health services hold each other to account in delivering serious case review action plans and the Board business plan. In *Sefton,* the LSCB performance sub group regularly challenges the performance of partners. Each agency in turn is invited to attend a meeting at which they are questioned by members of the sub group taking on the role of 'critical friends'.

A number of LSCBs have extended their quality assurance arrangements to include external scrutiny of their functioning and impact. In *East Sussex,* effective and formal challenge and oversight are provided by members of the Council's Scrutiny Committee which considers all Board papers and reports, making representations and seeking further information when necessary.

All LSCBs have some type of Challenge Log or Risk Register which highlights those issues, identified by the Board and which feature in the Annual Report, that need to be addressed by the Board. In this way, there is an expectation that there will be challenge. Further examples of how some areas approach this are:

Reading Safeguarding Children Board. Prior to each Board meeting, all relevant reports are received by the Quality Assurance Sub-group, then the them Executive Sub-group before going to the next full Board meeting where they are sent out to all members one week ahead of the meeting. Decisions are taken on recommendations made to the Board; and lead Board members from relevant agencies are then nominated to ensure that the actions are carried out. These actions are then monitored by the Performance and Scrutiny subgroup on a quarterly basis. Once a year, each LSCB member attends the Performance and Scrutiny Sub-group to account for their delivery of LSCB priorities using data that they have collected during the year.

In *Liverpool*, the Chair says the key to effective scrutiny is to make sure that different agencies talk to the Board as well as to each other and to do this, Liverpool has created a "scrutiny calendar". At each Board meeting, there is a scheduled guest

from a particular agency who presents its current action plan. Board members then ask questions and raise any concerns they might have in that agency's area. (Molly Garboden on June 24, 2011 in Child safeguarding, Community Care)

In *Swindon*, the Board restructured to improve members' interaction with each other and to allow at each Board meeting, an opportunity for workshops enabling members to have a very effective learning environment. The chair also ensures that he and sub-group chairs meet regularly to ensure that suitable progress is being made on working priorities.

The Chair of *Sefton* LSCB has instituted a challenge process where 2 members from 2 different disciplines/agencies, visit front line workers from a third discipline/agency; a standard form has been produced for the purpose. The results are fed back to the Board. A similar approach has been adopted in *Leeds,* where a recent *Challenge Event* took place; Board members were put into groups of 4 and each looked at 4 Section.11 cases with a view to challenging each other on the practice. These events take place annually.

In *Swindon*, the Chair together with Board members, demonstrate effective challenge to agencies. Examples of challenge include undertaking a test of assurance in relation to proposed senior management changes in Swindon and challenging health services on the provision of suitable accommodation for young people with serious mental health issues
http://ofsted.gov.uk/local-authorities/swindon

In *Oxfordshire* and *Cambridgeshire*, the lay members on the Board demonstrate effective independent challenge to the work of the Board; and, in *Portsmouth*, a Protocol for Resolving Professional Differences has been developed and implemented in order to raise practitioner and manager confidence in challenging and negotiating areas of disagreement.

Peer Review

Peer review is becoming more common as an approach to challenge and scrutiny and many LSCBs Chairs have had experience of peer reviewing and being peer reviewed, often on a reciprocal basis. For example, *Merseyside* and *Cheshire* who are neighbours geographically, have agreed reciprocal arrangements for peer reviewing each other. This approach enhances the "independent" nature of the challenge, but also knowing the context; it also provides an opportunity to share practices. Others, for example *Tameside*, have developed their own self-assessment tools, including independent peer review from a Chair of another LSCB. They are embarking on a 360 degree appraisal of the chair to improve accountability.

The *Eastern Region* has developed its own lighter touch peer review approach where all Boards peer review each other.

The Association of Independent LSCB Chairs has established a Peer Consultation Scheme for its members in relation to the Serious Case Review process. The driver for this is that this scheme increases LSCB Chairs' confidence and expertise in this challenging element of their role, by providing them with the support and wisdom of their peers at any stage of the SCR process. The Peer Consultation Scheme is administered through the regional infrastructure and the learning from this is channelled nationally, so that any lessons can be shared and utilised to improve SCR and other learning processes across LSCBs.
http://www.lscbchairs.org.uk/Peer_Consultation_Scheme

The Local Government Association has also recently begun piloting a peer review programme to provide LSCBs with an external view of the effectiveness and impact of the LSCB on safeguarding and protecting children. Further details can be found at http://www.local.gov.uk/peerchallenges//journal_content/56/10180/3511045/ARTICLE

In *Cumbria*, the LSCB regularly consults with a team of *Touchstones*. These are practitioners who are able to give their views about some of the initiatives and programs of work of the LSCB. The purpose of putting together this group was to enable the Board to make a quick check with frontline workers and managers, on issues that are relevant to their role and/or to seek views. The *Touchstones* recently gave feedback regarding the LSCB website.

And the feedback was used to make improvements and amendments to the site. These included incorporating more local and national sources of help and advice for both parents and children and young people.

9. Collaboration and Sharing Practice

Collaboration and sharing practice between LSCBs is greatly valued by LSCB chairs. Some collaboration between chairs has been highlighted above. The Association of Independent Chairs plays an important role in providing the means for chairs to do this, through its website where tools and resources can be accessed, its active regional network and its annual conference. Most of the regional groupings are pro-active in sharing their "what works" tools and forming collaborations and relationships either formally or informally

The London Safeguarding Children Board's website also provides an opportunity to share resources, practice and policy and procedures.

The majority of LSCBs say that they have a positive relationship with neighbouring LSCBs (either formally or informally). These links have been particularly beneficial in developing policies and procedures, and in sharing learning and information. For example, the hospitals in *Sefton* and *Liverpool* both serve populations from both areas. Therefore, a joint Health Sub-Committee has been established which services both Boards; in addition, there is a dedicated person who takes responsibility on behalf of the Boards for health for each LSCB area.

In *Stoke* and *Staffordshire*, two neighbouring areas, effective links have been established with their respective LSCBs and Adult Safeguarding Boards thereby ensuring that a co-ordinated approach across the area is taken.

10. Child Sexual Exploitation practice

LSCBs are naturally focusing on this high profile issue and anxious to do everything they can to ensure their vulnerable young people are safe. Some examples of strategies LSCBs are employing in this area are given below.

The *Barking and Dagenham* Young People's Safety Group contributes directly to the LSCB. It is made up of 11 to 18 year olds and is chaired by a young care leaver. 30 young people regularly attend its quarterly meetings to give their views and opinions on how safe they feel in the borough.

The *Sheffield* Safeguarding Children Board has led the development of an effective response to child sexual exploitation in Sheffield. Board partners have committed additional funding to support and promote this priority. A multi-agency team now provides a protective, supportive and investigative service for victims of child sexual exploitation. The work of the Child Sexual Exploitation response team has identified historical concerns in relation to sexual exploitation and is supporting current criminal investigations and prosecutions. The practitioners are well connected to their own agencies professionally and developmentally.
http://ofsted.gov.uk/local-authorities/sheffield

The *East Sussex* Safeguarding Children Board is currently refreshing its Child Sexual Exploitation Strategy. Extensive awareness training has been provided to all professionals, including those who do not work directly with children, for example, environmental health officers who may be in a position to identify situations of concern about children through their work. Further work is being planned to raise awareness with people working in the night-time economy including taxi drivers, staff in hotels and take-away food establishments.
http://ofsted.gov.uk/local-authorities/east-sussex

The *Bradford* Safeguarding Children's Board has been instrumental in improving inter-agency responses to child sexual exploitation (CSE). The development of an effective CSE hub involving co-location of police, social and a voluntary organisation has improved information sharing and the identification of young people at risk of sexual exploitation. This has enabled the Board to build a local understanding of high risk areas and the characteristics of local challenges. The Chair has also taken a strong leadership role in contributing to the development of a regional strategy for CSE in collaboration with the police. In addition, Bradford has developed a toolkit for safeguarding children who attend madrassahs which Ofsted has praised. Its use has been well supported through good engagement by leaders from the Muslim community.
http://www.bradford-scb.org.uk/mosques.htm

Portsmouth LSCB has a strong and well developed approach to E-Safety led by the Board which has ensured that awareness amongst children in the city is high. 'Beware of Lurking Trolls' is a very good and imaginative initiative borne out of research commissioned by the Board in conjunction with the Youth Parliament and University of Portsmouth. The project targets a wide range of children, engaging them through the use of a professionally published book and a rolling programme of workshops. Schools are fully engaged and to date over 3,000 children have taken part in a Trolls workshop.
http://ofsted.gov.uk/local-authorities/portsmouth

Leicester, Leicestershire and Rutland (LLR) LSCBs have collectively developed a strategy entitled Child Sexual Exploitation, Trafficking and Missing Strategy.
The strategy sets out how the LLR LSCBs will take action to safeguard children and young people at risk of sexual exploitation, being trafficked or running away or going missing from care, home or education. The strategy should be read in conjunction with current LLR LSCB procedures, policies and protocols on child sexual exploitation, trafficking and missing, and national guidance. It is based on the understanding that an effective response requires: an all-agency approach, including non-statutory partners; and, a whole community approach, including parents, carers, families, children and young people, which takes into account equality and diversity issues.
www.lcitylscb.org/EasySiteWeb/GatewayLink.aspx?alId=131407

Walsall Safeguarding Children Board has developed a Multi-agency Child Sexual Exploitation Strategy. It sets out how through its partnerships it will assess, challenge and provide an enhanced, effective service to reduce the harm and threats posed to children and young people from CSE. The purpose of the strategy is to ensure a

robust, coordinated multi agency response to CSE in Walsall under three broad headings: Prevention; Protection and Prosecution. A proactive approach is taken focused on early identification and intervention through an integrated approach, with effective joint working and a shared understanding of the problem. A key aim of the document is to ensure that the multi-agency response is child centred.
http://wlscb.org.uk/wpcontent/uploads/2014/07/wscb_multiagency_cse_strategy__v_4_updated_19_feb (2014)

In *Oxfordshire*, analysis of learning from SCRs nationally has led to the practice of sharing with schools all police domestic abuse reports where there are children over five years of age. This enables school staff to understand and respond to the situations faced by these children and young people. In addition, the development of toolkits to support the identification of cases of neglect and child sexual exploitation, are now used extensively by almost all agencies. The Board has also published a revised thresholds document to help professionals refer children to the right services for their needs and work is underway to develop a co-ordinated approach to female genital mutilation
http://www.oscb.org.uk/home_useful.html
http://ofsted.gov.uk/local-authorities/oxfordshire

11. Multi-agency Training and learning

LSCBs are responsible for promoting the welfare of children by ensuring that there are appropriate training and learning opportunities for people who work in services that contribute to the safety and welfare of children. This responsibility covers both the training provided by individual agencies for their own staff, and multi-agency training for staff from different agencies to train together. They are required to maintain a local learning and improvement framework which should enable organisations to be clear about their responsibilities, to learn from experience and improve services as a result.

In *North Yorkshire*, the LSC Board learns from the auditing and reviews that are undertaken which ultimately inform training. Conferences have been well received and have been attended by practitioners from across the partner agencies. The child sexual exploitation (CSE) conference is an example of the Board providing a quality learning event that professionals can see has made a direct difference to practice by raising awareness. This has included better screening of CSE concerns and an increase in referrals.

Also relevant, is the training required by Board members. In *Milton Keynes* the LSCB has produced an induction booklet for lay members, which provides them with

advice, information and guidance on how to become effective members of the LSCB. Also, in *Halton* the LSCB has introduced a planned induction processes for lay members of the board together with an appraisal system, which provides an opportunity for them to offer feedback about the operation of the LSCB. There are many examples of induction and introductory manuals that LSCBs have produced for their LSCB members.
http://www.londonscb.gov.uk/resources_for_lscbs/

In *Leeds,* the Chair explained that there is a complete loop of the learning from audit and quality assurance and performance management, feeding into the Board's learning and workforce development and training programme. One example is when a specific SCR was undertaken where the individual had a particularly complex life. The learning from this SCR fed into the Learning and Development Strategy, to create changes in practice, changes in processes, and had a huge impact on the organisation of services for the better. The process also led to a refreshing of the Leeds "Think Family" Protocol, which is now being embedded into practice across adult services (including those relating to community safety, adult mental health, etc) as well as across children's services. The Protocol ensures that the wellbeing of children and young people, is taken on board when practitioners are working with their parents/carers and vice versa.
http://www.leedslscb.org.uk/

In *Newham,* the Training sub-group is well chaired and well attended. It develops and commissions a wide range of targeted, multi-agency training programmes. The LSCB part-funds a training development officer, who has effectively reviewed, re-commissioned and expanded training. All the Board agencies support access to training within their organisations, overseen by the LSCB. It has employed a range of qualitative measures to evaluate the training including the course programme, and is now looking at how the training actually makes a difference to children's lives. The training development officer has recently begun to attend and quality assure the safeguarding training of individual agencies.

The *Isle of Wight* Board has undertaken a training needs analysis; the intention is to establish if training can be jointly commissioned with neighbouring LSCBs. The Board takes a holistic approach to training across the whole of the workforce, whilst at the same time being clear about the single agency training responsibilities as well.

Connect, share and learn: *Evaluating the outcomes of inter-agency training to safeguard children* (Jan 2011) explains how an LSCB training sub group can undertake an evaluation using the methodology in the toolkit.

Two levels of evaluation are feasible. The simpler level involves distributing the measures at the beginning and end of each course and comparing responses from these two time periods. A more complex evaluation involves the administration of questionnaires at additional time points, including registration, the start of the course, the end of the course and three months after the course. LSCB training subgroups can simply compare learning outcomes before and after the training. In order to assess whether learning has been retained, LSCB course administrators can follow up with participants after three months. Materials are provided in the toolkit.
http://www.nspcc.org.uk/Inform/trainingandconsultancy/piat/resources/piat_toolkit_fulltext_wdf79867.pdf

Research in Practice. Ensuring effective training: briefing for Local Safeguarding Children Boards (LSCBs), 2014. This briefing paper provides advice to LSCBs on how they can use their resources for training and staff development effectively. It focuses on:

- the DfE commissioned research on LSCB training programmes and what was identified from that research as good practice;
- best practice in getting training and learning translated into improved practice and better outcomes for children and families – 'training transfer';
- best practice in evaluation of training so that LSCBs can improve their ability to know what difference their training and staff development activity is making;
- questions that LSCBs can use to challenge themselves and partners to improve their training and staff development.

Some helpful questions are included in the briefing which are intended to help LSCBs consider some of the specifics of training transfer and evaluation and the scope of the LSCB role in respect of training, learning, improvement and development for the LSCB and its partners.

The briefing concludes that successful training requires dialogue between those who provide training, managers/organisations and staff, about the structures necessary to ensure training transfer is maximised. Training, particularly multi-agency training, is a partnership responsibility and one that includes responsibility for training transfer.
www.rip.org.uk/resources/publications/strategic-briefings/strategic-briefing--ensuring-effective-training-briefing-for-local-safeguarding-children-boards/

12. Resources References

Association of Independent LSCB Chairs
http://www.lscbchairs.org.uk/Measuring_LSCB_Effectiveness

Improving local safeguarding outcomes: Developing a strategic quality assurance framework to safeguard children, Local Government Improvement & Development/London Safeguarding Children Board; uses OBA approach
http://www.local.gov.uk/c/document_library/get_file?uuid=d9dfea72-4fe2-4498-9124-db3e42ecc7b2

Welsh LSCB self-assessment and improvement tool
CARE AND SOCIAL SERVICES INSPECTORATE WALES (2010)
Self assessment and improvement tool (SAIT) for Local Safeguarding Children Boards
http://wales.gov.uk/docs/cssiw/publications/101012saittoolen.pdf

What are the key questions for audit of child protection systems and decision-making? London: C4EO. (Safeguarding Briefing 2)
http://archive.c4eo.org.uk/themes/safeguarding/files/safeguarding_briefing_2.pdf

Safeguarding through audit: a guide to auditing case review recommendations, NSPCC.
http://www.nspcc.org.uk/Inform/trainingandconsultancy/consultancy/supportingproductsandresources/safeguarding_through_audit_pdf_wdf70186.pdf

The London Safeguarding Board
http://www.londonscb.gov.uk/audit_tools/

Leicestershire, Leicester city, Rutland – audit
www.lcitylscb.org/EasySiteWeb/GatewayLink.aspx?alId=131407

Sheffield safeguarding evaluation programme
https://www.safeguardingsheffieldchildren.org.uk/welcome/sheffield-safeguarding-children-board/sscb-information/s11-audit.html

SCIE Learning together to safeguard children: a 'systems' model for case reviews
http://www.cwrc.ac.uk/projects/documents/SCR_Report_March_2013_Version_2.pdf

Canary in the Cage – lead indicators and their use LSCBs and their partner agencies
http://www.cwrc.ac.uk/projects/documents/Lead_Indicators_report_revised_for_website_Sept_11_WP_No_6.pdf

Suffolk Audit Tool
http://www.suffolkscb.org.uk/about-us/learning-and-improvement-group/

Good Practice of Local Safeguarding Children Boards, 2001, Ofsted.
http://www.ofsted.gov.uk/resources/good-practice-local-safeguarding-children-boards

Safeguarding Sheffield Evaluation Programme
http://www.nfer.ac.uk/publications/LSGL01/LSGL01.pdf

LSCB Challenge and Improvement Tool, 2008
http://webarchive.nationalarchives.gov.uk/20130401151715/http://www.education.gov.uk/publications/eOrderingDownload/DCSF-00581-2008.pdf

Eastern Region *Making a Difference* toolkit: LSCB Performance Management Toolkit, 2013
http://www.nwsli.co.uk/download-file/89

LGA Peer Review Programme
http://www.local.gov.uk/peerchallenges//journal_content/56/10180/3511045/ARTICLE

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A Quality Assurance Framework for SE Region LSCBs
http://southamptonlscb.co.uk/wp-content/uploads/2012/10/Quality-Assurance-Framework-for-South-East-LSCBs1

West Midlands Children's Services Performance Data Pack
http://www.westmidlandsiep.gov.uk/index.php?page=900