VIRTUAL COLLEGE

The Wood Report

A review of the role and functions of LSCBs

Introduction

Director of children's services, Alan Wood CBE, has independently reviewed Local Safeguarding Children Boards (LSCBs), after the prime minister requested an urgent analysis back in December.

The Wood Report outlines a new framework for improving the organisation and delivery of multi-agency arrangements to safeguard and protect children.

Recommendations for the considerations of the government are contained in the report, suggesting that appropriate steps should be followed to recast the statutory framework that underpins the model of LSCBs, serious case reviews (SCRs) and child death overview panels (CDOPs).

In the report, Mr Wood comments:

"On a scale of prescriptive to permissive arrangements, the pendulum has locked itself too close to a belief that we should say how things should be done as opposed to what outcomes we want for children and young people. Taken together, the recommendations I have made propose fundamental reform to the way we do things."

This guide will outline and explore the findings and suggestions from the Wood report.

The case for fundamental change

According to the report, the case for fundamental reform is based on a widely held view that LSCBs are not sufficiently effective. Limitations of LSCBs in delivering their key objectives are exposed in this review and by the work of Ofsted.

Confidence must be restored in the strategic multi-agency arrangements made to protect children, that they are fit for purpose, consistently reliable and able to ensure children are being protected effectively.

Research from the report reveals that, in answer to questions about the coordination and effectiveness roles of LSCBs:

52.8%

said that they ensure the effectiveness of the work.

62.5%

claimed they felt the coordination role was effective.

The report argues that these statistics represent a low level of support, when aid for such critical activity should be as close as possible to **100%.**

1. Roles and expectations

The report found that there was a lack of clarity with regards to the role and expectations of an LSCB, and often the effectiveness of an LSCB is due to the ability of the chair. A dissonance among the partners between the accountability and the authority of an LSCB was also identified.

Such issues have previously been identified, namely by Lord Laming, who proposed the need for a new model to ensure collective accountability.

"It is clear that the duty to cooperate has not been sufficient in ensuring the coherent and unified voice necessary to ensure multi-agency arrangements are consistently effective," wrote the report.

2. Modelling effective partnership

According to the Wood Report, national government departments do not do enough to model effective partnership working between themselves for local agencies. In addition to this, the coordination demanded of local partners is not particularly evident at national level.

As it stands, the cost of arrangements to key agencies such as the police, health authorities and local government is not sustainable, with too much of practice leaders' time taken up in servicing the architecture of multi-agency arrangements.

Examples in the report, given by the police and crime commissioners, show that the wide variety of boards, committees and other bodies established to consider similar issues as LSCBs, compounds a growing demand on officers to attend meetings and produce reports.

The report recommends that at a time of growing pressure on available resources, effort and money should be concentrated on front line service delivery and not diverted to bureaucracy and meetings.

The proposed multi-agency arrangements

To carry out reform, the existing arrangements for LSCBs must be replaced with a new, more effective statutory framework that sets out the strategic multi-agency arrangements for child protection.

Key findings:

- The duty to cooperate is not a sufficient vehicle to bring about effective collaboration between key agencies of health, the police and local government
- These agencies should determine, for an identified area, multi-agency arrangements for protecting and safeguarding children
- They should draw up a plan that describes how their services will deliver the new statutory framework
- New arrangements should require health, local authorities and the police to make clear their leadership responsibility for multi-agency arrangements, to include the identification of a chief officer in each of the agencies to have responsibility and authority for ensuring full collaboration with those statutory arrangements
- All areas should be required to move towards new multi-agency arrangements for protecting children within a prescribed period

According to the report, a more effective and defined statutory framework focused on protecting children allows for much more flexibility in terms of how arrangements are made.
The report states:

"We should be asking for outcomes for children and young people to be improved, not how they are organised. We are seeing innovation and flexibility in the way partnership working between the police, health and local government is responding to the needs of older people.

We should seek that for children and young people too. We should look at incentivising all applicants for devolution deals to include arrangements for safeguarding children as part of their combined authority arrangements, but that is only a start."

In order to do this, the report outlines two things that must be done:

1. **Introduce a more effective statutory framework to focus the arrangements on child protection and ensure key agencies collaborate to deliver more effective services**

2. **Move away from an over prescriptive system to one that encourages and authorises local areas to determine how they organise themselves to improve outcomes for children and meet the requirements of the new framework**

Should these two things be achieved, the impact they will have is to allow practice leaders the space to be more innovative in organising services to better protect children and to drive closer, more effective collaboration between key agencies.

Serious Case Reviews

Currently, the UK does not have a national framework for considering the lessons of the tragic events that take a child's life or seriously harm them.

Although there is guidance to the contrary, the model of serious case reviews has not been able to overcome the suspicion that its main purpose is to find someone to blame.

Despite this, there has been some improvement in the quality of a selection of reviews, but the overall picture is not good enough, claims the report, and the lessons to be learned tend to be **"predictable, banal and repetitive".**

The Wood report recommends that the government discontinues Serious Case Reviews, and establishes an independent body to oversee a new national framework for inquiries into child deaths and cases where children have experienced serious harm.

The framework should be predicated on:

- High quality, published, local learning inquiries
- The collection and dissemination of local lessons
- The capacity to commission and carry out national serious case inquiries
- A requirement to report to the Secretary of State on issues for government derived from local and national inquiries

The report states that both local and national inquiries will be most effective if there is a skilled cohort of accredited reviewers. The new body should also be charged with setting out and consulting on a process of accreditation and on-going development for national reviews.

What factors characterise a good inquiry should also be considered by the new national body. According to the report, the body should consult with those who are most experienced in understanding and delivering models of review and draw up a good guidance framework.

In combination, the report believes these ideas will bring about a national resource of learning built on the foundations of effective local learning and skilled reviewers.

Child Death Overview Panels

Although the report acknowledges how compassionate local CDOPs are about the work they do and the learning they identify, the report also states that child deaths must be reviewed over a population size that gives a sufficient number of deaths to be analysed for patterns, themes and trends of death.

The report encourages regionalisation as they provide a source of data and intelligence which, when analysed, leads to the identification of key issues relating to deaths.

A priority for implementation has to be the introduction of a national database which would assist the collection of local information and a national analysis of child deaths to inform regional CDOPs.

It is recommended that a new Healthcare Safety Investigation Branch (HSIB) sets a common, national standard for high quality serious incident investigations. In its first year of operation, the HSIB will prioritise maternity and is proposed to develop a standardised perinatal mortality review tool.

The way in which CDOPs consider child deaths is likely to be implicated by both of these developments.

Research from the report revealed that over 80 per cent of child deaths have medical or public health causation. Clinicians estimate that only four per cent of child deaths relate to safeguarding or require a SCR to be carried out.

The report also states that ownership of the arrangements for supporting CDOPs should move from the Department for Education to the Department of Health.

Moving forward

Recommendations in the report pave the way for a fundamental reform of the system for protecting and safeguarding children.

The framework hopes to:

- Make sure contributions made by the health service, police and local government are better coordinated and deployed
- Clarify and outline the responsibilities of a lead chief officer in health, the police and local government in ensuring effective multi-agency arrangements
- Promote innovation and deliver efficiency in the design of local arrangements to safeguard children and young people
- Establish a National Learning Framework overseen by a new independent body
- Create a more effective model of learning from the deaths of children

It is hoped that a results-driven statutory framework will release resources to focus on the front line of practitioners engaging with children, young people and their families.

Outcomes of this will be measured in the development of more highly skilled practice leaders and practitioners using their professional skills and judgement in casework.

The report concludes: "If we want to achieve a safer system to protect children, we must create the environment in which better skilled practitioners can practise and get on with the work of protecting children."

Read our summary of the government's response here:
www.safeguardingchildrenea.co.uk/safeguarding-news/uk-safeguarding arrangements-face-radical-changes

Source

www.gov.uk/government/uploads/system/uploads/attachment_data/file/526329/Alan_Wood_review.pdf

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