Consultation on integrated inspections of services for children in need of help and protection, children looked after and care leavers and joint inspection of the Local Safeguarding Children Board

Consultation Response

1. Introduction

The Children's Society is a leading charity committed to improving the lives of thousands of children and young people every year. We work across the country with the most disadvantaged children through our specialist services and children's centres. Our direct work with vulnerable groups including disabled children, children in or leaving care, refugee, migrant and trafficked children, means that we can place the voices of children at the centre of our work.

We run 11 projects supporting young people in care and 13 specialist projects working with children who run away or go missing and/or are at risk or victims of sexual exploitation. We also run services that deliver emotional support, psychological interventions and counselling for children who have experienced domestic abuse and/or sexual exploitation. Many of the children we support are very vulnerable young people who come into contact with mental health services.

We welcome this consultation on multiagency inspection of services for children in need of protection and looked after children. Our submission is informed by learning from our direct work with vulnerable children and young people. We have chosen to respond only to questions where additional clarifications are needed in relation to how the multiagency inspections should work.

Proposal 1: How and where we will inspect

We do not have comments on proposals on how and where inspections will happen or the judgement structure.

We broadly agree with those proposals.

Proposals 3 and 4: the evaluation criteria

The Care Quality Commission

Q3b. To what extent do you agree or disagree with the criteria CQC propose for evaluating the effectiveness of health services:

- **The overall effectiveness of health services? (paragraphs 63–67)**

The Children's Society welcomes proposals to include the inspection of health services in the integrated inspection framework. We feel that it is crucial that health services work with other services to identify and respond to children who are in need of protection, looked after children and care leavers. This is particularly important in light of responsibilities of local authorities to commission some public health service such as substance abuse and sexual health services for children and young people. These services are vital in supporting children and young people who have experienced sexual abuse or engaged in substance abuse.

Recommendation: *The Children's Society supports the proposals to include the review of children's health services commissioned by the local government and that CQC inspects how health organisations work both individually and together for children in need of help, care and protection. We would like other inspectorates to adopt this approach.*

We support the joint inspection of Local Safeguarding Children's Board and for the CQC this will present an opportunity to inspect the role of health services in contributing to LSCBs and how health information is shared with Social Care Services and other services.

- **Commissioning and delivery of services for children in need of help and protection looked after children and care leavers**

From our direct work with children and young people (particularly with disabled children, looked after children and young carers) we know that they do not always get the support they need and are not always sure who to approach to access services available to them. Additionally, availability and quality of services from one area to another differs significantly.

Joint up multi-agency working is paramount to effective commissioning and delivery of support and services. From our direct work with vulnerable children we know that health services make an important contribution to Multi agency Safeguarding Hubs (MASH) or other relevant local multiagency arrangements, Local Safeguarding Children's Boards and Health and Wellbeing Boards.

We are concerned that despite the Department of Health's Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Well-Being Strategies placing a duty on Health and Wellbeing Boards to assess the need for services for vulnerable groups, these services are not always priorities for commissioning.

For example, we are particularly concerned about the commissioning of services for looked after children and disabled children placed away from home in long-term health or social care placements. Nearly a third of looked after children are placed outside their local authority area, and over 10% experience three or more placement moves in a single year.

Recommendation: *We recommend that as part of the multiagency inspection CQC looks at how data about vulnerable groups of children and young people is gathered and shared by the health services, both to inform responses to an individual child as well as to vulnerable groups of children, including those who are placed outside the boundaries of their home local authority.*

Recommendation : *We believe that CQC should assess how effectively Health and Wellbeing Boards are used to formulate and implement strategies to protect vulnerable children.*

Children's involvement in decision-making

We are pleased to see that as part of its inspection CQC seeks views from children and young people and their families about the quality of services they receive. From our direct work we know that children can provide a very helpful insight into the quality of services they receive as well as can inform the delivery of local services. We believe that along with asking children about the quality of services children receive, CQC should also ask about how engaged children felt in the treatment they received.

We believe that children and young people and their families do not have a strong voice in the health care system. Many young people we are working with, particularly vulnerable young people like disabled young people or looked after children, tell us repeatedly that they do not always feel in control of themselves and make decisions about the services they receive. This creates a barrier for them to ask for help if they need or to tell professionals when they do not feel safe.

Recommendation: *We believe that both, Healthwatch and Health and Wellbeing Boards should demonstrate how they enable children and young people, particularly those in need of support and protection to voice concerns about their individual care and to have a say in strategic decisions about the planning, delivery and review of health services***.**

- **Access to advocate**

The Children Act 1989 and relevant regulations and guidance gives children the right to have their wishes and feeling taken into account when decisions are made about their lives. From our direct work with children and young people we know that some young people need support of an advocate to access health services, to participate in decisions about their care and to have a say in strategic decisions about the planning and commissioning of services.[1] For example, a young person supported by one of our projects told us about not being believed that she experienced mental health issues and not being signposted to support. In another case, a disabled young person with a non –verbal means of communication and whose behaviour was slowly deteriorating was not getting relevant support until an advocate established that changes in his behaviour was caused by deteriorating eyesight. Seeing big shapes instead of people scared him and made him lash out at people.

Recommendation: *we believe that CQC as part of its inspection of health services should also look at whether vulnerable children and young people are informed about and can access the support of an independent advocate if they require help to communicate their wishes and feeling when engaging with health services.*

- **The experiences and progress of children in need of help and protection (paragraph 68)**

We welcome the focus on children and young people missing from home, care or education. Running away or going missing from home or care puts a child at risk of sexual exploitation, involvement in crime and other risks. The Children's Society has more than 25 years of experience of research policy and direct work with children and young people who run away or go missing from home or care. Our research shows that many children are not reported as missing to the police by their family or carers.[2] Our practitioners report that they receive referrals for children who have run away from home or care but have not been reported as missing to the police. These children can come to the attention of the police when they are found on the streets; to the attention of health services when they attend A&E department, or education services when they miss school or turn up dirty and hungry. Our research shows that some children who run away from home or care may still attend school during the day.[3]

Recommendation: *We would like the inspectorate to look at how well health and multi-agency arrangements work in identifying and responding to children who have run away but are not reported as missing to the police by their family or carers. As part of that, the inspection should focus on whether the staff receive training on the risks of going missing and are able to identify*

[11] Hounsell, D., Pona, I. (2012) The Value of advocacy for looked after children. The Children's Society.
[2]Rees, G. *Still Running 3* (2011) The Children's Society : London

[3] Williams, N., *Lessons to Learn: Exploring the links between running away and absence from school* (2012) The Children's Society: London

children who are at risk of harm as a result and whether there are pathways in place to refer children (including those who have not been reported as missing to the police) to other safeguarding services.

- **Transition to adults services**

Transitioning from children's to adult's services can be daunting experience for young people. It can be particularly overwhelming within health services. We know that more often than not children and young people themselves are not involved in planning their transition. We feel that this is particularly important for disabled children, children with mental health problems and care leavers to be supported during this period. The inspectorate's most recent review of children's transition into adult health services[4] found that 50% of young people and their families did not feel supported enough during their transition into adult health services, the inspectorate also found that the levels of planning to meet the health needs of a child in transition were insufficient in many areas.

From our direct work with looked after children, including disabled looked after children, we know that they experience greater difficulties in transitioning from children's to adult's services when they are placed outside their home local authority. Their experiences of transition are characterised by the confusion about responsibilities for funding and carrying out health assessments, such as continuing care assessments, delays in registering with general practitioners and thus delays in referrals to hospital specialists. CQC should inspect how health services particularly support disabled looked after children in transitioning to adult services.

Recommendation: *The CQC should inspect how health services are working together with other agencies to plan and review transition arrangements for vulnerable young people, including those in the looked after system and young people in out of local authority placements. .*

- **The experiences and progress of children looked after and care leavers – health services? (paragraph 69)**

We welcome the focus on the experiences of looked after children and care leavers using health services. Research has consistently found that the health and wellbeing of looked after children is poorer than that of young people who have never been in care. Many aspects of young people's health have been shown to worsen in the year after leaving care. Designated health professionals for looked after children should play a leading role in promoting their health outcomes and should raise concerns on their behalf. They also have a role to play informing the delivery and commissioning of services for this group as well as raising awareness of other professionals about the needs of looked after children and care leavers.

Recommendation: *The inspectorate should inspect the extent to which designated health practitioners for looked after children are involved in the commissioning and delivery of services for this group of children.*

- **Mental health of looked after children including unaccompanied asylum seeking children**

The level of mental health needs among looked after children are very high. Research shows that around 60% of looked after children and 72% of those in residential care have some level of emotional and mental health problem[5]. A high proportion experience poor health, educational and social outcomes after leaving care[6]. Looked after children and care leavers are between four and five times more likely to attempt suicide in adulthood. From our direct work with looked

[4] CQC (2014), From Pond into the Sea
[5] NICE: *Promoting the quality of life of looked-after children and young people*. NICE public health guidance 28. 2010.
[6] DCSF: *Children looked after in England (including adoption and care leavers) year ending 31 March 2009*.

after children we know that they often find it difficult to access mental health support and that the planning and co-ordination between the mental health services and social services is not working in many cases. This jeopardises their recovery and future life chances.

One of the issues that has been highlighted by our practice was the lack of co-ordination on the discharge of young people from mental health settings. From our practice we know that while the reviews may happen with a focus on mental health support they receive, there is a lack of efficient communication between the mental health practitioners and social care practitioners to ensure that care planning review ensure smooth transition for a young person from a mental health settings to care settings.

For example, in one case we know of a 17 year old was placed in Bed and Breakfast accommodation after the discharge from mental health hospital, which made him both vulnerable to abuse and also had a negative impact on his mental health. Such inappropriate transition arrangements can be prevented if there is a greater focus on all aspects of planning for discharge while young people are in mental health settings. Many of our case studies highlight how, regardless of the success of treatment, when a young person is released to temporary shared accommodation which is often overcrowded, noisy and lacking in privacy, their mental health can quickly regress.

***Recommendation**: We would recommend that the inspectorate looks at the quality and availability of mental health services to young people and how effective the multiagency arrangements are for providing support for looked after children discharged from mental health settings.*

- **Integrated plans**

Health and Social Care services should take coordinated and holistic approaches to looked after children and young people's health, care and pathway plans. Services should also strongly consider the views of children in the formulation of these plans and should keep children well informed in a clear manner. Care and pathway plans should make direct references to the health care arrangements for looked after children and should outline the steps being taken and those planned to be taken in the future. As part of their pathway plans, health and social care services should coordinate to address how the health needs of care leavers will be met.

***Recommendation:** CQC should examine how well integrated health plans are with care and pathway plans in supporting young people to take responsibility for their own health.*

Her Majesty's Inspectorate Of Constabulary

Q3c. To what extent do you agree or disagree with the criteria HMIC propose for evaluating the effectiveness of the police force:

- **The overall effectiveness of the police force? (paragraphs 75–79)**

The Children's Society overall agree with the proposals set out by the HM Inspectorate of Constabulary on how it will inspect the overall effectiveness of police forces. We strongly welcome the inspectorate's focus on how effectively police officers are in interacting with children, young people and their families. In protecting vulnerable children, the role of the police in multi-agency working is vital in identifying and responding to the needs of these groups of children. We therefore support the inspectorate's proposal to assess how accountabilities are embedded in professional relationships with partner organisations.

- **Attitude and criminalisation of vulnerable young people**

Through our research and practice work we know that children often report negative experiences of coming into contact with the police. Concerns have been expressed about the attitudes of front-line officers and the criminalisation of vulnerable children.

Quotes from young people on responses during missing episodes

'Tell the police not to judge us until they know the full story'

'Explain to us how they feel – about getting your family worried'

'They need to start learning how to work with us'

Vulnerable children like those who are victims of CSE or who have runaway stated that negative attitudes hugely impacted on their willingness to disclose their experiences or turn to the police for help.

Our practice reports that the attitudes of some professionals to children who are sexually exploited remain an issue of concern. This was highlighted in the APPG inquiry we supported into children who go missing from care[7]. The inquiry found that in many cases where children are at risk of, or have experienced sexual exploitation, they were seen by professionals, including the police, as "promiscuous" and making an active "choice" to become involved in a particular "lifestyle" or were seen in some way "complicit" in their abuse. For example a practitioner working with children and young people at risk of CSE told of a response from a police officer to a young girl who disclosed a sexual transgression "…what do you expect dressed like that, you're looking for it…". The inquiry was told that some professionals saw sexual activity between a child under 16 and an adult as acceptable. They believed that the young person had "consented" to sexual relations and therefore did not perceive it as a child protection or sexual exploitation concern. In other examples, professionals could recognise signs of CSE but believed that a young person could not be helped.

Our practice reports that prosecutions are more likely to be successful under the Sexual Offences Act 2003 when the young person makes a disclosure of CSE. At the same time in many cases there is an over-reliance on the disclosure by the young person and opportunities are missed to gather evidence for prosecution because identification of CSE is left to 'specialist' staff rather than something that all staff should be trained on. Our practitioner cited a case whereby the police did not write down names of all the people who were found in a flat when they responded to a call about disturbances at the address, even though there were young people present at the address at the time, which was a known local hotspot for CSE.

Recommendation: *We believe that HMIC as part of inspection should look at how the police force through adequate training and supervision ensures that staff of all ranks understand the vulnerabilities of children and young people and that negative attitudes can be challenged and addressed.*

- **Early interventions**

Learning from our practice shows that responses to CSE cases vary considerably from one area to another. There are examples of good joint working at a local level where professionals from all agencies show dedication to protect vulnerable young people and intervene as early as possible to disrupt sexual exploitation and to build evidence long before the young victim of sexual exploitation or grooming is prepared to make a disclosure. For example, our practice report instances where the police have successfully used provisions contained in different pieces of legislation to disrupt CSE and to build evidence for prosecution. Examples include: the application of Child Abduction Notices to break up contact between a child and a suspected

[7] The APPG for Runaway and Missing Children and Adults and the APPG for Looked After Children and Care Leavers (2012) Report from the joint inquiry into children who go missing from care

perpetrator, the application and breach of Anti-Social Behaviours Orders (ASBOs) to deal with grooming cases, investigating premises as part of health and safety or environmental checks, or working closely with the voluntary sector to build up a bigger picture and intelligence on local hot spots and individuals posing a risk to children.

Recommendation: *We believe that it is very important for safeguarding responses to be employed as early as possible to protect children from harm. We believe that HMIC should inspect at how effectively the police are using early intervention and disruption measures at their disposure and how well they engage in multi-agency work with a focus on early interventions.*

- **Working together with the voluntary sector**

We know from our direct work with the most vulnerable children that they often struggle to build relationships with staff at statutory agencies either because of their previous negative experiences of engaging with those agencies or because they fear getting into trouble. Voluntary sector organisations play an important role in providing a bridge between the young person and statutory services by developing trusting relationships with young people and supporting them in making disclosure. They can also help the police and other services to develop practice that is more responsive to the needs of a child. For example, our CheckPoint project in Torbay has been delivering awareness raising training to police officers on what actions to take if they come across a young person that has run away and/or been sexually exploited and how to identify risk indicators. Police can also do a two week placement with CheckPoint to gain greater understanding on the links between running away and CSE and how to address these.

In other examples our projects have been involved in mapping and gathering intelligence about perpetrators which have sometimes been the first step in uncovering grooming rings and have resulted in police operations. Frequently the site of exploitation, or perpetrator is uncovered through return interviews which should take place when a child has gone missing or run away and allow practitioners to explore what happens during a missing episode.

Information sharing is crucial, though it is very important that young people have a clear understanding of how and what information will be shared with other local agencies. For example, in one area where the project works closely with the police, we share information that the young person has told us about sexual exploitation with the police, even if the young person does not want to make a complaint or disclose. This is done in order to help the police disrupt and investigate key 'hot spot' areas for exploitation such as takeaways or hotels. The time we have spent building up relationships with young people means they trust how our services and the police will use the information.

Recommendation: *We believe that HMIC inspections should look at how effective the police are in working together with relevant voluntary sector organisations in gathering and mapping information about individuals posing a risk to children and in enabling children to make a disclosure about harm they have experienced in a way that does not cause them further distress.*

- **Missing and absent categories**

We are concerned that the new missing and absent categories used by the police are not capable of identifying risk or harm experienced by children. For example, recent evaluation by the University of Portsmouth[8] reveals a worrying lack of robust risk assessments when children are reported missing, inconsistent training and oversight of 'absent' cases and a lack of joined-

[8] Shalev Greene, K. and Pakes, F. (2013) *Absent: An exploration of common police procedures for safeguarding practices in cases of missing children* University of Portsmouth, the Association of Chief Police Officer and the National Crime Agency

up work. The police have said these changes are about better targeting of resources but without proper training and oversight, these changes are in danger of becoming a cost-cutting exercise that puts children at risk of serious harm.

Furthermore, children classified as 'absent' will not receive a return interview and may not even receive a police 'safe and well' check so will have fewer chances to be referred for further support. This means relevant information that could have been gathered during this check, or a return interview, may not come to light until the situation in the child's life worsens, or after a considerable delay.

Recommendation: *We believe that HMIC inspections should specifically look at how new definitions of 'missing' and 'absent' work within the multiagency safeguarding processes, and how information about 'absent' children is gathered, shared and acted on to ensure that children are not left without protection.*

- **Stop and searches**

Last year, The All Party Parliamentary Group (APPG) for Children and the National Children's Bureau launched an inquiry into 'Children and the Police'. Findings from the group's initial report exploring the use of stop and searches on children reveal that no police force was able to submit stop and search data on looked after children. 19 forces explicitly stated that this was because they did not gather this information. The Children's Society is worried by these findings, it is crucial that police forces develop a system to record this information as police officers may encounter children who may have absconded from a care placement or may have been trafficked and will therefore require them to take the necessary safeguarding steps.

Recommendation: *The inspectorate should examine what policies are place for when officers carry out stop and searches, to ensure they record data and identify vulnerable children, such as trafficked or looked after children.*

- **The use of police cells**

The Children's Society is concerned about the use of the police cells to detain children in cases where other the guidance says this should not be happening. Examples include, use of police cells for missing children because emergency accommodation is not available; for mental health assessments in cases of young people detained under Section 136 of the Mental Health Act 1983 as shown in the recent report from the Care Quality Commission[9]; for age assessments in case of migrant young people. Last year, figures obtained by The Howard League for Penal Reform found that there were more than 40,000 overnight detentions of children aged 17 and under in police stations across England Wales in 2011.[10]

Recommendation*: The inspectorate should examine the use of police cells to detain children overnight.*

Recommendation: *It is important in this section to inspect policies and practice in relation to emergency accommodation or health based places of safety and how the police are working with local services to ensure that children are not detained in the police cells inappropriately.*

The experiences and progress of children who need help and protection – the police force? (paragraph 80)

- **Domestic violence**

We are concerned that young people aged 16-17 are very often seen as young adults and are not safeguarded appropriately, despite legislation clearly stating that any person under the age

[9] http://www.cqc.org.uk/media/new-map-health-based-places-safety-people-experiencing-mental-health-crisis-reveals-restrictio

[10] http://www.howardleague.org/childreninpolicecells/

of 18 is a child[11]. The government changed the definition of domestic violence to include 16 and 17 year olds in March 2013. It is intended that this change will help to raise awareness of teen abuse amongst practitioners and police, and prevent young people from falling through the gap between child protection and domestic abuse services. As well as living in families experiencing abuse, teenagers are also vulnerable to becoming victims themselves.

Additionally, in recent years, there has been increasing evidence and awareness of the prevalence of abuse within teenage relationships. The British Crime Survey 2009/10 found that 16-19-year-olds were the group most likely to suffer abuse from a partner. 12.7% of women and 6.2% of men in this age group suffer abuse, compared to seven per cent of women and five per cent of men in older groups. Yet domestic abuse descriptors in many police forces focus too heavily on abuse in the context of the family home.

Recommendation: *The inspectorate should evaluate what support and services police forces provide for teenagers involved in relationships where there is domestic abuse.*

- **Runaways and Missing:**

The police are often the first people who young runaways come into contact with. This may happen in a variety of situations: when they approach a police officer for help when away from home; when they are picked up while away from home (as a result of being recognised as a missing person, or because they have committed an offence or been the victim of crime); or when they are visited by a police officer conducting a "Safe and Well" check on their return home. The police are responsible for carrying out a safe and well check when any missing person, child or adult, returns. This is set out in the Association of Chief Police Officers (ACPO) 2010 Guidance on the Management, Recording and Investigation of Missing Persons. This should take place as soon as possible after the person has returned to check for any signs that they have suffered harm whilst away. In 2012, we sent out a Freedom of Information request to all police constabularies and found that only 13 forces were able to provide data on the number of safe and well checks conducted in their area[12]. We are worried that crucial information about young runaways is not being properly recorded by the police. It is important that safe and well checks are conducted along with a return interview by the local authority to help identify the right support for young people and prevent the escalation of problems whilst also addressing the problems that made them run away in the first place. It is also helpful in collecting evidence about potential groomers that can be shared with relevant child protection services and multiagency groups.

Recommendation: *HMIC should inspect police forces on their use of 'safe and well' checks to gather evidence and facilitate information sharing to other relevant agencies such as social care services.*

- **Trafficked children:**

Children who have been trafficked into the UK encounter police when they are found during raids, for example, in brothels or cannabis factories. From our research and experience of working with trafficked children we are aware that this particular group of children and young people frequently have negative experiences with the police. Last year, we undertook a joint review of the practical care arrangements for trafficked children in the UK on behalf of the Home Office with the Refugee Council[13] The review highlighted a number of areas where trafficked children have come into contact with the police and had extremely negative experiences. This included a lack of identification and prioritisation of trafficking cases by the police, as well as the

[11] The Children Act 1989
[12] 2012, The Children's Society, Make Runaways Safe: The local picture, p10
[13] Still at risk: A review of support for trafficked children (2013), The Children's Society

criminalisation of trafficking victims instead of recognising them as children who cannot consent to being trafficked and were coerced into crime.

Recommendation: *We recommend that as part of multiagency inspection HMIC looks at how effective the police force is in identifying, recording, and responding to trafficked children and work jointly with other agencies to protect them from harm*

Leadership, management and governance – the police force? (paragraph 81)

Her Majesty's Inspectorate of Probation

Youth offending teams? (paragraphs 91–97)

Overall we agree with the inspectorate on how it will inspect Youth Offending Teams (YOTs) in protecting children.

- **Understanding role and contributing to multi-agency safeguarding work**

The Children's Society is concerned by the recent findings made by the inspectorate[14]. In particular, the review revealed that in some local areas, YOTs did not fully understand their role in multi-agency safeguarding provisions. The inspectorate also found that YOT work was very often overlooked in Multi-Agency Safeguarding Hubs and Local Safeguarding Children's Boards. We believe that the lack of understanding about their position impacts on their contribution to these groups, we support the inspectorate in highlighting the need for staff training in understanding their role in multi-agency child protection.

- **Restorative justice**

Restorative justice provides opportunities for those directly affected by a crime to agree on how to deal with the offence and its consequences. The Children's Society currently runs a longstanding restorative justice project in our Tees Valley centre to support children and young people who have been in or who currently involved in the youth justice system. Our restorative justice activities make a real difference to families and communities, helping young people address the cause and effect of their actions and supporting victims of crime. YOT should utilise the use of restorative justice techniques to encourage an informal resolution and encourage reconciliation between victim and offender.

Recommendation: *We recommend that as part of multiagency inspection HMIP looks at how effective youth offending teams are in using restorative justice approaches to work with young people who are in trouble with the law.*

- **Release from custody**

Prior to release there are a number of duties that YOTs must undertake in preparing for the release of children and young people from custody. These include making arrangements for their accommodation and education and also conducting a health needs assessment. Probation staff are required to work with prison services and local authorities in making these arrangements. Our practitioner working in our Safe Choices Project in London[15] generally reported a good working relationship with YOTs. However, they inform us of cases where probation services did not sufficiently prepare young people for release. In particular, there were

[14] 2014, HMI Probation, An Inspection of the work of Probation Trusts and Youth Offending Teams to protect children and young people

[15] Safe Choices works to prevent and reduce violent offending by young women. The project works with those who perpetrate violence, are associated with gangs and experience sexual violence and exploitation in this context.

instances where young people have been provided with unsuitable accommodation and were placed at risk of offending or being exploited as the location had been known to groomers. Our practitioner also found that their health needs were not properly addressed, on several occasions she supported young people in registering with health services.

Recommendation: *HMI Probation should inspect the preparatory measures taken by YOTs in preparing a safe and secure resettlement arrangement for children and young people*

- **Additional support and focus for looked after children**

Figures from the Ministry of Justice show that twenty-four per cent of prisoners had been in care at some point during their childhood. Those who had been in care were younger when they were first arrested, and were more likely to be reconvicted in the year after release from custody than those who had never been in care[16]. We are concerned about the levels of support for looked after children leaving the youth justice system. Research has shown that communication between children services and YOTs are poor[17]. Our practitioners tell us that there are insufficient arrangements in place for this group of young people. They have found on many occasions young people were given accommodation in high risk areas, our project workers challenged the local authority themselves to seek an alternative placement.

Findings from a DfE taskforce on looked after children explored issues faced by home YOT and host YOT in relation to children placed in out of area care arrangements. It found that poor information transfer between YOTs impacted on risk management and the delivery of effective services. These findings were also outlined in the 2012 HMI Probation thematic report on looked after children in out of area placements. We are concerned that the lack of strong collaborative working where a child is placed outside of their area can place children and young people in danger and can also cause them to unintentionally breach terms and conditions outlined in their release order.

Recommendation: *We believe that it is of great importance that the inspectorate focuses on the suitability of accommodation for looked after children in youth justice system as we know that it can contribute to reoffending behaviour. We believe that the suitability accommodation arrangements should be a part of the YOT's Risk Management Plans.*

Recommendation: *As part of their sample, the inspectorate should select and inspect cases where children are in out of area placements and should examine how information about these vulnerable young people is shared to ensure continuity of services and support.*

Q5. To what extent do you agree or disagree with our proposals for how we will report our findings?

Proposal 6: joint inspection of the LSCB

6. To what extent do you agree or disagree with our shared criteria for evaluating the effectiveness of the LSCB?

We currently sit on either the Local Safeguarding Children's Board or a relevant sub-group in seven 33 local authorities. Our practice has found that the existence of multi-agency forums within LSCB structures that can share information and protocols, as well as collect and analyse data about the levels of running away in the local area are instrumental in leading a safeguarding response to children and young people. Forums that bring together practitioners at an operational level to lead a coordinated multi-agency response to protecting children, such as

[16] Ministry of Justice, 2012, Prisoners' childhood and family backgrounds, p2.
[17] DfE taskforce on looked after children, 2012

MARACs and shared responsibility for case conferences and strategy meetings, are also extremely beneficial in providing preventative and effective safeguarding responses.

In inspecting LSCBs we believe that the grading awarded should be in line with the grading for individual services being inspected as part of the integrated inspection in the local area. The LSCB is the uppermost platform for the establishment of multi-agency safeguarding policies and procedures within a local area and must engage with and include all relevant children's services.

For further information please contact Iryna Pona, Policy Adviser
iryna.pona@childrenssociety.org.uk

or Kadra Abdinasir
kadra.abdinasir@childrenssociety.org.uk