

An overview of Alan Wood's Review of the role and functions of Local Safeguarding Children Boards & the government's response

In December 2015, the Department for Education (DfE) asked Alan Wood CBE to lead a review of the role and functions of Local Safeguarding Children Boards (LSCBs) in England. As part of the review he also looked at Serious Case Reviews and Child Death Overview Panels. The DfE has published the Wood report on 26/5/16 along with the government response to the review with explanations of how the proposed new arrangements will be implemented.

Local Safeguarding Children Boards

The Wood Review's findings:

For multi-agency working to be strong and effective it needs to be responsive and involve the right people. A new system is needed which will guarantee accountability.

What the government has said it will do:

- A new statutory framework will be introduced, which will set out clear requirements, but give local partners the freedom to decide how they operate to improve outcomes for children.
- The 3 key partners (local authorities, the police and the health service) will be required to make and publish plans showing how they will work together to safeguard and promote the welfare of children in the local area. These should include:
 - the area or region which is covered by the plan
 - how other local agencies with a key role in protecting children will be involved
 - how the arrangements will be resourced
 - how independent scrutiny will be ensured.
- All local organisations involved in the protection of children will be expected to cooperate with the multi-agency arrangements. They must help the key partners to understand how agencies are performing across the local area, and make evidence-based decisions.

- So that the key partners have the flexibility to respond to existing and emerging needs, the requirement for LSCBs to have set memberships will be removed. However if they see the current arrangements as the most effective form of joint working they will be able to continue them.
- Legislation and statutory guidance will be published to underpin the new framework. Arrangements for inspection and review will be established.
- In the event that the 3 key agencies cannot reach an agreement on how they will work together, or where arrangements are seriously inadequate, the Secretary of State will have power to intervene.

Serious case reviews

The Wood Review's findings:

The current system of serious case reviews should be replaced with a national learning framework for inquiries into child deaths and cases where children have experienced serious harm. This would include:

- high quality, published, rapid 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.

What the government has said it will do:

- The current SCR system will be replaced with a system of national and local reviews. This will ensure that reviews are proportionate to the case they are investigating, and improve consistency, speed and quality (this will include accrediting authors).
- Under the new system, lessons from reviews will be captured and shared more effectively so that they can inform good practice.
- A National Panel will be established. This will be responsible for commissioning and publishing national reviews and investigating cases which will lead to national learning.
- Local partners will be required to carry out reviews into cases which are considered to lead (at least) to local learning. These should be published.

- The planned What Works Centre for children's social care will analyse and share lessons from local and national reviews.
- Up to £20m has been announced by the Government to fund the centralisation of case reviews and the What Works Centre.

Child Death Overview Panels

The Wood Review's finding:

Child death reviews should continue to be carried out by multi-agency arrangements but Child Death Overview Panels (CDOPs) should be hosted within the NHS, supported by the Department of Health.

What the government has said it will do:

- As only 4% of child deaths relate to safeguarding, the government agrees to transfer national oversight of CDOPs from the Department for Education to the Department of Health, whilst maintaining the focus on learning within child protection agencies.

Swindon LSCB's Position

Swindon LSCB has noted the review and the government response and welcomes the continued focus that there will be on the importance of strong multi-agency arrangements for the safeguarding and protection of children. Swindon LSCB members have confirmed that the current multi-agency safeguarding arrangements continue as constituted presently to ensure there no risk to safeguarding children by any destabilisation.

Further information regarding the detail of the proposed actions and the timescale for implementation is required before the partners of the LSCB can consider the most appropriate way forward for Swindon.

Further Information:

Department for Education (DfE) (2016) [Review of the role and functions of Local Safeguarding Children Boards: the government's response to Alan Wood CBE \(PDF\)](#). [London]: Department for Education (DfE)

Wood, A (2016) [Wood report: review of the role and functions of Local Safeguarding Children Boards \(PDF\)](#). [London]: Department for Education (DfE)