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The Evaluation of Arrangements for Effective Operation of the New Local Safeguarding Children Boards in England - Final Report

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EXECUTIVE SUMMARY

The report presents findings from the national evaluation of Local Safeguarding Children Boards (LSCBs), commissioned by the Department for Children, Schools and Families (DCSF) and Department of Health (DoH), to examine the extent to which LSCBs have overcome the weaknesses of Area Child Protection Committees (ACPCs), and the effectiveness of the Boards in meeting their objectives. These are:

> *To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority and;*
>
> *To ensure the effectiveness of what is done by each person or body for that purpose.*
>
> (Children Act 2004, Section 14(1))

The evaluation found that:

- LSCBs have addressed a number of weaknesses of ACPCs. Across a range of effectiveness measures LSCBs in Case Study areas were performing at 65 per cent effectiveness.

- LSCBs that have been able to determine their main priorities have been realistic about what is feasible, have maintained focus and have been more effective than those that have been overly ambitious and opted for a very broad remit (in the context of the resources available to them).

- Professionals at the strategic and operational levels are embracing the notion that safeguarding children is a shared responsibility, rather than one confined to Children's Social Care. However, there were differences of opinion as to whether LSCBs should be embracing the wider safeguarding agenda or concentrating their efforts more narrowly on protecting children from harm.

- Local Authorities have struggled to establish accountability mechanisms, especially for Chairs. Governance arrangements in general remain weak.

- LSCB Chairs have provided strong leadership and broad membership and agency representation on Boards has been secured. Independent Chairs have struggled to be active in the wide strategic framework within local areas.

- Demarcation of roles and responsibilities between the Board and Children's Trust have not always been as clear as they should be.

- Representatives on LSCB Boards are largely of sufficient seniority to speak for their organisation with authority, commit their organisation on policy and practice matters and hold their organisation to account, although in some areas securing the right levels of seniority still needs to be addressed.

- Securing appropriate levels of participation by Board Members in LSCB meetings remains a challenge. Changes in agency representation on the Board and the lack of continuity of Board membership can make it difficult to maintain a shared vision and to sustain progress and development. It can also limit the establishment of relationships and trust, effective networking and operation.

- The size of the LSCB and the time and resources available to support the work of LSCBs are influential; small Boards lack enough members to be able to invest enough time to meet the LSCB role and remit, while large Boards become unwieldy and impersonal. The most effective size would seem to be between 20 and 25 members.

- LSCBs have struggled to fulfil all their functions. The time and resources required to undertake Serious Case Reviews, in particular, has inhibited capacity to move forward and fulfil other responsibilities.

- Effective communication channels between the LSCB and partner agencies are essential. Findings reveal, however, that generally these links and mechanisms, to ensure the effective dissemination of information to inform operational practice, were relatively weak.

- LSCBs are helping progress inter-agency work but developments in this respect have also been influenced by wider changes, such as the establishment of Children's Trusts and implementation of the Common Assessment Framework.

- Progress has been made in relation to inter-agency communication and the development of a shared language across agencies although a number of challenges remain.

- Substantial variations existed in terms of the resources that LSCB receive from partner agencies. The Local Authority is the main provider with health (and to a lesser extent, the Police) making a substantial contribution. Other agencies

contributed finances and/or in kind but the level of these contributions was small in comparison to the main agencies.

- For LSCBs to function effectively they need agencies to contribute resources to pay for support staff and training (among other things). They also rely on in-kind contributions and the release of staff to attend meetings and to engage in the activities of the LSCB. The combined cost of these contributions is not insubstantial, ranging from £136,494 to £472,658. This does not include costs associated with Serious Case Reviews or Child Death Processes.

- Annual estimated costs associated with attendance at subgroups (excluding Serious Case Review and Child Death Processes) range from £20,272 to £135,776.

- In the absence of a funding formula, Boards spent considerable time negotiating and securing contributions towards the operation of LSCBs and there were considerable variations in the resources each had available.

- Findings suggest that work to address public understanding of the work of LSCB is weak and has been inhibited by lack of resources.

- Engagement and consultation with children and young people is underdeveloped; although they may be informed about the work of the Boards it is unusual for them to be actively involved or for their views and opinions to influence LSCB business and priorities.

Messages for Policy and Practice

Role and remit

- The most effective LSCB case studies had been realistic about what they were able to achieve and had focused upon the core business of ensuring that work to protect children was properly co-ordinated and effective before seeking to develop their preventative work.

- Without adequate resources it is not viable for Boards effectively to fulfil all their functions. The balance that LSCBs strike in this respect should inform decisions concerning membership and agency representation on the Boards.

Independent Chairs, leadership and accountability

- The Chief Executive's Office and Lead Members, through scrutiny committees, should be more central to the governance process to ensure that the Chair and the Board are held to account.

- LSCBs need to clarify governance arrangements and separate out accountability from management.

- Consideration needs to be given to mechanisms to ensure that Independent Chairs are linked into local networks and structures.

- The authority of the Chair and the LSCB needs to be acknowledged and respected by agencies.

- The implications of non-compliance with Board recommendations should be clarified and systems should be put in place to support the resolution of differences of opinion.

Size and membership of the LSCB

- In determining the appropriate membership of the LSCB it is worthwhile to consider both seniority and the specialist knowledge and expertise that individuals may bring.

- Continuity of Board membership needs to be addressed.

- Clarifying roles and responsibilities of Board Members and clarifying the distinction between 'representing their agency' verses 'representing the Board'. How this is achieved needs to be considered.

- Regular and consistent attendance at meetings is necessary to take forward the LSCB agenda. Increased active participation by Board Members and those on subgroups is required.

Communication between the LSCB and agencies

- Arrangements in respect of communication between LSCBs and agencies need to be clarified and strengthened.

- Information exchange in large organisations is challenging. There was limited knowledge about the extent to which information reached the appropriate personnel to influence policy and practice and affect change. This needs attention.

- Forums to engage with operational staff and ensure that their experiences inform strategic priorities and that the work of the Board influences practice are critical. Communication with GPs, schools and the Third Sector are a challenge and strategies to strengthen links with these groups are needed.

Communication to the general public and children and young people

- This area of work in LSCBs is currently underdeveloped. Work to improve public understanding of the work of LSCBs is weak and under resourced.
- LSCBs need to develop opportunities for children and young people to be more involved in the work of LSCBs.
- There is scope for the LSCB to undertake activities aimed at counteracting the negative portrayal of the social work profession and raising public awareness of the role and contribution that Children's Social Care and other agencies play in improving outcomes for children and families.

Training and support

- LSCB Independent Chairs and Business Managers would benefit from improved access to training and support to fulfil their responsibilities.
- Training for Board Members of their roles and responsibilities, and the operation of the LSCB, both at induction stage and on an ongoing basis would be valuable.
- It would be valuable to consider professional development opportunities and career pathways for LSCB Business Managers.
- Frontline staff identify that inter-agency training should not be at the expense of single-agency training, which is also important.
- The role of Government Offices for the Regions needs further clarification.
- LSCBs would benefit from advice and guidance about how to judge the impact that they are having upon the effectiveness of their work.

Resources

- Without adequate funding and the release of staff to attend meetings and undertake activities to take forward work LSCBs are unable to operate effectively.

- Chairs, Business Managers and Board Members indicated that a funding formula would assist them. LSCBs are vulnerable to funding cuts which would limit their capacity to fulfil their responsibilities.

1   INTRODUCTION

Both the statutory inquiry into the tragic death of Victoria Climbié, 2003, and the first joint Chief Inspectors' Report on Safeguarding (Chief Inspector of Social Services et al., 2002) emphasise the importance of effective joint working between agencies and professionals to safeguard children from harm and to promote their welfare. Subsequent policy developments, underpinned by the Children Act 2004, are intended to ensure an integrated approach to service provision and that children achieve their potential in terms of being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic well-being (HM Government, 2004). *Working Together to Safeguard Children* (HM Government, 2006: p.10) identifies one of the most important developments in this context as the establishment of Local Safeguarding Children Boards (LSCBs). The Boards put former Area Child Protection Committees (ACPCs) on a statutory footing. Research had found that ACPCs, lack of statutory power had limited their effectiveness (Chief Inspector of Social Services et al., 2002). A series of other weaknesses were also identified including: variations in levels of representation and membership, structure and practice, poor leadership and insufficient resources (Chief Inspector of Social Services et al., 2002; Horwath and Glennie, 1999; Narducci, 2003; Ward et al., 2004).

The report presents findings from the national evaluation of LSCBs, commissioned by the Department for Children, Schools and Families (DCSF) and Department of Health (DoH), to examine the extent to which LSCBs have overcome the weaknesses of ACPCs and the effectiveness of the Boards in meeting their objectives. During the course of the evaluation the actual and potential role and contribution of LSCBs within the wider policy context was further reinforced by the tragic death of Baby Peter and subsequent reports (*The Protection of Children in England: A Progress Report,* Laming, 2009; T*he Government's Response: The Protection of Children in England: action plan*, HM Government, 2009a). It should be acknowledged that this has influenced the social and political environment in which the data was collected and that findings from the evaluation have fed into the policy process (Laming, 2009; HM Government, 2009a; France et al., 2009).

The chapter outlines the objectives and functions of LSCBs. These need to be understood and located within a wider context and this is briefly explored. It concludes by outlining the approach adopted by the research team to measure and evaluate the effectiveness of LSCBs.

Objectives of the LSCBs

The functions of the LSCBs are outlined in the Children Act 2004 as follows:

> *a   To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority; and*
>
> *b   To ensure the effectiveness of what is done by each person or body for that purpose.*

(Children Act 2004, Section 14(1))

The scope of the LSCB role falls into three categories:

> *Firstly, they will engage in activities that safeguard all children and aim to identify and prevent maltreatment, or impairment of health or development, and ensure that children are growing up in circumstances consistent with safe and effective care; secondly, they will lead and co-ordinate proactive work that aims to target particular groups; and thirdly, they will lead and co-ordinate arrangements for responsive work to protect children who are suffering, or at risk of suffering, maltreatment.*

(HM Government, 2006: p.13)

Figure 1, below, taken from Working Together, shows the aims and objectives of the LSCB as:

Figure 1   LSCB objectives and functions

| LSCB objectives… | … pursued through LSCB functions… | … help produce outputs… | … that contribute to overall outcomes |

Developing **policies and procedures** for safeguarding and promoting the welfare of children, including on:
- action where there are concerns, including thresholds
- training of people who work with children
- recruitment and supervision
- investigation of allegations
- privately fostered children
- co-operation with neighbouring authorities

To **co-ordinate** local work to safeguard and promote the welfare of children

Participating in the **planning of services** for children in the area of the local authority

Communicating the need to safeguard and promote the welfare of children

Procedures to ensure a co-ordinated response to **unexpected child deaths**

Effective local work to safeguard and promote the welfare of children

Wellbeing of children especially 'staying safe'

Monitoring effectiveness of what is done to safeguard and promote the welfare of children

To **ensure the effectiveness** of that work

Undertaking **Serious Case Reviews**

Collecting and analysing **information about child deaths**

Evaluating effectiveness and advising on **ways to improve**

Source: *Working Together to Safeguard Children* (HM Government, 2006: p.75)

Dimensions Influencing the Work of LSCBs

Identifying how effective LSCBs are in the operation and delivery of their core activities requires an understanding of the national and local contexts that influence the ways in which they operate. Figure 2 below models the different dimensions and relationships that influence the establishment and operation of Boards.

Figure 2   Dimensions influencing the work of LSCBs

LEGAL AND POLICY FRAMEWORK FOR LSCBs
i.e. Children Act (2004), Every Child Matters: Change for Children (2004), Working Together (2006), Local Safeguarding Children Board Regulations (2006)

LOCAL CONTEXT

i.e. geography/deprivation /service infrastructure

LOCAL SAFEGUARDING CHILDREN BOARDS (LSCBs)
Membership
Decision making process

LEADERSHIP
Governance and Goals and Vision Setting

LOCAL STRATEGY AND CHILDREN AND YOUNG PEOPLE'S PLANS

Relationship with Children's Trust

STRUCTURES AND RESOURCES

- Decision making
- Infrastructure
- Finances
- Subgroups
- Executive

PROCESSES AND POLICY

- Regulatory Policy Framework
- Communication strategy
- Monitoring and evaluation

INTER-AGENCY WORKING

- Information sharing
- Inter-agency training
- Breaking down professional cultures

PROFESSIONAL PRACTICE AND OPERATIONAL FRAMEWORK FOR SAFEGUARDING CHILDREN AND YOUNG PEOPLE

Legal and policy framework and local context

Under the Children Act 2004 each Children's Services Authority in England was required to establish an LSCB. This, alongside the Local Safeguarding Children Board Regulations 2006 and Working Together (HM Government, 2006) provides guidance concerning the operation of LSCBs. The Every Child Matters programme and other related policy developments are also influential in terms of the work of the Boards (DoH and DCSF, 2004; HM Government, 2004; DfES, 2007a; CWDC, 2009). However, at the same time Boards need to be sensitive and responsive to *local* needs (HM Government, 2006: Section 3.2, p.74). Capacity for individual LSCBs to go beyond their core business, (ensuring that work to protect children is properly co-ordinated and protected) to undertake more preventative work, will be influenced by local Children's Services, and other partners, performance and the extent to which inter-agency working relationships have been established. The work of the LSCBs also needs to be understood within the wider context of the Children's Trust arrangements and should contribute to delivery and commissioning through the Children and Young People's Plan (HM Government, 2006: Section 3.3-3.6, p.74).

LSCB membership and decision-making

The Children Act 2004 outlines those partners that have a statutory duty to be represented on the LSCB. However, there is scope for individual LSCBs to make decisions concerning the inclusion of additional members. In defining and constructing the model of LSCB operation, authorities need to take into consideration the local context i.e. size and structure of agencies, specific local needs and circumstances and the ways that services are being delivered. These factors may influence both the membership of the Board, the focus of the work that is undertaken and the issues that are prioritised. Each of these may, in turn, influence the effectiveness of individual Boards in fulfilling their core functions (Ward et al., 2004). Leadership is also a key dimension influencing the likelihood of effective operation.

Leadership

Strategic partnerships need to have strong leadership that can keep Boards focused on identifying priorities and keeping them on target (Horwath and Morrison, 2007; Percy-Smith, 2006). LSCB Chairs have a key responsibility to lead the Board and

provide a sense of direction. They also have a central role in ensuring that the Board has an independent voice and operates effectively (HM Government, 2006: Section 3.50, p.83). Their role is not only to manage meetings and to provide effective leadership but also to act as a core representative for the LSCB in external meetings with partners and other bodies (for example, the Children's Trust). The Chair needs to be of sufficient standing and expertise to gain both respect and authority from Board Members (HM Government, 2006: Section 3.50, p.83). They are a critical player in helping the Boards to develop a clear vision about what they are trying to achieve and in setting annual goals, targets and objectives.

At the outset of the study Local Authorities had the scope to determine what type of leadership and governance arrangements to put in place. Nationally, 40 per cent of areas decided to appoint Independent Chairs and 83.3 per cent of these were accountable to Directors of Children's Services (France et al., 2009).

Structures and resources

Lack of a clear and well defined structure to support the operation of Boards were seen to be a major weakness of ACPCs (Ward et al., 2004). As such, establishing an effective infrastructure to support the work of an LSCB is important. Statutory guidelines suggest that LSCBs may wish to form an Executive group and/or subgroups to support their operation. Data from the national mapping exercise reveals that 65 per cent of Boards have established an Executive and every Board had introduced at least two subgroups (mean = 6.7; median = 6) (France et al., 2009). Having adequate resources in place to support the development of LSCBs is also seen as crucial if Boards are to be effective (Chief Inspector of Social Services et al., 2002; Ward et al., 2004 and Percy-Smith, 2006).

Working Together (HM Government, 2006) indicates that member organisations should provide adequate financial resources to help run Boards (HM Government, 2006: Section 3.74-3.80, p.88). While the level of contribution is to be defined locally, there is an expectation that the Local Authority, Primary Care Trust (PCT) and Police will be core contributors. Resources are needed to fund support staff to facilitate the day-to-day operation of the Board and assist with the diverse range of activities in which LSCBs engage. In the national survey, 88.7 per cent of Boards

were found to have employed a Business Manager and all but four LSCBs had also appointed at least one other full-time member of staff (Administrator, Safeguarding Manager, Audit Manager or specialist worker) to assist with the work of the Board (France et al., 2009). As well as making financial contributions to the operation of the LSCB, Board partners may commit resources in kind, this includes staff time to attend meetings or undertake roles for the LSCB (HM Government, 2006: Section 3.77, p.88). Adequate funding and in-kind contributions to the operation of the LSCB are important if it is to be able effectively to meet its goals.

Processes and policy

A core function of LSCBs is to develop policies and procedures for safeguarding and promoting the welfare of children in the following areas:

- *The action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention.*
- *Training of people who work with children or in the services affecting the safety and welfare of children.*
- *Recruitment and supervision of people who work with children.*
- *Investigations of allegations concerning people working with children.*
- *Safety and welfare of children who are privately fostered.*
- *Co-operation with neighbouring Children's Services Authorities (i.e. LAs) and their Board partners.*

<div align="right">(HM Government, 2006: Section 3.18-3.28, p.78-79)</div>

Each LSCB is also expected to consider whether a wider range of protocols (beyond the policies and procedures set out in the Regulations) is required, for example, resolving professional differences of view in specific cases or the management of complaints from families concerning, among other things, the handling of child protection case conferences (HM Government, 2006: Section 3.9, p.80).

Additionally, LSCBs have a communicating and raising awareness function (see HM Government, 2006: Section 3.30, p.80) and a monitoring and evaluation function to determine the effectiveness of Local Authorities and Board partners work, and to advise on areas for improvement (HM Government, 2006: Section 3.31-3.35, p.81).

They are also responsible for Child Death and Serious Case Review (HM Government, 2006: Section 3.38-3.41, p 81-82). The diversity of roles and responsibilities and the Board's capacity to fulfil these are explored throughout the report.

Inter-agency working

Another key dimension influencing the work of LSCBs and the contribution they make is in relation to inter-agency working. Although successive government guidance has stressed the importance of inter-agency working to safeguard children, the literature on the subject reveals a lack of conceptual clarity with respect to the terminology used (Lupton and Khan, 1998; Hudson et al., 1999; Ward et al., 2004). The definitions adopted for the purposes of the report are those employed by Lloyd et al., 2001, p.2.

Box 1 Definitions

Inter-agency working - when more than one agency work together in a *planned and formal* way.

Joint working - professionals from more than one agency working directly together on a project, for example, teachers and social work staff offering joint group work. School-based inter-agency meetings may involve *joint* planning, which reflects *joined-up* thinking.

Multi-agency working - more than one agency working with a young person, with a family or on a project (but *not necessarily jointly*). It may be *concurrent,* sometimes as a result of *joint planning* or it may be *sequential.*

Inter-agency communication - information sharing between agencies – formal and informal, written or oral.

Source: Lloyd et al., 2001, p.2.

Evidence shows that effective inter-agency working requires roles and responsibilities to be clear and commitment and trust between agencies (Atkinson et

al., 2007). A history of good working relationships is also seen to facilitate effective inter-agency work (Horwath and Morrison, 2007).

In reading this report it is important to recognise, that while LSCBs have a significant contribution to make to inter-agency collaboration they are one of a series of developments. While Boards are likely to contribute to changes, Every Child Matters, the creation of Children's Trusts and the Laming recommendations and governments subsequent response are also likely to be influential in shaping practice (HM Government, 2004; 2006; 2009a; Lord Laming, 2009).

Two particular areas of work that LSCBs are expected to be active in are the development of protocols for information sharing and inter-agency training. Both are seen as critical factors in helping to break down professional boundaries and improving local service delivery. In relation to training LSCBs have a core function in developing policies, and overseeing quality assurance and evaluation, although they do not necessarily have to deliver it (HM Government, 2006: p.91-97). This has been seen as core to LSCB work in that 90 per cent of LSCBs have training subgroups that aim to oversee (or deliver) and evaluate training on safeguarding and the promoting of the welfare of children (France et al., 2009).

The diversity of roles and responsibilities and the Board's capacity to fulfil these are explored throughout the report. In doing so, the key dimensions (leadership, structures and resources, processes and policy and inter-agency working) influencing the operation and effectiveness are examined further. The approach adopted to measure effectiveness in this context is discussed below.

Measuring Effectiveness

In measuring effectiveness it is important to recognise the broader context of practice and the internal and external challenges that can and do impact on performance. It is not appropriate to judge an LSCB on one single effectiveness measure as there are many components that need to be considered. Traditionally, evaluators would see effectiveness being measured and understood through the use of control or comparison groups in a Randomised Control Trial. This would aim to show that one type of activity or intervention is better than another by comparing the

actions of LSCBs against a control group that was not delivering an LSCB (or was delivering another type of programme). Effectiveness would also be judged by using outcome measures to show differences between the two programmes (LSCB and another). However, such an approach is not viable in the context of LSCBs and therefore an alternative strategy has been employed. Firstly, because there was a statutory duty placed on authorities to establish LSCBs, they have been introduced across the country and therefore no control group is available. Secondly, assessing the impact of LSCBs against outcome measures is problematic. Linking LSCB activity to outcomes is highly complex; Boards are not responsible for service delivery and a vast number of variables will influence the well being of children in a local area. The New Public Service Delivery Agreement 13 (Children and Young People's Safety) (HM Government, 2009b) should facilitate exploration of outcomes against key indicators over time.

The strategy adopted to evaluate the effectiveness of LSCBs for the current study is to draw upon existing evidence about what makes strategic partnerships effective (Ward et al., 2004; Percy-Smith 2006, Horwath and Morrison, 2007, Warmington et al., 2004). In the context of LSCBs there are two major sources of evidence:

1 Assessing LSCBs in comparison to the body of literature on the effectiveness of ACPCs. The weaknesses of ACPCs are well documented and evidenced – do the new arrangements address them?
2 Assessing LSCBs' operation against a broader literature on strategic partnerships working and the delivery of Children's Services.

It is important to acknowledge that this study is not a comparison between ACPCs and LSCBs as no data was gathered directly on the operation of ACPCs. Assessments are based on existing knowledge about aspects of the operation of ACPCs that 'worked' and those that did not, as well as the broader literature on strategic partnership working. This evidence was used to inform the development of 'proxy measures' of effectiveness (conditions to support the effective operation of Boards'). The authors' propose that thirteen key factors promote the effective operation of LSCBs. As outlined above these are *'proxy measures'* and not criteria for effectiveness in themselves, but they do offer an indication of whether the

foundations are in place to enable case study areas to co-ordinate and ensure the effectiveness of what is done to safeguard and promote the welfare of children in the locality to best affect. These are outlined in Table 1, below. The conceptual framework and factors used to determine conditions for the effective operation of LSCBs are underpinned by findings from a range of studies and reviews. Findings from many of these are outlined in *Safeguarding Children: A Scoping Study of Research in Three Areas* (Ward et al., 2004), which was commissioned by the Department of Health to provide a summary of the current knowledge base on safeguarding children, including examination of the literature on inter-agency working. Other evidence that informed the measures are outlined above. While factors 1-12 in Table 1 are all informed by a body of literature, judgments concerning the final factor (13, professional practice) are based upon the research teams assessment of frontline professionals, knowledge of their roles and responsibilities in relation to safeguarding children. Chapter 9 provides an overview of findings on this aspect of the evaluation.

Table 1   Conditions for the effective operation of LSCBs

	Effectiveness Factor	Effectiveness Indicator
1	Clarity of governance arrangements – accountability.	Clear lines of accountability for the Chair and Board.
2	Clarity of governance arrangements – management.	Clear management structures for the Chair and the Board.
3	Strong leadership.	Skilled Chair with authority who is able to keep partnership focused on core tasks.
4	Clear priorities and focus of the work.	LSCB have clearly defined aims and objectives that are strategic in their focus on safeguarding.
5	Clear planning and reviewing of work.	There is good planning and reviewing of progress.
6	Maintaining clarity of purpose, values and vision.	There is a clear vision amongst Board Members about purpose of the LSCB.
7	Adequately resourced infrastructure.	The LSCB is supported by a Business Manager and appropriate level of staff and resources to help it function effectively.
8	Importance of having the appropriate levels of seniority.	The Board has a good level of seniority amongst its membership – the right people are present who can act on the behalf of their agency.
9	Stability of Board membership.	Attendance and participation in the Board and subgroups are stable and active.
10	Strong links exist between the LSCB and operation.	Clear conduits exist between the LSCB and professional practice.
11	Understanding of roles and responsibilities by Board Members.	Members of the Board understand their roles and responsibilities in the LSCB and act upon them.
12	Need for open communication and shared language between professionals.	Open communication both between and within agencies that facilitates co-ordinated service delivery.
13	Professional Practice Frontline professionals fully understand their roles in safeguarding.	Frontline professionals have a clear understanding of roles and responsibilities in terms of safeguarding.

The thirteen factors outlined in the table above informed the design of research tools for the evaluation and assessment of the six case study LSCBs. By capturing evidence from a range of sources (see Annex A) it has been possible to explore the

strengths and weaknesses of Boards against key indicators of conditions needed for effective operation. The mixed methods employed for the study have allowed findings to be triangulated and enabled the research team to make an evidence-based assessment of how effective the six case study areas have been in a wide range of areas. It has also been possible to identify areas in which LSCBs have been less effective and to explore the challenges and difficulties that areas have encountered as they have sought to meet their aims and objectives.

In presenting the study findings, details concerning the case study areas and/or professional backgrounds of respondents have been withheld. While this is necessary to protect anonymity and confidentiality, it does, at times, make it difficult for the reader to make their own judgements concerning the overall effectiveness of each of the Boards. In recognition of this, a summary table of the effectiveness of each case study area, against all thirteen conditions for effective operation, is presented in the conclusion. The judgements and subsequent scores attributed for each LSCB against each effectiveness measure were determined by the research team based upon analysis of all the data collected on each area (details concerning the point scoring system are outlined in Chapter 10).

Methodology

The aims and objectives of the study were to examine and assess:

- if LSCBs are fulfilling their core functions to safeguard and promote the welfare of children;
- the working practices put in place and their effectiveness in securing effective operation of the LSCB functions and ensuring that all member organisations are effectively engaged;
- how LSCBs manage and evaluate their role in safeguarding and promoting the welfare of children and the effectiveness of lines of accountability;
- how LSCB partners transfer knowledge and information between member organisations;
- how LSCBs work alongside other local strategic bodies and partnerships;
- if the new systems and arrangements are 'fit for purpose' and whether they safeguard and promote the welfare of children in the local area;

- how far the new LSCB arrangements are influencing and improving frontline practice; and

- the estimated costs of the new LSCB arrangements.

A mixed method approach was adopted, including a national survey and mapping exercise of all LSCBs in England and in-depth case study work in six areas, including:

- face-to-face interviews with six LSCB Chairs and Business Managers and five[1] interviews with the Director of Children's Services in each area;

- 49 telephone interviews with Board Members, these included partners from Health, Social Work, Education, Youth Justice, Police, Early Years and the Voluntary Sector;

- 132 telephone interviews with frontline professionals (holding both managerial and non-managerial responsibilities) with similar professional backgrounds as the Board Members;

- Content and thematic analysis of minutes of Board meetings;

- Social Network Analysis (SNA) was piloted in two case study areas, providing detailed micro information on practice and effectiveness. SNA facilitated examination of the relationship between individuals and groups within the LSCB structure in order to gain an insight into how the LSCBs were functioning; and

- A detailed analysis of costing of LSCB meetings was conducted in two of the case study areas.

The study was approved by the National Research Ethics Committee and where necessary, local research governance committees. It was agreed with DCSF and the Research Advisory Board that the areas would remain anonymous to protect the confidentiality of individuals and the LSCBs involved.

The strength of the mixed method approached employed was that it was possible to triangulate the findings. The national survey and mapping samples were large and provide an extensive picture of developments across England. However, the research team faced a number of challenges during the course of the research (see

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[1] In one area the Chair is the Director of Children's Services

Annex A for further details). Awareness of these and associated limitations in the data are outlined below to help the reader contextualise the results. They include:

- Potential sample bias in the data from frontline staff.
  This arises from the fact that the National Research Ethics Board required Board Members to facilitate access to operational staff. If Board Members failed to provide contact details then the views of individuals or organisations were not represented. In addition, because frontline participants were selected by the Board Members there is potential for a bias in favour of positive responses. Members may have selected potential participants who they perceived were operating effectively.
- The low response rates for the Social Network Analysis mean that results on relationships remain inconclusive. However, analysis of data on participation levels taken from the minutes does enhance the results.
- A number of assumptions had to be made in the costings exercise.
  It should be noted that job titles and salaries are not universally consistent across areas or agencies. Wherever possible salaries were taken from nationally published pay scales. However, most of the salary information used for cost calculations was based on internet searches for jobs advertised in November-December 2009 for posts with the same job title as survey respondents.

The cost exercise recognises the time Board Members spent on key activities. It does not include the time spent by staff working on behalf of Board Members to complete work for the LSCB. Further, the time spent on Serious Case Reviews and Child Death Review Processes is not included. As such, the figures presented are likely to underestimate the costs associated with operating an LSCB.

2   CHAIRING, LEADERSHIP AND GOVERNANCE

Introduction

It is recognised in the literature that for strategic partnerships to be effective they need to have strong leadership that can help keep the partnership focused on the task at hand and ensure that priorities are set and that targets are achieved (Horwath and Morrison, 2007). Boards will also need to be clear about governance arrangements that are in place ensuring that accountability and management structures are transparent and workable (Percy-Smith, 2006; Horwath and Morrison, 2007). Research on the operation of ACPCs supports these conclusions indicating that there were a number of obstacles to their effective operation. These included: poor leadership and weak governance structures (Chief Inspector of Social Services et al., 2002; Ward et al., 2004). This chapter begins by discussing the role of the Chair and their experiences of heading up and leading the LSCBs, drawing out both strengths and weaknesses of the existing arrangements. In the second part of the chapter the ways that governance arrangements have been put into place, with the aim of ensuring accountability and management, are explored. In doing so, tensions that exist in the process are highlighted, while also identifying positive developments. In the final section the relationship between LSCBs and the Government Offices for the Regions (GOR) and Ofsted and the impact of this on the effective operation of LSCBs is considered.

Chairing and Leadership

At the start of our research, chairing arrangements in our six case study areas were mixed. Three Boards had Independent Chairs, two had Chairs who were Directors of Children's Services (DCS) and one had a Senior Manager in Children's Services in this role. As the research progressed one of the areas moved to having an Independent Chair instead of the DCS.

Evidence shows that strong leadership is critical if strategic partnerships are to be effective. A 'collaborative champion' is needed to help the trajectory of the partnership and help it become established and effective. Leaders of strategic partnerships need to have credibility, influence, charisma and integrity and this should be acknowledged by other agencies (Horwath and Morrison, 2007). Leaders

should also have high quality interpersonal skills, the ability to network, negotiate with a wide range of agencies, help bring people together with a common aim and address tensions and difficulties (Horwath and Morrison, 2007). Individuals also need to command respect and have the authority to act (Ward et al., 2004).

Across the six case study areas the LSCB Chair was identified as the 'collective champion' by both Board Members and DCSs. They were seen as the critical player in leading the Board and giving it direction. Members also expected the Chair to play a significant role in the wider strategic planning of the authority and to help embed safeguarding into the operation of agencies responsible for the welfare and protection of children and young people. A large majority of the Board Members interviewed felt that the Chair of their LSCB was effective. One of the most effective Chairs in the case study areas was an Independent Chair who was able to bring to the role the necessary skills and experience:

> *'The Chair is excellent, he has a very broad vision, I think he has a great understanding of what is going on in [name of area]. He bears no prejudice, he feeds back, he works hard, I am quite happy with him. I think it is much better to have an independent person who can look in from outside, rather than the big problems that are going on inside.'*
>
> (Clinical Director of Children's Services)

Others agreed suggesting that this Chair uses the agenda in an '…efficient and effective way and is adaptable and …displays flexibility' and he is '… charismatic, very knowledgeable doesn't suffer fools gladly, he's very able to manage the meeting and keep us on track, very business oriented' (Head of Children in Need). The Chair was also seen to have '…an all round view…geared to the strategic rather than business and operational matters' (Educational, Protection Advisor for Social Care). The fact the Chair also chaired other LSCBs was also seen to be beneficial as it provides them with a broad perspective of what works well in different contexts. The Chair had substantial authority because they had the support of the other Board Members. This is critical as it gives the Chair the power to be able to challenge a wide range of agencies (either on the Board or external to it) who have a duty to safeguard children and promote their welfare. While this example is of an Independent Chair the general feeling from Board Members was that all the Chairs

in the six case study areas were of a good standard and brought relevant and important skills to the role as leader.

Independent Chairs

Independent Chairs were seen as bringing something different to the role. In particular, having someone 'outside' of the main agencies was thought to ensure the Board's ability to be more effective in challenging the activities of agencies. This was exemplified in one of the areas with a Statutory Chair where there was consensus that brining in an Independent Chair was a step in the right direction. This was not only driven by government requirements, but by the fact that it was felt that someone from outside was needed:

> *'Well it would make sense for them to be independent, not because I can think of any particular reason why it's not worked, but we are scrutinising, we want somebody to be there to really be challenging all of our practice, and it's quite hard to challenge yourself or the practice of your own agency isn't it?'*
> (Designated Doctor)

All of the Independent Chairs had the support of their Board Members, and all were seen as effective leaders, although in a number of cases concerns were raised about how effective Independent Chairs were outside of the meeting. Quotes from Board Members in two different case study areas illustrate this:

> *'She seems very competent, very capable and knows stuff…she makes the meetings happen on time, information is sent out…she seems very well organised…it's always difficult for an outsider to understand the internal workings of an organisation and they can be fobbed off quite easily, whilst people are shuffling paper around the telling them different things…Whereas someone in the heart of it, you ring someone up and demand or get an answer.'*
> (Community Engagement Manager)

> *'The Chair is an effective Chair, I can see the benefits of the Chair being independent from Children's Services, but the other side of that is that the Chair's involvement is quite limited..[they] Chair very effectively…he's the link to the Board Manager but I think maybe he should have a bigger role outside the Board.'*
> (Senior Manager for Home Start)

Independent Chairs themselves acknowledged that they were not always linked into local networks and structures as much as they would have liked. They could also feel too isolated from the main decision-making forums of the Local Authority. The fact that the authority was also undergoing major restructuring was, in two areas, seen to have contributed to this problem. In one area in particular the Children's Trust was not fully established and as such the infrastructure to influence was not in place. As the Independent Chair suggests, the development of the Trust in their area remained limited:

> *'The second meeting I attended, I've read the minutes too, but I have no solid recall of what went on there. That tells you a lot really.'*
> (Independent Chair)

However, Independent Chairs struggled to become fully embedded in strategic operation, not only because of local restructuring but also as a result of limited resources. Some Chairs were only being paid for a small set number of days which they felt was insufficient for the level of activity necessary. This could create real tensions for the Chair in that they knew what work was required but were not being resourced adequately to achieve the level of input required. This difficulty could be compounded if the infrastructure to support the operation of the Board was lacking. All the Independent Chairs argued that it was very difficult to be effective in their leadership if they lacked the right kind of administrative support:

> *' [Name of Business Manger] left us at the end of January and we've been without a Business Manager for a few months, which has been a huge problem, because I cannot compensate for that face-to-face work. He was attending all the subcommittees and therefore he would be an early warning, and I haven't been able to keep a closer eye on the co-ordination…while the Chair is not the Board, much of the time the Chair and the Business Manager is the Board, so that is a problem.'*
> (Independent Chair)

Over the course of the research each of the six case study areas lost their Business Managers. Reasons for this varied but this had a major impact on the operation of the Board's and the Chair's ability to be effective. Delays in replacing Business Managers could mean that Chairs were spending considerable time on the day-to-day operation of the Board, organising meetings, setting the agenda and distributing

minutes and information. In one particular case study area the Business Manager left when a number of Serious Case Reviews (SCRs) were underway and this, alongside the minimal time allocated for the Independent Chair to Chair the Board, combined to have a substantial impact on the Chair's capacity to engage in other matters. This type of problem limited the time available for them to engage in strategic debates and activities and to act as an effective leader of the Board.

Statutory Chairs

The Statutory Chairs in our case study areas were also generally perceived to be effective by Board Members. They were seen to be highly skilled and experienced, with the substantial knowledge needed for the role:

> *'He has been effective, because he knows his stuff, and it is really important to get someone who has got a deep knowledge…well developed over the years knowledge base, of safeguarding. It is not always easy to find somebody who is also in a senior position, so he has got credibility and influence at different levels. I would say that he has got all those things.'*
> (Head of Children and Young People's Health)

One reason they were seen to be effective was because they had detailed local knowledge about strategic developments. They were also recognised as powerful agents in the area, who had the authority to challenge other senior colleagues and confront poor performance. In one sense the two DCSs and one Senior Manager were best placed to understand these contextual issues as they had worked in the authority for many years. However, this could also be a disadvantage if they were too close to the issues.

DCSs do not always have sufficient time to invest in the everyday activities of the Board. For example, in one area the Chair only put in one day a month (which was usually related to the Board meeting itself). Day-to-day work was delegated to either Business Managers or employees of the Board. This could mean the Chair was less engaged in the process. Some Board Members also expressed concern that the Chair may not always be impartial or able to operate inclusively in their style of chairing. While it was acknowledged by Board Members that Statutory Chairs tried not to dominate and to be inclusive this was not always achieved:

'There were lots of benefits to having a Chair who was a DCS. Our particular DCS, who I have high level of respect for, is quite a powerful [person] but at times they could be doing most of the talking…'

(Head of Children's Legal Services)

All of the Statutory Chairs recognised this as a danger and were clear that they tried, where possible not to use their position as Director of Children's Services to control the meetings, yet inevitably this was not always avoided and the direction the Board took could be unduly influenced by the DCS.

Accountability and Management of LSCBs

Strategic partnerships are usually responsible for long-term planning and overseeing and monitoring of the delivery of services yet they are not necessarily elected bodies. As a result lines of accountability and management need to be built into the partnership (Percy-Smith, 2006). It is important that the management and accountability arrangements in the context of the broader infrastructure are clear (Fox and Butler, 2004; Atkinson et al., 2007). The Sainsbury Centre (2000) argues that agencies need to be held to account on a collective basis to ensure effective joint working, otherwise there can be confusion and uncertainty about the operation of the partnership (see also Frost and Lloyd, 2006).

Accountability in public services is a complex and abstract term, usually associated with questions of local democracy and how public officials are brought to account in a specific geographical area. Over the past twenty years public policy has constructed a wide range of new bodies, especially at local level, that aim to either oversee the delivery of services or plan strategically such as Local Strategic Partnerships (LSPs). One of the big challenges for those who deliver public services at local level is determining how accountability should operate on a day-to-day basis. Jones and Stewart (2009) define accountability as:

'…the liability to give an account to another of what one has done or not done, and to be judged accordingly.'

<div align="right">(Jones and Stewart, 2009: p.59)</div>

This involves bonds that bind groups together in delivering particular outcomes. Certain mechanisms can contribute to ensuring accountability is achieved i.e. dialogue, scrutiny and transparency. It is important to recognise that responsibility differs from accountability. Responsibility is about power, duty and resources while accountability is about how these are used (Jones and Stewart, 2009). Responsibility, therefore, defines the boundaries of accountability. Lord Laming (2009) identifies the importance of establishing clear lines of accountability, although LSCBs have found this a challenge.

Working Together (HM Government, 2006) emphasises that LSCBs are *not* accountable for service delivery. At the same time, it is clear that LSCBs are responsible for 'overall' performance. The focus is, therefore, geared towards responsibilities to safeguard children from harm and promoting their welfare, rather than mechanisms to bring LSCBs to account. The following section explores accountability arrangements in case study areas and highlights some of the tensions and difficulties that have been encountered as systems have been put in place. The implications for the effective operation of LSCBs are also considered.

Lines of accountability of LSCB Chairs

Across the six case study areas, accountability was discussed in terms of how the Chair was accountable for the actions of the LSCB and how the Chair was able to make the Children's Trust accountable for the delivery of the Safeguarding agenda. Issues concerning Board Member accountability were also identified as important but these are discussed in Chapter 3 (in relationship to the active participation of agencies in the LSCB process).

Interviews with Chairs, Directors of Children's Services (DCSs) and Board Members revealed that the Chair was ultimately seen to be accountable for the actions and activities of the LSCB. Local Authorities also constructed governance arrangements that aimed to bring 'Chairs to account'. All but one of the DCSs saw the Chair as the key person responsible for what was being produced by the LSCB and its partner

organisations. Perceived failings could have serious consequences. For example, in one area the DCS indicated that the Independent Chair would be sacked if the performance of the LSCB did not improve:

> *'[Name] has been told he'll be performance managed and within three months if he hasn't improved it [the LSCB] we're sacking him…'*
>
> (DCS)

However, a question does arise about the extent to which the Chair should be held accountable for actions taken on behalf of, or supported by Board Members. Data from the Board Member interviews revealed that on the whole all the Chairs had substantial support from their members. In a small number of cases Board Members did raise some concerns about the way the Chair operated but this tended to relate to their perceptions of how well they operated in the local context (as discussed above). In one area concerns were raised about the Chair (a DCS) having too much power and influence[2] (see above, Chairing and Leadership section). In another area the continued support for the Chair was determined by annual 'reappointment' by the Board. This was seen as a mechanism for the Board to express continued support and as a way of acknowledging that the Chair was performing effectively. In reality of course, the Chair in this area was employed by the Local Authority (through Children's Services) and only they could renew the Chair's contract. Thus, the support of other partners is symbolic and can afford little protection.

Accountability of Independent Chairs to the Director of Children's Services
Findings from the national survey of LSCBs revealed that overall 45 per cent of LSCB Chairs saw the local DCS as the person who 'brought them to account' (France et al., 2009). This figure was higher amongst Independent Chairs (83 per cent) with the majority of Statutory Chairs identifying themselves as accountable to the Chief Executive of the Local Authority (58.1 per cent).

All the non-DCS Chairs in the case study areas felt that accountability took place in 'one-to-one' meetings, although the purpose of meetings was not centred on issues

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[2] This arrangement has now been changed.

of accountability. In meetings with the DCS discussions focused on developments and future plans and this was seen as a natural way for the DCS to be kept informed. This was seen to be important by DCSs as safeguarding children, as defined by Working Together, is their core responsibility and therefore will impact on their Ofsted assessment. The structure and frequency of meetings varied between areas. In one area, the opportunity for regular meetings was disrupted when the authority restructured.

> *'We've seen quite a change really. When [name] was Director of Children's Service I met him fairly frequently, quite robust meetings too, which was good on both sides. When [name] arrived, I think I met him twice, possibly three times in the last 12 to 15 months and certainly the robustness was not there…'*
>
> (Independent Chair)

Chief Executives were accessible to the Independent Chairs but they tended to be perceived as a background resource if particular issues arose. Such relationships were unstructured and informal.

One major concern raised by Independent Chairs was the relationship of management to accountability and the potential for this relationship to be one of control. If Independent Chairs were seen to be accountable to the DCS and also managed by them while also being expected to comment on or challenge them (or their service) a tension existed about how this was to be done. For example, in one area concerns were raised by Board Members that the DCS was 'controlling the Chair through intensive management meetings' even though the DCS was not a member of the Board. It was suggested by Board Members that Children's Services were 'working behind the scenes' and that the authority of the Chair was not being recognised or respected. In this context members thought that the DCS was setting the LSCB agenda and that processes were being driven by their interests and not those of the partners. This raises issues concerning the power and influence of Children's Services as compared to other agencies. In another case study area a similar concern was raised by the Independent Chair. They felt that their position was continually being undermined by the actions of the DCS and others within Children's Services. Reviews of services and resource decisions were being made without the Independent Chair's active involvement. While they recognised that the

limited time they were paid for their role as Chair meant they could not realistically be involved in everything, they did feel that the DCS controlled what should be an independent process:

> *'Here it's [the LSCB] too closely aligned with Children and Social Care and there's always been a history of that. The DCS sees all the papers that go out, I don't have a particular problem about that, but again it's about, whose papers are they?'*
> (Independent Chair)

As the Chair suggests, part of the problem is that the DCS is accustomed to being responsible for safeguarding children and is therefore unwilling to cede control. In this context the relationship between the DCS is one of management not accountability, with the DCS overriding the Independent Chairs authority to manage LSCB activities.

> *'…it still feels as though we ought to have an Independent Chair so we'll have one, but it doesn't have the same profile or, there's still some issues about, how far should that person go in challenging what we are already doing in Children's Services.'*
> (Independent Chair)

Accountability of Statutory Chairs

Different issues arose when boards were chaired by the DCS. One DCS in our case study areas did not support the idea of independent chairing arrangements. They argued that as safeguarding was defined in Working Together as *their* core responsibility it was logical for them to Chair the LSCB:

> *'…if you go back to why there's a Director of Children's Service anyway, which obviously became a post-Climbié concept, or that was the main thing that drove it, it was about having single accountability in a single post, so if you've got single accountability in a single post and the safeguarding Board is responsible for safeguarding in a given area then there's a logic in it being chaired by the person who has that accountability…'*
> (DCS Chair of LSCB)

Normal line management arrangements such as meetings with the Chief Executive typically provided a way of holding the DCS to account although again these meetings tended to be either informal or/and have a broad agenda about strategic

developments related to Children's Services. More recently, as a result of the Baby Peter case and recommendations from Lord Laming, the role of the Chief Executive has been changing in that it is being seen as having a more central role in accountability. In those areas with the DCS as Chair representation of Children's Services on the LSCB tended to be delegated to Deputy Directors or other senior managers. This meant that some decisions had to be referred back to the DCS for ratification.

Accountability to the Children's Trust

Working Together requires LSCBs to have a close working relationship with the Children's Trusts (HM Government, 2006, p.83). It suggests that clear lines of demarcation are required to ensure there are no gaps in policies, protocols, services or practice. LSCBs are '…not to be subordinate or subsumed within the Children's Trust arrangements..' (HM Government, 2006, p.83) and they are expected to have an independent voice. Interviews revealed that how this operates in practice is somewhat confused and unclear. In part this relates to issues concerning accountability. While Lord Laming (2009) has rightly highlighted the importance of clarity about this relationship a number of tensions exist over how this happens in practice.

The national survey of LSCBs revealed that having the Chair as a member of the Children's Trust was critical to communication and information sharing between the two Boards (77 out of 103 said this was most important or important) (France et al., 2009). All but one of the Chairs in the case study areas were members of the Children's Trust, yet relationships between the Boards remained ambiguous. The roles and responsibilities of Chairs and how they either 'represented' the LSCB position, challenged the Children's Trusts, or how they might be accountable remained unclear (See Table 2).

Table 2   Relationship with the Children's Trust

Chair relationship in the six case study areas to the Children's Trust	Relationship between LSCB and the Children's Trust
Chair is a member of the Children's Trust.	LSCB reports to the Children's Trust and undertakes a challenging function. This relationship suggests a 'mutual accountability' where both are held to account.
Chair is a member of the Children's Trust.	No clear reporting structure. Relationship unclear.
The former Chair (DCS) was also a member of the Children's Trust. The new Independent Chair is re-assessing the relationship.	Through the Chair the LSCB reports to the Children's Trust quarterly. The reporting system was regarded as central to the accountability of the LSCB.
Chair is the DCS and is a member of the Children's Trust.	The Chair represents the LSCB to the Trust when necessary and also reports on progress.
Chair has open invitation to attend but does not sit on the Children's Trust as a full member.	Unclear how this works. Reliance on the DCS to report.
The Chair was a Statutory Chair (but not a DCS) and was a member of the Children's Trust Executive. New Independent Chair will not be a member (resource issue).	A representational role and contribution to planning of services.

In one area the Chair was clear that while they were willing to report to and give account of the activities of the LSCB they attended the Trust meetings mainly to challenge them and comment on their plans. In this sense the Chair felt he had a critical role to play in scrutinising the activities of the Trust. The DCS Chair in one of our other areas saw the relationship differently. They felt that the Children's Trust was an accountability mechanism and a central role of this was to 'bring the Chair to account…'. In another area, the Chair saw that they had a reporting function to the Trust but perceived that their main role was to contribute to the planning and direction of the Trust. As the Chair stated:

'…. you could say I am a company person, I've worked for the Local Authority since 1975 so I have come to a view about what is achievable, what's not achievable, how you do things and how you get things done..'
<div align="right">(LSCB Chair)</div>

As a result the Chair argued that their work on the Trust was about helping the Trust develop in the right way rather than being 'an agent provocateur'. Another Chair (DCS) felt they had a dual role as Chair of the LSCB and as a member of the Trust and felt they could operate across the two Boards to help both. Again, accountability was not part of this relationship, although the Chair would give regular updates to the Children's Trust. Confusion could exist if the roles had not been defined clearly. For example, in one case study area the Trust was in its early stages of development and respective roles and responsibilities had not been clarified. The Chair's role on the Board was unclear at the time of interview. In the other area, the relationship of the Independent Chair to the Trust was unclear as the DCS had a dominant role on both the Board and the Trust and the LSCB Chair did not attend although there was an 'open invitation' to do so. Reporting was done through the DCS but it was not clear to the Chair what was reported or how. In this context accountability was not part of the Chair's relationship with the Trust.

A major issue that came out of the research was the fundamental tension that arises over using the Children's Trust as an accountability mechanism for LSCBs because of joint membership.

'…I would be on it [DCS], the lead member, our Social Care, our Senior Safeguarding Manager was on the Children's Trust, our child health lead, is on the Children's Trust, as are the health commissioners, because you would want all these on your Children's Trust, but a lot of these are also on the Safeguarding Board challenging it fails to recognise that a lot of those are the same people, and I just think there are serious flaws in these recommendations.'
<div align="right">(DCS Chair of LSCB)</div>

Problems also arise in terms of scrutiny, if the LSCB is supposed to be scrutinising the activities of the Trust, but the Trust is being used as a mechanism to hold the LSCB to account:

> *'…the Children's Trust Board will be accountable for the management of safeguarding and the Safeguarding Board is the scrutineer of the challenger.'*
> (DCS Chair of LSCB)

This reinforces the importance of clarity about the role and purpose of the LSCB. This has an impact on the role of the Chair and the accountability and management structures that need to be put in place. It would seem that if the LSCB is to challenge the Trust then LSCB Chairs need to be line-managed by someone external to the Trust that they are supposed to be scrutinising.

Effective Models of Achieving Accountability and Management?

All of our Chairs and DCSs in our case study areas identified tensions around accountability. Independent Chairs could be in a position where they were trying to fulfil their role as 'independent voice' and raise concerns about Children's Services with the DCS who they were managed by, accountable to and also held their contract. Similar problems exist in terms of the relationship between the LSCB Chair and the Children's Trust. These tensions, especially for Independent Chairs, were acknowledged and Local Authorities were trying to construct governance systems to address such difficulties. For example, in one area they were having discussions about 'mutual accountability' being built into the system where:

> *'…the (Children's Trust) Board is shifting its position, they've seen that we are mutually accountable, we've had some work commissioned to help redefine our governance arrangements, inside which is how the two Boards work together…'*
> (LSCB Independent Chair)

However, operationalising this may prove to be a challenge and such systems need to be built on trust. In other areas the issue of accountability and management have been addressed by moving the managerial role of the Chair to the Chief Executive. Local Authorities are aware that difficulties exist with a model that both asks for scrutiny while also needing to be managed and 'brought to account'.

The expansion of political scrutiny in the context of safeguarding is an important development. In terms of the democratic process having scrutiny of unelected

bodies is seen as a critical function for local councils (Jones and Stewart, 2009). In one case study area the LSCB Chair had to produce an annual report outlining progress and future plans and they were also required to go before the scrutiny committee every year. The committee was comprised of the lead member for children and families and other senior political members. This process was seen as a mechanism to bring the LSCB to account. The inclusion of a local elected member on the LSCB in this area was also seen as important to introduce public scrutiny, although how this role should function on the Board needed some clarification (i.e. was it as an active member or an observer?). In this area the scrutiny process also involved being asked questions by the local Youth Parliament which was seen as a good way of involving young people in the process of accountability, providing young people with the opportunity to raise issues and ask the Chair questions. Since the release of Lord Laming's progress report on the protection of children in England, political scrutiny of boards in our case study areas has increased. In one area the LSCB was called upon by local members to answer questions which proved to be a very powerful process and put the Chair under substantial pressure to justify their actions:

> *'And then we have the scrutiny committee [policy commission in the local council] who scrutinise everything. Since all the trouble in Haringey and the Laming Report, they've decided on quarterly reports on safeguarding on all performance indicators, ….[name] took it very badly because he came to the last scrutiny meeting and the members challenged him as if he was an officer, I don't know if you have worked in local government, but they're not very polite.'*
> (DCS)

The process is one which can make LSCBs accountable to the local community, without threatening their independence.

LSCB relationships with the Government Offices for the Regions and Ofsted

The relationship with the Government Offices for the Regions (GOR) and Ofsted are important for LSCBs. These relationships were constructed, by central government, as a form of governance, providing a mechanism for monitoring and auditing the activities of LSCBs and ensuring they are functioning effectively, while also providing guidance and advice. Lord Laming (2009) has raised the need for clarification of relationships, especial with Ofsted, to support an effective system that helps LSCB

develop a more effective form of operation. These themes emerged throughout our interviews and in the second phase of the research (following the Laming Review) our LSCB case study areas were raising a number of important issues about how these relationships were impacting on effectiveness.

Government Offices for the Regions (GOR)

Lord Laming (2009) identified the important role that Government Offices for the Regions need to play in both the management and support of LSCBs:

> *'There must be a particular focus on their [Office of the Regions] role in challenging performance and sharing learning and expertise at a regional level.'*
> (Lord Laming, 2009)

From our interviews with Chairs, Business Managers and Directors of Children's Services a number of concerns were raised about the role of the GOR in the Safeguarding process. The central concern raised related to the tension that was built into this role. Having to challenge, monitor and also offer expertise and support at a local level was seen as problematic. For example, in a discussion about the notion of independence on Serious Case Reviews the Independent Chair of one of our case study areas asked for guidance from their GOR. At one meeting they were told that they had to have an external person chairing, yet at another it was suggested that Business Managers could Chair:

> *'At another meeting with government office, it was said there is nothing to say that Board Managers couldn't do this because they could be seen as independent, which is it?'*
> (Independent Chair)

Similar concerns arose when a Chair asked the local Safeguarding Advisor from GOR to clarify a point in Working Together (HM Government, 2006). In the discussion they highlight the tension between 'support' and 'challenge' as a core difficulty to the relationship:

> *'I needed some advice, and [Safeguarding Advisor at GOR] regurgitated what was in Working Together or the fact raised by Laming. At this point she was sitting on the fence and I found myself saying, I know what Working Together says, I know what Laming is saying, I would just like some advice, but there is a*

feeling that this challenge and support role from government office is much more about challenge than it is about support.'

<div align="right">(Independent Chair)</div>

These issues were raised again by the same Chair when they asked for guidance on an SCR issue. They had written to local GOR for advice on whether to delay submission of an SCR report. They had concerns about the quality of the overview and therefore wanted to address this before submission. The Chair asked GOR to support this option. The letter she received back was seen as less than helpful:

'We know what your letter says but I'm sure that Ofsted will have a comment to make about this, and of course if you had the right quality assurance in place then this would have been picked up sooner. I thought, I know that, why state the obvious, I don't need a lecture at this point.'

<div align="right">(Independent Chair)</div>

A number of respondents were concerned that GOR operated to fulfil its own functions and was trying to achieve its own targets rather than function to support the development of the LSCB. One Chair outlined concerns about how GOR organised regional meetings for Board Managers, Chairs and Child Death Panel Chairs. They felt that the agendas for these meetings were designed to meet the needs of the regional office rather than those of the LSCB. The Chair had two concerns. Firstly, that separate guidance was being given to Board Mangers without Chairs being informed of the nature of this or the requests being made. Secondly, it was not clear whether attendance at meetings was voluntary or obligatory:

'I did say to folk there on one occasion….can I be clear, is the attendance at these meetings voluntary or expected? Oh no, no, no, it's voluntary. Ok as long as we are clear about this, because a lot of ways in which you choose to phrase things kind of suggests that there is a mandate that folk must be there, and I just want to ensure that we haven't lost the voluntary agreement.'

<div align="right">(Independent Chair)</div>

Their main concern related to the extra work and demands this was causing for the Business Manager and the lack of knowledge LSCB Chairs had about what was being asked of them. As they go on to say *'…there is enough work to do locally without picking up work with government officers'* (Independent Chair). In another

example, one of our other Independent Chairs raised concerns about a request they had for a member of the GOR to be a member of the Board.

> *'In [name of area] we were asked if the Safeguarding Advisor from government office could sit on the [name of Board] as a part of their evaluation…because it was her role to evaluate the board therefore she thinks she ought to be able to come and sit on it….'*
>
> (Independent Chair)

The Chair was concerned that this potentially compromised the relationship between the GOR and the Board and they felt that this would not be a positive relationship to have. After consultation with members the Chair wrote to the officer concerned and declined to permit this access.

The role of Ofsted

> *'I think the other thing that's made it very difficult is the increased scrutiny by Ofsted and government office...it has just been phenomenal really…'*
>
> (Independent Chair)

In the interim report Chairs and Business Managers raised a number of concerns about the operation of Ofsted and the impact it had on their work (France et al., 2009). This was especially relevant to the evaluations of Serious Case Reviews. Concerns were raised about how Ofsted had become focused on the process of SCR rather than the outcomes, and guidance had not been provided early enough or in enough detail (France et al., 2009, pp.60). These issues have been recognised by Lord Laming and Ofsted themselves and in their new framework, which was announced in February 2009, changes to the review process are to take place. While our research cannot comment on the new arrangements being put into place, interviews with Chairs, and the DCSs in the second round of interviews provided some important comments on recent experiences and on the value of some of the changes being proposed.

Concerns surrounding the evaluation of the Serious Case Reviews were still an issue. How they were being judged and what the criteria of assessment was remained points of tensions although it was recognised that this process was going through changes. Serious Case Reviews remained a central focus of the workload

of LSCBs so these issues remain important. Part of the concern was that the quality of inspectors could vary and that no two reviews were the same. For example, one of our Independent Chairs, who was employed as Chair in another area, expressed their frustration about how inspectors would approach reviews differently. They had seen similar cases judged inadequate in one area and adequate in another.

> *'I have experience in another authority, probably the best overview report I have ever read criticised by Ofsted, but to me that was much more about the inspector who had evaluated it…'*
>
> (Independent Chair)

Concerns were also raised by DCSs. For example one DCS explains how in previous communications on Serious Case Reviews the authority had received a

> *'…a dry letter that just said, inadequate for the following reasons and they had no information on X, Y, Z, if they had asked us we'd have given you that..'*
>
> (DCS)

More positively, the DCS above went on to explain how things seemed to be changing. They had been concerned about the relationship the authority had with Ofsted so they had arranged a meeting with them to talk about how to improve communication and relationships. The DCS suggested that after this Ofsted were very responsive and keen to have a dialogue about how the process could be improved. This resulted in a different way of working which the DCS thought was valuable:

> *'This specific case is complex…and the guy [from Ofsted] has rung us up and said, I can't quite find this, could you explain that to me, in such a nice way, interested, oh we have that, we hadn't realised that was part of the package, so we can provide you that.'*
>
> (DCS)

This 'change' in approach was very well received by the DCS as they thought previous relationships had not been about dialogue *'…I did feed this back to Ofsted inspectors …it is so welcome to have a dialogue'* (DCS).

Other DCSs also thought there were some positive signs in how Ofsted was re-organising itself. DCSs thought it was critical that Ofsted could create systems that

help them bring individuals and agencies to account. In one area the DCS had agreed to being a pilot for the new evaluation model being developed by Ofsted and he had thought this had been very rewarding and beneficial to his own assessment of events:

> *'We just did the safeguarding bit, one of the criteria …is the effectiveness of LSCB. It would be fair to say we came out as inadequate…a lot of the recommendations we got are around the LSCB not being effective…'*
>
> (DCS)

As a result the DCS used the evaluation by Ofsted to challenge the Chair to require the development of more robust performance indicators. The Board was put under review and major changes were recommended to the level of seniority of the Board and the need for the Chair to be more effective in challenging the existing status quo.

One final but important point raised by a DCS related to the expanded role of Ofsted in building in new requirements to other evaluations. The main one raised related to education. The DCS argued that getting education in schools to respond to the Safeguarding agenda was '…very challenging…' arguing that they were '…all incredibly independent' and difficult to engage in the process (see Chapter 4 for further discussion). The DCS saw changes to the Ofsted inspections of schools as significant and an important step:

> *'…the increasing emphasis in Ofsted school inspections on safe recruitment…the importance of the designated teacher being significantly trained and working with local Safeguarding Board… if they haven't got their safe recruitment sorted out, or they haven't got their designated person on a course recently, they can find themselves in difficulties…'*
>
> (DCS)

Conclusion

Across the case study areas all of the LSCB Chairs were seen as being effective, having both the skills and knowledge to take on a central role in leadership of the Boards. Independent Chairing was seen by the majority as the right decision and direction to go in and offered a mechanism of creating a more independent model of operation that helped the Board be more effective. The core weakness related to

the difficulties that Independent Chairs could have in becoming embedded and active in broader strategic networks and activities, which could have an impact on effectiveness. Under-resourcing of the Independent Chair post or lack of administrative support could both pose difficulties and could leave Chairs with insufficient time to undertake wider strategic functions. This could lead to over-reliance on the DCS and impact on perceptions of the impartiality of the Board.

In terms of accountability major problems remain. Firstly, there is a failure to separate the functions of accountability from management, especially when the two roles are located with the DCS. The merging of these roles can create uncertainty amongst Board Members about the authority and the independence of the Chair. It can also cause problems for Independent Chairs who may wish to challenge the operation of Children's Service but at the same time they are accountable to the DCS. Tensions also remain over the model that locates accountability with the Children's Trusts in that a lack of clarity about purpose can create confusion. Evidence suggests that 'mutual accountability' of being both accountable and 'scrutinised' by the Trust, especially when the same people could be members of both organisations is not appropriate. However, an alternative option exists, that of linking accountability to either (or both) the Chief Executive's Office or Political Scrutiny which allows the independence of the LSCB to remain while also establishing a form of public accountability.

One final issue relates to the tensions between support and monitoring functions. This is evident in the tensions that exist between LSCBs and GOR and Ofsted. Tensions are bound to exist over the relationship of these two organisations and LSCBs in that they have a central function in monitoring, auditing and evaluating the activities of LSCBs. This makes the proposed roles of 'giving support' or 'helping development' that are part of the remit of GOR and Ofsted more difficult to achieve. Evidence from the research suggests that dialogue and positive responses to requests are critical if the relationships are to be improved. Having skilled and knowledgeable staff who work closely with LSCBs is also important if good relationships are to be development and maintained.

3   BOARD MEMBERSHIP

The chapter explores the ways that two LSCBs have constructed how they operate. It examines two models, one that is 'exclusive' in that membership is limited and the other that is 'inclusive' (more open membership). Issue of influence and the impact of the size of Board on practice, alongside analysis of meeting participation rates, are discussed. Social Network Analysis (SNA) has been employed to contribute to an in-depth understanding of links and relationships between the different aspects of the LSCB (see Annex A).

As Table 3, below, shows, the case study Boards vary in their size. Area Two had the lowest number of members (14), while Area Six had the highest (36). The average and median of the case study Boards compared well with the national picture, with a mean average of 25.3 (compared to national sample of 25.8) and with a median of 27 members (compared to national sample of 24.5).

Table 3   Six LSCB Case Study Areas Membership

Total Members of six case study areas (excluding Chair and Business Manager)
24
14
30
30
18
36

The national survey revealed that 80 per cent of LSCBs had representation from Youth Offending Teams (YOTs) (France et al., 2009). Two out of the six case study areas did not have a YOT representation. The Children and Family Court Advisory and Support Service (CAFCASS) was not represented on the Board in another area. Three of the Boards were lacking a representative from the Strategic Health Authority and three Boards did not have a Connexions Representative[3]. In terms of

---

[3] This could be because Connexions has been integrated into Children's Services.

seniority levels, membership in the case study areas was consistent with the findings from the national mapping exercise (France et al., 2009). Forty per cent of Board Members were coded 1 or 2 (39 per cent in national survey), 56 per cent were coded 3 or 4 (56 per cent in national sample) and four per cent were coded 5 (five per cent in national sample) (1 = most senior; see Annex B for definitions of levels of seniority).

LSCB Infrastructure

Executive Groups have been found to be important mechanisms to support the operation of LSCBs (France et al., 2009). Working Together (HM Government, 2006) permitted the use of such mechanisms to help *'…LSCB members to carry out some of the day-to-day business by local agreement'* (HM Government, 2006: Section 3.69). The national survey found that 65 per cent of Boards had established an Executive Group (France et al., 2009). Nearly half (48 per cent) of LSCBs felt that the main purpose of the Executive Group was to separate operational and strategic issues. Membership tended to reflect the distribution of members on the main LSCB rather than being a meeting of the most senior partners.

The mapping exercise also revealed that every LSCB had established subgroups (France et al., 2009). The lowest number of subgroups per Board was two and the highest was twenty. The average number was six (mean of 6.7; median of 6). The most common subgroups were Training (90 per cent of areas) and Policy and Procedures (73 per cent). Areas also constructed specialist subgroups with E-safety (38 per cent) and Employment and Safer Recruitment (31 per cent) being the most common (France et al., 2009).

Social Network Analysis

Social Network Analysis (SNA) was undertaken in two case study areas (Areas One and Three) to facilitate in-depth exploration of relationships, contacts and meetings between Board Members. The method also assisted with understanding levels of participation and the influence different individuals had on the operation of the Board. The two sites were randomly selected for this aspect of the evaluation. Further details concerning the methodology are outlined in Annex A. The findings from each Area are outlined below, before going on to discuss the similarities and

differences in the approaches adopted in each area and the implications of these on the effectiveness of each LSCB.

Relationships between subgroups and the LSCB in Area One

The two case study areas (Area One and Area Three) had different approaches to membership. In Area One membership was closely controlled. The Chair was clear that decisions concerning membership should be informed by individuals' capacity to contribute and represent their agency. Board Members were informed about expectations and their core roles and responsibilities through an induction process. The Chair took the view that it was important to limit Board membership to the most relevant partners and to encourage greater participation in subgroups:

> *'Everyone wants to be on the Board for some reason, and the message I give to people is that it is a dull place, where you actually want to be is on one of the sub-committees, because that's where the real work goes on… for instance somebody from the Fire Bridgade wants to be on the Board and my reply is that the links are not so much with the Board but with the prevention sub-committee….so I do try and keep it as tight as possible.'*
>
> <div align="right">(Chair, Area One)</div>

Overall, therefore, in Area One membership was exclusive and controlled. This is reflected in the SNA data.

Figure 3   The number of groups that Area One members belong to

● Pink	Belongs to one group	(39 people, 68 per cent)
● Red	Belongs to two groups	(11 people, 19 per cent)
● Grey	Belongs to three groups	(3 people, 5 per cent)
● Yellow	Belongs to four groups	(1 person, 2 per cent)
● Green	Belongs to five groups	(2 people, 4 per cent)
● Orange	Belongs to six groups	(1 person, 2 per cent)

● Black circles:
LSCB   Local Safeguarding Children Board
CDO   Child Death Overview subgroup
SCR   Serious Case Review subgroup
PP   Policies and Procedures subgroup
Au   Audit subgroup
SIE   Safeguarding in Employment subgroup
Tr   Training subgroup
ESA   E-Safety subgroup

Figure 3 includes percentages (and percentages are quoted throughout the report) in order to facilitate comparisons across the two areas. However, as there were only 57 people included in the wider Safeguarding community in Area One, each person represents approximately two per cent of Area One's safeguarding community. For this reason, relatively small differences in the percentages between the areas should be ignored.

As Figure 3 shows, Area One had seven subgroups (no Executive) and a total of 57 people were involved in the LSCB and/or subgroups. Twenty six of these people (including the Chair and Business Manager) were members of the LSCB. The close relationship between the LSCB and the subgroups was reinforced by virtue of the fact that a number of individuals (18) belonged to more than one group. This cross fertilisation has the potential of helping maintain clear messages about the Board priorities across the infrastructure. As Table 4 shows there was strong representation of LSCB members on the subgroups. This offered a conduit for information exchange between the LSCB and the different and varied subgroups. For example, four out of the nine members on the Safeguarding in Employment subgroup also sat on the LSCB, thereby offering opportunities for information to be fed between the Board and subgroup.

Table 4   LSCB Representation on Subgroups

Subgroup	Number of Members	Number of LSCB Members	Per Cent of LSCB Members
LSCB	26	26	100
Safeguarding in Employment	9	4	44
Audit	8	5	63
Training	13	2	15
Serious Case Review	6	6	100
Child Death Overview	5	5	100
Policies and Procedures	12	7	58
E-Safety	11	2	18

Figure 4 and Table 5 also show commonalities in subgroup attendance by LSCB members. The lines connecting two subgroups represent a situation where the two subgroups had at least one member in common. It clearly demonstrates that the LSCB and the subgroups were connected to each other not just to the Board. Each group had links with at least five others, with the LSCB, E-Safety, Serious Case Review, and Policies and Procedures having links with every other group. Inevitably, the LSCB was connected to all the subgroups since, as Table 4 shows,

the LSCB had representation on all the subgroups. There were only three situations where two groups did not have common members (Training and Child Death Overview, Training and Audit, Child Death Overview and Safeguarding in Employment). This reinforces the picture of strong two-way links between the subgroups and the LSCB, alluded to earlier.

Figure 4   How well the LSCB and Subgroups are connected together in Area One
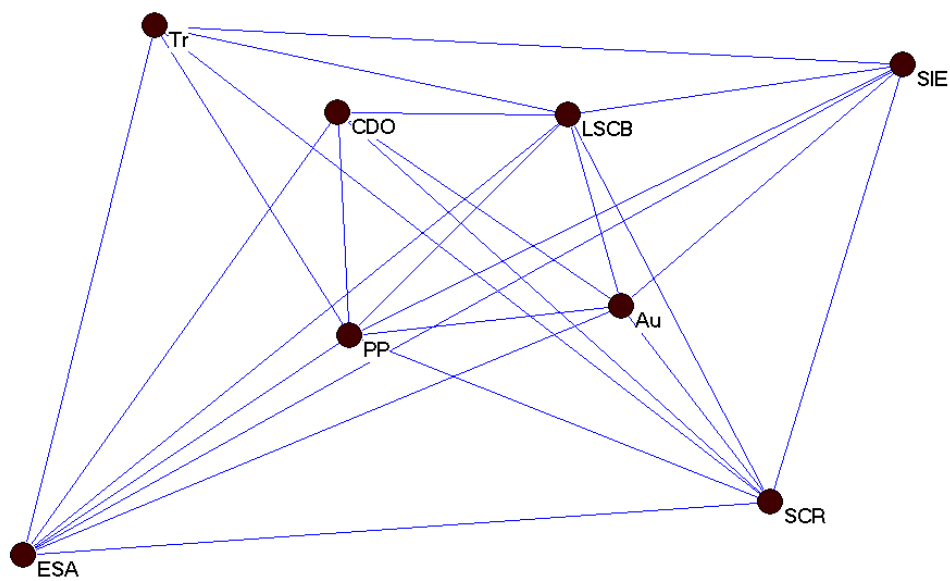
LSCB   Local Safeguarding Children Board
CDO   Child Death Overview Subgroup
SCR   Serious Case Review Subgroup
PP   Policies and Procedures Subgroup
Au   Audit Subgroup
SIE   Safeguarding in Employment Subgroup
Tr   Training Subgroup

Table 5   Group connections in Area One

Number of Connected Groups	Number of Groups with these Connections	Names of Groups with these Connections
5	2	Training Child Death Overview
6	2	Safeguarding in Employment Audit
7	4	E-Safety Policies and Procedures Serious Case Review LSCB

The distribution of Board Members on subgroups reflects Area One's approach to membership. The importance of maintaining a strong connection between the activities of the LSCB and the subgroups is recognised. Not only were LSCB members actively involved in the subgroups but they also created structural processes that actively engaged subgroup members in the planning process. LSCB members and subgroup members met on an annual basis to set priorities. As the Chair suggested, the purpose of these meetings was to help people get a broader understanding of how their subgroup was connected to the operation of the LSCB:

> *'But what could happen there is it has actually dropped people who are remote from the overall Safeguarding Board, into a greater understanding, because they are hearing not just what their subcommittee's doing but they are seeing the other subcommittees and see the relationship. If you merely turn up to your committee you just don't have the full picture.'*
>
> (Independent Chair)

Subgroups were also accountable directly to the LSCB in that they had a clear reporting system built into LSCB meetings. Firstly, the Chair organised pre-meetings with all the Chairs of the different subgroups as a mechanism for monitoring their progress but also keeping them focused on the tasks they were

addressing. Secondly, each subgroup had a slot on the agenda where they were expected to report back on progress. This was also a two-way process where the LSCB could feed back and give guidance to the subgroups about direction. The approach adopted to facilitate strong links between the LSCBs and subgroups was viewed positively. However, it was recognised that sharing work between a relatively small number of members placed high work demands on individuals. Such issues could be exacerbated if participation in certain subgroups was poor (see discussion below, active participation at meetings).

As Table 6 shows, in Area One, Children's Social Care (18 per cent) and Health (21 per cent) contributed the most to the membership of the LSCB and subgroups, although Police and Education were also active in five of the subgroups.

Table 6   **Agency to which group members belong in Area One**

(Per Cent)

Agency Type	Number of Members of Groups								
	LSCB	**SIE**	**Au**	**Tr**	**SCR**	**CDO**	**PP**	**ESA**	**Total ***
Children's Social Care	4	1	2	3	1	0	3	0	10 (18)
Education	1	1	0	1	1	0	1	2	2 (4)
Health	5	3	1	3	2	3	3	1	12 (21)
Police	3	0	1	1	1	1	2	0	5 (9)
Housing	1	0	1	0	0	0	0	0	2 (4)
Probation	1	0	0	1	0	0	0	0	2 (4)
Connexions	1	0	1	0	0	0	0	0	1 (2)
Third Sector	1	1	1	0	0	0	0	0	1 (2)
YOT	1	0	0	0	0	0	1	0	1 (2)
Adult Social Care	1	1	0	0	0	0	0	0	1 (2)
CAFCASS	0	0	0	0	0	0	1	0	1 (2)
Mental Health	1	0	0	1	0	0	0	0	2 (4)
Prison service	0	0	0	0	0	0	0	0	0 (0)
Other	6	2	1	3	1	1	1	8	17 (30)
Not known	0	0	0	0	0	0	0	0	0 (0)
TOTAL	**26**	**9**	**8**	**13**	**5**	**5**	**12**	**11**	57

In total, there were 57 people who were members of the LSCB and subgroups. The total in the bottom row does not add up to 57 because it was sometimes the case that members belonged to multiple groups.

Membership in Area Three

There were 17 groups involved in the safeguarding collaboration in Area Three, with between five and 32 members (Figure 6). In total, 186 individuals were members of the LSCB or at least one of the subgroups. Of these 186 individuals, only 32 were members of the LSCB itself (including 11 members from non statutory agencies, so there was no legal requirement for them to sit on the LSCB). Clearly this LSCB had adopted an inclusive strategy of inviting a large number of people to contribute to co-ordinating and ensuring the effectiveness of safeguarding arrangements in the local area. One Board Member offered an explanation of the size of the safeguarding community in Area Three.

> *' [Area Three] is a big beast, it is a big animal and that it has a lot of structures underneath it, but it has got a lot of people there, it has got a lot of issues, whether it is unemployment, deprivation or whatever and the social economic issues that exist in pockets within the area and I don't think many other boroughs have got that many district boroughs underneath it as well. It is such a big area, it probably warrants it, the level of workload shall we say.'*
>
> (Board Member)

The safeguarding network in Area Three was very 'open' and inclusive, that is there were a large number of people involved in the LSCB and the infrastructure that surrounded it. In this model, most people belonged to just one group (Figure 5), and there were relatively few links between groups relative to the number of individuals included in the process. Seventy-eight per cent, or nearly four fifths of the people represented in the process only belonged to one group. Only 22 per cent of members were involved in more than one group. Area One had a smaller number of people involved (57) but they were more active across subgroups (68 per cent in one only and 32 per cent in more than one).

Figure 5   Group Membership, number of group individuals belong to in Area Three
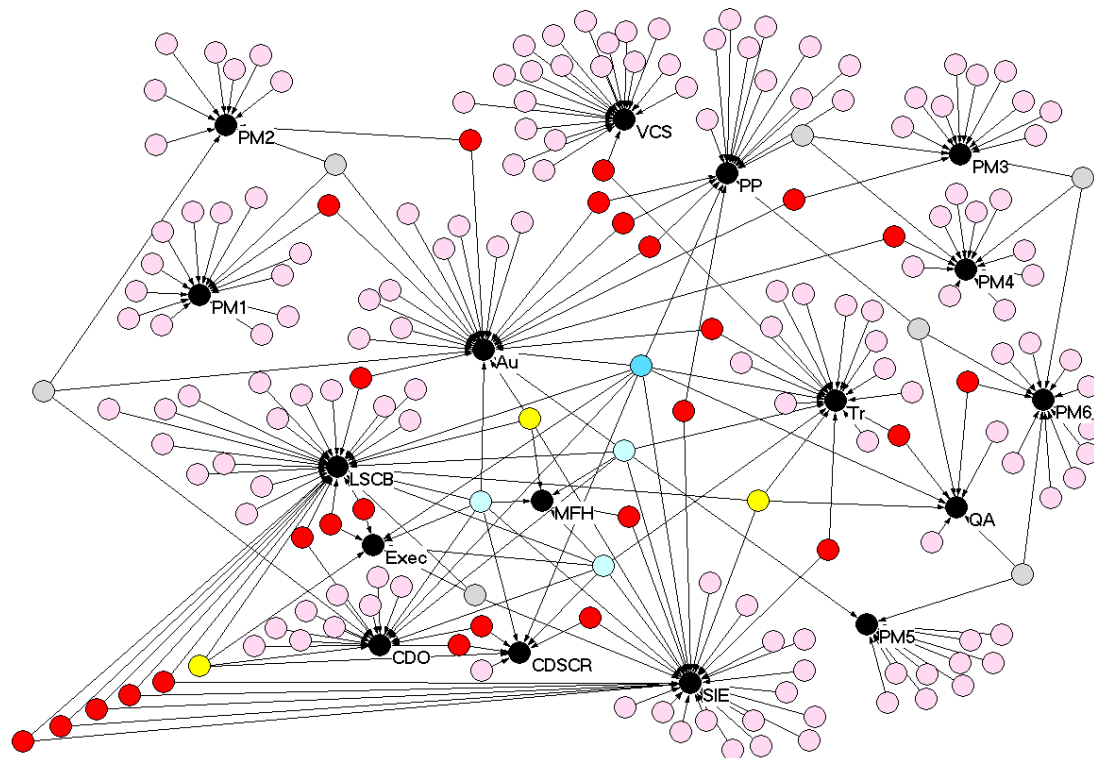
	Pink	Belongs to one group	(146 people, 76 per cent)
	Red	Belongs to two groups	(26 people, 14 per cent)
	Grey	Belongs to three groups	(7 people, 4 per cent)
	Yellow	Belongs to four groups	(3 people, 2 per cent)
	Light Blue	Belongs to seven groups	(3 people, 2 per cent)
	Bright blue	Belongs to nine groups	(1 person, 1 per cent)

● **Groups (Black circles)**

CDSCR	Child Death and Serious Case Review
CDO	Child Death Overview
PM1 to PM6	Practitioner Meetings (Each meeting covers a different geographical area)
Exec	Executive Board
LSCB	Local Safeguarding Children Board
MFH	Missing from Home
Au	Audit
PP	Policy and Procedures
QA	Quality Assurance
SIE	Safety in Employment
VCS	Voluntary and Community Subgroup
Tr	Training

A different distribution of LSCB members across the subgroups emerged in Area Three, compared to Area One, as Figure 5 shows[4]. Firstly, Area Three had established an Executive Group. Consistent with the national picture, this group was entirely composed of LSCB members (France et al., 2009). However, the relationship between LSCB members and subgroups was less structured and less closely managed, compared to Area One. In Area One the decision was taken to ensure that a number of LSCB members were involved in the subgroups, whereas in Area Three this was not the case. The involvement of LSCB members in subgroups was much more varied in the latter infrastructure. For example, as Table 6 shows, four out of five of the Missing from Home group were members of the LSCB, while the Voluntary and Community subgroup did not involve any LSCB members[5]. In Area One, 58 per cent (or seven out of 12) of the Policy and Procedures subgroup were also LSCB members, whereas in Area Three only one Board Member (out of 17 Policy and Procedures members) sat on this subgroup (six per cent). Twenty one per cent (five out of 24) of the members of the Audit subgroup in Area Three were also LSCB members. Sixty three per cent of Board Members (five out of eight members) sat on the equivalent subgroup in Area One. The only subgroup that had similar participation rates was the Safety in Employment subgroup, with 39 per cent (12 out of 31) of Board Members sitting on this subgroup in Area Three and 44 per cent (four out of nine) in Area One.

---

[4] Percentages have been quoted in order to facilitate comparisons of the proportions of LSCB members who are present in each subgroup. However, because the subgroups are relatively small, the percentages should be interpreted with caution. For example, 80 per cent of the members of the Missing from Home subgroup are also members of the LSCB. However, as there are only five members of the Missing from Home group, this means that four of the five members are also members of the LSCB. So a high percentage may not mean that many LSCB members are members of a subgroup. To gain an accurate sense of LSCB representation of subgroups, the number of representatives must also be taken into account.

[5] This situation may have changed as it was recognised by the Chair and Business Manager that this was not appropriate.

Table 7   Per cent of LSCB members belonging to each subgroup in Area Three

Group	Number of subgroup members	Number of LSCB representatives in subgroup	Per cent of LSCB representatives in subgroup
Missing from Home	5	4	80
Executive Group	7	7	100
Quality Assurance	8	2	25
Child Death and Serious Case Review	8	4	50
Policy and Procedures	17	1	6
Child Death Overview	18	6	33
Training	19	4	21
Voluntary and Community Subgroup	20	0	0
Audit	24	5	21
Safety in Employment	31	12	39
LSCB	32	32	100

Figure 6   How well meetings are connected together in Area Three
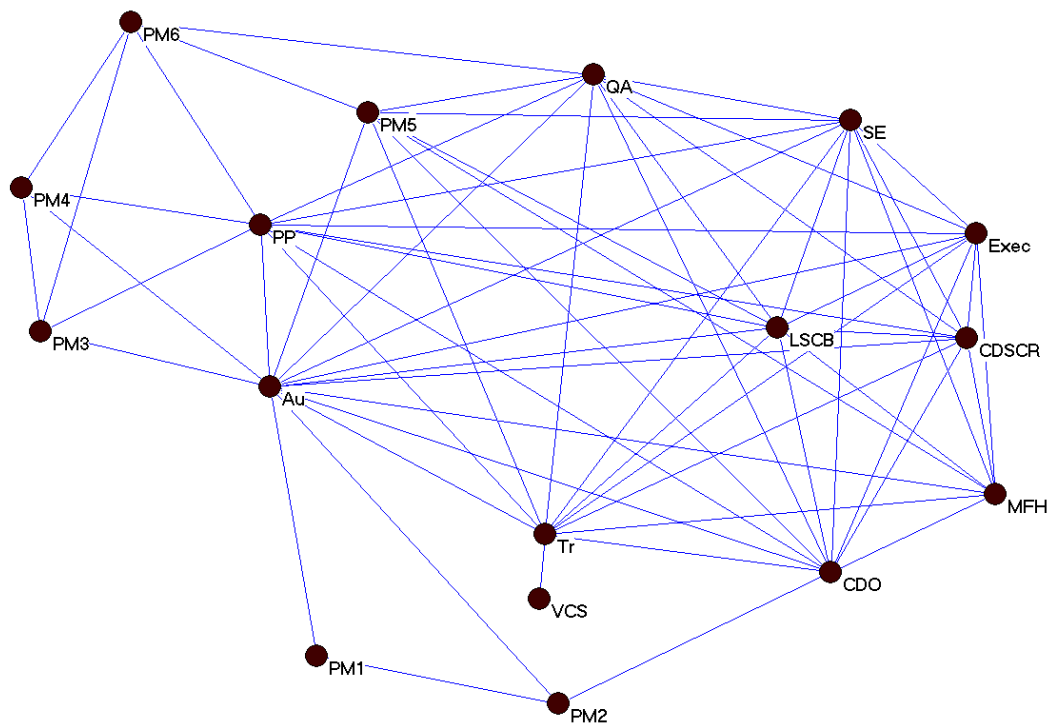
When it comes to connectivity, Area Three had a similar pattern to Area One in that connections existed across the infrastructure of the Board, although when it came to the Practitioner Meetings the connections were weak. This was a set of subgroups that were formed to engage directly with practitioners in the different districts of the areas. The mechanism that had been established to connect the Practitioner meetings to the LSCB was via reports to the Audit subgroup, which then reported to the LSCB.

> *'So they obviously contribute to the discussions at the [Practitioner Meetings], which then get fed up through the [Audit subgroup], into the Board. I think the difficulty there, obviously bearing in mind what I have just said about the higher levels that the Board should be doing, is making sure that, any critical messages that are coming from the front line are actually not lost.'*
>
> (Board Member, Area Three)

There were also issues concerning the connections between the voluntary and community sector group (VCS) and other groups, as only one link was in place to facilitate feedback (see Table 8). The purpose of this group was to give the voluntary and community sector an opportunity to contribute to the safeguarding agenda. However, the group did not have a direct link with the LSCB and only had one link to another subgroup (Training). Although there were undoubtedly written communications between the LSCB and the subgroups it had created, the limited scope for informal communication may have limited the effectiveness of this subgroup. However, the VCS meeting minutes showed that the Business Manager had been attending the VCS meetings between July 2007 and June 2008. It was also clear from the Board Members interviews that one of the main ways the Board communicates to subgroups was via the subgroup Chair, who was also a Board Member. Therefore, the isolation of the VCS group appeared to be a relatively recent phenomenon and temporary situation (the membership lists were more recent than the meeting minutes).

Mechanisms for feedback from subgroups to the Board were less clear in Area Three than Area One. Each group was supposed to report to the LSCB every quarter but this did not always happen. The Business Manager also identified that keeping members on message and focused could be a challenge.

'I used to go to all the groups and I've had to stop…I don't go to them all now, but in some of them they think the action plan is my agenda and if I am not there then a couple of them have said 'oh [name of Business Manager] not here so we'll defer the action plan and they don't quite own it and realise that that is their work…'

(Business Manager, Area Three)

Subgroups in Area Three were set up and monitored through an annual Action Plan. However, unlike in Area One not all those involved in the LSCB infrastructure were involved in the development of the terms of reference and this may raise issues concerning ownership. Clarity concerning the contribution of the subgroups to the bigger picture was problematic and members could struggle to understand how they connected to the 'bigger picture'. Board Members in Area Three struggled to remember the full range of subgroups. In fact, the majority could only talk about one or two subgroups and they tended to be aware of those only because they were members.

Table 8   Group Connections in Area Three

Number of Connections between Groups	Number of groups with this number of connections to other groups	Name of Groups with these Connections
1	1	Voluntary and Community subgroup
2	1	Practitioner Meeting 1
3	1	Practitioner Meeting 2
4	2	Practitioner Meeting 3 Practitioner Meeting 4
5	1	Practitioner Meeting 6
8	2	Missing from Home Practitioner Meeting 5
9	2	Executive Group Child Death and Serious Case Review
10	3	Quality Assurance Safety in Employment LSCB
11	3	Policy and Procedure Training Child Death Overview
14	1	Audit

It is noteworthy that although the LSCB should monitor the subgroups it did not have the most connections to other groups (Table 8). In part this reflects the model that Area Three had developed and in which some groups, for example the Practitioner Meetings did not report directly to the LSCB, but instead reported to the LSCB through the Audit subgroup.

Table 9   Agency to which group members belong (Area Three)

Agency Type	Number of Members of Groups							
	LSCB	Exec	MFH	QA	CDSCR	PP	CDO	Tr
Children's Social Care	3	2	1	2	1	7	4	3
Education	1	1	0	1	1	1	1	2
Health	8	2	1	2	1	2	2	3
Police	3	1	0	1	3	2	4	0
Housing	1	0	0	1	0	1	1	2
Probation	1	0	0	1	0	1	0	1
Connexions	1	0	1	0	0	0	1	2
Third Sector	2	0	1	0	1	1	1	2
YOT	1	0	0	0	0	1	1	2
Adult Social Care	1	0	0	0	0	1	0	0
CAFCASS	1	0	0	0	0	0	0	0
Mental Health	5	0	0	0	0	0	0	0
Prison Service	0	0	0	0	0	0	0	0
Other	3	1	1	0	1	0	2	1
Not Known	1	0	0	0	0	0	1	1
TOTAL	**32**	**7**	**5**	**8**	**8**	**17**	**18**	**19**

Table 10   Agency type to which group members belong (Area Three)

Agency Type	Number of Members of Groups									Total Number of Agency Representatives (per cent)
	PM1	PM2	PM3	PM4	PM5	PM6	VCS	Au	SIE	
Children's Social Care	4	1	4	3	2	3	1	7	4	38 (20)
Education	1	1	0	1	1	1	0	1	3	14 (8)
Health	4	3	3	3	3	4	0	4	7	35 (19)
Police	1	1	1	1	1	1	0	2	1	13 (7)
Housing	3	1	2	2	1	2	0	1	0	16 (9)
Probation	0	1	1	1	1	1	0	1	1	7 (4)
Connexions	1	1	1	1	1	1	0	1	1	8 (4)
Third Sector	0	0	0	0	0	0	16	2	3	24 (13)
YOT	0	1	0	0	0	0	0	1	3	6 (3)
Adult Social Care	0	0	0	0	0	0	0	0	0	2 (1)
CAFCASS	0	0	0	0	0	0	0	1	2	3 (2)
Mental Health	0	0	0	0	0	0	0	1	0	5 (3)
Prison Service	0	0	0	0	0	0	1	0	0	1 (1)
Other	0	0	0	0	0	0	0	0	3	6 (3)
Not Known	0	0	0	0	1	0	1	1	2	8 (4)
TOTAL	**14**	**10**	**12**	**12**	**11**	**13**	**19**	**23**	**30**	**186**

Note: rows may sum to more than the total number of agency representatives because representatives may be members of more than one group.

The pattern of agency representation in Area Three was similar to that found in Area One. Social Care (20 per cent) and Health (19 per cent) contributed most members to the groups, although the Police (seven per cent) and Education (eight per cent) also made a considerable contribution. Differences emerged in the number of representatives (24 representatives, 13 per cent) and contribution being made by the Third Sector. However, it is important to recognise that 16 of these representatives were members of the Voluntary and Community Subgroup and had no other connection with the rest of the LSCB infrastructure.

Influence

To explore Board Members influence, as part of the SNA, data were collected using a short questionnaire (See Annex A). A response rate of 44 per cent was secured in Area Three (14 out of 32). In Area One a 35 per cent response rate was secured (nine out of 26).

Figure 7   Influential Individual Board Members Area One

	Black	Not nominated as influential	(2 people)
●	Light Blue	Nominated as influential by one person	(2 people)
●	Red	Nominated as influential by two people	(3 people)
●	Yellow	Nominated as influential by three people	(3 people)
●	Bright Blue	Nominated by four people	(1 person)
●	Orange	Nominated by six people	(1 person)
●	Grey	Nominated by seven people	(1 person)
	white	Nominated by nine people	(1 person)

Interestingly, the most influential person in Area One was not the Chair, but the Assistant Director for Children and Families (nominated by nine people). The Assistant Director was also the Deputy Chair of the LSCB and Chaired two subgroups. The Independent Chair was nominated as most influential by seven people. Five people identified the Head of Systems and Performance Management for the Strategy and Partnerships as the most influential. As Figure 8 shows, there was a broad range of agencies defined as influential although no single agency seemed to dominate.

Figure 8   Agencies of Influence in Area One

🟡	Yellow	Health	(2 people)
🟢	Green	Police	(3 people)
⚪	Grey	Other Backgrounds	(6 people)
🔴	Red	Children's Social Care	(3 person)
🔵	Light blue	Education	(1 person)
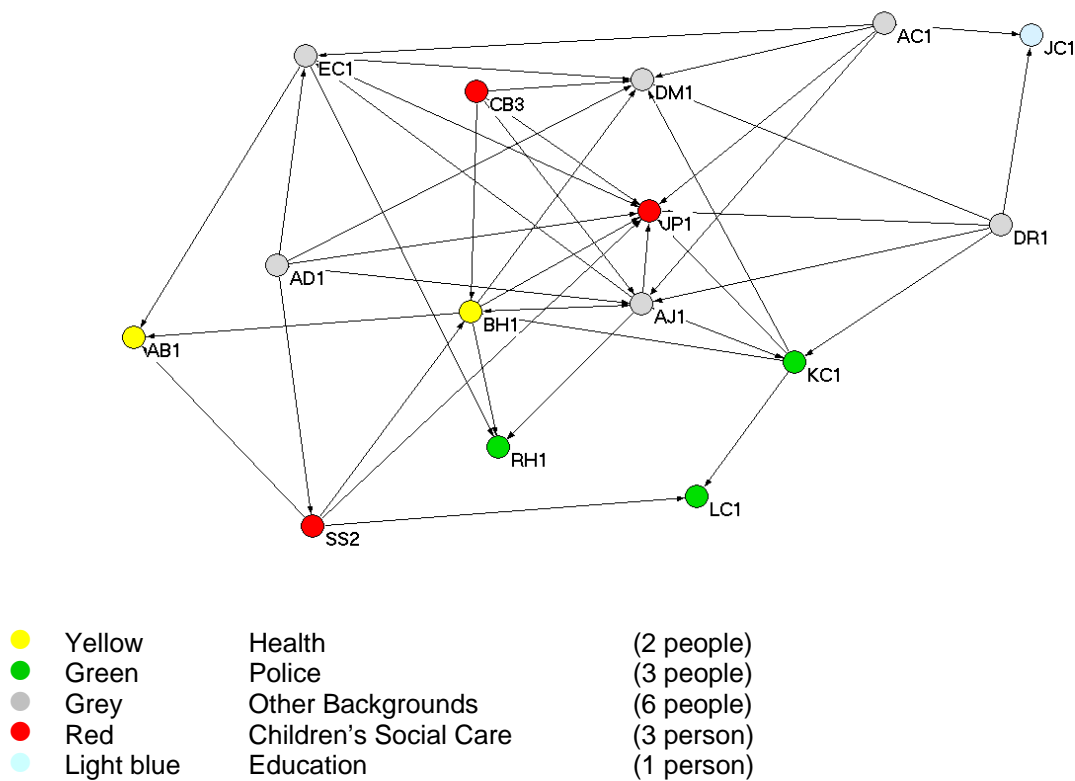
In Area Three (Figure 9) the two people nominated as the most influential were the Consultant Nurse (nominated by 11 people) and the Chair of the LSCB Board[6] (also nominated by 11 people). This was followed by the Assistant Director of Children's Services

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[6] The Chair was also Director of Children's Services.

(10 people), the Business and Performance Manager (seven people), Head of Safeguarding (seven people) and Public Health Consultant (seven people).

Figure 9   Influential Board Members Area Three
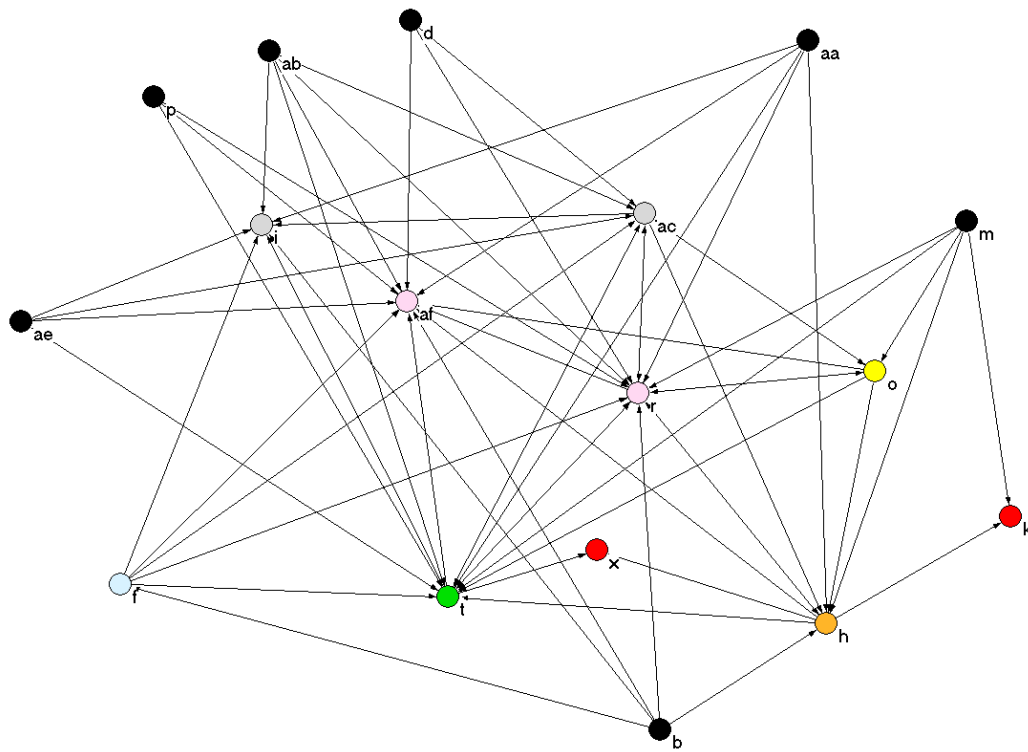
The circles represent LSCB members
- ● Black   Not nominated as influential
- ◯ Light Blue   Nominated by one person as influential
- ● Red   Nominated by two people as influential
- ● Yellow   Nominated by three people as influential
- ● Orange   Nominated by six people as influential
- ● Grey   Nominated by seven people as influential
- ● Green   Nominated by ten people as influential
- ● Pink   Nominated by eleven people as influential

Examination of influence by agency (Figure 10) reveals that that Health (which had four representatives nominated as influential) and Mental Health (four influential representatives) were seen as the most significant players.

Figure 10   Agencies of Influence in Area Three

🟡	Yellow	Health	(4 people)
🔵	Blue	Mental Health	(4 people)
🟢	Green	Police	(2 people)
⚪	Grey	Other Backgrounds	(4 people)
🌸	Pink	Third Sector	(1 person)
🔴	Red	Children's Social Care	(1 person)
⚫	Black	Background not known	(1 person)
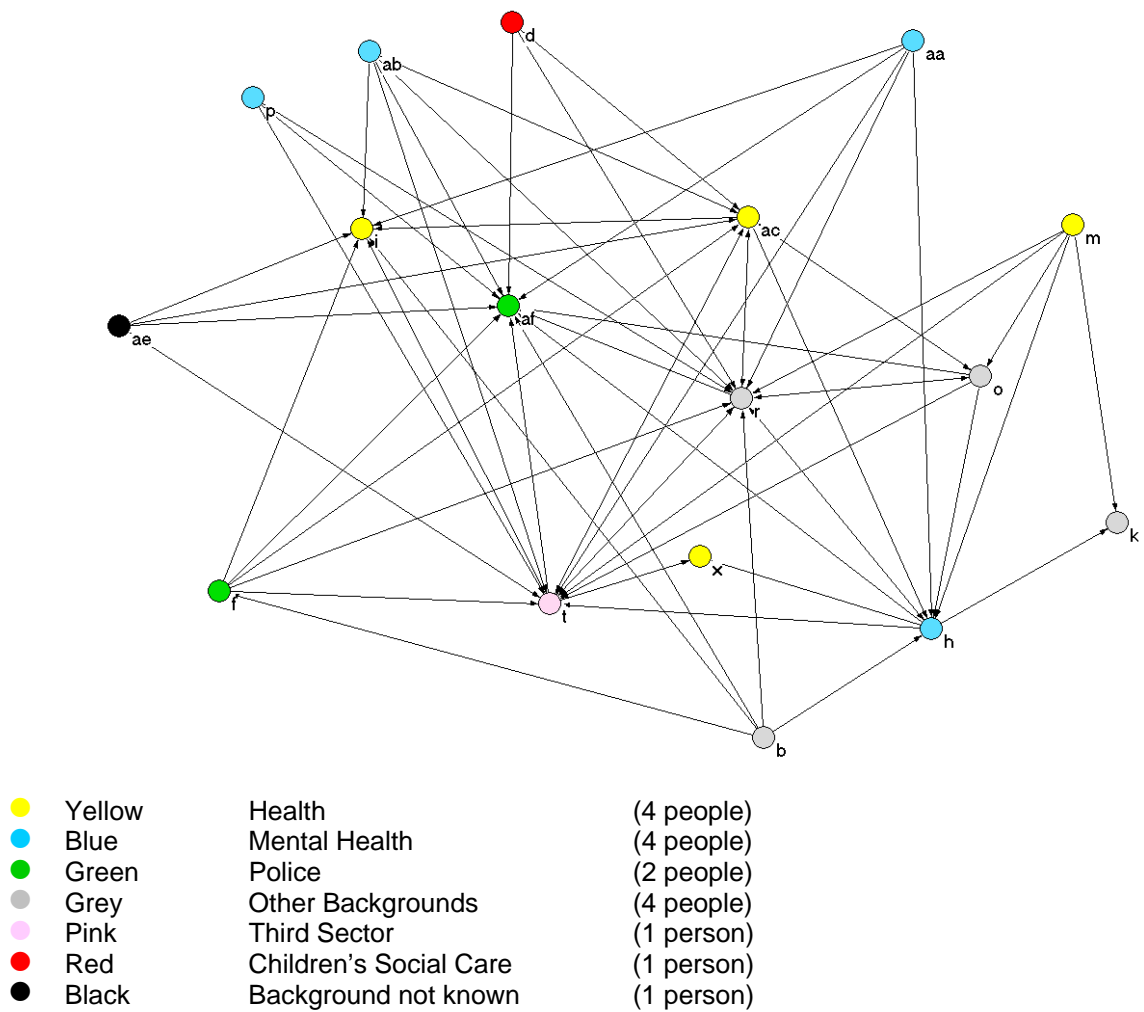
Size of Boards

In discussions about the effectiveness of ACPCs it was recognised that some Strategic Boards had been unwieldy (Hallett, 1995; James; 1987 cited in Calder and Barratt, 1997). In the case study areas the theme of LSCB size was raised as a concern by interviewees in three areas, each of which had 30 or more members. Over half of the Board Members in this area, as well as the Chair and DCS identified problems connected to the size of the LSCB. In two other areas it was not seen as too problematic by the Chairs and DCS although it was raised by the majority of Board Members as an issue. Case study areas struggled to balance the requirements of Working Together and inclusion of other key representatives on the

Board (depending on the organisation of local services) while also keeping the size manageable.

As outlined above the Chair in Area One made a clear decision that the Board would keep to a reasonable size and that membership would be restricted. They invited individuals to present information on specific issues during Board meetings or to sit on subgroups to ensure that others were engaged in the process. As a result the number of members on the LSCB was low. In the areas where numbers were higher, there was not always a clear rationale for including specific people on the Board. For example, in one area, the local Fire Service was included in the main LSCB, whereas in another a decision was taken that a representative from the Fire Service should sit on the Prevention subgroup instead. In three areas with the largest Board, membership concerns were raised about the implication of this on decision-making:

> *'It can't be any bigger, because it's already a big group, and I'm sure you understand that if you've got a bigger group you're less likely to make a decision because you're got too many conflicting issues there.'*
> (Designated Doctor)

Facilitating the active engagement of a number of professionals from different agencies within a large meeting was also identified as a challenge:

> *'So meetings are characterised by low levels of participation, too; domination is perhaps too strong to put it but certainly some agencies speak more than others, you're going to get that…it's challenging, you know you've got 30 people there…it taxes the skills of a chair to develop a participative style.'*
> (Independent Chair)

This issue was raised by some of the agencies outside Children's Services and Health. For example, a number of people working in the Third Sector expressed concerns about how the size of the Board could limit their participation and stop them from contributing in the debates:

'…I don't feel like I am making a huge contribution to the main Board. Not because I'm not willing to, or that I want to, it's just the way it is, and I try to look for opportunities to become more involved or to be able to offer a contribution but it's not always easy.'

(NSPCC Representative)

This discussion is linked, not only to the way that agendas are set but also to the size of the Boards.

Managing larger meetings and trying to progress through the agenda was identified as being difficult. For example, in one area meetings were held monthly and meetings could still last well over two hours. Sometimes this was due to the size of the agenda but it was also recognised as a problem of having too many people involved in the meeting. As a result Boards need to create alternative structures:

'The number of people on a Safeguarding Board challenge the ability to do business in a way that Laming and Working Together, and the government define, so inevitably some form of breaking down is going to happen, whether it's the executive, you're going to get sub-committees.'

(Independent Chair)

The rationale for forming an Executive was to reduce the workload on the Board. However, concerns were raised by Board Members in Area Three that certain decision-making powers were located with the Executive Group and that the main Board had become a forum for ratifying decisions that had already been taken. In one area, which also has a large Board issues were raised about what could appropriately be dealt with by the subgroups and what should be considered by the LSCB.

'…they're big meetings, and that's always interesting because you're not going to have the same amount of discussion as you do in smaller meetings…I was wondering what should we be scrutinising in our Board meeting or does all the scrutiny need to happen at the Business Subgroup (Executive)…at the big Board meeting you won't want to go down in that detail but how far can we be confident that things are happening…'

(Designated Doctor)

Finally it was also suggested that if Boards are too large (and change membership too often) then the ability of Board Members to make and build the personal contacts

they see as important are limited. Size effects who you get to know and the scope to network at meetings:

> *Interviewer*   *'What about bringing representatives from organisations together in the Board forum. Do you feel that relationships have been improved?'*
>
> *Respondent*   *'Actually at the moment I think they are sliding, and the reason for that seems to be so big now that I think it's almost impossible…well we can't even seat everybody around the table. There are always a couple of people absent, I think we are talking 20 something people….I can't name them all now and a year ago I could have.'*
>
> <div align="right">(Head of YOTs)</div>

However, problems could also exist if Boards were two small. One of our areas had elected to have a small Board (14 members) as a way of managing the new safeguarding arrangements. When appointed the Chair had been clear that his approach was to have a small and more effective Board. Large numbers, it was claimed made it difficult to maintain commitment and to get people to take up their responsibilities. As a result the Chair proposed to keep the Board small:

> *'When I first joined there were over 60 people but only about 13 of them spoke, I'd loathe to get back into this situation… my concern is to make sure there are sufficiently few people around that they actually feel committed to action…if there are too many people sat around the Board, they think somebody else will pick it up, I'm not volunteering.'*
>
> <div align="right">(Independent Chair)</div>

Smaller Board size was seen by the Chair as a way of encouraging commitment and ensuring that the work got done. However, some difficulties were encountered. Firstly, they sometimes struggled to engage the broad range of agencies necessary to be fully effective in getting those responsible for safeguarding. The Chair himself recognised that the Board had not always managed to engage either a good representation of relevant agencies and the level of seniority. This was also picked up by the local DCS who expressed concerns that the Board did not reach all the parts necessary for it to be engaging the key agencies. This had then led to a review being undertaken of membership and an examination over levels of seniority. For example, one Board Member suggested that a large gap was the lack of

involvement of adult services and the reason they were not involved was because they had not been invited:

> *'And Adult Services are missing. They should be there, although it is a LSCB they should be representation because obviously cross cutting themes and issues of transition and transformation. But they are not there. They haven't been asked to be, but they should be.'*
>
> (Representative of Children's Service)

A second issue related to the ability of the Board to carry out all of its core functions and responsibilities. The Chair recognised that levels of participation (not dissimilar to those above for Areas One and Three) had created major problems for the functioning of the Board and as a result it had not 'travelled' as far as it could have done. Non-attendance at LSCB meetings and subgroups could considerably delay progress. It could also be made worse if people left and replacements from the organisations concerned did not take up their position on the LSCB quickly. This had happened in a number of cases because of the re-organisation of local services (especially in health and education) and as a result the Boards found themselves without significant people to take work forward. Having too few people could therefore also cause problems for the effective operation of the Boards.

Active Participation at Meetings

As outlined above the core statutory agencies required to be members of the LSCB were well represented across the case study areas. However, a theme that was raised by Chairs in early interviews was variation in the level of participation amongst people contributing to the operation of the LSCB. Minutes from meetings in the two SNA case study areas were analysed to explore this further. Changes of membership, particularly those that were unrecorded, made monitoring attendance difficult. However, it did prove possible to follow core member levels of involvement. Table 11 shows levels of attendance at the LSCB and the subgroups in Area One. Attendance at all subgroup meetings was fairly high. These ranged from 71 per cent of the maximum possible attendance for Audit through to 88 per cent for Policy and Procedures. Four of the six members on the Serious Case Review group attended all five meetings. The variation in attendance rates could reflect the competing commitments of members, who may belong to several groups.

Table 11   Percentage attendance at meetings in Area One

Subgroup	Number of Members	Number of Meetings	Maximum Attendance*	Actual Attendance	Attendance Rate (per cent)
LSCB	26	5	130	113	87
Serious Case Review	6	5	30	22	73
Safeguarding in Employment	9	6	54	43	80
E-Safety	11	5	55	43	78
Policy and Procedures	12	4	48	42	88
Audit	8	3	24	17	71

*Maximum attendance is the total number of attendance episodes which would have occurred over the year if every member attended every meeting. It was calculated by multiplying the number of members by the number of meetings.

Table 12 shows that E-Safety, Serious Case Review and Audit had the most consistent attendance rates of all the subgroups. The attendance rate fluctuated most within the LSCB itself. Only 35 per cent of Board Members were present at the LSCB meeting with the lowest rate of attendance. Sixty five per cent attendance was the highest rate secured. Less than half of Board Members had attended at least half of the Board meetings (42 per cent). Attendance at subgroups was better, with most members having attended at least half of subgroup meetings between August 2007 until July 2008. This ranged from 67 per cent among Serious Case Review group's LSCB members, through to 92 per cent for Policy and Procedures. The majority of LSCB members of each group attended all of the meetings during this period; ranging from 56 per cent in Safeguarding in Employment through to 75 per cent in Policy and Procedures. A high attendance rate could indicate a high level of engagement with work to safeguard children from harm and to promote their welfare. Low attendance rates could suggest difficulties in managing competing time commitments for members of multiple groups. This could explain why the figures for regular attendance at the LSCB were comparatively low.

Table 12   Meeting attendance in Area One

Subgroup	Number of Members	Lowest Attendance Rate*	Highest Attendance Rate**	Attending at least half of Meetings***	Attending all Meetings****
LSCB	26	9 (35)	17 (65)	11 (42)	4 (15)
Serious Case Review	6	4 (67)	5 (83)	4 (67)	4 (67)
Safeguarding in Employment	9	5 (56)	9 (100)	7 (78)	5 (56)
E-Safety	11	8 (73)	9 (82)	9 (82)	8 (73)
Policy and Procedures	12	9 (75)	11 (92)	11 (92)	9 (75)
Audit	8	5 (63)	6 (75)	6 (75)	5 (63)

*Lowest attendance rate: The number (per cent) of members attending at the worst attended meeting.
**Highest attendance rate: The number (per cent) of members attending at the best attended meeting.
***Attending at least half of meetings: The number of members who attended at least one half of the meetings over the year.
****Attending all meetings: The number of members who attended all of the meetings over the year.

As Table 13 shows, attendance at meetings was lower and more varied in Area Three compared to Area One. Attendance at groups ranged from 31 per cent in the Safety in Employment to just over three quarters (78 per cent) for the Child Death Overview subgroup. The LSCB had an attendance rate of 56 per cent; considerably lower than the LSCB in Area One (87 per cent). The Safety in Employment and VCS subgroups had attendance rates below 50 per cent. Clearly, even allowing for staff turnover, attendance was low in Area Three, especially in comparison to Area One. This does have implications in terms of the operation of these groups and their effectiveness.

Table 13   Percentage attendance at meetings in Area Three

Group	Number of Members	Number of Meetings	Maximum Attendance*	Actual Attendance	Attendance Rate (per cent)
Policy and Procedures	17	3	51	34	67
Child Death Overview	18	8	144	113	78
Voluntary and Community Subgroup	20	6	120	50	42
Audit	24	6	144	80	56
Safety in Employment	31	3	93	29	31
LSCB	32	11	352	197	56
Total Attendance			**904**	**503**	**56**

*Maximum attendance is the total number of attendance episodes which would have occurred over the year if every member attended every meeting. It was calculated by multiplying the number of members by the number of meetings.

As Table 14 shows, the proportion of members attending all meetings in Area Three was lower than in Area One. In Area One 74 per cent of members of the Policy and Procedures subgroup attended every meeting (Table 11), whereas in Area Three only 24 per cent of members did so (Table 13). Fifty six per cent of members of the Safety in Employment subgroup attended every meeting in Area One. In Area Three only 10 per cent did so. The pattern was the same in terms of participation in the LSCB meeting. Only two members (six per cent) of the LSCB attended all the main meetings in Area Three and 18 (56 per cent) attended at least half of these. In Area One, four members (15 per cent) attended every meeting and 11 attended at least half the meetings (42 per cent).

Table 14   Meeting attendance at Area Three

Group	Number of Members	Lowest Attendance Rate*	Highest Attendance Rate**	Attending at least half of Meetings***	Attending all Meetings****
Policy and Procedures	17	11 (65)	12 (71)	11 (65)	4 (24)
Child Death Overview	18	12 (67)	16 (89)	12 (67)	4 (22)
Voluntary and Community Subgroup	20	6 (30)	10 (50)	7 (35)	1 (5)
Audit	24	11 (46)	18 (75)	12 (50)	2 (8)
Safety in Employment	31	7 (23)	12 (39)	11 (35)	3 (10)
LSCB	32	13 (41)	26 (81)	18 (56)	2 (6)

*Lowest attendance rate: The number (per cent) of members attending at the worst attended meeting.
**Highest attendance rate: The number (per cent) of members attending at the best attended meeting.
***Attending at least half of meetings: The number of members who attended at least one half of the meetings over the year.
****Attending all meetings: The number of members who attended all of the meetings over the year.

Participation in LSCB meetings

It is clear from the previous discussion, based on the SNA, that levels of participation in LSCB and subgroup meetings in the two areas are not consistent. Having committed and engaged Board Members is critical if the LSCB and subgroups are to be effective. If this is not being achieved then its progress is likely to be limited (France et al., 2009). Interviews with LSCB Chairs, Business Managers and Board Members revealed that attendance and participation were major issues. As the Chair in Area One outlined, both factors that could have a major impact on Boards' capacity to progress at a reasonable pace. Delays were encountered because people did not turn up for meetings and this could result in the postponement of decisions.

> *'…in terms of committed people who, because of the demands of their day job are struggling to achieve deadline 'A', this means that there has to be an extension of at least two months for the procedure to be delivered, which can be awful.'*
>
> (Independent Chair)

Organisational restructuring can contribute to this problem; a number of areas had seen changes in this respect, particularly within Children's Services and Health. The restructuring resulted in changes in the personnel representing some agencies on the LSCB.

> *'We have to recognise that both Health and Children's Services have been through massive reorganisation during these periods… we had a very effective subgroup, and the communication and public awareness is a good example: where three people were plucked out because of other work, other jobs. Suddenly the core of the group is gone and it's about replacing them.'*
>
> (Independent Chair)

Seniority of membership can also influence the time that individuals are able to spend on LSCB activity and the priority afforded to this work:

> *'…we need to have members of the Board chairing the subgroups. We haven't resolved that yet, and that is quite simply to do with the time of key people as Board Members. For example, I spend an awful lot of time sitting on the SCR Panel, we are meeting at the moment once a fortnight, so to Chair other meetings as well would be very difficult…'*
>
> (Director of Children's Social Care)

However, it is also the case that not having full engagement of members means that some of the most senior people on the LSCB are having to take up roles that are not always appropriate. For example, in the following discussion the Chair highlights how the local DCS has had to step into the process of chairing subgroups:

'One other issue here and, again it's about engagement, is trying to get volunteers to Chair subgroups which is really, really difficult. At the moment we have the DCS chairing one subgroup, which is totally inappropriate, but otherwise it was going to fall to the Board Manager.'

(Independent Chair)

Not only does this seem inappropriate in terms of the use of their time but it also raised issues, for both the Chair and the DCS, about their levels of influence and the impact this may have upon the engagement and participation of others. Consistency in representation at meetings was also raised as a concern in some areas. In at least three case study areas the participation of some agencies was seen as being in flux and uncertainty existed about who would attend meetings. This changing membership can make it difficult for the Board to maintain a clear and shared sense of direction.

'…the other thing is the fielding of members from agencies, and I don't have a particular problem in terms of the level of the people who are approved …but it's the throughput of those people, and not just the throughput of any one person and any one agency, but the combined effect of throughput across agencies, which actually renders the Board relatively vulnerable to the loss of continuity, and the constant need for inducting people.'

(Independent Chair)

This theme was picked up by one of the Board Members who felt a sense of frustration about the extent of change on the LSCB:

'Now that is partly because we have had a few changes…Health have reorganised in [name of area] and so we have had some new Health people and the Police have changed who they send but, yes, going around the table I wouldn't be able to name all of them anymore, even though we have been introduced, you know it takes a while, doesn't it, to work out who is who and some people rarely say anything.'

(Head of Youth Offending Team)

The Head of the Youth Offending Team suggested that changes of membership impact on individual's knowledge and understanding of who is representing who and on the opportunities available to build good working relationships. Given that having a strong sense of vision and good personal working relationships are critical to the effective operation of the Board and multi-agency work (Percy-Smith, 2006), this can create uncertainties that will limit trust and active engagement between members.

A final point about participation related to the quality of participation. Simply turning up to meetings was not seen as sufficient. For example, in one area where there had been a change in chairing arrangement, the DCS expressed their frustration that even with new chairing arrangements in place past problems seemed to have persisted:

> *'I have struggled with the Board in terms of getting a contribution from people, and I used to get quite irritated by it, sort of pushy with them…[name of new Chair] doesn't do that but he doesn't get any more from them, so I don't know what the answer is …he's still getting the sort of blank face thing.'*
> (DCS, ex Chair of LSCB)

The DCS suggested part of the problem related to people not fully understanding their roles and responsibilities:

> *'If I was one of the safeguarding Board Members I'd be freaked, in a sense that we've made it absolutely clear, yet I don't think some of them get it or see that it's participation that's needed.'*
> (DCS, ex Chair of LSCB)

Conclusion

The two areas examined using SNA identified different approaches to membership and involvement. Neither could be seen as more effective than the other although both had strengths and weaknesses that could either help or hinder effective operation. The size of population, geography and social problems in each Area did not appear to explain the large differences in the infrastructures established by the two LSCBs. Both of these areas were urban in their classification. Area Three had one third larger and more deprived population than Area One (being in the top 50 areas, while Area One is in the top 100). That said, Area One had a more diverse population and had large pockets of deprivation.

Area Three had decided to construct an 'inclusive' model that engaged as broad a membership as possible. This included a forum for the voluntary sector and a forum for practitioners. They also had a large number of subgroups and an open approach to membership, which resulted in 186 people being involved in LSCB related activities. This was an advantage in that it created greater awareness among professionals and also gave direct links to practice. It also gave the Board a larger cohort of people with which to share the work. Area Three had a large number of subgroups covering a diverse agenda ensuring local needs where being addressed. Yet, the weaknesses of this model were that links between subgroups and the core activity of the LSCB were weak and information exchange did not always take place. It was also the case that the contribution of the subgroups to long-term planning and development was not always clear. Keeping 186 people informed of how their own contribution was influencing the wider safeguarding agenda was also challenging. The isolation of subgroups and lack of clarity about their role and contribution seemed to prove problematic.

In Area One, the Chair had taken a decision that membership on the main LSCB would be 'exclusive'. It was evident that membership of the subgroups was tightly controlled and regulated by the Board. In total, 58 people were involved in the Board and subgroups which was considerably smaller than in Area Three. Area One had implemented a process to enable the subgroups to contribute to development and planning. Clear management structures were also in place to ensure that the subgroups were reporting back to the Board on a regular basis, while also getting direction and guidance from the Board. Evidence on effectiveness suggests that a good infrastructure and clarity of roles and responsibilities across partnerships are essential (Horwath and Morrison, 2007; Percy-Smith, 2006). Issues about connection to operation are less clear. Within the structure there are no direct routes (apart from representatives on the Board) into professional practice and this means there is a danger that messages are not disseminated widely enough. The fact that the LSCB had a small number of subgroups and more limited focus to the work plan may be a reflection of the small number of people involved. Unlike Area Three, this LSCBs work was limited by the small numbers involved. This may not be a problem but it is clear that having a small number of people as

members of the LSCB and subgroups limits what can be achieved in terms of breadth of coverage.

The size of the main LSCB was also an issue. Evidence suggested that the larger the group the more difficult it was to manage the meeting and to ensure that business was being addressed. Making decisions, creating an inclusive meeting structure and networking opportunities are difficult in large groups. Equally, having a small Board can pose difficulties, both in terms of meeting statutory requirements on membership and having a sufficient number of people to enable the board to fulfil its roles and responsibilities. Therefore size does matter, with the evidence strongly indicating a medium size of between 20 and 25 offers the best model of practice.

In terms of influence it is clear that Children's Services, Health and Police representatives played an important and major part in both infrastructures. Across the LSCB and the subgroups there was a good representation of these agencies at all levels. The most influential player in Area One was identified as being the Assistant Director of Children's Services and in Area Three it was the Designated Nurse, yet, when an analysis of agency influence was undertaken no one agency was found to dominate. That said, there may be differences in levels of investment, for example:

> *'…the local Children's Services and the Local Authority have a vested interest in the majority of issues around the Safeguarding agenda and for a lot of other people around the table it is a small part of their work and so they are not as knowledgeable …it's not as important to them, and it doesn't have an impact on their Annual Performance Assessment….for [name of Director of Children's Services] it is a full-time job.'*
> (Business Manager)

Finally, while all the agencies who were required to participate in the LSCB were members, levels of participation in meetings did fluctuate. Details of this from Area One and Three showed the extent of participation highlighting how different subgroups and the LSCB themselves could be effected by non attendance of key partners. Its impact on the work programme of LSCB was detrimental and could slow down progress. High levels of attendance and active participation are, therefore, clearly important if LSCBs are to be effective.

4   THE PARTICIPATION OF CORE AGENCIES IN THE LSCB

The previous chapter showed that levels of participation influence the extent to which Boards are able to fulfil their remit and operate effectively. This is explored further below. This chapter examines the nature and quality of participation from Children's Services (including education), Health and the Police. Third Sector participation is also considered further, in light of concerns raised about this in the interim report (France et al., 2009).

Children's Services

Across the national sample it was identified that 99 per cent of areas had Children's Service's representatives on the LSCB. Sixty-six per cent also had representation from education and 53 per cent from Connexions. The variation in education and Connexions representation is likely to have arisen because of policy changes and restructuring. As a percentage of the membership of LSCBs, Children's Services provided 17 per cent of members (compared to 12 per cent of NHS Trusts and seven per cent of Police). In terms of other agencies that can be involved (HM Government, 2006: Section 3.62) 32 per cent of LSCBs had representation from Secondary Schools, 40 per cent from Primary Schools, 31 per cent from Further Education establishments, 16 per cent from other education[7], seven per cent from Early Years (including Children's Centres) and, finally, five per cent from Independent schools.

Engaging Children's Services

As outlined in France et al., 2009, Children's Services were actively engaged, at a national level, in LSCBs. This was reflected in the case study areas in that the representation matched the national sample. As outlined in Table 15, Children's Services representation on the LSCB varied across the case study areas. In four of the areas the DCS or their assistant was a member of the Board. In another area only two representatives from Children's Social Care were present and there were no Board Members from education or Connexions. This Board was the smallest

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[7] This included Learning and Skills Council and Head Teachers representing the schools sector in general.

amongst the case study areas and a decision had been taken by the Chair to keep membership to a minimum (see Chapter 3, Size of Boards).

Table 15   Children's Service involvement in the six case study areas

DCS/ Assistant DCS	Social Care	Education	Connexions	Other	Total
1	2	1	1	Youth Service	**6**
0	2	0	0	0	**2**
2	0	1	1	0	**4**
1	5	0	1	0	**7**
1	3	0	0	0	**4**
0	5	2	0	0	**7**

Engaging Children's Social Care was not a problem. As the figures in Table 15 above show Social Care tended to be well represented on the LSCB. As was discussed in Chapter 2, the biggest challenge to the Boards was trying to ensure that Children's Social Care did not adversely dominate meetings or have undue influence on the direction and development of the LSCB. Finding a balance and trying to ensure real opportunities for others to participate was an ongoing challenge for LSCB Chairs. Part of the reason Children's Social Care tended to be most vocal was because other agencies felt that it was appropriate for them to lead given their expertise and knowledge of child protection. In areas where Chairs were highly skilled, managing this 'drift' towards Children's Social Care dominance was possible. Problems could emerge if the DCS and Children's Services representatives were operating in the background, as this could undermine the authority of the Chair (see Chapter 2 for discussion).

Engaging Education

One of the most important challenges that emerged in discussions was that of how to actively engage education representatives. Questions arising about 'agency' representation in the context of the restructuring and bringing together of education and Children's Social Care created challenges to Boards about how to manage the diversity within the new integrated service. Integration was proving challenging, as a DCS reflected:

> *'Education is part of my responsibilities and it hasn't been good at times, definitely not…but one thing I've had to do in the city is completely overhaul and redesign the education service.'*
>
> (DCS)

This Director had worked hard to try and ensure that education professionals were engaging with the safeguarding agenda although concerns existed over their level of representation:

> *'…and [Board Manager]…will say people aren't attending, and they're not coming back with…as Director of Children's Services I am not having this…this is my side of things, I am trying to get other people to be involved…but it's my own house has got bricks missing.'*
>
> (DCS)

This reflected challenges that most case study Boards had to address. One of the major difficulties was deciding who the most appropriate person or people were to have on the Board to help ensure a clear conduit existed between the Board and the educational establishments. As the national survey revealed, a number of LSCBs had included school representatives on Boards (France et al., 2009). One case study LSCB included a primary Head Teacher and a representative from the Independent school sector but elsewhere there appeared to be uncertainty about how best to engage with the schools and whether having school representatives sitting on the Board was helpful or not. School timetables could make attendance at the LSCB and inter-agency meetings difficult as most meetings would be held in the day time when teachers and Heads would have commitments. In some cases though, schools were also resistant actively to engage with the safeguarding agenda:

> *'…the Board Manager has been trying very hard to engage with a senior manager who has responsibility for Head Teachers, to get involved in the Board, and also he has asked to attend their Head Teachers meeting, but there is some sort of resistance to that even though he has asked several times to go…so we don't get the involvement from people on the ground really in terms of schools.'*
>
> (Independent Chair)

The attendance of DCSs or their Deputies on the Board was seen as a way of ensuring access to education, but this did not guarantee engagement from the education sector as a whole.

> *'The trouble is that education means schools, and schools are incredibly independent so engaging them is challenging.'*
>
> (Deputy DCS)

> *'…it's the independent practitioner issue, they [Head Teachers] think, they're quasi-independent, …because we don't manage Head Teachers, they're accountable to their governors and most governing bodies do what the Head Teacher wants….I can write to the Chair of governors and say I don't agree with this, but the Chair of Governors is going to protect the Head Teacher.'*
>
> (DCS)

Getting schools that come under the jurisdiction of the DCS to conform to local policy requirements was difficult because of their independent or quasi-independent

status. Even though the local DCS has statutory responsibility for education in the Local Authority they do not always have the power to influence the actions of Head Teachers. Governing bodies are powerful and they tend to support the decisions of their Head Teacher. This was found to have implications for safeguarding in that dealing with safeguarding issues was not always in the control of the DCS:

> *'We've had a safeguarding issue…a serious safeguarding issue, with a Head Teacher, about where we considered he didn't deal appropriately with a member of staff who hit a child, and we ended up threatening to withdraw delegation, taking advice from DCSF on what to do, and there is very little we could do, we can't suspend their staff, they have to do it, and if they refuse we can't do anything…'*
>
> (DCS)

Lack of influence was also an issue as LSCBs sought to engage with Independent schools. For example, one Chair explains how they had struggled to get an Independent school to respond to an Independent Management Review (IMR):

> *'…an Independent school did a very poor IMR and they didn't want to co-operate with the education department…so that was quite a difficult issue about where are they in terms of safeguarding issues?'*
>
> (Independent Chair)

Major changes in the delivery of education services and new arrangements such as Academies and Foundation schools are also starting to shape the local educational landscape. These raise new challenges, including issues concerning governance arrangements. As the DCS in one area reflected:

> *'…perhaps the bigger issue for us is the complexity of different schools, because we've got all the ordinary groups of schools, be we have [number] of Academies coming soon, we have also got one or two who want to be Foundation schools…and it's figuring out how all this operates…'*
>
> (DCS)

Chairs and DCSs were anxious to ensure that schools were keeping children safe and making appropriate referrals to Children's Social Care but felt that it was difficult to determine the extent to which this was happening, other than when issues were identified during Serious Case Reviews. It was acknowledged that this was not a desirable method of ascertaining whether schools were meeting their requirements.

> Interviewer: *'How would you, as Chair of the LSCB know what schools are doing in terms of safeguarding?'*
>
> Independent Chair: *'The main way you do find out about that, and it's not the way you want to find out, is if issues arise through serious case reviews, which again is not the right way to be finding out, so it's another gap…'*

Although there were evidently challenges in ensuring the engagement of education professionals with the safeguarding agenda, there were examples of positive developments. For example, in one area channels of communication between the LSCB and Head Teachers had been developed. In another region the LSCB had made efforts to secure the representation of the independent sector on the Board. It was recognised that this increased the size of the LSCB but this was seen to be justifiable to secure the engagement of this sector, which had been excluded in the past.

In the discussions with Chairs and DCSs it was recognised that although the integration of Children's Social Care and education had been challenging the new arrangements were yielding some benefits.

> *'I think it's starting to broaden the agenda… bullying, e-bullying, all that sort of stuff, that's coming together…I think it's one of the benefits of Children's Services as opposed to social services and education, it allows you to be more joined-up around issues like safeguarding.'*
>
> (DCS)

It was identified that the renewed focus on safeguarding children in *The Framework for School Inspection* (Ofsted, 2009) was encouraging schools to engage with LSCBs. It was noted in some areas that LSCBs were being approached by schools as they became aware of the inspection requirements. However, it was identified that changes in operational delivery of services were also seen as a means of encouraging effective collaboration between schools and other agencies. For example, in one area the DCS suggested that re-locating meetings and holding them in schools had improved attendance at conferences and reviews:

'I think it's a lot better, it's been an incremental improvement over the last couple of years really…little things start to make a difference, for example, we are having many of our case conferences out in schools now…and they are welcoming that. The other thing that worked in three communities…was the multi-agency assessment panels, we have a pilot in [name of area], it's one of our nightmare areas for Social Care and safeguarding generally, we have piloted it here and the Head Teacher can't speak highly enough about this process.'

(DCS)

Changes in the organisational delivery of services were also discussed by interviewees from another two case study areas. Targeting resources and effort into changing the way services were organised on the ground was perceived as critical to promoting educational engagement in safeguarding children and promoting their welfare.

'…joined-up working was out in the areas and that's been worked on really strongly over the last year. I think the final bit has been having the educational area managers in place. For example, I Chair the [name of area] area planning group which is a quarter of the county. I've got the area educational manager and the Social Care manager and the partnership manager, representative Head Teacher, representative specialist schools, representative primary schools all there working together…it works really well.'

(Chair)

Home Education

Issues in respect of elective home education were raised by one LSCB. While this was a particular local 'problem' the issues identified have policy implications. In this case study area elective home education had expanded over a number of years and the local DCS was concerned about the limitations of legislation to protect this group of children and young people:

'…one of our big issues is the large number of home-educated children and how safe they are and there is no easy answer to that, because the law is so lax in relation to home education and statutory responsibilities.'

(DCS)

At present authorities can monitor home-educated children once a year, although there is no requirement for professionals to visit the child or family. This afforded authorities little power to monitor the health and well-being of home-educated children. This was a major concern:

'Potentially you've got youngsters who you've very rarely seen, unless they go to the doctors if they're ill. Whereas if they're going through the school system there are people who've gone through all the training, signs to look for, you're not getting that with [home-educated] are you?'

<div align="right">(DCS)</div>

The recent Badman Review (2009) identified that changes need to be made to the elective home-education system. Recommendations include changes to current regulations to ensure that designated Local Authority officers have the right of access to homes and the right to speak to children alone to allow them to ascertain that children educated at home are safe and well (Recommendation 7). Recommendation 21 outlines that the Children's Trust should ensure that:

'The Local Safeguarding Children Board (LSCB) reports to them on an annual basis with regard to the safeguarding provision and actions taken in relation to home-educated children.'

<div align="right">(Badman, 2009, p.43)</div>

The Department for Children, Schools and Families are planning to implement changes in response to findings from the review.

Health

The national survey of LSCBs found that a high proportion of Boards had representation from the local PCT (93 per cent) and NHS Trust (97 per cent) (France et al., 2009). Seventy-six per cent of Boards had a designated nurse and 68 per cent had a designated doctor on the Board; 59 per cent had both. Other health professionals also sat on a small proportion of LSCBs. Eighteen per cent of Boards had a GP representative, five per cent had a professional from Sexual Health Services on their Board and 13 per cent included a representative from Drug and Alcohol Services. In the case study areas a total of 11 health professionals were interviewed, including representatives from the local PCTs and NHS Trusts, designated doctors and nurses and a representative from a Drug and Alcohol Service.

Engaging Health Representatives

The major challenge for all of our case study areas was understanding the constituency of health within their geographical boundaries. Professionals across the areas struggled to determine who should be represented on the Boards and how to ensure that those with direct contact with children and their families were engaged in the safeguarding process. While Working Together indicates that the Strategic Health Authorities and Primary Care Trusts should be represented, along with NHS Trusts and NHS Foundation Trusts, confusion existed about appropriate representation and membership in the context of local health infrastructures. This led to uncertainty about who should sit (and represent 'health') on the Board and how feedback and communication should be managed. Although membership in terms of the number of health professionals on Boards was unproblematic, connections back into health services were less clear.

Three areas had established a health forum or subgroups where health professionals could meet on a regular basis to discuss how safeguarding was being managed in their agencies and to consider how to co-ordinate responses to emerging issues. This was seen as a successful method of getting clarification on responsibilities and in facilitating communication and could also act as a forum for health practice audits.

> *'It's a health subgroup which has the designated doctor and other health people on it and they look at health policy and other issues, and it gets fed back through the LSCBs…'*
>
> (Chair)

However, such arrangements created a second level of power and influence operating outside the LSCB. For example, in one discussion the Director of Public Health outlined how health representatives met with Children's Services representatives to discuss policy:

> *'We've got common policies, under the Board we have a health professions forum where the designated clinicians meet with the head of children and young people's social services, so there is a forum underneath the board…that allows more open discussion on issues…'*
>
> (Director of Public Health)

Continuity of membership on LSCBs was also found to be important. It was not unusual for there to be a lack of consistency in the health representatives sitting on Boards. This arose due to changes in people's job roles and/or because members sent a representative to the Board on their behalf if they were unable to attend. Such changes could lead to confusion concerning responsibilities and feedback. One DCS expressed their frustration in a discussion about partners participation on the Board and relationships with individuals:

> *'The other issue is they're consistently changing health people who go to meetings…we have had four different doctors involved from the hospital over the last 18 months, they're all great people, don't get me wrong, but then a query will come in and so you'll pass it to the last known doctor and they'll pass it on to the previous one but how does this work?'*
>
> (DCS)

As discussed in Chapter 3 this continual shifting and changing of membership, usually without consultation, created serious problems as LSCBs sought to develop, both limiting the pace of change and scope to establish effective working relationships. The constant turnover of professionals made formal and informal networking problematic. The seniority of members was also an issue and in all of our case study areas frustration was expressed about the problems of securing senior strategic representation on the Board. In one area a Designated Nurse was the most senior health representative on the Board. This meant that lines of communication to health agencies at a strategic level were weak.

> *'…it's quite important to have someone who's at a level who can begin to say, we have a strategic board looking at X next month. I'll ensure that's put up the agenda. Rather than someone who perhaps is the named nurse who says I need to pass it up through three layers in the hope that we might possibly get it on the agenda…'*
>
> (Independent Chair)

Senior health representation was perceived as being indicative that local health authorities were taking their responsibilities seriously. Relatively junior representatives or poor attendance were seen as demonstrating a lack of commitment:

'I think it's important work, therefore if my organisation is taking it seriously I will put somebody senior on it, now to me it's a demonstration: if you're going to put operational people in you're not taking it seriously…'

(DCS)

The Strategic Health Authority

Strategic Health Authorities (SHAs) are statutory Board partners of LSCBs with duties under the Children Act 2004 sections 13 to 16. They should:

'… oversee local health bodies to ensure they meet core standard on child protection work towards the delivery of standard 5 of the National Service Framework.'

(HM Government, 2007: Section 5.10, p.45)

Following reorganisation of SHAs and changes in their role and function it was acknowledged that many SHAs might not have been able to send a senior member of staff to LSCB meetings. However, it was identified that SHAs should continue to engage effectively with the LSCB. It was recommended that SHAs should take the following steps to facilitate this:

- *SHAs should open communication with all the LSCBs in their area. They should explain their role to the LSCBs, how they will operate as an LSCB partner, and how the LSCB should approach the SHA if there is a particular issue to raise.*
- *The LSCB regulations allow for one individual person to represent two or more Board partners on the Board. This flexibility could be used by SHAs who by agreement might nominate someone who represents a PCT to additionally represent a SHA on a LSCB. This needs to be explained clearly to the other Board partners and the SHA and PCT need a clear agreement on the role of that individual, to avoid any potential conflict between their role as PCT and as SHA representative.*
- *SHAs can usefully have collective discussions directly with LSCBs in their region to talk about overall issues of concern and any specifics that arise.*
- *Regional partners of SHAs may act as intermediaries helping to gather views and convey intelligence. For example, the children and learners teams within Government Offices may play this role in their work to support and challenge LSCBs.*

- *LSCBs should be able to contact and involve the SHA when necessary, for example to raise individual cases or to discuss with the SHA matters that fall within its remit and which impact on the LSCBs safeguarding work, e.g. about the safeguarding performance of a Primary Care Trust (PCT).*

(DfES, 2007b: p.62)

In three of the case study areas SHAs were not present at LSCB meetings. Each of these Boards had invited an SHA representative to attend but they had declined on the basis of the number of LSCBs they had to service and the resource implications of this. There was confusion amongst Chairs and DCSs about what role the SHA should have on the LSCB post re-structuring:

> *'…there are issues about the SHA not being involved in Boards…I don't think we have resolved it, Should they get the minutes? Are they members or aren't they? Are they contributing or not?'*
>
> (Independent Chair)

This Chair went on to explain that the SHA had never been to a Board meeting, even though they had been invited and they had never actively responded to any contact that had been made, although they were sent the minutes of all Board meetings. At the same time, the Chair felt that health representation was better achieved through the Director of Public Health and representatives from the local PCT. In two areas there had been contact between the LSCB and the SHA, but the approach adopted by the SHA was perceived to be inadequate. In one area the SHA wrote to the Chair and ceded their responsibilities to the local PCT. The Chair was unhappy with this and challenged them about the logic of this and how it worked in practice:

> *'…they said we are ceding our responsibility to the PCT and I wrote back: I'm not sure you can do that. The PCT is responsible to you. You're saying you're not going to attend the Board meetings but will make the PCT responsible on your behalf. How are you going to hold them to account?'*
>
> (Independent Chair)

As outlined above, the SHA argued that the problem was that they had a large number of Boards to service and it was just not practical for them to be involved in all of them. In another area a similar situation arose in which the SHA refused to join

the Board, arguing that it was not a central part of their responsibility. For them the 'terms of reference' for how and who from health should be involved in the LSCB were to be agreed with the local PCT. The Chair was not happy with this arrangement suggesting it was not for the SHA to tell the Board how it should operate:

> *'…they perceive themselves as standing on high…saying that the chief executive of the PCT should be agreeing terms of reference, my response is that it is the Safeguarding Board that agrees the terms of reference. …it is as though we are accountable to them…'*
>
> (Independent Chair)

The Chair was unhappy because he saw the SHA using the local PCT as a way of trying to 'run the show' without the SHA being accountable to the Board in any way. The SHA had offered to attend one meeting a year but this was seen as inappropriate by the Chair in that he thought this was not good practice and did not create the lines of accountability he thought was necessary:

> *'…they've written to the Board saying they will attend one meeting a year and my response to that is no you won't. You're either a Board Member or you're not and we're not condoning that in any way, shape or form.'*
>
> (Independent Chair)

Engaging GPs

In discussions about engaging health, relationships with GPs were regularly cited as problematic (see also Hallet, 1995; Tompsett et al., 2009). It was recognised that the LSCB was not the best place to ensure the engagement and involvement of this group, as an individual GP would not necessarily be able to represent the views of all GPs in the area. The independence of GPs, surgery times and out of hours visits were also seen as limiting the scope for GPs to sit on the main LSCB. Questions were also raised about the value of them doing so. As one Chair suggested, they could have a greater impact by being at their surgery:

> *'I think it's interesting to get the views of GPs but equally they sit here for a couple of hours on the safeguarding Board, with patients who queue up, who have things wrong with them today. I'm wondering if there are different mechanisms for engaging GPs.'*
>
> (Independent Chair)

That said, concerns were raised about how to ensure that GPs understood their responsibilities and that channels of communication were effective. Inter-agency training was seen to be one mechanism to facilitate this but GPs did not always attend or prioritise this (see also Carpenter et al., 2009):

> *'Yes it would be foolish to say all GPs are engaged, they're required to do training and we try and ensure they turn up, and some do, but it depends from GP to GP, it's a constant struggle.'*
>
> (DCS Chair)

The importance of engaging GPs was recognised, given their regular contact with children and families, meaning that they are well placed to identify children in need or at risk of harm. However, there were indications of ongoing issues concerning the tendency for GPs to focus upon the needs of parents and/or the family and a reticence to refer concerns to Children's Social Care. As one DCS outlined this is an issue of fundamental importance and difficulties need resolving:

> *'I'm talking about basic awareness..[for example] I've seen this mum who's using drugs, I saw her child, 13, upset and sexually active, here's the oversight …how do I piece that together as a GP, what should I do about it? We're talking about basic action, that's one fundamental challenge. Where are GPs sat in terms of family? It's critical and we've said it for donkey's years, but we've never quite nailed it down yet.'*
>
> (DCS)

The semi-independent status of GPs was also seen to have created difficulties for LSCBs when they sought to raise concerns about safeguarding practice or tried to hold GPs to account. The lack of direct management structures also caused problems. For example, one Chair highlighted this by comparing GPs with Health Visitors:

> *'…you've got far less clout to require people to do as they are supposed to like with Health Visitors we can make sure they take their safeguarding responsibilities seriously, because if they don't we'll do something about it but it's much more difficult with a GP.'*
>
> (DCS Chair)

A similar problem was highlighted in relation to changes requested to an IMR written by a GP. The report was deemed to be inadequate but the Chair and Health Authority appeared to lack the authority to require the GP to respond.

> *'We had an issue where a GP had completed an IMR for the NHS, and it was dreadful …we had worked really hard with everyone contributing, producing a standard we expect, …but the GP ignored all of that…we went back to the NHS and said, it isn't good enough but they said it was up to the GP…in the end I went to the chief executive to force the GP to rewrite it…'*
>
> (DCS)

Lack of authority and influence in this case led to delays in the SCR process.

The Police

The Children Act 2004 places a statutory duty on the Police to provide representation on the LSCB. Findings from the national survey of LSCBs found that every LSCB (100 per cent) had a Police representative. Interviews identified that the Police acknowledged the role they had to play in terms of safeguarding children and recognised the need to be involved in the LSCB. It was evident that their participation and engagement was influenced by the organisational culture of the Police.

> *'From a policing point of view I think maybe five, ten years ago we were more concerned with the prosecution of offenders rather than the protection of children…I now think the protection of children is number one.'*
>
> (Detective Inspector, Police)

The Police were core members of ACPCs and therefore had historically been involved in similar arrangements to those required under the establishment of LSCBs. However, securing consistency of representation was identified as a challenge and such issues were seen to be influenced by the organisational culture of the Police. In one area the Chair outlined the impact this had on Police participation:

> *'…we've had variable representation from the Police, as they are prone to saying themselves that they move around a lot, get promoted so we've had good people but it changes quite a bit…'*
>
> (DCS Chair)

The Police themselves recognised that the complexity of their organisation made it difficult to know who should represent the Police on the LSCB. Representation from the Public Protection Units (PPU) was common but it was not unusual for attendance at the Boards to be delegated to others. For example in the following discussion the Police Officer explains his role and how it relates to both the Board and the other sections of the Police:

> *'I'm different to some other Board Members, who's role is quite specific, and quite strategic…whereas my role is actually practitioner, manager…therefore in essence I'm really suppose to be doing four jobs…I am delegated…the Borough Police for [name of area] are different from me. So you have got Commander for [name of area] [name of person] who runs the Police Protection Units… I am only a tiny little unit that deals with interfamilial child abuse.'*
> (Detective Inspector, Police)

As the Officer outlines the Police in this area 'share' the responsibility of attendance at the LSCB. The Detective Inspector has a less senior and strategic role but did have specialised knowledge of interfamilial abuse, but not necessarily of a broader range of safeguarding issues in the local area. Chairs and Board Members did raise concerns about the number of different Police Officers who would attend meetings, with a tendency for substitutes to attend if the main representatives were unable to do so. Lack of continuity could cause difficulties in terms of securing a 'Police perspective' and also meant there was no guarantee that information was being shared across the senior command structures in the Police. Interviewees were not always sure whether the seniority of representation from the Police was at the right level.

The issue of who represented the Police on Boards could have a major impact on the quality of their input. For example, one of the DCSs raised an important point about getting 'local' involvement in the Board in order to ensure an understanding of the local context:

'…the [county] wide force was there but locally the issues weren't getting picked up, I knew the ones who were going to case conferences but they were not the one's directly involved in Serious Case Reviews…its endemic all the way down through the structure, it's just not healthy.'

<div align="right">(DCS)</div>

The Police who were involved in the Board were from county level but were less familiar with the local issues in the LSCB area.

Feedback and communication from the Board to the force were also discussed with interviewees. Although seniority may be influential, clarity about responsibilities and authorisation to act are important. A Detective Inspector identified that:

'… in terms of the management level…if it's a issue within the child protection remit then I have direct authority over that and I have the ability to make decisions and change processes…'

<div align="right">(Detective Inspector, Police)</div>

In the PPU this officer had the authority to make decisions. Different channels of communication were employed to obtain decisions on wider safeguarding issues. This process could take time, however, decision-making structures and communication routes up and down the chain of command were clear. Furthermore, it is important that representatives know where to take requests and who will take key decisions and there was clarity about how this operated in the Police.

'..if it's something that is going to affect every officer in the district, in the way they work, then that would have to go back to our senior management team…if it goes wider then there is a slight delay while we go up the chain and come back down…I have direct contact with the chief superintendent…and I think realistically from a Police point of view to have regular attendance…it's going to be at this sort of level.

<div align="right">(Detective Inspector, Police)</div>

Similarly,

'It [decisions] has to go up, because we are a hierarchy within the Police, therefore within my command it would go up to commander level or deputy…'

<div align="right">(Detective Inspector on Child Abuse)</div>

The Police's approach to engagement in the LSCB was influenced by a number of factors. Firstly, they took participation in the Board seriously and at an organisational level it appeared to be unacceptable for the Police not to send a representative to every meeting. As one Chair suggested the way the Police operated was viewed as refreshing. The Police were always present at meetings and could be relied upon to take an active part. The Chair argued that this way of working reflected the internal structures of management within the Police:

> *'It's very interesting when you compare with the Police, there's loads of Police, well defined structures, they're told to be there, they're there, told to make a report, they make a report. There is no woolliness about it….'*
>
> (Independent Chair)

Secondly, the Police had struggled to resource LSCBs especially in areas where their geographical boundaries meant that the Police were required to be involved in more than one LSCB. This can, and does have a significant impact on resources and decisions on attendance. This came out particularly in a discussion about the financial resources the Police would provide:

> *'…their [Police] Assistant Chief Constable reviewed the whole thing, and she couldn't give us what we wanted, but she said I have reviewed it and you're all going to get X, across the [large number] of LSCBs….'*
>
> (DCS Chair)

The issue was not just about finances but also related to physical staffing levels. This could impact on whom, and how many Police Officers were involved in the LSCBs. For example, in one case study area the Police felt unable to actively engage in subgroups because this would involve too many staff across the LSCBs they were required to service (see also, Chapter 8).

The third issue related to the question of organisational priorities. There was strong recognition that the Police had to be present on LSCBs, given their role in child protection, but they were not always so engaged with the broader safeguarding agenda. For example, in a discussion about safeguarding priorities in the Police the tension between their role in crime reduction, general policing and safeguarding was identified:

'It's quite difficult for us because from a Police point of view we see much wider local needs, local issues, and certainly you look at the wider picture, there's an awful lot of concern about anti-social behaviour, there's an awful lot of concern about levels of crime and people being safe at night...'

(Detective Inspector, Police)

Within this context, child protection was prioritised above wider activities to promote the welfare of all children. A Chair in one case study felt that the Police were never fully engaged in the LSCB, even though they always attended, because they would not focus on or engage with the broader safeguarding remit. Lack of accountability within the system was perceived to be one reason for this. While the Police have a statutory duty to act as LSCB partners their performance in this respect was not measured. It was identified that in this context resourcing to support safeguarding activity was vulnerable to funding cuts:

'I'm hopeful that Laming will be helpful because in the aftermath of Victoria Climbié the Police were right back up there in terms of funding, but because child protection and safeguarding was not a performance indicator…when cuts came round they got chopped back down again….'

(Independent Chair)

Inclusion of other Agencies on the Board

Working Together states that Local Authorities should secure the involvement of other relevant local organisations, including faith groups, state and Independent schools, further education colleges (including sixth-form colleges), children's centres, GPs, independent healthcare organisations, and voluntary and community sector organisations (HM Government, 2006: Section 3.62). As Table 16 shows a diverse picture emerged in terms of other agencies representation on each case study LSCB. Although CAFCASS are statutory partners they were not represented on three of the six case study Boards. Chairs identified that CAFCASS were struggling to provide representatives for 144 LSCBs. Working Together suggests that LSCBs should draw on the NSPCC where representatives are made available (HM Government, 2006: Section 3.62). The NSPCC was well represented on the six case study Boards (five out of six).

Table 16   Other Agencies

Criminal Justice Agencies	Voluntary Sector	NSPCC	Housing	District Council	CAFCASS	Faith Group	Adult Service	Legal Services	Other
0	0	0	1	n/a	0	1	1	1	0
1	1	1	0	n/a	1	0	0	1	0
0	1	1	0	n/a	0	0	1	1	1
0	3	1	1	3	1	1	0	1	2
0	1	1	1	n/a	0	0	1	1	1
1	2	1	0	1	1	0	0	0	3

Apart from having the Police, Youth Justice Teams and Probation on the Board, one area invited a local magistrate and another the Crown Prosecution Service. A number of our respondents (usually working in legal services or Criminal Justice) suggested that there may be value in having the Crown Prosecution service on the Boards as it would help them understand more about safeguarding and it may also be possible to involve them more in thinking about how to help manage difficult and complex cases where children are at risk and involved in criminal cases. Five areas also made Children's Legal Services members of the Boards, so they were on hand to offer legal advice. In those areas that had District councils it was identified that having a District Councillor or representatives from the District Council on the Board was valuable. Other agencies that were identified included a teenage Pregnancy Co-ordinator; Armed Forces representative; Leisure Services; Domestic Violence Forum, and Community Cohesion Manager.

The Third Sector

Consistent with findings from the national survey, case study areas had good representation from the Third Sector (France et al., 2009). All but one area had Third Sector representation on their Boards. Two areas included more than one Third Sector representative. Representatives in these areas were from the Children's Society and Action for Children. Third Sector representation was therefore being provided by national organisations working in local areas. A strong theme that emerged from the Chair and Board Member interviews was the absence of representatives from smaller local agencies on the Boards and in turn it was felt that difficulties could be encountered in terms of information exchange between Boards and a diverse Third Sector.

> *'I think sometimes the voluntary sector can assist with giving us an understanding of how to operate and particularly the different framework they use. I think the difficulty in such a real diverse area is getting representation of those because we have a huge number of groups and one organisation may not represent them all. It's about looking at some key organisations and how they can be involved…'*
>
> (Safeguarding Adults Co-ordinator)

This issue was also identified by those Board Members who were 'representing' the voluntary and community sector. They did not necessarily feel they had the knowledge or authority to speak on behalf of the sector as a whole.

> *'Sometimes I am asked to complete things on behalf of the voluntary and community sector and I won't do that because I can speak for my agency to some degree but I can't speak for the whole of the VCS, so sometimes that does not quite work.'*
>
> (Voluntary Programme Manager)

As was outlined in Chapter 3 some of the case study areas did try and develop structures to try and bring the diversity of the voluntary and community sector into the infrastructure. In Area Three a community and voluntary subgroup had been established, although, as Chapter 3 shows, connections between this and the main LSCB were fragile. In another area the Board tried to liaise with the NSPCC to set up a project involving a wide range of local voluntary sector organisations. Although this was seen to have been successful to an extent it was noted that the organisations that engaged the most were those that were already embracing the safeguarding agenda and harder-to-reach groups were still not actively involved:

> *'We were part of the NSPCC community partnership project, where initially the plan was that the NSPCC was going to put in a worker to contact the voluntary organisations and to get them to take on board safeguarding and training material. Unfortunately that changed and then turned out to be less effective because, all the voluntary organisations that are very much part of safeguarding were part of it and all the hard-to-reach areas weren't reached.'*
>
> (Head of Children in Need Services)

Conclusion

The chapter has explored the ways that different core agencies have (or have not) engaged with their responsibilities as members of the LSCB. Although the core statutory agencies are meeting their membership obligations, the level and type of participation secured is not always helpful for the development of the Board. Membership alone is insufficient and active engagement is important. The way different agencies are organised can influence their participation and cause difficulties that have implications for the effective operation of LSCBs. Firstly, substitution is a practice that takes place, especially in health and the Police. This can lead to delays in the decision-making process. It can also undermine the

collective identity of the Board and impact upon progress with work programmes. Continuity of members is critical if the Boards are to be effective. Secondly, securing the appropriate involvement of agencies within large structures such as health and Children's Services also poses an ongoing challenge to Boards. While GPs and Head Teachers do not necessarily need to sit on the LSCB mechanisms do need to be in place to obtain their views and to ensure that they are fulfilling their safeguarding responsibilities. The 'quasi autonomous' status of these professionals can also raise challenges. Although representation of the Third Sector by national charities is good, challenges also remain in terms of developing and maintaining links with smaller local organisations.

5 ESTABLISHING EFFECTIVE INTER-AGENCY WORKING RELATIONSHIPS

Introduction

Government guidance stresses that the task of safeguarding children and promoting their welfare is a joint responsibility to be shared by a range of agencies, all with different areas of expertise (HM Government, 2006). However, past research identifies a number of obstacles to inter-agency working, including fragmentation of service responsibilities, differences in values, variable understanding of other professionals' roles and tensions concerning status, autonomy and professional expertise (Easen et al., 2000; Hardy et al., 1992; Hudson et al., 1999; Jones, et al., 2002; Lupton and Khan, 1998; Ward et al., 2004a). Role confusion was also identified as undermining effective inter-agency collaboration (Calder and Barratt, 1997; Hallet, 1995). The implementation of LSCBs was one of a range of measures intended to try and address some of these difficulties. Other policy developments, including the establishment of Children's Trusts and the implementation of the Common Assessment Framework are also likely to be influential in this context.

This Chapter explores the extent to which LSCBs have been able to establish relationships that can be seen to be helping to embed inter-agency working in the practice of safeguarding. Discussion focuses on the role of the LSCB in breaking down professional boundaries to meet their aims and objectives and considers the role and contribution of LSCBs in breaking down professional boundaries. Inter-agency training and the engagement of different agencies on the LSCB are also considered. A discussion on information sharing will be used to explore evidence of how well inter-agency working is taking place in the Case Study areas.

Breaking Down Professional Boundaries

For inter-agency working to be effective professionals need to find ways of overcoming professional boundaries and tensions caused by differences in professional cultures. Involving and engaging a wide range of agencies in safeguarding children is recognised to be challenging but has the potential to support the development of new practices and enhance the decision-making process.

'….we all have different ways of working…we have different ways of looking at risk, we have different attitudes in information sharing, we have different ways of making things happen within organisations….I would hope from making a decision point of view that that's a strength, in that you get variety, you know different opinions on risk, so hopefully you come to a sensible decision.'

(Designated Doctor)

Many of the Board Members were enthusiastic about the role of the LSCB in helping to develop effective relationships between agencies and in breaking down professional boundaries. There were indications that LSCBs were bringing about changes in this respect:

Interviewer: *'So overall how do you feel that the Safeguarding Board is contributing to the breakdown of professional cultures?'*

Director of Children's Social Care:
    'Very positively. It has been an iterative process but there has been a massive willingness. In the last two years, we seem to have turned a corner and really consolidating people's responsibilities to Safeguarding from each agency. So very positively.'

However, a number of respondents indicated that the contribution of the LSCB in this respect should not be over-emphasised and that wider policy and practice developments are also influential. Children's Trusts were seen to be making a major contribution to changing attitudes towards joined-up working and also influencing the structure and delivery of services.

Interviewer: *'Can you describe the impact the Board has on promoting effective inter-agency working across your Local Authority?'*

Policy and Development Officer:
    'I think it does have an impact but I think probably what has had more of an impact because it has been going longer is the Children Trust arrangements that were set up quite early on.'

Findings suggest that LSCBs are not the agents of change driving forward integrated working but they are making an important, and in some places extensive contribution. An established history and culture of effective inter-agency working will assist with establishing new arrangements (Percy-Smith, 2006). However, it is

important that the Boards are also environments in which people challenge one another and where agencies are held to account.

> *'Historically, it has just got a good history of multiagency working. But the disadvantage could be that because you work with people and you know you have to have a good relationship, it can be difficult to challenge….'*
> (Head of Children and Young People's Health)

> *'I think that we are failing to ask some of the challenging questions we should be asking because we are pretty confident that everybody is doing OK, therefore we don't ask…there is this thing about Local Authority staff sticking together, that is what is expected really. You don't criticise…'*
> (Head of Youth Offender Services)

While in some areas the potential dangers of complacency and lack of challenge were identified, Board Members also identified a number of benefits and developments resulting from attendance at LSCB meetings. Meetings were seen to help people learn about the roles and responsibilities of others. Bringing professionals together for the LSCB was seen to have assisted people to learn about others roles and responsibilities, enhance understanding of the challenges faced by partners and to learn more about the way other agencies operate. This is important in promoting effective inter-agency working. Board meetings also offered a forum in which to share problems and develop solutions.

> *Interviewer:*   *'Do you think the Board has contributed to the breakdown of professional boundaries?'*
>
> *Head of Children's Legal Services:*
> *'Yes, yes. You still get tensions like the one with the Police. The Police are saying, we haven't got the resources to send an officer to every review conference…but we all sit down and try and work out what can be done about it.'*

Levels of trust between Board Members influence the effectiveness of the LSCB and inter-agency working.

> *'It's trust, trust is the big one especially around safeguarding, you've got to feel that when you pass information on, it's handled respectfully, sensitively, and carefully, and they are key words really. If people don't feel right about this they'll go back into their corners.'*
> (Lead Officer for Early Years)

Board Members from a range of agencies identified that sitting on the Board had helped foster 'informal relationships' with individuals from different agencies and that they felt able to turn to partners to draw on their expertise and seek guidance or support on relevant issues.

One area that was identified as important was the working relationship with health professionals. Across the case study areas Board Members and Chairs suggested that inter-agency working relationships with health had generally improved as a result of the work of LSCBs. Having a wide range of professionals on the Board and involved in subgroups was perceived to have helped build up networks and interpersonal relationships. There was a strong sense of trust amongst a wide range of professionals about the involvement of health professionals in safeguarding children and promoting their welfare, however, this is not to say that tensions had been eradicated. Across the case study areas a number of examples were given that indicated strained working relationships. Tensions tended to be explained by cultural differences in how different agencies operate and work. As a Designated Doctor suggested:

> '….but certainly culturally we just have very different ways of working…but we also have different ways of looking at risk, we have different attitudes in information sharing, we have different ways of making sure things happen within our organisations.'
>
> (Designated Doctor)

The notion of 'being different' was also recognised as a structurally significant factor. Each organisation had its own responsibilities and, therefore, it was inevitable that tensions and disagreements about priorities and practice would emerge. For example, in the following discussion a Police Representative highlights the challenges of resolving some differences of opinion:

'Sometimes it's not always possible, the reason being that we come from all separate statutory bodies and if you get Social Care, Police, the PCT and NHS Trusts together in a room the fact that we exist as statutory bodies in our own individual structures sometimes prohibits us from being able to agree, we might as individuals agree that something is a good idea, however the structures within which we exist in our individual bodies does not allow us to.'

(Detective Inspector)

While professional cultures and structures can limit inter-agency working, it was noted that confusion about the expectations of central government and perceived differences in the guidance issued by different Departments could limit inter-agency working:

'…there's all sorts of issues around different policies around CRB checks between the NHS, Local Authorities, issues around data security, data sharing, a whole host of things where we have differing policies and some guidance from the Department for Children, Schools and Families doesn't join up with guidance from the Department of Health.'

(Director of Public Health)

Inter-Agency Training

Inter-agency training was identified as an important mechanism of helping professionals to 'understand the respective roles and responsibilities of each agency involved in child protection' (Laming, 2009). Although it is perceived as a significant mechanism to promote effective inter-agency working, the existing evidence to support this remains inconclusive. Charles and Horwath (2009) suggest when examining the evidence on effectiveness of inter-agency training that:

'… investment in inter-agency training is mainly an act of faith albeit one encompassing elements of reason.'

(Charles and Horwath, 2009: pp.372)

Charles and Horwath (2009) indicate that part of the problem is the lack of robust evaluation that recognises the contextual nature of training. However, they recognise that there is growing evidence that indicates the 'essential ingredients' that promote more effective training. These ingredients include the building up of knowledge, skills and attitudes which should inform course content (Charles and Horwath, 2009).

Inter-agency training is identified in Working Together as being core to the activities of LSCBs (HM Government, 2006: Section 3.22) and LSCBs are responsible for identifying training needs (HM Government, 2006: Section 4.7-4.13). Decisions concerning who delivers and commissions training need to be agreed between LSCBs, Local Authorities and the Children's Trust (HM Government, 2006: Section 4.7). Safeguarding training was clearly seen as having a major function in promoting effective inter-agency working and equipping those in regular contact with children to identify concerns about maltreatment. Training was also offered to staff working regularly with children, young people, and adults who may be carers or who could be asked to contribute to assessments of children in need, including for example, GPs, family and children's centre workers and teachers (HM Government, 2006: Section 4.19). Others, including operational mangers and strategic managers (including LSCB members themselves), are also to be targeted (HM Government, 2006: Section 4.20). Under the Safeguarding Children Initiative a study was commissioned to examine training issues in-depth, in particular exploring the organisation, outcomes and costs of inter-agency training for safeguarding children (Carpenter et al., 2009). However, during interviews for the current study Chairs, Board Managers and Board Members discussed the role and value of training.

Experiences of Inter-Agency Training

Findings from the interim report indicated the importance of training in the responsibilities of LSCBs, with 90 per cent of Boards having constructed a training subgroup (France et al., 2009). Each case study area had implemented a training strategy that aimed to increase inter-agency training. These plans would normally be developed in the subgroups and ratified by the LSCB on an annual basis. With regard to implementing training, management and approaches of commissioning varied. Some areas would employ 'teams' of trainers to deliver a programme developed by the training subgroup and trainers may be private consultants or in-house experts. For example, in one area the Police would deliver large sections of inter-agency training to a wide range of professionals. Sometimes training could also be delivered by the Business Manager or other members of the Safeguarding Team. Much would depend on who was best suited to deliver the training with the resources available. How the delivery was managed on the ground was beyond the

scope of this evaluation although it was found that what was provided was usually limited by the resources available:

> *'…every year there will be a training plan…it identifies people that have got dealings with children, a training plan will be developed to meet their needs where possible. But again you have got to understand that there is only a certain amount of money available for training.'*
>
> (Head of Public Protection Unit)

In one area Board Members recognised that the resources they received from partner agencies were insufficient to finance their annual delivery plan. Training needs were perceived to require appointment of a full-time trainer, but funding was only available to fund a half time post. The local PCT commissioned the LSCB to deliver all its GP training which helped with resourcing of the training team but to meet the shortfall, the LSCB charged commercial organisations for the delivery of safeguarding training and through this secured extra resources to enable them to finance part of the training post and to train more professionals.

> *'…we are likely to raise £20,000 from that commercial training we worked out its about a months work a year, so after that we can fund another half time post which means eleven months of being able to provide free training to organisations that work with children.'*
>
> (Business Manager)

Training plans reflected the requirements of Working Together to provide training to meet the needs of professionals from a range of agencies with different levels of knowledge and experience of safeguarding children. The internet was an important tool for the delivery of basic, level one, training. This afforded frontline staff easy access to basic knowledge about their core roles and responsibilities, however, the courses did not bring individuals from different agencies together. Inter-agency training was offered more widely for those professionals working regularly with children, or with particular responsibilities for safeguarding children.

> *'We've got a training framework …which reflects the level of need on individual workers. Level one is basic awareness and people who don't work very closely with children would be involved. Level two is a higher level for those that work with children…mainly done on an agency or within an agency level and then there is multi-agency training at the higher levels for people like me and some*

of the consultants, or people who have quite a high interface with children at risk.'

(Designated Doctor)

However, a number of Board Members did raise concerns that inter-agency training was sometimes provided at the expense of single-agency training. The importance of single-agency training to allow practitioners to explore issues with colleagues from their own specialism was identified as being important. Some felt recognition of this had been lost in the drive towards inter-agency training. The depth of training was also raised as an issue for those working with children with additional support needs and on or above the threshold for statutory Social Care intervention. Training needs in this respect may also arise in the context of the implementation of the Common Assessment Framework.

'…we have been saying we think we need some deeper training…the work of our team is so close to Social Care that we need even more in-depth training I think.'

(Lead Officer Early Years Child Care)

Training needs in relation to neglect were also identified. This is consistent with evidence on the challenges of identifying and responding to this form of abuse (Ward et al., 2004; Daniel et al., 2009).

'I think it's timely for us to reflect more holistically at how families who are at risk of either neglecting or hurting their children, how we can provide better support. You need to know the signs and symptoms, you still need to know the impact it's going to have on the child but I think we need to develop other ways of assessing risk. Rather, then you walk into a house and because a child is wrapped up nicely does not mean that neglect is not going on…we need a more sophisticated way of understanding how neglect manifests itself….'

(Director of Family Services)

Other proposals and plans included ensuring that key messages from Serious Case Reviews informed future training.

Responses of Board Members to questions about the effectiveness and value of training were usually positive and it was recognised by the majority that the training subgroups were amongst the more effective subgroups in operation. The clarity of focus and identification of a series of set tasks for delivery were seen to contribute to

this. Annual training plans also aided this process. Evaluation remained a concern, but the general perception amongst respondents was that training was working well:

> *'Training, is excellent. Very, very well attended. Equally the amount of training that they put on, multi-agency training, not just for core members but for everyone involved in safeguarding is very good.'*
>
> <div align="right">(Head of Public Protection Unit)</div>

Inter-agency training was also seen to bring diverse agencies together and offer an opportunity for Board Members to explore issues together and improve their understanding of how other agencies operate (and what their respective roles and responsibilities are). It was also seen as a way of building effective networks with colleagues from other agencies to help in future work:

> *'…the best training often is the multi-agency training where you're sitting with colleagues from other agencies and seeing their perspective on things, particularly for people who don't do a lot of child protection work. It would be the only time they've ever had lunch with a Policeman, say, and that is really useful…it's not just the information you share, sometimes it's being confident to pick up a phone and talk to them and ask questions, because you have got that relationship already.'*
>
> <div align="right">(Designated Doctor)</div>

Information Sharing

Evidence of effective inter-agency working can be explored through an examination of how information sharing was working (or not) in the case study sites. This tends to be an area of tension and something that can illuminate both progress and blockages to good inter-agency working. Each of the case study LSCBs had established protocols aimed at facilitating information sharing and there were indications that procedures in this respect were clearer than they used to be. However, as Cooper and colleagues (2003) identify, inter-professional trust is enhanced through positive experiences and good communication, rather than through protocols alone. In the current study there was evidence that protocols had not fully resolved issues concerning information sharing, even though they were perceived as beneficial in so far as they offered a framework to support decision-making.

Perspectives on information sharing between agencies were mixed. A small number of respondents felt that communication and information sharing were effective under the ACPC and that they could not discern any significant changes since the inception of LSCBs. Others felt that advances had been made with the introduction of LSCBs:

> 'You build trust and confidence and you can discuss issues and, you feel more inclined to be able to share info…I think it [info sharing] has improved significantly.'
>
> (Board Member, Area Six)

> '[It's about] having an understanding of individual roles, even though we're coming from different angles…I think it's much clearer now, people used to be very worried about the confidentiality aspects.'
>
> (Board Member, Area Six)

> 'I think people are better at asking should I share it and taking advice, rather than just not sharing, which is what used to happen.'
>
> (Business Manager)

Although interviewees were not asked directly about their trust and confidence in professionals from other agencies, some respondents alluded to the fact that trust is central to successful collaborative working relationships. Hudson and colleagues (1999) also identify that trust and reciprocity are integral to successful inter-agency relationships. Although progress was identified by some respondents, it was difficult to determine if they were attributable to the LSCB or wider policy developments, including implementation of the Common Assessment Framework (see also, Chapter 9). It is noteworthy that although trust is important there is a danger of assuming that actions are being implemented simply because individuals or agencies say so. A Business Manager suggested that:

> 'It's difficult to know if it's happening in terms of information sharing until you get a specific issue that you do a random audit with staff. Obviously people say they're doing it, but it's only when you [conduct an audit]…that you actually find out if people have got the information…it's a balance between how often you randomly sample, and how often you trust people.'
>
> (Business Manager)

Evidence suggested that information sharing issues had not been fully resolved in the case study areas although progress had been made. *The Protection of Children in England: A Progress Report* also identifies ongoing problems concerning information sharing across organisational boundaries (Laming, 2009). Board Members saw information sharing as an ongoing challenge affecting inter-agency working in a child welfare context.

> *'There is a commitment in principle and wherever technologically between Board Members, to share information in relation to Safeguarding issues, but it's frustratingly slow for two reasons, both of which are outside of the remit of the Board. One is the lack of clear…government guidance about what can or can't be shared by whom, from whom and when…the second is the gremlins that seem to beset anything to do with technology and the different [IT programmes] and data sets.'*
>
> (Board Member, Area Five)

Barriers to communication and information sharing at operational levels were also identified which indicates that longstanding tensions concerning information sharing between Children's Services and Adults Services persist. Training needs were also apparent.

> *'This is not directly related to the Safeguarding Board, but doing work through the Local Strategic Partnership on the problems of children whose parents are drug or alcohol abusers and the agencies who we met were saying that they sometimes have problems sharing information because…their clients are concerned that if the information ended up with Social Services that their children would be taken into care…So getting permissions to share information was sometimes difficult.'*
>
> (Board Member, Area Four)

Traditionally, Health have been seen as slow or reluctant to share information, yet across the case study areas there was a recognition that this had improved:

> *'I think the most difficult organisation at first to recognise the need to share information was health, but certainly in the last 18 months there's been a paradigm shift, and they are so much more willing…there use to be a difference between what some organisations…would refer to as confidentiality, and now there is a consensus of opinion of what confidentiality is and what information can be shared and what consent you need from a young person or family.'*
>
> (Connexions Representative)

Part of this change had arisen because national government had provided guidance on this, but LSCBs have also been developing local protocols that help re-assure and clarify what information can be shared and how. This was reinforced by practice in that as agencies started to use the protocols confidence and trust increased, thus promoting information exchange. In a number of areas this seemed to have improved health's willingness to share information. Concerns were still raised about the speed of responses to requests for information and that certain groups were not always willing to pass on information. GPs were one group that were identified as reluctant to share information. Recent research on the role of GPs in safeguarding children identifies a range of issues affecting inter-agency collaboration and communication (Tompsett et al., 2009).

> *'Despite increasing professional and policy guidance on information sharing, the majority of GPs interviewed reported difficulties in sharing information with particular agencies, such as Children's Social Care Services, which related to trust. GPs expressed concerns about how and why they were asked for information, the management of third party information and the lack of shared information and reciprocal discussion with Children's Social Care Services.'*
> (Tompsett et al., 2009, p.5)

In one case study area Health continued to be reluctant about sharing information more generally and information sharing protocols had still not been implemented:

> *'…every time we try to introduce a policy on information sharing there's just a reluctance for Health to come on board with it…their arguments are valid and we can understand them but they just seem reticent, so it's taking longer to move forward…they rely on their confidentiality a huge amount and so it's so difficult to get them engaged.'*
> (Detective Inspector)

The Department for Children, Schools and Families (HM Government, 2008a; 2008b) has developed guidance to assist authorities in making decisions about whether information sharing has a legitimate purpose and meets the public interest test. However, as the quote above illustrates, and other Board Members reflected, agencies were still encountering difficulties in operationalising information sharing in practice.

Practical difficulties were also encountered due to differences between the Integrated Children's System operated by Children's Services and Health, Police and other agencies' information systems. Research demonstrates that alongside IT system issues, there were a number of other obstacles to obtaining and making use of information outputs to improve practice. These included attitudes towards recoding, using and sharing information (Gatehouse, Statham and Ward, 2004). Such issues are likely to be exacerbated when attempts are made to do this at an inter-agency level. Variations in the type, frequency and quality of data collected by different agencies was identified as a challenge for Boards as they sought to interpret information once it had be obtained.

Conclusion

There is a body of evidence from the evaluation that suggests that LSCBs are making a contribution to improvements in inter-agency working, although it is important to recognise that broader policy developments may well be driving this. As the literature on effectiveness identifies having an established history of inter-agency working and positive relationships is valuable. However, as this research shows it is important that complacency does not set in and that agencies are sufficiently challenging of one another. Trust remains important and LSCBs that build up trusting relationships are more likely to create effective forms of practice. This is especially relevant in terms of relationships between health and other professionals. Evidence suggests that progress has been made but that some tensions and challenges remain. These include: information sharing and engagement with GPs. Professional cultures and practices are difficult to change but evidence suggests progress is being made (see also Holmes and Munro, forthcoming). Operationalising government guidance on information sharing (HM Government, 2008a; HM Government, 2008b) still remains a challenge in some areas. Areas that still need attention include ensuring Adult Services share information where necessary.

Inter-agency training was considered in annual plans and is a core area of activity for LSCBs. The availability of training was limited by resources, although some areas were being innovative and creative in finding ways of funding inter-agency training. While there were positive views about its impact, concerns were raised that

not enough single agency training was being undertaken and that for some agencies this was important as staff needed to know specific details about how to deal with concerns within their own agency. Gaps in training on neglect were also identified.

6   THE FOCUS OF LSCB WORK

'It's all very well stuff happening but you know, is it effective, is it keeping children safe, that's the question isn't it … I think that's the challenge.'
(Board Member)

Introduction

Narducci (2003) identified that effective ACPCs were strategically focused, had clear business plans outlining their objectives and an action plan to monitor and evaluate progress. The wider literature on the effectiveness of strategic partnerships also highlights the importance of developing business plans and a clear and shared vision amongst Board Members (Atkinson et al., 2007; Frost, 2005; Horwath and Morrison, 2007; Percy-Smith, 2006). Shared goals need to be negotiated and agreed (even when strategic partnerships are formed as a result of a legal mandate, as compliance cannot be guaranteed). This can help structure the focus of work and key priorities (Atkinson et al., 2002; Frost and Lloyd, 2006). Horwath and Morrison (2007) suggest that:

'Effective implementation of mandates depends on political consensus, systematic reinforcement of collaborative practice and shared values at partnership level.'
(Horwath and Morrison, 2007, p.60)

Differences in organisational culture and differences in language and terminology can raise challenges (Horwath and Morrison, 2007; Ward and Rose, 2002). Large and complex structures involving a wide range of partners can also be problematic (O'Toole and Montjoy, 1984). Working Together (HM Government, 2006) outlines the importance of recognising that safeguarding children is a shared responsibility and that effective joint working is required to protect children from harm and to promote their welfare.

This chapter begins by examining the approaches that LSCBs have adopted to try and establish a shared vision, the extent to which Boards have embraced the wider safeguarding agenda and the challenges and issues that they have encountered in the process. It goes on to explore the extent to which Boards are operating at a

strategic level, how they are seeking to influence practice and hold agencies to account and how developments are monitored and evaluated.

Constructing a Shared Vision and a Sense of Purpose

Creating inclusive processes for planning and development are critical to establishing a shared vision and understanding. Clear and realistic business plans and agreed priorities, which were regularly reviewed, provided a useful framework from which to build. This process, which was time-consuming, was seen as essential to develop shared agreements about the direction of travel and the Boards' priorities. Maintaining focus on key priorities and ongoing monitoring were recognised as being important. Evidence suggests that this increases the chance of Boards being effective (Horwath and Morrison, 2007).

All of the Boards in the case study areas arranged 'development' or 'away days', on a regular basis. They could have multiple functions although most used them to construct annual Business Plans and as a way of helping to create a collective identity which were seen as a mechanism to develop working relationships and shared vision amongst Board Members. Vision or focus could be undermined if membership of the Boards changed or attendance was poor at LSCB meetings and in turn this could delay the pace at which LSCBs were able to develop. A large or complex set of priorities could also make it difficult for professionals to obtain a clear sense of direction. Simple and focused goals were seen to be helpful.

> *'Given I have actually only missed one or two meetings in the three years I have been here, I attend. It is a priority for me, and I am relatively bright and pay attention most of the time but I don't know what our priorities are … when I worked in [organisation] there were six simple statements that were your objectives for the year, for the whole service and they communicated them really well.'*
>
> (Head of Youth Offending Team)

Two case study areas appeared to have been particularly successful in constructing and maintaining a shared vision that Board Members understood and accepted. In Area One, for example, there was evidence from both interviews and the minutes of meetings that the LSCB had successfully developed a strong sense of vision. Prioritisation of tasks in the business plan, the leadership of the Chair, alongside

continuity of Board membership were all seen to have facilitated this. The Chair was also perceived by the Board Members to have an inclusive approach to discussion and debate and built in a number of LSCB events that focused on collaborative working and establishing a shared vision for the LSCB. Such a model had clear support from Board Members but the Chair did worry that the vision that was being developed was fundamentally his. For example, in a discussion about challenging his position in relation to strategic issues in the authority he thought the Board would accept his view with little challenge:

> *'… it's fine if I have been able to take a focus to the Board and get them all to agree to it quite happily, but for them to get together to kind of collectively challenge something at the strategic level, I think currently would be a problem …'*
>
> (Independent Chair)

While the Chair raised concerns about this, Board Members had confidence in his leadership, valued his impartiality and felt that he helped people contribute to development of a shared vision for the LSCB. This could be more difficult when an LSCB was chaired by the DCS. In two case study areas Board Members felt that the Statutory Chairs and Children's Services had taken a lead and this has meant that others had not been able to challenge the vision of the Board or contribute to determining the Board's direction as much as they would have liked. That said, there was clear evidence that the wider safeguarding agenda was being embraced by all the LSCBs.

Perceptions of the Role and Remit of the LSCB

Consistent with legal and policy developments, all the Chairs and Business Managers and the vast majority of Board Members interviewed were clear that the remit of LSCBs is broader than the one that was previously assigned to ACPCs.

It was acknowledged in interviews that Boards could no longer focus simply on child protection, but also needed to contribute to the wider goal of improving the welfare of all children.

> *'Following Lord Laming's report in 2003 and the Every Child Matters agenda that followed, I saw the Board develop a broader responsibility for safeguarding, rather than being focused on only those children who were regarded as high risk, those children who were subject to child protection plans, the Board took on a role of looking at broader issues around safeguarding including community safety, child safety within the home, child safety within the community. I think it's managed to maintain that oversight.'*
> (Director of Family Services)

Another Board Member suggested that:

> *'The ACPC was around protection it was all about child protection and children at risk. LSCB is about that but it's also much wider than that, it's much more about ensuring that all children are safeguarded and looked after … not harmed or disadvantaged.'*
> (NSPCC)

Across the case study areas these developments were viewed positively.

While at a theoretical level there was near universal consensus that LSCBs were 'Safeguarding' Boards, rather than 'Child Protection' Boards, in practice, there was considerable variation in how far LSCBs had travelled in fulfilling their wider brief. Board Members had different views on whether it is possible to focus energy and resources on preventative work, while at the same time ensuring that child protection receives sufficient attention. For some, the preventative agenda was seen as a distraction from core business.

> *'I think it's good that LSCBs are getting the message across that [safeguarding] is a shared responsibility but I think the remit is too broad and we've lost sight of the most vulnerable children.'*
> (Designated Doctor)

The balance of work and capacity of LSCBs to meet their aims and objectives are explored further below. The discussion also identifies some of the challenges Boards have faced as they have sought to implement plans.

Attempting to Meet the LSCB Role and Remit

Examination of LSCB minutes revealed that although child protection was prominent on the agenda, a much wider range of safeguarding and welfare issues were also being examined. The national survey also found that Boards had introduced a number of subgroups focusing on early intervention and preventative work. For example, 46 per cent of Boards had E-safety subgroups, 27 per cent had sexual exploitation and trafficking subgroups, 21 per cent had domestic violence subgroups and 18 per cent had anti-bullying subgroups (France et al., 2009). However, data from the case study areas did reveal considerable variations in how much time and resource Boards were devoting to the wider safeguarding agenda. In one area, chaired by a DCS from a Children's Social Care background, the core focus of the agenda was on child protection. In another the Chair was clear that the LSCB needed to prioritise activities to safeguard children from harm. Moving forward with the broader agenda was seen to be conditional on having established that core functions of the Board were being fulfilled. He reflected that there was a huge struggle at the beginning, because:

> *'Everybody understood Safeguarding Boards to be all-encompassing, safeguarding issues Boards … Working Together says 'put the core business in place first' [but] most people hadn't heard that message … they were hearing the much wider one … I'm very clear that we weren't in a position to say that we could do everything because if we were doing that we'd have been constantly failing.'*
>
> (Independent Chair)

The importance of a shared sense of purpose, clarity concerning focus and priorities and a sense of realism about what is possible is supported by research evidence on effectiveness (Atkinson et al., 2007; Frost, 2005; Horwath and Morrison, 2007; Percy-Smith, 2006). Working Together emphasises that:

> *'Ensuring that work to protect children is properly co-ordinated and effective remains a key goal of LSCBs, and **they should not focus on their wider role if the standard of this core business is inadequate**. However, when this core business is secure, LSCBs should go beyond it to work to their wider remit, which includes preventative work to avoid harm being suffered in the first place.'*
>
> (HM Government, 2006: Section 3.10, emphasis added)

The Business Manager in another area also identified the importance of ensuring that core business has been dealt with before devoting significant energy to other activities. At the same time, he welcomed the fact that since the inception of the LSCB attention had been paid to wider safeguarding concerns and issues that would not have warranted examination by ACPCs. The broader agenda does also facilitate the active participation of all members of the Board, whereas child protection policies and procedures, language and terminology may serve as barriers to the full engagement of all the Board partners.

> *'… you tend to get certain individuals who are very knowledgeable, very experienced, very confident, and it will usually be the big three. It will be Children's Services, Health and Police who tend to do most of the talking.'*
> (Children's Legal Services representative)

In two case study areas the Chairs attempted to ensure that the agenda included a number of items relating to prevention and early intervention as these were seen as issues that everybody, irrespective of their background and specialism, could engage in. However, Boards appeared to be struggling as they were attempting to cover so much ground - attempting to address concerns regarding child protection policies and procedures, undertaking serious case reviews and trying to cover a lot of the broader remit. Those Boards which set clear parameters around what they were doing, were realistic about what they could feasibly achieve and maintained their focus on the priorities they set were more effective.

It was clear that Board Members had different views on whether it is possible to focus energy and resources on preventative work, while at the same time ensuring that child protection receives sufficient attention. For some, the preventative agenda was seen as a distraction from core business. This said, issues of time and resources and the impact that Serious Case Reviews could have on what was possible was seen to limit capacity to focus on other issues (France et al., 2009).

> *'The expectations are so great in terms of serious case reviews, I've got managers saying I don't have time to do anything else now. And we're losing the safeguarding agenda because we're so busy concentrating on serious case reviews.'*
> (Independent Chair)

The second round of interviews with Chairs and DCSs, as well as some of the Board Member interviews, revealed that the balance of Board activity had also shifted following the tragic death of Baby Peter and subsequent media attention. In this climate, it was suggested that there had been a retraction from the broader agenda and a renewed focus upon child protection.

> *'I think we have almost gone backwards in the wake of Haringey. I think that we would have said 12 months ago … or even 6 months ago that, we had got our core business in hand …our emphasis was … obviously always on child protection … but that we were [also] looking at making progress with the broader agenda and I think what has happened is because of the media scrutiny … I think that we are very, very, very much focused on our most vulnerable children.'*
>
> (Policy Officer)

> *'With safeguarding how do you deliver this very broad agenda really, because ultimately you will get pulled back, you know what's gone on in Haringey, how do we make sure that children at risk are safe … we don't necessarily have the resources to do all the things we would like to be doing in terms of prevention.'*
>
> (Director of Family Services)

All the LSCBs reflected that due to resource and capacity issues they had not been able to develop their communication strategy to the general public or children and young people to the extent they would have liked (see Chapter 7 for further discussion).

Strategic Focus

LSCBs should be strategically focused and have long term plans in place to ensure the relevant organisations in each area will co-operate to safeguard and promote the welfare of children in their locality and to ensure the effectiveness of what they do (HM Government, 2006: Section 3.16). Interview data and the minutes of Board meetings revealed that all the Boards recognised that they should be strategically focused.

> *'The role of the Board is to try and stay at a strategic level and oversee everything … ACPCs … they were happy in micro-managing specific things,*

now Safeguarding Boards have to do that to an extent, you have to look at
Serious Case Reviews, you have to look at performance data and understand
it … But the role of Board is to remain strategic.'

(Independent Chair)

Another Chair identified that the strategic focus of Board meetings had to be maintained, but that this could be a challenge, in practice, as people do become preoccupied by specific cases or key concerns:

'People's comfort zone is talking about something that happened last week,
whereas really that's not what we're there for, we're actually there for picking
up on strategic issues and pursuing these so agencies are properly
challenged.'

(Independent Chair)

'If someone raises something that is operationally focused then Board
Members all just go with it, like a discussion on CAF … CAF is owned by the
Children's Trust, not by the Safeguarding Board, we want to know what's
happening … but shouldn't be- pursuing … an operational discussion'

(Independent Chair)

A further concern was raised that although these Boards did appear to be fulfilling their role as strategic bodies, they were much less confident of how the decisions they were making as a Board were influencing operational practice. This is discussed further in Chapter 7.

In the early stages of the evaluation there were indications that three out of the six case study LSCBs had on occasions become preoccupied with operational issues. One of these areas had an LSCB which lacked sufficiently senior or strategic Board Members to meet the requirements of Working Together. This Board focused on relatively low level issues and was operationally focused and lacked the authority to engender change.

Data from the second round of interviews suggest that changes have been, or are in the process of being implemented, to address issues in this respect. In the first round of interviews the Chair in one LSCB recalled going out to visit an organisation in response to a complaint about a specific case that had been received by Ofsted.

He explained that: '*he wanted to see first hand what was going on*' and felt that *'to get our strategy right it's important to see what goes on from time to time'* (Independent Chair). However, others saw this as straying into operational territory. This LSCB is currently in the process of reappraising the structure and operation of their LSCB and its role. The DCS indicated that:

> *'The LSCB has got no remit in a sense to get in and say to Health you're not doing this properly. We can do that through the Trust far easier, but as I see the LSCB role developing it will be able to say this is what should be happening, we don't think it's happening, what are you doing about it?'*
> (Director of Children's Services)

While the Boards are meant to be strategically focused it is important that strong links with operational practice are maintained. As one Board Member reflected:

> *'I do sometimes feel that there's a gap, a big gap between the Safeguarding Board and actually what happens on the ground, but I do think what works well is the numerous sub-groups … for feeding in.'*
> (Director of Nursing)

The inclusion of more operational and/or specialist staff on subgroups was identified as being important to contribute to the understanding of issues affecting frontline service delivery and acting as a bridge between strategic and operational personnel (France et al., 2009). One area also has a multi-agency practitioner group that facilitates dialogue between the LSCB and frontline staff. Feedback from this forum is presented at each LSCB meeting to ensure that Board Members are aware of key operational issues and concerns in the local area. The capacity of the Board to influence practice in local organisations is critical if LSCBs are going to be effective.

Influence

The impact and influence of LSCBs on policy and practice in a given area will be affected by a range of factors, including: the statutory powers they are afforded; knowledge of local needs and the infrastructure in place to meet these; the effectiveness of other key strategic bodies; culture and history of inter-agency working and the extent to which working relationships are established and the power and influence of key individuals.

LSCBs need to be able to hold agencies to account if they perceive them to be failing in their duty to safeguard children from harm and promote their welfare. However, they do not have formal powers to sanction agencies for non-compliance. One Chair recalled being questioned by Chief Executives about the legal repercussions of failure to comply with recommendations, but as he acknowledged, there are none. That said, Chairs were clear that they would raise concerns with government departments or the relevant inspectorates should they need to do so.

> *'I have written to an agency saying we understand this is the line that you're taking [but] it's not compatible with our policies and if you endure with this we will pass the information on to the relevant inspectors.'*
>
> (Independent Chair)

While this is one way of holding agencies to account it was acknowledged that most issues could be resolved via meetings or written correspondence. For this to be effective, however, agencies need to take their duty to safeguard children seriously and to perceive the LSCB to be an authoritative and legitimate body to challenge them. As the Head of Children in Need in one area reflected:

> *'It's about clarity of responsibility, so if you go in to the Director and say 'look I'm sorry but this is not happening and it's not good enough', 'oh but you know what staffing is like', actually you've then got the authority to say, 'no this isn't good enough.'*
>
> (Head of Children in Need)

The leadership of the Chair and the support and backing of senior strategic managers are important in this respect. A few Board Members questioned whether Independent Chairs were well placed to hold agencies to account:

> *'How does an Independent Chair hold agencies to account when [the agencies] carry all the money, all the clout, all the officers, all the influence, and then you've got this one Independent Chair, who is appointed by them.'*
>
> (Community Services)

The limited time Independent Chairs have allocated to their role and the fact they are not automatically linked into existing local networks can raise challenges. In one

area, in particular, the Chair felt that she was not kept sufficiently informed of significant changes in Children's Social Care. Lack of information made it difficult for her to effectively influence the wider agenda. In contrast, DCSs acting as Chairs were well placed to network and invest in maintaining strong working relationships with strategic managers in other agencies and ensuring that 'a chain or web of communication' is maintained. These relationships can be positive and assist in influencing strategic developments in local areas. However, there is a danger of over-reliance on individual working relationships to affect change.

> *'I think we were often misled in the past, by thinking we had cracked it when it turned out to be highly dependent on one or two individuals. So we used to think our relationships with the Police are really good. They were good, but only in so much as the local commander clicked with us and then a new one would appear and you would find yourself back to square one. It wasn't a relationship with an agency so much as with an individual.'*
>
> (Policy Manager)

Monitoring and Measuring Performance

All the case study LSCBs acknowledged the importance of monitoring and evaluating agencies' performance with regards to safeguarding children and promoting their welfare. Statistical data to facilitate understanding of key issues featured on the minutes of each Board. Meeting minutes and interviews revealed the Boards were not only examining child protection and looked after children's statistical returns but a broader range of data, collected from a number of agencies, including, for example, data on road deaths, bullying and allegations against staff. A Policy Manager identified that the amount of statistical information presented at Board meetings kept expanding, as Board Members raised additional questions as data were presented. While data were being presented to the Boards there were indications that meaningful comparison and analysis of data could prove challenging due to definitional issues and variations in the quantity and quality of data collected by different agencies. Board Member interviews also indicated that members were not necessarily clear how information was being used to identify trends and/or monitor progress.

'I certainly know the information is collected, but I haven't seen evidence of it being analysed yet … I suspect it is analysed, and does contribute to the overall strategy.'

(Detective Inspector)

Elsewhere, one Chair raised concerns about the tendency to focus on Children's Services performance:

'Insufficient emphasis on outcome and rather too much emphasis on looking at performance in terms of Children's Social Care performance indicators.'

(Independent Chair)

It was also suggested that there was a tendency to judge performance in narrow terms (for example, whether assessments were completed within statutory timescales) without giving due consideration to qualitative analysis of the quality of the service response (cf. Holmes and Munro, forthcoming). That said, there were a number of examples of more in-depth evaluative work and case auditing taking place in the case study areas. This included audits of: plans for children aged under four; examination of the quality of child protection plans; agency representation at conferences; child neglect cases. Findings from Serious Case Reviews also contributed to understanding the strengths and weaknesses in areas safeguarding policies and procedures. Two of the case study areas had designated Policy and Performance Officers for the LSCB who were working across agencies to monitor performance. In one area the post holder was supporting agencies with their internal auditing procedures and ensuring that SCR action plans were being implemented. This was seen to mark a departure from past approaches to monitoring, which were more informal.

'She's introducing a process, the audit, which means it is more systematic, it is more thorough and it is better recorded…[it identifies that] yes, the following agencies have acknowledged the action plan in relation to the Serious Case Review and they have confirmed it is in place…It tended to be word of mouth before, or simply a letter hoping that we agreed events of three months ago have now happened.'

(Safeguarding Advisor)

LSCBs were also trying to get a handle on how they could determine their impact on safeguarding children in their localities. The interview data revealed mixed views on

how far Boards had come in this respect and variations in perspective as to the extent to which the impact of Boards can meaningfully be measured.

> *'We don't know if we're doing well … we can't really tell you … how can you show that the Board is having a direct impact?'*
>
> (Director of Children's Services)

> *'I'm not sure we've got good indicators that tell us we're working as a partnership, or that tell us how effective we are as a partnership or as an individual organisation.'*
>
> (Director of Nursing)

In one area they have developed a multi-agency action plan which is going to be updated through the subgroups and this is intended to measure and monitor a range of issues and help demonstrate what impact the LSCB is having.

Training Needs for LSCB Members

Training may help Board Members understand the remit of the Board and the key roles and responsibilities associated with being a member of the LSCB. It was recognised that Independent Chairs and Board Members themselves needed to build up greater skills and knowledge about what it means to be part of the LSCB.

Business Managers

The interim report showed that 89 per cent of LSCBs have appointed Business Managers. Sixty per cent were employed full-time and 25 per cent half time (France et al., 2009). The roles and responsibilities of Business Managers in case study areas were varied, although each acted as a critical linchpin in the delivery of LSCB work. In some areas the Business Manager attended all the subgroups and co-ordinated work between agencies. In one area the Business Manager acted as a trainer. The posts were filled by professionals from a wide range of backgrounds and included some who did not have experience of working in Children's Social Care.

> *'I've worked across a lot of disciplines and a lot of agencies, I was a psychiatric nurse and I've worked operationally with that in supported housing support work and then I did strategic and planning officer across Adult and Children's*

Services…there is a degree of tension about this …should you have child protection experience…'

<div align="right">(Business Manager)</div>

Although it was identified that there was scope to access training, work demands and multiple responsibilities meant that securing time to attend courses was identified as being difficult:

'The LSCB deliver multi-agency training I am sure I could access it but I haven't done so largely because I'm too busy and its one of those things that you don't have space to do really…'

<div align="right">(Business Manager)</div>

Given that all six Business Managers in our case study areas have since left their respective LSCBs it would seem that there is a need to consider both their roles and responsibilities and access to training and career pathways.

Training for Independent Chairs

The training needs of Independent Chairs also warrant attention. Acting as 'private consultants' and employed on a daily basis, Chairs do not automatically have access to training opportunities. Specialist training to support Independent Chairs in fulfilling their responsibilities was not provided by any of the case study areas. The Government Offices for the Regions were a forum for discussing training and support, but questions were raised about the appropriateness of this given the Offices role in monitoring progress and contributing to the governance of LSCBs (see Chapter 2). Given that Independent Chairs will be servicing all 144 LSCBs, having a forum for shared learning and a training programme for Independent Chairs may be of value. As one Chair reflected:

'There is none of that growth potential that happens, developmental potential…I think what could be put in place in terms of Chairs training is to put action learning sets in place…if you are talking about developing potential and learning from each other it's got to be good investment of time and money.'

<div align="right">(Independent Chair)</div>

Board Member training

Training for Board Members tended to be ad hoc and erratic. A number of areas had done initial inductions for staff including developmental days looking at core

roles and responsibilities but it was recognised by the Chairs that induction processes for new members were not always as well developed as they could be. This was a particular concern in areas where there was a large turn over of members or where 'deputies' were used. It was also found that Board Members did not necessarily have a full understanding of their role on the Board or about how the Board operated, if they joined after its establishment:

> *'I think one of the things I would have liked if I was to join the Board now is a bit more of an induction to the Board, because, for a long time I was thinking what is this all about! So there is an assumption that people just join and know what they are doing.'*
>
> (NSPCC Representative)

What Board Members wanted was more specific (and regular) information about the Board functions and roles. One member, for example, suggested that they had no idea what the responsibilities of the Chair were or how they were accountable to the Board (or not). Clarity about how certain key players contributed was also identified as being useful to support the effective operation of the Board:

> *'I'm not clear about the chair's role, I've gleaned that he does X amount of hours, obviously I know what chairing a meeting means but what else does he do? I'm not really quite sure what is the Board Manager's role…'*
>
> (Voluntary Sector Representative)

The process of Serious Case Review and Child Death Review also remained a mystery to some Board Members. Similarly there was an issue about how members could become more aware of how the Board needed to function around core tasks such as Serious Case Review and Child Death Review Panels.

Much of the training that Board Members did receive tended to be provided by people with specialist knowledge attending Board meetings and presenting information on specific issues or developments. In one area they had a presentation by specialist Police Officers working on gangs and guns and antisocial behaviour. In other areas professionals from Domestic Violence Units, Housing Teams and Mental Health teams presented information, which helped Board Members understand particular problems children, young people and families were facing. This was seen as a valuable part of the experience of being a Board Member in that it broadened

member's knowledge and understanding about safeguarding and strategies to promote the welfare of children and young people.

Conclusion

Evidence from the research shows that overall the case study LSCBs have been trying to create a shared vision that is inclusive and embraces the wider area of the safeguarding agenda. To be effective, Boards need to set realistic plans and appropriate parameters. Board Members need to be part of this process and own the plans. The role of the Chair as strategic leader is critical as their role is to help the Board determine the focus of the LSCB and maintain this as targeted work programmes are initiated.

Findings reveal that all the case study areas have been attempting to embrace the wider safeguarding agenda and move beyond just focusing on activities to ensure that work to protect children is properly co-ordinated and effective. A number of the areas have struggled because they have not had the capacity to maintain such a broad focus and have taken on too much. The areas that have been more successful are those that have concentrated on the 'core' business of child protection and then expanded into preventative activities as and when resources have permitted. The Baby Peter case has also served to influence the focus and balance of activity, with renewed emphasis being placed upon LSCBs core child protection functions. Determining what is feasible and establishing the core priorities for a given year is important. Annual business plans should reflect this and be considered in the context of the resources available. The implications of SCRs on other plans and activity should also be considered, given the significant time that needs to be invested in them.

While case study areas have been collecting a range of data they have not always known how to interpret this effectively, which can lead to difficulties in assessing and monitoring performance and progress. Some areas were heavily reliant on Children's Services statistical returns and data from other agencies were limited, although in others a broader range of information was supplied and considered. The LSCBs that had appointed Auditing Officers and Performance Review Officers had benefitted from this and been able to develop more robust inter-agency monitoring

and evaluation. However, Boards were experiencing difficulties in determining the impact they were having across agencies and whether this was contributing to improvements in the welfare of children in the local area.

Issues of influence and challenge are important to the effective operation of Boards. LSCBs do not have any statutory powers to insist on changes to policy or practice. Evidence from this research suggests that on occasions Independent Chairs could struggle to get different partners to respond to requirements. However, there is scope for them to raise concerns, about non compliance, with the Chief Executive or Government Offices in the Regions. It is important that mechanisms for addressing such issues are transparent and that there is a shared understanding of the actions that will be taken if agencies are perceived to have failed to respond to issues raised by the LSCB.

Boards have been active and successful in developing inter-agency training. However, the evaluation did reveal training issues. Board Managers are critical in supporting the effective operation of LSCBs and it is important that training (and career progression routes) are made available. Each of the case study areas had experienced changes of Business Managers and, therefore, it would seem this needs to be addressed. Lord Laming (2009) (and the government's subsequent response) highlighted the need for training for DCSs. It would also seem appropriate that Independent Chairs have access to similar training. They are usually contracted for a relatively low number of days and opportunities to access training can be limited. Finally, there is a need for clear training plans to be put in place for Board Members. Given there can be a turn over of membership, induction training is critical. Ongoing training around a wide range of functions of the Board would also be valuable.

7   COMMUNICATION

The erosion of trust between different professionals and agencies involved in safeguarding children is identified as one reason for a lack of communication within and between agencies (Cooper et al., 2003). Forums to promote open communication between professionals, shared vision, language and understanding about safeguarding children and multi-agency and multi-disciplinary teams are all mechanisms that should help promote trust (ibid.). Effective communication *between* agencies is also highly dependent on the quality of intra-agency collaboration, *within* agencies (Morrison, 2000: 368).

Working Together requires LSCBs to communicate 'to people and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done, and encouraging them to do so'. The guidance also indicates that 'this also involves listening to and consulting children and young people, and ensuring that their views and opinions are taken into account in planning and delivering safeguarding and promoting welfare services (HM Government, 2006: Section 3.29-3.30). Therefore, effective channels of communication between Board Members, between the Board and partner agencies and between the Board and the public need to be developed. This chapter explores the approaches that Boards have adopted to facilitate communication to support the effective operation of LSCBs and considers the challenges that have been encountered in doing so in practice.

Communication Between Board Members

In the context of Board meetings Chairs and Business Managers recognised that the size of Boards, variations in levels of seniority, individual personalities and differences in experience and knowledge of child protection and policies and procedures could all impact on communication between Board Members both at meetings and more informally.

> *'I have been at pains to try and treat all agencies around the table equally, irrespective of their size, and I think probably some folk from Children's*

Services find that a bit irritating…but if we start deferring to one because it apparently has more power than the others all the trust is going to disappear.'

(Business Manager)

It was acknowledged that there were challenges in trying to facilitate communication between Board Members from different organisational backgrounds and with different ways of working.

'It's really difficult. For example, we've just had to agree a teenage pregnancy protocol, and it's very difficult when you agree a joint working protocol in some civilisations, it's very different cultural backgrounds, Police being very punitive in their approach, Children's Social Care being about protecting and safeguarding children, which the Police are as well, but their approach comes from a much more punitive background. It's very difficult to consolidate it, and there are tensions sometimes.'

(Business Manager)

'... you need to be quite brave to be able to say I don't understand how this works it is sometimes easier to keep quiet.'

(Business Manager)

Questions were also raised about how far the perspectives of different professional groups within larger agencies were represented and communicated by individual Board Members. For example, the extent to which Children's Services members represented early years or the Youth Service. At the same time, it was acknowledged that increasing the size of Boards could render meetings unmanageable and cause difficulties in terms of the active engagement of such a large group (see Chapter 3 for further discussion).

On the whole, interviews with Board Members indicated that communication at meetings was generally unproblematic and that people felt willing and able to communicate their views during meetings.

'People are willing to listen to other people which you'd never get if people weren't at a Safeguarding meeting. And it's always the case in my view that if you're trying to work on this type of work and know the person the other end who you're talking to, you're more likely to get a good working relationship.'

(Board Member, Area One)

Opportunities to network were welcomed and it was felt that this helped to build relationships with professionals from other backgrounds. Meetings presented Board Members with a chance to learn more about the roles and responsibilities of other agencies, as well as providing them with an opportunity to enhance links with individuals from a wide range of agencies. The development of personal contacts was perceived as beneficial both in the context of communication concerning Board business and day-to-day practice. For example, a Board Member from the voluntary sector outlined how being involved in the Board gave them access to expert knowledge which they could then use in their own organisations:

> *'I've picked up ideas and then I can approach people while they are there and meet up and have a chat about it…that's how I got involved in doing CAF training and was able to introduce it to [voluntary agency] so I made contact with the training group and had a chat about implementing it in [voluntary agency]. I probably wouldn't have got us involved in it if I had not been a part of Safeguarding.'*
> (Substance and Misuse Manager for Voluntary Agency)

Another example arose in discussion with the Police representative. He explained how he was working on a project about alcohol and sexual offences with young people and how his connections on the LSCB gave him access to relevant professionals who could help him:

> *'I can pick up the phone now and speak to [name of individual] from the YOT, I can pick up the phone and speak to [name of person] from Children's Social Care or I can go to [name of individual] who is the named paediatrician…and so there are no restrictions now.'*
> (Detective Chief Inspector, Area Six)

Research evidence also demonstrates the contribution these factors make to enhancing inter-agency communication (Ward et al., 2004).

> *'If I've got a problem I can just phone somebody and feel confident that they'll help me sort it out…you need to meet people to get those relationships.'*
> (Board Member, Area Four)

However, an Independent Chair, did suggest that 'everybody getting along' at meetings does not necessarily mean that the Board is operating effectively.

Concerns were raised that there was an absence of constructive challenge in meetings:

> *'I think people find it difficult to move into that challenging [role] some feel they have the confidence or perhaps the knowledge to challenge practice [in] another agency as good, bad, or indifferent.'*
> (Independent Chair)

> *'Some people don't feel sufficiently confident to challenge some of that but I think where it is challenged then certain people can become quite defensive.'*
> (Business Manager)

> *'I don't think it goes deep enough. The Board needs to be a bit more expansive and a bit deeper in its functioning and I think it only touches the surface…I don't think the Board goes down far enough.'*
> (Head of Targeted Services, Area Two)

At the same time it was felt that challenging agencies about their practice could lead to defensiveness and undermine collaboration, particularly if Board Members perceived their role as representing their own agency rather than acting as an independent member of the LSCB.

Communicating Information from the Board to Partner Agencies

Two-way communication from the LSCB to partner agencies and from partner agencies back to the Board is important to facilitate information exchange. The national survey revealed that the most common method of communicating policies and procedures was via Board Members. Nearly 50 per cent of LSCBs identified this as their main approach to communication. In 18 per cent of LSCBs there was an expectation that professionals would access information on policies and procedures from websites. Training was seen as the main method of communicating information in 17 per cent of Boards (France et al., 2009).

To corroborate the data from the national survey, interviews with Chairs and Business Managers in case study areas also revealed that Board Members were responsible for communicating information to their respective agencies. There was, however, rather less certainty about the extent to which this took place and whether information reached the appropriate personnel to influence policy and practice and

affect change. Data from the Board Member interviews suggested that Board Members tended to be aware of their responsibilities in this respect. As a Police representative reflected:

> *'Female Genital Mutilation policy. I know that I'm responsible for making [change] happen in the [area] Police force divisions…there's a clear directive there that I'm responsible for getting that as a policy in [force]…that's a very specific example of something I'll now have to promulgate in my organisation.'*
> (Board Member, Area Three)

However, Board Members were rarely clear about how effective other agencies were in communicating information from the Board to strategic and operational staff. Knowledge and awareness of the actions that other agencies took tended to be assumed rather than explicit and underpinned by evidence. As Chapter 6 outlines, difficulties were also encountered in determining whether recommendations from the Board had the intended impact within the agency in question.

> *'Assuming that other partner agencies are within their own agencies, feeding information down and bringing it back through their representatives, then yes, the processes are there, it's how well individual agencies are using them that is the bit that I wouldn't know.'*
> (Board Member, Area Four)

Dissemination of information and implementation of changes within agencies was largely reliant on the effectiveness of pre-existing structures and communication channels and networks within individual organisations. A Head of Youth Offending Services (Board Member, Area Three) explained the process they had in place:

> *'I have a senior management meeting with the five team managers, and we always have a Safeguarding slot on that and I bring to that any issues that come from the Board, and the Safeguarding lead will bring any issues that have come from his work in the last month. And then they can be disseminated from there into the team meeting structure.'*
> (Head of Youth Offending Services)

The Head of Service was also monitoring and evaluating safeguarding policy and practice and evidencing change. Such clear explanations of how channels of communication operated in practice and how this linked with wider strategies of monitoring and evaluation were fairly rare. In part, this was because Board

Members were the first link in a chain of communication. Once information had been passed on to the 'relevant' colleague then it became their responsibility to disseminate this.

Although Board Members were viewed as an important conduit for information from and to the LSCB, other strategies were also employed to inform staff of the work of the Board and policies and procedures.

> *'There's a Safeguarding Board website, and of course we all contribute to the [area] CP procedures website…we have a newsletter that used to come out from the Safeguarding Board…so that was always quite useful in passing information down, and the other way is through the Designated Nurse who was always quite useful for passing on bits of information.'*
>
> (Board Member, Area Six)

The Business Manager also played an important role in the dissemination of information. Indeed, one manager raised concerns that Board Members had not fully grasped the critical role they had to play in this respect.

> *'I think part of the confusion about me [the Business Manager] and my team and the LSCB is that the people around the table, some people, say well it's the LSCBs responsibility to do that, without realising that that is them, they almost think that we are an entity that has the capacity to do those kinds of things.'*
>
> (Business Manager)

This is also linked to resource and capacity issues. Concerns were raised by Board Members about the quantity of information generated by the Board, although in two areas, work had been undertaken to try to streamline this. This also reinforces the importance of targeting information at the relevant professionals within the agency. Even when information is communicated from the Board to the appropriate individuals within agencies (either via a member or the Board Manager) issues can arise as they attempt to engage and respond.

> *'Within my organisation sometimes the difficulties in implementing some stuff can be that, you need resources for instance and finding additional resources can be very difficult.'*
>
> (Board Member, Area Six)

A Business Manager also reflected on this:

> *'I've got to continue to be generating recommendations or advice or issues that we've identified people need to look as…how they actually in the end [get them]…implemented, or resourced or whatever happens elsewhere…How are people actually allocating resources, to what extent does the Board influence that?*

Interviews with frontline managers and practitioners also reveal how workload pressures influence day-to-day practice. Chapter 9 explores such issues more fully and looks at the extent to which information communicated from the LSCB to agencies informs frontline practice.

Communication from Partner Agencies to the LSCB

The two main routes for ensuring information from individual agencies was fed back to the LSCB were via Board Members and subgroups. The national mapping exercise found that every LSCB had established subgroups and that the majority of subgroups tended to communicate information to the LSCB through meeting minutes or written reports (66 per cent of Boards). Verbal feedback from subgroup Chairs was the main method of communication in 23 per cent of LSCBs. Subgroups were recognised by Chairs, Business Managers and Board Members as a way of facilitating communication and of engaging operational staff. The importance of this, particularly given the strategic and senior nature of the Board was identified in interviews. Two areas had also established groups specifically designed to try to ensure effective communication from operational staff back to the Board. Area Six hold multi-agency meetings across the county on a quarterly basis to ensure that the views of operational staff are sought and then fed back to the LSCB.

> *'We wanted practitioners to be actively involved…in the work of the Board…so we set up groups across the county…quarterly meetings…run by Operational Managers.'*
>
> (Business Manager)

Similar arrangements have been implemented in Area Three where six multi-agency district forums have been established.

*'Through the local fora, there is the opportunity for agencies to really
participate in discussion around Safeguarding and for feedback from that
local fora to go back to the Board via the Chairs.'*

(Board Member, Area Three)

Although attempts have been made to develop mechanisms to ensure effective
communication to assist the Board in meeting its aims and objectives, a number of
challenges persist. Information sharing, building trust and fulfilling responsibilities in
respect of communication with the general public and children and young people are
discussed below.

Communication Challenges

Communicating with local organisations

Working Together indicates that the LSCB should make contact with a wide range of
organisations and develop networks and forums to facilitate communication (HM
Government, 2006: Section 3.62). The national survey demonstrates that there are
variations in how well developed channels of communication between Boards and
local organisations are. As Table 17 shows, effective communication with GPs and
the Independent school sector were found to be relatively weak (France et al.,
2009). However, there are indications that communicating with these groups is
important and necessary to assist with breaking down professional boundaries.

Table 17   Degree of communication with local organisations if communication is via a network or forum

	Degree of Communication				
	Well developed	To some extent	Limited extent	Not developed	Number of LSCBs
Faith groups	15	30	31	14	90
State schools	54	38	5	0	97
Independent schools	10	24	21	18	73
Non-maintained or special schools	9	20	16	9	54
Further education colleges	27	35	18	12	92
Children's centres	40	33	15	2	90
Communication with GPs	11	34	33	7	85
Independent health care organisations	4	6	10	29	49
Voluntary or community sector organisations	46	38	10	3	96
Local MAPPA	68	26	5	0	99

Forty out of 85 LSCBs identified that their links with GPs were limited (33) or not developed (seven) (France et al., 2009). The relative autonomy of GPs was identified as problematic in one of the LSCB areas (see discussion in Chapter 4 for more details). For example, in the following quote the Chair recounted raising concerns with the NHS about an IMR written by a GP.

'It was a dreadful piece of work…we've worked really hard with everybody contributing, producing a standard we expect, this is the format…the GP ignored all of that…we went back to the NHS and said, this really isn't good enough, it doesn't meet the quality we expect, and are you happy signing it off as a quality piece of work representing the NHS. Back came the reply, well, it's GPs, what can we do?'

The national survey of LSCBs also identified communication between Boards and the Independent school sector as problematic (see discussion in Chapter 4 for more details). Thirty nine out of 73 LSCBs stated that communication was limited (21) or not developed (18). Similar distribution figures were evident for non-maintained and special schools (France et al., 2009, p.46). Issues in this respect were also identified during interviews with LSCB Chairs and Directors of Children's Services in case study areas.

'We have a multi-agency working group that we run that covers the breadth of Safeguarding…it has representation right across the piece including schools…If you're looking at engagement outside what we would regard as Local Authority schools you know you have very little engagement with Independent schools.'

(DCS)

Sir Roger Singleton's review of Safeguarding arrangements in schools (Singleton, 2009) identifies that LSCBs need to take:

'Initiatives to understand the distinctive needs of independent, non-maintained special schools and boarding schools, recognising their particular circumstances and respecting their unique contribution whilst being willing to share Safeguarding knowledge and experience.'

(Singleton, 2009: 29)

As was discussed in Chapter 4 more positive developments were evident in terms of communication between state schools and LSCBs. Over half of LSCBs judged

channels of communication to be well developed (France et al., 2009). In Area Five incremental improvements in relationships with Head Teachers and schools were identified. In part, this was perceived to be due to changes at an operational level, including, for example, holding case conferences in schools.

Communication with the general public

Each of the case study areas had established an LSCB website to disseminate information to Board Members, practitioners and the community. However, there was a general consensus that developments in terms of communicating the work of the LSCB to the general public had been limited by budgetary and time constraints. It was recognised that LSCBs had a low public profile.

> *'I mean if you ask the man in the street what does the [area] LSCB do, he'd have no idea.'*
>
> (Board Member, Area Five)

At the same time, some questioned whether there was a need for the public to be aware of the role and remit of LSCBs or whether the critical issue was the Boards' success in raising awareness of what action individuals and communities can take to safeguard children from harm and to promote their welfare.

> *'It doesn't actually matter whether people know what the LSCB is, it matters that people know about Safeguarding, because the LSCB is a bureaucratic machine created by government, and not itself a service deliverer, what we need to do is make people aware it's everybody's business.'*
>
> (Business Manager)

Discussion around this topic also identified different perspectives on the role and contribution that LSCBs should take in responding to media reports on alleged failures to protect children or provide appropriate services to meet their needs. Some felt that the LSCB should be proactively responding, while others felt that the Board should not be speaking on behalf of the agencies involved. In light of the predominately negative portrayal of Children's Services and social workers in the media it was also identified that the LSCB could do more to promote awareness of the work they do to support children and families in the community.

'The only time you get a press release regarding Safeguarding is when something goes horribly wrong...Not many good news stories that they promote [although] there's a lot of good work going on. But there isn't that vehicle to promote it…to members of the public.'

<div align="right">(Board Member, Area Five)</div>

'Internally with agencies [communication is] quite good, externally to members of the public , parents I feel [the LSCB has had] no impact whatsoever…You need some kind of budget to promote what Safeguarding is, what Safeguarding does, the reasons behind, it to give a better understanding to members of the public.'

<div align="right">(Board Member, Area Five)</div>

Although promoting the work of the LSCB to the public was not a key priority for LSCBs it was recognised as a responsibility. Area Two held an annual event for children and families. This included a range of free activities and entertainment, but was also used as a forum for consultation and distribution of leaflets. In this case study area, the LSCB also circulated a booklet to every household in the area to explain the work of the LSCB. A large number of the case study areas had also undertaken specific work with children and young people.

Listening to children and young people

Increasingly, steps are being taken to listen to and consult children and young people to inform the planning and delivery of services (Munro, 2008). The *Children and Young People's Plan (England) Regulations 2005* placed a duty on authorities to produce a strategic overarching plan for all services affecting children and young people. The regulations explicitly state that during the preparation of the plan the authority shall consult 'such children, relevant young persons and families… as the authority consider appropriate' (Section 7 (1a)). Working Together also states that these groups should be consulted and their views and opinions should be taken into account by LSCBs in the planning and delivery of services to safeguard children from harm and to promote their welfare (HM Government, 2006: Section 3.30). While the importance of listening to and consulting children was generally recognised by Chairs, Business Managers and Board Members it was acknowledged that this was an area of activity that LSCBs needed to continue to develop.

The Youth Parliament and national Tellus survey (which gathers children and young people's views on their life, their school and their local area) were used to inform LSCBs about issues affecting children and young people. Young people's views were also sought via events and forums that individual agencies had already established. Although these methods of eliciting young people's views were being employed Board Members were largely unaware of this work. This, therefore, raised questions about the effectiveness of feedback mechanism and the extent to which the information collected was informing the operation of the LSCBs. In general, Boards had not developed a systematic approach to ensuring that children and young people's voices fed into the planning process. There was also evidence from one area that professionals were reluctant to believe findings from the Tellus survey:

> *'We tend to get a lot of bullying…we came out poorly on the Tellus survey…but now everyone's trying to say it must be wrong…but my view of that is that if [young people have] ticked a box saying their being bullied they must have felt it.'*
>
> (Director of Children's Services)

More positively, the youth council was used in one area as a mechanism to try and engage with young people and obtain feedback and looked-after children had also been involved in the development of the corporate parenting strategy. In another area, young people's involvement was identified in the objectives of a number of the subgroups.

> *'One of the things that is written into the multi-evaluation sub-committee terms of reference is that for all the activity they should be seeking the views of adults and children…we do also link into the children's parliament…'*
>
> (Independent Chair, Area One)

Consultation with children and young people had also informed the development of leaflets about child protection. The UK Youth Parliament had also run focus groups to inform the work of the E-safety subgroup and mechanisms were being established to facilitate feedback from young people to the Board. The Chair in one area was committed to attending two meetings a year with the young people's consultation group to discuss the work of the LSCB. This group was consulted on a wide range of issues affecting their community and also had representation on interview panels when appointing staff.

Conclusion

Effective communication is critical if LSCBs are to be effective. This is reliant on good communication conduits and agreement about who is responsible for ensuring that messages reach the appropriate professionals. Evidence from the research suggests that there is an expectation that Board Members will take a central role in communicating critical messages from the LSCB to their own agencies. However, some Board Members thought it was the Board as a collective that was responsible for this, rather than them as individuals. Others expressed uncertainty about how messages reached the broad range of professional groups within larger services. For example, how are representatives from Children's Services making sure information is communicated to Early Years professionals and, equally, how are the views of the latter fed back to the Board? There are also a number of challenges (as also outlined in Chapter 7) in developing effective communication channels between the Board and schools, GPs and the Third Sector. Strategies to engage practitioners (as outlined in Chapter 7) in subgroups or other forums do aid forums and will aid the dissemination of information.

Communication to the wider public and to children and young people themselves is clearly underdeveloped. Part of the reason for this is related to resources. Although such activity may have many benefits (e.g. improving the image of social work) it was not a priority that Boards felt able to allocate substantial resources towards. It was recognised by a wide range of professionals in the Case Study areas that consulting and engaging children and young people was an important responsibility of the LSCB. Not only was it set out as a responsibility in Working Together but it was seen as appropriate that their voices were heard in the development of the work programme. In a number of case study areas consultation had taken place but there was little evidence that it had shaped or greatly informed the work of the LSCB. This is illustrated by the fact that most Board Members were unaware of any such work. That said, a number of examples of good practice did exist and opportunities exist (for example, through closer engagement with Youth Parliament) to develop ways of more actively engaging young people in planning and monitoring LSCBs.

8   RESOURCES AND THE COSTS OF OPERATING LSCBS

Introduction

The joint Chief Inspectors' report indicated that one of the obstacles to the effective operation of ACPCs was lack of resources (Chief Inspector of Social Service et al., 2002). The Children Act 2004 makes provision for payments towards expenditure incurred by, or for purposes connected with, a Local Safeguarding Children Board (Section 15(1)). Bodies may also provide staff, goods, services, accommodation or other resources (Section 15(2)). Working Together acknowledges that LSCBs need to be adequately resourced to function effectively (HM Government, 2006: Section 3.74, 3.75 and 3.76). However, the level of funding required to operate effectively and the contribution that individual agencies should make are not prescribed. As a result, there are considerable variations in LSCB budgets and expenditure (DfES, 2007b; France et al., 2009). *Local Safeguarding Children Boards: A Review of Progress* (DfES, 2007b) found that in 2006-2007 the average funding level for LSCBs was approximately £150,000, compared with about £95,000 for ACPCs in 2004-2005 (p.48). Staffing, followed by training accounts for the highest proportion of LSCB expenditure (p.54). Local Authorities consistently contribute the majority of costs, followed by health bodies and the Police (p.51-2). This funding allows the LSCBs to appoint staff, such as Independent Chairs and Business Managers, who comprise the infrastructures of the LSCBs and enable them to operate. Costs of a different kind arise in connection with the meetings that are held by LSCBs and their subgroups, in that the members who attend them take time off from their normal duties to enable them to attend.

This chapter examines resource issues and outlines both types of estimated annual costs that are incurred in running case study LSCBs. These costs are influenced by a range of factors, including:

- number of Board Members;
- types of positions they hold;
- amounts of time members spend in relation to Board meetings;
- amounts of time members spend in relation to subgroup meetings;
- number of Board meetings per year; and

- number of subgroup meetings per year.

The approach employed values the time that Board Members spend on work that is related to the scheduled operation of the Boards and the associated subgroups in place of their normal duties. These costs are additional to the administrative costs of the board. Further details of the bottom-up costing methodology employed are provided in Annex A. Each of the case area LSCBs is constituted differently and this has implications in terms of the costs of operating. Variations and the implication of these are discussed. It should be noted that Serious Case Review (SCR) and Child Death Overview Panel (CDOP) processes have been excluded from calculations. It is, however, acknowledged that both these processes involve considerable human and financial resource and can influence the capacity LSCBs have to fulfil their wider remit (France et al., 2009).

Infrastructure to Support the Operation of LSCBs

The Government's priority review (DfES, 2007b) found that staffing, followed by training, accounts for the highest proportion of LSCB expenditure (p.54). This section outlines the arrangements case study areas had and were putting in place[8] to facilitate the effective operation of the Board, and provides an estimate of the cost of these arrangements. Over the course of the research there were a number of staffing changes and staffing levels to support the running of each Board did fluctuate. As Table 18 shows, the DCS Chairs in Areas Three and Four allocated less time on activities connected to running the LSCB than Independent Chairs.

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[8] Boards with Statutory Chairs were in a period of transition and in the process of appointing Independent Chairs.

Table 18   Infrastructure to support the operation of LSCBs

LSCB	Chair	Business Manager	Administrative Support	Other Posts	Estimated Cost*
Area One	3 days per month	Full-time	1 FTE	1 FTE Training co-ordinator	£123,937
Area Two	2 days per month (additional 0.5 for CDOP – another 3 LSCBs contribute) 1 day per month (DCS)	Full-time	0.4 FTE	0.5 FTE Training co-ordinator	£96,600
Area Three	5 days per month (proposed contract for Independent Chair) 1 day per month (DCS)	Full-time	3 FTE* 0.5 FTE (to support training)	1 FTE Policy Officer 1 FTE Training Officer 1 FTE Allegations manager	£250,502
Area Four	Missing data on contractual arrangements for an Independent Chair	Full-time	1 FTE	0.5FTE Policy Officer	£89,656
Area Five	3 days a month (includes chairing SCR panel)	Full-time	1 FTE	0.5 FTE Training Officer	£105,107
Area Six	2 days per month (former Chair) 3 days per month (Independent Chair)	Full-time	2 FTE*	1 FTE Training Officer 1 FTE Audit Officer	£181,981

Figures exclude time on SCR and CDR unless indicated.
*Staff not full-time.

Both the DCS Chairs indicated they spent approximately a day a month on Board-related activity. However, it should be acknowledged that in their posts they will have been undertaking work that complements and takes forward the work of the LSCB and the boundaries between 'LSCB activity' and 'day-to-day' work are blurred. In Area Three, at the time of follow up interviews it was anticipated that an Independent Chair would be contracted for five days a month. Details for Area Four were not available. Similarly in Area Six, which was formerly chaired by a Senior Local Authority employee (two days) the new Chair has been allocated three days work per month on LSCB business. The national survey found that 43 per cent of Chairs spend two days a month on LSCB business. A further 23 per cent spend three days a month on LSCB business. Nineteen per cent of Boards had Chairs that spent four or five days a month on LSCB business. Only four Boards indicated that the Chair spent more than five days on LSCB business (France et al., 2009).

The national survey of LSCBs also revealed that 89 per cent of LSCBs have appointed a Business Manager to support their operation (France et al., 2009). Each of the case study areas had also done so. The post was seen to be important to facilitate the effective operation of the LSCB and in case study areas Business Managers were critical players, facilitating information exchange between the Board and members. In areas Three and Six the fact that the Board Manager was seen as a multi-agency resource and independent was also welcomed[9].

> *'The [Business Manager] has been very important…that person's been respected by lots of agencies…and that role has helped bring things together…I do think those sort of leadership roles are very important in terms of setting the tone of safeguarding and setting the ambiance for working together.'*
>
> (Board Member)

However, over the course of the research every Board had experienced a change of Business Manager. While each Board had appointed a full-time Business Manager there were variations in levels of additional staffing to support the work of the Board. As Table 18, above, shows, Area Three had appointed a full-time Policy Officer, Training Officer and Allegations Manager and had invested in considerable

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[9] Both these areas had Statutory Chairs in post at the time interviews were conducted.

administrative support both for the LSCB meetings, subgroups and for training. These posts, plus an Independent Chair for 60 days a year and a full-time Business Manager cost an estimated £250,502. The planned budget for this Board indicates that 38 per cent of contributions to the LSCB were provided by the Local Authority. The Health and Police also contributed 17 per cent each. Elsewhere, staffing levels were considerably lower. The estimated cost of the Board with the lowest estimated infrastructure costs was Area Four (£89,656). This LSCB, along with two others did not fund full-time training co-ordinators. A Business Manager in one of these areas reflected that this was due to a shortage of available funds. Interviews revealed frustrations about the challenges of securing enough resources to undertake the work needed and the expectation that Children's Services would pay the lion's share of the costs.

> *'It's not satisfactory, the Local Authority are the major contributors by a long chalk, so it's been hard to get agencies to contribute accordingly. So we are still working to the old ACPC formula.'*
> (Business Manager)

> *'The budget and contributions don't lend themselves to financing…roles that are really needed to make [the LSCB]…more effective…we do have learning development support from the officer from Social Care, but that is one post covering the entirety of Social Care…It's just not workable really. So I find that part of my time goes into fulfilling that role as well.'*
> (Business Manager)

Time Spent by Board Members on LSCB Activity (excluding SCR and CDOP)

Accurately determining the contributions agencies make to the operation of LSCBs is problematic, as alongside financial contributions, some agencies make substantial in-kind contributions. Time spent on work that supports the operation of the LSCB and fulfilment of core responsibilities, including SCRs and CDRs is difficult to quantify, as much of this work is undertaken by staff who do not sit on the LSCB. The information presented is based on the time Board Members spend on key activities. It does not include the time spent by staff working on behalf of Board Members to complete work for the LSCB. As such, the figures presented are likely to underestimate the costs associated with operating an LSCB.

Board Members in each of the six case study areas were asked how much time they spent on LSCB work. Many found it difficult to provide an accurate estimation of how much time they spend on preparation for the LSCB, in part, due to fluctuations in contributions to different meetings and/or subgroups. Estimates ranged from a quarter of a day a month to six days a month. The latter figure came from a Director of Family Services. They reflected that:

> *'There's not been any proper analysis of the amount of work that people contribute to the Board. I think it's just a historical thing that…you work for Children's Social Care, so therefore this is part of your remit.'*

Data from time use event records (see Annex A and Annex C) also revealed considerable variations in the duration of time members spent on key activities. For example, estimates of preparation time for a LSCB meeting ranged from 30 minutes to six hours for Board Members (excluding data from Chairs and Business Managers). Feedback time ranged from 30 minutes to three hours. Table 19, below shows the average time spent by Board Members for one LSCB meeting. These figures have been used for subsequent cost calculations.

Table 19   Average time spent by Board Members for on LSCB meeting

Activity	Average Time Spent (per meeting in hours*)
Travel	0.89
Preparation for meetings	3.07
Feedback to own agency	1.33
Total	**5.29 hours**

*Figures do not include the time spent in the meeting itself.

Qualitative data from interviews with Board Members revealed that the competing demands on people's time could mean that investing sufficient time on a LSCB activity was problematic and that the time professionals spent did fluctuate according to other work commitments. The time consuming nature of SCRs was also a recurring issue and one that influenced the Boards' capacity to fulfil their broader safeguarding remit.

Estimated Costs of Board Member Attendance at LSCB Meeting (per meeting and per annum)

Table 20, below, shows the estimated cost of the time spent by Board Members on travel to and from one LSCB meeting, preparation for the meeting and feedback from the meeting to their own agency for each case study area. Further details concerning the seniority of Board Members (Annex B) and associated implicit costs to their employers are presented in Annex D.

Table 20   Estimated costs of Board Member attendance at LSCB meetings

LSCB	Estimated Cost Per Meeting	Estimated Cost Per Annum
Area One	£10,637	£63,822
Area Two	£6,649	£39,894
Area Three	£16,113	£193,356
Area Four	£14,841	£59,364
Area Five	£8,832	£52,992
Area Six	£15,424	£61,696

Once again, there are considerable variations in the estimated costs of each LSCB meeting in the different areas, ranging from £6,649 to £16,113. The least expensive Board, Area Two, has the lowest number of members and seniority was mixed. While six out of 14 (43 per cent) members in Area Two were classified as seniority 2 (overall responsibility for a large department within their organisation, or if they were accountable only to the head of their organisation) an equal number (6/14: 43 per cent) were coded 4 or less (if they were a manager or had responsibility for a small team within their sub-section). A similar picture emerges in Area Five, which was the second least expensive. Although these Boards cost less than the others, it is noteworthy that during interviews questions had been raised by respondents about whether these areas had secured enough partners of sufficient seniority. In contrast, the most costly LSCB meeting, as one might anticipate was a Board with an inclusive approach to membership and thus a large board (33 members). It had also secured a high proportion of senior Board representatives. Over one third of

members (12 out of 33: 36 per cent) were classified as seniority 1 or 2 and a further 48 per cent (16 out of 33) were classified as a 3[10].

Annual costs, taking into account the length and frequency of LSCB meetings in each area are also shown in Table 20, above. In Area Three the implicit costs incurred by the employers of Board Members in the course of a year were much higher than the other Boards. The LSCB in this area met on a monthly basis, whereas the other Boards met less regularly. As such, Board Members were investing more time on attending meetings. Indeed, those interviewed noted the heavy time demand of the Board and the large amount of paperwork and follow up generated by having such regular meetings. More positively, there were indications that this Board had been able to embrace the wider safeguarding agenda to a greater extent than other Boards that were more child protection focused (see Chapter 6). This Board also had the highest budget, as agencies contributed more to the LSCB than elsewhere. As such, they were able to fund the most staff to support their operation, as Table 21 (infrastructure) shows. Elsewhere Boards were identifying challenges in fulfilling their remit due to financial resource constraints but also because of the limited time Board Members had available to take forward work for the LSCB.

Infrastructure Costs and the Cost of LSCB Meetings

For LSCBs to function together they need agencies to contribute resources to pay for support staff and training (among other things). They also rely on in-kind contributions and the release of staff to attend meetings and to engage in the activities of the LSCB. As Table 21 shows the combined cost of these contributions is not insubstantial, ranging from £136,494 in Area Two to £472,658 in Area Three.

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[10] Members were coded **1** if they had overall responsibility for their entire organisation.
Members were coded **2** if they had overall responsibility for a large department within their organisation, or if they were accountable only to the head of their organisation.
Members were coded **3** if they had responsibility for a smaller sub-section of their organisation.

Table 21   Estimated costs of infrastructure to support the operation of the LSCB and main meetings (per annum)

LSCB	Infrastructure (staffing, including Chair)	Cost of Meetings (implicit costs)	Total Cost
Area One	£123,937	£63,822	£187,759
Area Two	£96,600	£39,894	£136,494
Area Three	£279,302	£193,356	£472,658
Area Four	£89,656*	£59,364	£149,020
Area Five	£105,107	£52,992	£158,099
Area Six	£181,981	£61,696	£243,677

* Only one day a month salary has been assumed in cost calculations for this Board although it is likely that this will increase when an Independent Chair is appointed meaning that costs will rise. If the LSCB appointed a Chair three days per month at £600 per day this would cost an additional £14,400.

Estimated Costs Associated with Attendance at Subgroups

Having subgroups as a part of the LSCB infrastructure is recognised in Working Together as a mechanism to help Boards manage the workload, obtain specialist advice and involve a wider body of partners (HM Government, 2006: Section 3.68). Every LSCB in the national survey was found to have introduced at least two subgroups. The number introduced ranged from two to 20 (France et al., 2009). Membership and representation on subgroups varies, although they offer an opportunity to include operational staff who would not meet the seniority requirements for the main LSCB.

Details concerning subgroup membership were made available by four out of six case study LSCBs. Data were used to estimate the implicit costs of operating subgroups in each of these areas (excluding SCR and CDOP). In the absence of data on the length of different subgroup meetings and their frequency for calculation purposes it was assumed that each subgroup met four times a year, with each meeting lasting two hours. It was also assumed that each subgroup member spent 5.5 hours preparing for each meeting (travel to and from the meeting, preparation for the meeting and feedback time).

As Table 22, below shows, the implicit costs of subgroups were highest in Area Three, totalling £135,776. This LSCB had the most subgroups (six in total), which ranged in size from nine to 29 members. The authority serves a large population and in some instances it may be necessary to involve agency staff from a number of localities on subgroups. In contrast, Area Two, which covers the smallest geographical area, also has the lowest costs (£20,272). This Board only has three subgroups with the largest involving eight professionals. A higher proportion of members on Area Two's subgroups are also of lower seniority, when compared to those on Area Three's subgroups. Relatively small subgroups involving staff of similar status may facilitate joint working and trust but may also pose problems if large volumes of work are falling on a small number of staff. Thirty four staff in total were involved in the LSCB and/or subgroups in Area Two. Capacity issues may also delay developments and the contribution that groups can make to the effective operation of the LSCB.

Table 22   **Annual estimated costs associated with attendance at subgroups (excluding Serious Case Review and Child Death processes)**

LSCB	Cost of Subgroups (implicit costs)
Area One	£61,836
Area Two	£20,272
Area Three	£135,776
Area Four	£73,820
Area Five	Missing data
Area Six	Missing data

Estimated Costs Associated with the LSCB and Subgroups According to Agency

In each of the four case study areas for which data are available, the Local Authority contribute the highest number of staff to attend the LSCB meeting and subgroups.

Table 23   Estimated costs of members attendance at meetings by agency (based on attendance at one LSCB meeting and one meeting of every subgroup)

Area	Local Authority		Health		Police		Other agencies		Total
	Estimated Costs	Contribution as a per cent of the total	Health Costs	Contribution as a per cent of the total	Police Costs	Contribution as a per cent of the total	Other Agency Costs	Contribution as a per cent of the total	
Area One	£11,712	44	£7,366	28	£2,023	8	£4,995	19	£26,096
Area Two	£3,691	31	£3,172	27	£2,355	20	£2,499	21	£11,717
Area Three	£15,524	31	£13,384	27	£3,176	6	£17,607	35	£50,057
Area Four	£15,375	46	£11,199	34	£1,273	4	£5,449	16	£33,296

As Table 23 above, shows, the estimated costs incurred by case study authorities, for an LSCB meeting and one meeting of each of their subgroups, ranged from £3,691 in Area Two to £15,524 in Area Three. The discussion above outlines reasons for this. However, considering the proportion of costs that fall to the Local Authority, as a percentage of the total in a given area, reveals a different picture. In Areas One and Four the proportional contributions made by the Local Authority are higher than in Areas Two and Three. In Area Four, 44 per cent of the implicit costs of the Board and subgroups are borne by the Local Authority. Health also makes a substantial contribution to the operation of this LSCB (34 per cent). This is also the case in the other Areas, with the lowest proportional contribution from Health standing at 27 per cent. Figures for the Police tended to be much lower (with the exception of Area Two).

Between them, other agencies (Probation, Fire and Rescue, CAFCASS, Connexions, YOT and Third Sector) provided nine to 36 professionals to engage in LSCB-related activity. Overall, the implicit costs of other agency engagement in LSCB meetings and subgroups ranged from £2,499 to £17,607. The latter figure includes 19 members of a voluntary and community sector subgroup operated by the LSCB in Area Three. In financial terms the implicit cost of these members contributions totals approximately £9,293 of the sector total of £17,607. It is important to recognise both the implicit costs incurred by individual agencies and in-kind contributions, as well as financial contributions to the operation of the Board.

Securing Resources and Impact

Working Together identifies that for LSCBs to function effectively they need to be financially supported by their member organisations (HM Government, 2006: Section 3.74, p.88) and the decisions about contribution levels should be decided at the local level. However, Local Authorities, the PCT and the Police are expected to be core contributors (HM Government, 2006: Section.3.77). This requirement relates to spending for the infrastructure and management of LSCBs. However, it did not prove possible to obtain detailed figures from case study areas about the financial contributions made by each agency.

Contributions made by partners

Getting reliable information about contributions made by different agencies was a challenge and information on all the case study areas was not readily available. However, a number of LSCBs have put such information on their website (either in Business Plans or Annual reports). The research team accessed the websites of 59 LSCBs to search for information about contributions from partner organisations. The LSCB websites that were accessed were identified as having high quality websites during the mapping exercise undertaken in early 2009. These websites were considered to be most likely to provide the required financial information, which is why they were selected. Useable information was obtained from 18 of these sites. The majority of the data (10 LSCBs) were from 2008-2009. Five LSCBs had published data from 2007-2008 and the remaining three sites had data from 2006-2007. All of these data were included in the analysis.

Only five LSCBs had recorded contributions from the Local Authority *and* from Children's Services. Of the others, 10 LSCBs had recorded contributions from the Local Authority only and three from Children's Services only. It, therefore, appears that the LSCBs generally do not distinguish between contributions from the Local Authority and contributions from Children's Services, therefore these two contributors are grouped together in the analysis.

All of the LSCBs had received a contribution from Health, Probation, Police and CAFCASS. Eleven had received a contribution from Connexions, although in one case this was recorded with the amount from the Local Authority, so it is not clear how large the contribution from Connexions was. Five of the LSCBs also received contributions from other partners. These have been included in the analysis.

Table 24   Financial contributions to the operation of LSCBs by agency

Contributor	Smallest percentage contributed	Largest percentage contributed	Mean Percentage contribution	Median Percentage contribution
LA and Children's Services	31	77	56	56.5
Health	8	40	25	24.5
Probation	1	6	3	2
Police	0	20	9	7.5
CAFCASS	0	1	0	0
Connexions	0	10	4	2.5
Other contributors (where applicable)	1	23	11	9

The results of the analysis in table 24 show that, unsurprisingly the Local Authority/Children's Services makes the largest contribution to the operation of the LSCB, with a mean percentage contribution of 56 per cent. Health makes the next highest contribution (25 per cent). The Police make a mean contribution of nine per cent. How much this distribution reflects a national picture remains unknown. It is also unclear how regional and geographical variations exist.

Both the data on the financial contributions made by each agency toward the operation of Boards and analysis of the implicit costs of operating the case study Boards reveal that Local Authorities followed by Health invest the most. Although the Police are also identified as 'core contributors' under Working Together their proportional contributions both in terms of finance and staff to support the operation of LSCBs are low compared to counterparts from Children's Services and Health.

Was the Budget Adequate?

Over half of respondents in the national survey of LSCBs indicated that the budget they had was inadequate for their LSCB to function effectively. Resource shortages and differences in funding mechanisms can hinder inter-agency working and the operation of Boards (Hardy et al., 1992). In case study areas the majority of the LSCB budget was secured from Children's Services and Health, followed by the Police. A common complaint during interviews was the absence of a funding formula to clarify what agencies should be contributing.

> *'If you want people to be effective you say, this is the funding formula, this is what we require you to do, would you please go and do it.'*
> (Independent Chair)

> *'Most of us feel that it would be very useful to have a bit of action from government [to say] this is what we would expect [agencies] to contribute to the LSCB, because we're under-funded.'*
> (Business Manager)

The time consuming nature of negotiations was also raised as a concern by Chairs, Business Managers and Board Members. Analysis of the minutes of Board meetings also revealed that considerable time was spent looking at the budget and expenditure of the Board.

> *'Generally we do get the contribution but you have to chase though…the different agencies work out their budgets at different points during the year…so you don't necessarily have the pot at the beginning of the year.'*
>
> (Business Manager)

Annual negotiation of agencies financial contributions to the LSCB and uncertainty concerning the budget from year to year can limit the scope for effective strategic planning.

The national survey revealed that just over half of LSCBs perceived that their budget was inadequate. The biggest impact of this was seen to be that it reduced the number of issues the Board could address (France et al., 2009). Interview data also revealed that some local priorities were set aside in favour of responding to 'high profile' issues.

> *'They're broader national issues that the Boards are expected to respond to or have something in place for, so there is an agenda that is more centrally driven that Boards are having to respond to and because of limited capacity …we are having to lay things aside to deal with the profile [issues].'*
>
> (Business Manager)

Interview respondents identified that fulfilling the LSCB remit with the resources available was a challenge. Limited availability of resources to fund staff to facilitate the effective running of the Board was an issue for some LSCBs. Funding also influences what agencies are able to deliver to safeguard children from harm and to protect their welfare. As one Chair explained:

> *'One of the frustrations…is I can only do so much in 36 days a year in [name of LA] of which most of that time has been taken up with Serious Case Reviews because of the volume, but I can suggest what needs to be done but I can't necessarily put it right, I can say yes we should be doing this, or this panel should be working more effectively and you can try your best to influence it, but you don't have those, resources to actually try and influence that.'*
>
> (Chair, Area Five)

Such difficulties are likely to be exacerbated in the current financial climate. This may lead to cuts in agency contributions to the LSCB, as agencies attempt to reduce

expenditure where they can. Financial issues will also impact on the resources available to safeguard children from harm, particularly as ring-fenced funding for schools means that Local Authorities cannot reduce expenditure in this area, leaving Children's Social Care budgets particularly vulnerable to cuts (see also, Holmes and Munro, forthcoming).

> *'Councils are going to be under horrendous financial pressure, and chief executives won't be able to afford to say child protection is exempt from that, so I will inevitably have less money and be desperately trying to protect the current level of service.'*
>
> (Chair, Area Four)

Such issues are likely to impact both upon the finance available to operate LSCBs and demands on them as they seek to ensure that organisations are co-operating and operating effectively to protect and promote the welfare of children in a difficult economic climate (see also, Holmes and Munro, forthcoming).

9   THE LSCB AND THE IMPACT ON PROFESSIONAL PRACTICE

Introduction

Since the 1970s, the findings from research, public inquiries and Serious Case Reviews have identified a number of recurring themes which require attention from all agencies in order effectively to safeguard children from harm (Butler-Sloss, 1988; Clyde Report, 1992; Laming 2003; 2009). These themes include: inadequate information sharing at inter- and intra- agency level; failure to identify an emerging pattern of risk or to revise initial risk assessments; unstructured assessments; and a lack of effective supervision (see, among others Munro, 1996 and 1999; Reder and Duncan, 1999; Sanders et al., 1999). Policy developments and legislation both pre and post Laming (HM Government, 2004; DoH and DCSF, 2004; Laming, 2003; 2009; Children Act, 2004) have sought to address such issues and ensure an integrated approach which is responsive and proportionate to the needs of all children and young people and which ensures that all achieve their potential in terms of being healthy, staying safe, enjoying and achieving, and making a positive contribution and achieving economic well-being (HM Government, 2004).

In working towards an integrated approach one of the core objectives of LSCBs is to ensure that organisations work together and co-operate to safeguard and promote the welfare of children in that locality and for ensuring that agencies and practitioners work effectively with a particular focus on the 'staying safe' outcome (HM Government, 2006). In accordance with the strategic role of the LSCBs all organisations that have responsibility for the safety and welfare of children are expected to focus on developing systems and processes to ensure that children and young people are protected and their welfare needs are addressed. Managers and practitioners are, in turn, responsible for engaging with safeguarding issues on a day-to-day basis and acting on the LSCB requirements and guidance.

As identified throughout this report, the LSCBs in the six case study areas have implemented a range of policies and procedures that impact on practice at the frontline, including developments in training, information sharing, and safer recruitment. This chapter aims to draw on the earlier discussion to explore how information and knowledge about safeguarding, as defined in policy and through the

work of the Boards, shapes and defines practice for both managers and frontline workers. As outlined in Annex A, 132 practitioners were interviewed across the case study areas, 83 of these were frontline staff responsible for working with children and young people on a day-to-day basis and 49 of them had managerial responsibility for those staff. For the purpose of this chapter where we refer to practitioners this encompasses both frontline workers and managers and where distinctions are made this will be clarified.

The impact of the LSCBs and the extrinsic effectiveness of the Boards will be discussed according to a number of themes, namely, how the work of the Board has shaped practitioners understandings of safeguarding and how policies and procedures are disseminated through, and across, agencies to both managers and frontline workers. The chapter will conclude with a discussion of the overall impact of the LSCBs on developing effective inter-agency working.

Definitions of Safeguarding in Practice

One of the core objectives of the LSCBs is to work with all agencies to improve the overall well-being of all children in the local area (HM Government, 2006: Section 3.3). The objective of improving the overall well-being of all children is no small task and requires practitioners to engage with a broad definition of safeguarding which draws on the five Every Child Matters (ECM) outcomes, thus marking a shift away from a focus primarily on child protection (HM Government, 2004). In order to drive forward the principles of safeguarding one of the central aims of the LSCBs is to create a clear understanding of roles and responsibilities for safeguarding which is disseminated within and across agencies and is adopted by frontline practitioners in their daily work. Taking this as a starting point the research found that across each of the case study areas there was a clear awareness amongst practitioners that safeguarding applies to all children, is the responsibility of all agencies and is more than child protection. In fact managers, in particular, were especially well versed and could often refer directly to policy:

'Safeguarding replaced child protection and is more generic to safety-related issues in line with Every Child Matters.'

(Children's Social Care Manager,)

'Safeguarding came after child protection and it is about ensuring children are safe from harm either at home or in the community and to enable them to reach the level of achievement they should do, their full potential as adults.'

(Police Officer)

This was a common view held by practitioners from all agencies and therefore, it appears that the broad remit of safeguarding was recognised by most staff working with children and young people. However, when asked to offer a working definition of safeguarding 51 per cent of all frontline practitioners interviewed had a 'limited knowledge' and 39 per cent of managers had a 'fair knowledge' and tended to revert back to the core principles of child protection with an emphasis on protection and prevention from harm, thus prioritising 'staying safe' over the promotion of well being and the improvement of life chances for all children (HM Government, 2004). When asked to define safeguarding in practice typical examples included:

'Ensuring that the child is living in a safe environment free from the risk of abuse psychologically, physically or sexually, and free from abuse through neglect to allow them to develop safely into adults.'

(Probation Officer)

'It is more or less the prevention of harm. Trying to prevent something happening before it causes them harm.'

(Health Practitioner)

'To make sure children are 100 per cent safe, that they get the services they should be getting and to report even the slightest concern.'

(Family Support Worker)

'Child protection and safeguarding are about the same thing, it's mostly down to terminology.'

(Team Manager, Children's Social Care)

The research found that by defining safeguarding according to the parameters of child protection, practitioners were drawing on their personal experiences in the workplace rather than with reference to wider policy objectives. One hypothesis for why a limited definition of safeguarding prevails might be associated with resource

limitations and the implications of these on practice. In line with the Board Members'
views about preventative work highlighted in Chapter 6, frontline workers in
particular felt that in practice it was not feasible to engage with all aspects of
safeguarding beyond the core responsibilities of child protection due to a lack of time
or staff shortages.

> *'Frontline workers are overstretched and even though we are aware of the
> wider safeguarding agenda there is little more that can be done in practice.'*
> (Police Officer)

While there was acknowledgement of the wide reaching objectives of the
safeguarding agenda which is undoubtedly a positive development, the practical
engagement with safeguarding was thought to be hindered by resource issues and
practice appeared to be entrenched in reactive work as opposed to the preventative
work which the safeguarding agenda promotes.

The interviews also revealed that practitioner's views about safeguarding were
further shaped by their limited knowledge of the role of the LSCB, with 52 per cent of
frontline workers having little knowledge about the role of the Board or a limited
knowledge (40 per cent). In particular frontline workers across the case study areas
reported that their knowledge of the role of the Board was limited because it was
regarded as beyond their professional scope to engage with the LSCB directly.

> *'I think they are there to ensure the safety of children. I don't really know
> though, it is way beyond me.'*
> (Family Support Worker)

> *'I have a vague idea about them overseeing all the child protection work…'*
> (Health Practitioner)

The tendency for practitioners to guess the role of the Board was indicative of a
disjuncture between the Board and frontline workers. This disjuncture was further
compounded by frontline workers that referred to the Board as a distant body which
had little direct impact on their practice. As one manager explained:

'Many practitioners see the Board as something up in the ether rather than something that affects practice.'

(Children's Social Care Manager)

Interestingly, from the managers that were interviewed 86 per cent claimed they knew the role of the Board and 33 per cent were found to have a high knowledge of the Board's role which was indicative of their professional role and their broader engagement with strategic developments.

Furthermore, in Area Three frontline workers clearly had a greater understanding of the role of the Board. While there was little data to suggest what facilitated this, one hypothesis is that the LSCB in Area Three has honed in on local issues such as gangs and gun crime and has developed a broader approach to engage with all staff (for example, the development of District Fora). As a consequence of this local focus of the work and active engagement of frontline workers there may be a greater connection between strategy and practice.

In terms of bridging the gap between the LSCB and work on the frontline, managers were seen as crucial in shaping the parameters of safeguarding work. In particular frontline workers often reported that they relied on their managers to translate policy defined at the strategic level into practical application.

'The written policies are useful but only in combination with actually speaking to my manager and getting verbal advice about how something would actually apply.'

(Social Worker)

'We have to turn information into a language that can be applied in practice, for instance its important to work with manager's and ask the questions "how will this impact on what I do? Why do I need to do this? What are the wider implications?"

(Children's Services Practitioner)

With particular reference to the role of the Board, frontline workers often referred to the work involved in Serious Case Reviews and once again managers were seen as central to the process of interpreting recommendations and implementing them in practice within agencies. While managers in turn saw the practice of knowledge transfer as one of their key responsibilities this somewhat restricted the potential for

frontline workers to engage with wider safeguarding issues, as the manager's appeared to filter information to frontline staff that was directly relevant to the work already undertaken within the agency. While this in itself was not problematic, and in fact the managers saved frontline workers time in terms of understanding the implications of policy and procedure, frontline workers did feel that it potentially limited their awareness of the work done in other agencies which was considered to be counter to the ethos of inter-agency working.

However, it is important to note that frontline workers were not disengaged from the wider safeguarding principles in theory, as in each of the case study areas they saw preventative work as an aspiration. However, as highlighted in the above discussion the potential to engage in preventative work was argued to be hindered by a lack of resources. The way in which practitioners engage with the safeguarding agenda and the recognised limitations therefore raises questions about the potential for LSCBs to change practice at the individual level, as frontline workers in particular remain focused on what appear to be fairly linear practices. For example, many frontline workers often defined safeguarding according to their work which was reactive and described their working practice as a staged approach that was centred on the referral process discussed below. In particular they typically saw their work as being about the identification of concerns in the first instance, followed by a referral to Children's Services. Furthermore, these linear processes tended to define frontline workers views about their roles and responsibilities and in some instances led to safeguarding being perceived as implicit and almost taken for granted:

>*'It goes without saying.'*
>
>(Housing Advisor)

>*'It is what my whole job is about, to protect young people from harm and to identify the risks of them coming to harm. It is a normal part of practice.'*
>
>(Health Practitioner)

Safeguarding in Practice

One of the core functions of the LSCBs is to develop policies and procedures in a number of areas including training, the referral process, recruitment and supervision and the investigation of allegations. The aim of these policies and procedures is to

improve working practices across the sector and in order for the policies and procedures to be adopted by agencies and in turn frontline workers, information sharing and communication are key. This section explores these aspects of safeguarding in turn to consider how practitioners are affected by policies and procedures in their day-to-day work (HM Government, 2006).

Policies and procedures

When discussing policies and procedures a significant number of practitioners from across the case study areas referred to longstanding policies as underpinning their occupational roles and responsibilities:

> *'The policies haven't changed but there is now more awareness about them.'*
> (Team Manager, Children's Social Care)

> *'Many procedures were established well before 2006 but the wording around what is being done has changed and been updated. The threads are basically the same about what people do and the way they react to things.'*
> (NSPCC, Children's Services Practitioner)

For these frontline workers and managers the establishment of the LSCBs was regarded as having little impact on their working practices. In this regard, any changes to policies and procedures were seen as an enduring part of the job, a natural consequence of developments and improvements in working practices.

> *'All of our systems have always been set up to ensure we keep an eye on the well-being of the child. Changes tend to be incremental but fairly constant. It is something we get used to as part of the development of new knowledge.'*
> (Children's Services Practitioner)

> *'Policies come and go as do different management staff but the job remains the same…'*
> (Probation Officer)

In particular, practitioners often felt that while the core policies had remained the same, the establishment of the LSCB had brought about changes in procedure. In this respect there was a widespread view across the case study areas that the work itself had not changed, but the methods and processes of working had. In particular

practitioners referred to procedures that support inter-agency working as being the main development since 2006.

> *'Obviously most [policies] go back a long way and have developed but the approach now is more focused on multi-agency working and all agencies understand that bit more about what each other doing and how it should fit together.'*
>
> (Detective Sergeant)

In two of our areas in particular there was a general perception amongst both managers and frontline staff that developments in practice were driven by procedural changes, such as changes in the referral process, and that practice had improved as a result. Furthermore, developments in these two areas had tended to focus on protocols aimed at local issues, as opposed to national priorities.

> *'Since 2006 we have had stuff on guns and gangs, underage sex and forced marriages. The protocols on guns and gangs in the area is certainly new and has been very useful for us and very practical.'*
>
> (Connexions Officer)

As the above discussion highlights there was a widespread view that the policies that guide practice preceded the establishment of the LSCB. However, one of the main developments that practitioners did associate with the establishment of the LSCBs was a raised awareness of the requirement to follow policy and procedure more closely:

> *'Procedures have changed over time but increasingly over the last couple of years…all our practices have sharpened with recognition of the need to be seen to be doing it in the right order and in the right place.'*
>
> (Probation Officer)

Interestingly, the above quote suggests that for some frontline staff following procedure was perhaps an indication of impression management, or rather a 'need to be seen' to be working in a certain, desirable way. In relation to the notion of impression management there was a view shared by a significant number of practitioners, frontline workers in particular, that the widespread awareness of high profile cases such as the tragedy of Baby Peter had compounded the need to be seen to be working according to tightly defined procedures:

> *'I assume that all policies were in place before 2006 but that extra efforts
> have been put in place since the Baby P case and the others to try and
> prevent anything similar happening again…the expectations are much
> greater.'*
>
> <div align="right">(Family Support Officer)</div>

For other practitioners, clear policies and procedures were welcomed as there was a perception that they enabled them to work according to the expectations laid out in the guidelines. In this respect frontline workers in particular often implied that having clear guidance gave them confidence in their working practice and made them less vulnerable in the event of an investigation or further action:

> *'As a result of clear policy guidelines I am more confident now to deal with it
> or pass on safeguarding issues. Before I used to think it was just social
> services who dealt with it.'*
>
> <div align="right">(Probation Officer)</div>

> *'I know my job and I have the help if I need it…there is always a lot of support
> available.'*
>
> <div align="right">(Family Support Worker)</div>

Importantly, comments about the impact of guidance on confidence and concerns regarding vulnerability in practice were typically from less experienced frontline workers who reported that they referred directly to policy and procedures on a fairly regular basis. Conversely the research found that for many practitioners, particularly those with more experience, there was an implicit awareness of procedure as it was considered to be so ingrained in their everyday work and was therefore not something they were explicitly aware of. However, with regard to policies and procedures practitioners across all case studies generally felt that they knew where and how to access guidance but felt they would only do so when dealing with what they considered to be unfamiliar practice. When seeking guidance practitioners typically relied on the intranet as a key source of information.

> *'If I had a specific situation I would find it useful to find out more of the detail by referring to the policy.'*
>
> (NSPCC Children's Services Practitioner)

Accessing information on a 'need to know' basis was associated with resource limitations, as practitioners often felt that time constraints prevented them from engaging directly with the policy. In this respect, as highlighted above, practitioners tended to rely on their managers for updates or summaries relating to any key policy developments and procedural change. As discussed in Chapter 7, pre-existing structures at the agency level were viewed by practitioners as key in providing opportunities for open discussion regarding the introduction of new policies and procedures:

> *'The face-to-face team meetings are valuable where you can get an instant response to questions and concerns about new developments.'*
>
> (Health Practitioner)

The importance of face-to-face interaction was a general theme across the case study areas and many practitioners valued the opportunity to discuss the implementation of new policies and procedures. In addition, the importance of the opportunity to constructively challenge policy and practice was identified by Laming (2009) and in turn practitioners saw this as a core aspect of their supervision. In particular, supervision was regarded as an opportunity to confirm the importance of policy developments and the implication for changes to individual practice.

> *'I use my supervision to discuss what changes actually mean for me…stuff comes through all the time and sometimes you just need to be clear about how you need to use it.'*
>
> (Community Worker)

> *'Newsletters and written information is good for changes and the bigger picture but the supervision is more useful on a day-to-day basis.'*
>
> (Health Practitioner)

In terms of operational procedures all practitioners, both managers and frontline staff, had been CRB checked and understood the process for renewal. In particular managers felt that the increased importance of the CRB check had improved recruitment ensuring that the right staff were being employed for the right jobs.

In terms of reporting inappropriate behaviour most interviewees claimed to understand the process but there was a distinct lack of awareness about the Local Authority Designated Officer (LADO) and their role. Policy states that an allegation should be reported by a frontline worker to their designated manager, who is then expected to report the allegation to the LADO within one working day (HM Government, 2006). While there was considerable evidence that frontline workers would report concerns to a manager, the role of a 'designated manager' within agencies was not always identified. However, it is possible that the practitioners interviewed had not had any experience of reporting allegations and in turn that the managers interviewed were not those responsible for dealing with allegations. Therefore the findings are by no means an indication that agencies are not following the procedure for reporting inappropriate behaviour.

In terms of the most positively received procedural changes managers and frontline workers across the case study areas spoke about the benefits of inter-agency working. In addition, information sharing and training were identified as having a significant impact on practice (as discussed below). While changes were recognised to have taken place, there was a widespread reluctance on both the part of the managers and frontline staff to acknowledge the LSCBs as the driving force behind such changes. A number of interviewees felt that there had been developments in research in recent years which had led to changes in professional practice across the professional groups, while others spoke of the impact of high profile cases and their portrayal in the media as effecting change.

> *'Practice is harder because media portrayal has altered everything…work is now more complex and chaotic and people want to protect themselves in their work.'*

(Social Worker)

Training

The training received by practitioners was fairly consistent with most interviewees having received training on the following:

- responding to referrals;

- providing information to children and families;

- providing information for other services; and

- identifying abuse and neglect and assessing children and parental needs.

Of those practitioners that had received training the most common type of delivery was workshops and seminars, with 36 per cent of frontline workers and 41 per cent of managers attending workshops and 22 per cent of frontline workers and 31 per cent of managers attending seminars. The frontline workers that were interviewed had mixed impressions about the impact of training on practice with 30 per cent of frontline workers reporting that training had impacted on their work 'to a great extent', 39 per cent 'to some extent', 22 per cent 'to a limited extent' and seven per cent 'not at all'. Interestingly amongst the managers that were interviewed 43 per cent reported that training had impacted on their practice 'to a great extent'. While there was clearly some disparity over the value associated with training, there was a general consensus amongst frontline workers in particular from all case studies that rather than impacting on practice directly, for example leading to procedural change, training was mostly aimed at 'refreshing' existing practice:

> *'The courses are useful as a refresher. It is not particularly new material but it is about keeping up to date and keeping safeguarding at the forefront of thinking.'*
>
> (Community Worker)

> *'Every time you do a course it just flags things up even more. It's just awareness really, you don't necessarily learn anything new, it just refreshes your memory.'*
>
> (Family Support Worker)

As discussed above, frontline workers often associated training of this nature with improving their confidence in a variety of practical situations. In particular, while frontline workers often felt that training was not necessarily telling them anything new, it served to confirm their existing working practices by highlighting the interaction between policy and practice.

> *'Mainly it is about revisiting what we already know but it keeps things in mind, 'what to do if…' it shows the theory and the practice together.'*
>
> (Health Practitioner)

While the majority of practitioners across the case studies talked about their involvement in locally delivered training which covered national priorities, in Area Three the majority of practitioners referred to training specifically focused on local issues. In particular training had been developed around forced marriages, sex exploitation and children in gangs which were priority areas for local practitioners at the time of the research.

Interestingly, a perceived by-product of training opportunities that also appeared to have had a positive impact on procedural change was the increased opportunity to engage with practitioners from other agencies. Most practitioners from across the case studies reported that there were more opportunities to attend inter-agency training since the establishment of the LSCB and this was regarded as particularly beneficial. As discussed in Chapter 5, frontline workers appreciated the opportunity to engage with practitioners from a wide range of agencies which it was felt had improved their working relationships and their understanding of agency roles and responsibilities.

> *'[Training] has made me think about how we deal with other agencies. It is always good to refresh ideas and it helps us to identify gaps and misconceptions other agencies might have about our work.'*
> (Social Worker)

A significant number of practitioners also felt that the networking opportunities associated with inter-agency training events had gone some way towards breaking down professional boundaries by promoting a shared focus and vision across a wide range of agencies.

> *'The multi agency training is very good. It's useful to have face-to-face contact and an opportunity to talk about differences in practice…it pulls us all together.'*
> (Team Manager, Children's Social Care)

> *'The training events show other professional's perspectives and how it all fits together.'*
> (Probation Officer)

While practitioners were generally positive about training opportunities, there was some concern from more senior frontline workers and managers that training was often delivered at a basic level and, in turn, there was a call across each of the case study areas for more developmental training opportunities, which further corroborates the view that training was generally at a relatively basic level rather than progressive as discussed above.

> *'There is an assumption that senior staff already know what to do but there needs to be more understanding developed.'*
> (Children's Centre Area Advisor)

> *'A great deal of the available training tends not to be for experienced people. There is an assumption that you know everything so there are fewer options. There needs to be some more updating and refresher courses for managers.'*
> (NSPCC Children's Services Practitioner)

In addition to concerns regarding the level of training, there was a distinct lack of training opportunities in one area where the LSCB was struggling to hire trainers and pay for training. A further limitation with regard to accessing training opportunities was highlighted by managers across the case studies who reported difficulties in finding the time to attend training events.

Referrals

The research found the referral process to be relatively clear across all case study areas with managers typically being the first port of call for staff, particularly those that had been in post for less than one year. Across the case study areas a formal referral generally began with an initial phone call to Children's Services followed by a written referral, at which stage the majority of frontline workers ceased to be involved in the case unless the client was already known to them or they were actively involved with that client at the time of the referral. In Areas Three and Six the point of contact in the referral process was particularly clear following the establishment of specialised contact centres. However, where specialist contact centres had been established there was some concern that those manning the centres were not adequately qualified to deal with referral issues. In contrast, in Area One there was a call for an updated process, such as an online referral system, as it was felt that having to fax through a referral was archaic.

While 62 per cent of frontline workers were fairly knowledgeable about the referral process there were mixed responses with regard to satisfaction with the referral system, with 30 per cent reporting their dissatisfaction and 55 per cent claiming to be satisfied. However, the majority of those frontline workers reporting either satisfaction or dissatisfaction shared concerns over feedback, in particular the fact that it tended to be 'hit or miss'.

> *'Overall I would have to say I am dissatisfied for the simple reason that it is so variable. It might be satisfactory or it might be dissatisfactory. Sometimes you feel that more robust action is required and other times the whole thing works the way you feel it should.'*
>
> (Social Work, Youth Offending Team)

> *'Written feedback is expected but not always forthcoming. I would at least demand an acknowledgement and it can be frustrating when you have to chase it.'*
>
> (Health Practitioner)

> *'Part of the reason I am dissatisfied is that you are referring into the void, you get nothing back.'*
>
> (Youth and Community Worker)

However, when discussing the lack of feedback frontline workers often expressed a degree of sympathy towards Children's Social Care as there was widespread acknowledgement that they were under-resourced as a service. Furthermore practitioners often sympathised with the high case workloads of staff working in Children's Social Care.

> *'Well generally the referrals get dealt with but social services are very stretched and so we have to push for feedback. It can be a bit of a constant battle.'*
>
> (Connexions Officer)

> *'Generally it seems to work. We might not always be satisfied with the outcome but passing the information is straightforward but sometimes you have to chase feedback. But we should be mindful of the pressures others might be working under.'*
>
> (NSPCC, Children's Services Practitioner)

Importantly, in accordance with a recommendation from the Laming Inquiry (2009) that all referring practitioners should be provided with feedback, frontline workers often discussed the need for feedback in relation to accountability. In particular a significant number of frontline workers felt that feedback was a way of protecting their professional role in the advent of further investigation.

> *'There is an increased perception of the need to cover your back.'*
> (Community Worker)

> *'There is an expectation over paperwork which is challenging practice in terms of time and focus…it is a question of who are we safeguarding, us or the kids.'*
> (Community Support Office)

> *'I ask to be informed, I need to know so I ask. I am accountable so I need to see what is happening and that others are playing their part.'*
> (Probation Officer)

> *'I would make sure I did get feedback. Often the people concerned are busy so you should take the responsibility to ask, to find out for yourself for your own good.'*
> (Children's Services Practitioner)

While feedback was evidently a concern for many frontline workers in particular, there were examples of where particular agencies had clear systems for recording referrals and this led to greater consistency with regard to feedback. In Area Four the Police highlighted one such system which enabled them to record details of feedback and when it was received, which had served to strengthen the working relationship between Police and Children's Social Care. Across each of the case study areas there was also evidence of a particularly strong relationship between the Police and Children's Social Care although there was limited information about the nature of this relationship or how it came about. One hypothesis for the strong relationship between these two agencies might be a history of integrated working.

> *'Police and Children's Services have always typically sat down to discuss a referral and decide how an investigation should be progressed.'*
> (Detective Inspector)

'We have a very good relationship with social services and we know most of the local social workers personally.'

(Police Office)

The research also highlighted concern about the bureaucratisation of the referral process, in particular the potential for the process to prevent direct communication with someone who 'knows the case'. Concerns were often expressed by the practitioners that worked in multi-disciplinary teams in close proximity to the person taking the referral.

'…[the referral process] could be a lot less bureaucratised. Because we are all in the same office we ought to be able to just refer as a fellow professional and not have to go through the procedure at front officer just to get it back here.'

(Health Practitioner)

'I think the referral system now is an issue. Before you could just go up the road and speak directly to a social worker. Now you have to go through a call centre in town 30 miles away and talk to someone who does not know the case.'

(Social Worker)

As Datta and Hart (2008) identified there is a longstanding tendency for health practitioners to perceive social workers as reluctant to intervene. From the frontline workers interviewed there was a widespread concern over the different interpretations of thresholds across different agencies and such concerns tended to come from health practitioners:

'It's difficult because thresholds tend to differ and they're different for different agencies and different areas, it's very inconsistent. There are issues around how Children's Services prioritise referrals but this often comes down to perceptions of urgency. Often Social Care and Mental Health have different views in terms of how anxious they are about a certain case.'

(Safeguarding Nurse)

'There are different views about how a case should be dealt with and as a school nurse I don't always agree with the level of priority given to some cases. I feel that sometimes we are all on a different page.'

(Health Practitioner)

'It can be contentious. We have had examples where we think they should be referred but the social worker has said it doesn't meet the criteria for action so no worker has been allocated. I worry that not all children get safeguarded.'
(Family Intervention Support Worker)

Information sharing and communication

From the practitioner interviews information sharing and communication were discussed in a number of ways, often interchangeably. Broadly speaking practitioners views about this theme fell into three categories: receiving information; sharing information; and consultation and feedback with children, young people and families.

In terms of receiving information, both managers and frontline practitioners felt they were overloaded with information which they received in a variety of ways, most commonly email, newsletters and briefings. The main problem associated with information overload was a lack of time which prevented practitioners from engaging with policy in any detail.

'All methods have their uses but I don't have the time to read them. It is more important to know where the information is when I need it.'
(YOT Officer)

The challenge for frontline workers in particular was found to be keeping up to date with procedural changes and to prioritise the information received and in order to do this they typically sought guidance from their managers.

'We get loads of emails but I don't always read them unless they are flagged, it depends on the time and the circumstances. If I got something from a manager saying 'read this' then of course I would, but there are other priorities.'
(Youth and Community Worker)

The research showed that practitioners were generally well versed with regard to information sharing protocols with 57 per cent of managers demonstrating a high level of knowledge of policies and procedures and 64 per cent of frontline workers a fair knowledge. There was also general consensus amongst most of the interviewees that information would always be shared where there were safeguarding issues and that confidentiality would be breached if necessary. When

asked if there were any circumstances in which they would *not* share information typical responses included:

> *'No, absolutely no way. We are very passionate about working together and sharing information. How can anything not be relevant if it is about safeguarding a child.'*
>
> (NSPCC Children's Services Practitioner)

> *'In any circumstances the sharing of information would be on a need to know basis. On a safeguarding issue I would breach confidentiality to protect a youngster but only to a relevant agency.'*
>
> (Health Practitioner)

This widespread view that information would always be shared was very much about putting the welfare needs of the child at the forefront of practice and was a view that was representative of how practitioners understood safeguarding as discussed earlier in this chapter. In other words, practice shaped the way in which frontline workers in particular defined safeguarding and kept child protection principles at the core of day-to-day work.

Practitioners generally felt that the importance of sharing information within and across agencies had become more prolific following the establishment of the LSCB. In one area, for example, the majority of practitioners interviewed felt that procedures introduced since the establishment of the LSCB had improved information sharing and in particular Multi Agency Public Protection Arrangements (MAPPA) and the introduction of Common Assessment Framework (CAF) were seen as having a crucial role in improving the transfer of information between agencies.

However, while practitioners did see information sharing as a priority area they generally regarded it as an ongoing challenge. While information sharing was thought to have improved practice and was regarded as a core aspect of day-to-day work, there was often a suggestion that information sharing was hindered by processes. In two areas in particular practitioners referred to the incompatibility of databases held by certain agencies which reflected differences in organisational

cultures and language as identified in early studies (see for example, Horwath and Morrison, 2007; Ward and Rose, 2002).

The research also highlighted concerns over the inconsistency of information sharing and in particular there was considerable evidence to suggest that frontline workers felt that information sharing was often one way.

> *'Information sharing is a bit one sided and it certainly needs attention.'*
>
> (Police Officer)

> *'Reciprocity is vital but not as good as it could be. Many organisations know little about the probation services and whilst mutual events and training help there is still more to be done.'*
>
> (Probation Office)

Importantly, several interviewees from across the case studies referred specifically to Children's Social Care as limiting the potential for two-way communication.

> *'Communication with Social Services can be a bit mixed, it is a bit all-or-nothing. I get the impression people don't want to speak to us unless absolutely necessary.'*
>
> (Health Practitioner)

> *'Police to Children's Services is an officially systematic response backed by documentation. Children's Services to Police is ad hoc and needs to be more systematic to make it a genuine two-way operation.'*
>
> (Police Officer)

In order to improve information sharing and communication, as highlighted in the above quotations there was a view that systems needed to be developed to ensure information was shared appropriately and in a timely fashion. From the views expressed by the Health practitioner above there was also some concern that certain agencies, in particular Health, remain on the periphery with regard to information sharing although it was unclear from the research why this might be the case. One hypothesis is the historical relationship between Health and Children's Social Care which have tended to work in isolation from each other as the respective agencies have traditionally assumed separate and distinctive roles (Jones et al., 2002). As one team manager from Children's Social Care explained there was an

impression that Health took a long time to accept the principles of Every Child Matters and the wider safeguarding agenda because they were working to a medical model. Interviews with several Health practitioners supported the view that while changes were happening and information sharing was slowly improving, it had only recently picked up speed at the time of the research.

Despite the widespread awareness of information sharing protocol, the research found that there were instances where the decision of *when* and *what* to share across agencies remained subjective and were guided by individual practice, in particular by protocols operating at the agency level.

> *'It's very subjective…professionals make a judgement about what needs to be shared, and it depends on the culture of the organisation. The thresholds for sharing can be quite different.'*
> (Divisional General Manager, Health)

To further illustrate the way in which organisational cultures defined what information was shared there was evidence from a number of Police personnel to suggest that they would not share information relating to safeguarding if it was tactical to an investigation (Detective Inspector).

> *'I would not share if it was relevant to an ongoing investigation.'*
> (Police Officer)

The research also illustrated a feeling of vulnerability as expressed by a number of frontline workers in relation to information sharing. Framed according to wider discussions about high profile cases such as the tragedy of Baby Peter, frontline workers reported that they sometimes felt concerned about naming people because of fear of blame. In one area concerns over information sharing and communication had been acknowledged by the LSCB and training was being implemented to clarify procedure which it was anticipated would improve practitioners confidence in this area.

When discussing communication with practitioners there was evidence of a disjuncture between the Board and those working at the frontline. While frontline workers generally felt they would be able to feed back to the Board via their agency

representative it was clear that feedback was not something they engaged with regularly. However, in two areas the opportunity for feedback was associated with events such as regular subgroup meetings and staff meetings. In Area Three inter-agency events such as a conference organised by the LSCB and training events were highlighted as particularly good examples of opportunities where practitioners could directly interact with the LSCB.

While listening to and consulting with children and young people at all stages of planning and delivery is seen as a core element of safeguarding practice (see HM Government, 2006: Section 3.29-3.30), in terms of involving children and their families in decision-making many interviewees from across the case study areas reported that rather than *involve* them, they would *inform* them.

> *'I keep them informed yes, but they would have very little or no actual input to the decision.'*
>
> (Probation Officer)

> *'Informed is probably a better word because we would tell them what we were going to do, it is our decision.'*
>
> (Health Practitioner)

In this respect the research suggests there is a danger for consultation to be somewhat tokenistic as ultimately practitioners decide how to progress when action is required. In line with the views of Board Members discussed in Chapter 7, practitioners saw this as an area of work that required development. However, while consultation appeared to be sporadic there were good examples of work undertaken, in two particular areas youth consultation was a prominent feature of safeguarding practice. In one area a young people's participation officer attended Board meetings and in another an annual review meeting was held with the general public which provided an opportunity for consultation. Frontline practitioners often referred to their own consultation as patchy and where it was perceived to have taken place it was often seen as incidental, a consequence of practice rather than a planned aspect of their work.

'One or two of them might ring up and say thank you and that is very much appreciated, but not normally.'

(Police Officer)

Inter-agency Working

Across all case study areas practitioners frequently referred to the widespread drive to develop effective inter-agency working and aspects of practice such as training and the referral process as discussed above were regarded as central to working in this way. Generally speaking, across all case study areas there was evidence of effective inter-agency working as practitioners often felt that working with other agencies had led to clarity over roles and responsibilities, better support networks amongst professionals, better information sharing and improved communication.

In particular, practitioners often referred to changes in the procedures discussed throughout this chapter, as underpinning effective inter-agency work. An example of a procedural change which was generally well received was the Common Assessment Framework.

'The CAF has enabled us to look at and improve the way we work with other organisations.'

(Connexions Officer)

While practitioners generally felt that inter-agency work had improved there was a general view that it was an ongoing challenge. In this respect it was acknowledged that practitioners need to maintain an outward focus, looking beyond the working practices of their respective agencies for inter-agency working to be successful. Furthermore, it was felt that understanding the roles and responsibilities of other agencies was crucial and those aspects of work such as information sharing and communication needed to be a two-way process so as not to isolate any agencies.

However, from the research there was some evidence of siloed working practices characterised by a lack of connectivity between agencies. When agencies work in isolation practitioners lack a broader understanding of cross agency policies and procedures.

> *'I know my own organisation's policies but not the LSCB policies that well. I know they are there and I know where to find them so can do that if I need to but for the time being by going with our own policies I assume that we conform.'*
>
> (Family Support Worker)

Further evidence of siloed working practices was found in two areas where agencies were continuing to implement their own procedures and systems. In one area, managers spoke of how agencies continued to use different forms and methods of referral and similarly in another practitioners felt that agencies continued to work with different recording systems and tended to prioritise safeguarding meetings in different ways.

The research found that where co-location had been introduced practitioners welcomed the opportunity to work more closely with frontline workers from other agencies. Furthermore, this type of integrated working appeared to be particularly valued by Health practitioners.

> *'Since being co-located with Social Care colleagues all the local services are now able to work much more closely together.'*
>
> (Health Practitioner)

The benefits associated with co-location were improved personal relationships and a greater awareness of working practices across agencies which practitioners felt had gone some way towards the break down of professional boundaries. In particular practitioners felt that the ability to simply discuss issues with colleagues from other professional groups led to a shared understanding and improved working practice.

> *'More working together helps to develop a greater understanding of all the different things that can be involved in someone's life. I am less narrow-minded in my practice.'*
>
> (Connexions Office)

> *'More diversity in the team means we can offer more effective support to the children and to each other.'*
>
> (School Nurse Team Leader)

However, those practitioners that were based in inter-agency teams or that shared a work space with staff from other agencies were frustrated by the bureaucratisation of procedures such as the referral system. As one practitioner explained:

> *'I think the referral system now is an issue. Before you could just go up the road and speak directly to a social worker. Now you have to go through a call centre in a town 30 miles away and talk to someone who does not know the case.'*
>
> (Social Worker)

The Impact of Safeguarding on Practice

While the research highlighted significant changes in practice which have been discussed throughout this chapter, when asked to state the extent to which they thought safeguarding arrangements had impacted on practice 56 per cent of frontline workers rated the impact as 'fair' with 39 per cent rating the impact as 'limited'. In comparison 37 per cent of managers felt that safeguarding arrangements had greatly impacted on their practice with 31 per cent rating the impact as 'fair'. Interestingly, only five per cent of frontline workers felt safeguarding arrangements had highly impacted on their work. Furthermore, as discussed earlier in this chapter, practitioners in general were reluctant to attribute changes in practice solely to the establishment of the LSCB.

However, it is important to recognise that practitioners were not of the view that the LSCB had not had an impact on practice, but rather that its establishment was just one aspect of wider changes. To illustrate this point there were additional influences that practitioners regarded as having a direct impact on their work including the portrayal of high profile cases in the media, a rise in public awareness around safeguarding issues, professional development as a result of research and training and general modernisation within social and child services.

> *'There is a greater awareness and the issues are in the public domain, thus it cannot be solely attributed to the LSCB as it is a concern of professionals more widely.'*
>
> (Manager, Education)

However, practitioners did attribute certain key changes directly to the establishment of the LSCBs. The research found that practitioners in each of the case study areas

felt the LSCBs had the greatest impact on methods of working, more specifically with reference to the development of inter-agency working and increased training opportunities which they regarded as having a positive impact on their working arrangements.

As discussed throughout this chapter there was considerable evidence from across the case studies to demonstrate effective inter-agency working. Interestingly, for practitioners a key driver in the development of effective inter-agency working was the increase in training opportunities. In particular, more opportunities for inter-agency training were introduced following the establishment of the LSCBs which had enabled practitioners to learn about other sectors. Engaging with other agencies in this way is an example of boundary crossing that is traditionally acknowledged to be a marker of effective inter-agency working (Warmington et al., 2004).

Interestingly, frontline workers in particular often referred to the development of inter-agency working and increased training opportunities as having a positive impact on their confidence in practice, as they felt better supported by colleagues within and beyond their own agency and generally well informed about new developments in policies and procedures. As an example of expansive learning, inter-agency working in all case studies had therefore enabled professionals to work collaboratively with others outside their immediate professional group and as a consequence practice was enriched (Warmington et al., 2004). The research found that the 41 per cent of frontline workers and 29 per cent of managers were very confident in their ability to undertake their roles and responsibilities in relation to safeguarding children. However, practitioners spoke personally about confidence in practice and tended to support such claims with reference to training opportunities they had undertaken and therefore the role of the LSCBs in professional development should not be underestimated.

Conclusion
Frontline professionals recognised the broad safeguarding agenda but identified that much of their work focused upon 'staying safe' and child protection rather than preventative work to promote the welfare of children and young people. Knowledge about safeguarding policies and procedures was shaped by existing practice.

Managers played an important role in keeping practitioners informed of developments. They also had a better understanding of the activities of the LSCBs, compared to frontline staff who had limited awareness of the roles and responsibilities of the Boards. Staff were better informed in areas that had developed practitioner groups (for example, the District fora in Area Three).

Evidence suggests that LSCBs have improved the information available to both frontline and managerial staff to support their work. There was a widespread view that the work itself has not changed but methods and processes had. LSCB had reinforced the importance of procedures, although staff tended to access information on a 'need to know' basis (which emerged because of resource problems). Staff valued face-to-face communication and the opportunity to discuss the implementation of new policies and procedures. As was identified by Board Members in Chapter 5 one of the most positive developments seemed to have been that inter-agency working was becoming more embedded. The LSCB was contributing to this, but changes were also seen to relate to wider policy and practice developments.

Most professionals received training, although frontline staff (non-managerial) were less positive about the impact this had on practice than managers were. They did however value training to review and 'refresh' their practice and because it provided an opportunity for inter-agency communication. Training that was sensitive to the local context was also welcomed. Concerns were expressed about accessing training, with professionals struggling to find enough time to attend. Senior managers found this particularly problematic. This group also identified the need for more advanced training, feeling that what was provided tended to be 'basic'.

The research found the referral process was generally well understood across the case study areas. There were differences in perspective as to whether centralised call centres were desirable, some workers felt it made the process simpler and easier to understand while some expressed concerns that it de-personalised the process and made it more difficult to remain involved. Practitioners emphasised the importance of feedback and being kept informed but also recognised the pressures

that Children's Social Care were under. Differences in professional perspectives concerning thresholds appear to persist.

In terms of information sharing practitioners felt that progress was being made but challenges still remain. Having database that were compatible and universal agreements about when and how data should be shared are critical. Evidence suggested that these were not always in place and some agencies including Children's Social Care and health were still not clear about their own processes.

LSCBs are helping to improve inter-agency working and LSCB procedures are shaping professional practice and encouraging closer collaboration. However, the silo mentality is difficult to eradicate and can limit what is achieved. Co-location was seen as a positive model to help overcome some of the cultural and physical barriers to inter-agency working. While LSCBs have had an impact on professional practice there is still much to do. Both frontline staff and managers thought that the new safeguarding agenda had brought about changes in practice and had contributed as a part of the wider developments taking place elsewhere, yet it would seem that its overall impact on practice has been limited and slow. Where it was most valued was in its support and encouragement of inter-agency working especially with the expansion of training.

The fact that practitioners regarded the LSCBs as having a limited impact on practice suggests a possible disjuncture between the work of the Boards and frontline workers. Furthermore, frontline workers in particular did not seem to regard the Board and its work as anchored in practice but rather saw it as an isolated body and therefore it could be argued that an 'us and them' culture remains. In particular frontline workers often felt that the Board did not appreciate the practical limitations as they operate at the strategic level and there was a perception that developing policies and procedures was all well and good, but if the resources were not available at the frontline to implement change, strategic developments cannot be operationalised. As two practitioners succinctly put it:

'…with Children's Services there just aren't enough people or resources to follow things through. There are more and more procedures and policies and strategies and directives but not the people to do it.'

(Police Officer)

'There are such a lot of staffing difficulties so a lack of capacity evens out what might have been an improvement in service ideals.'

(Children's Centre Area Advisor)

In this respect frontline workers had a tendency to see the Board as 'up in the ether' and detached from practice largely because the strategies developed at Board level in response to government legislation were considered to be beyond the realm of their practical engagement. However, this is not to say that frontline workers did not value the wider principles of the safeguarding agenda but rather that they were prevented from wider engagement as a consequence of limited resources. Interestingly, in Area Three there was less evidence of a disjuncture between the Board and frontline workers as the LSCB had homed in on local issues which were regarded as directly relevant to frontline practice and which frontline workers felt brought them closer to the Board.

10   CONCLUSION

An Overview of Conditions for the Effective Operation of LSCBs

Overall, the evaluation found that LSCBs have addressed a number of weaknesses of ACPCs. Strong leadership and broad membership and agency representation have been secured. Largely, representatives are of sufficient seniority to speak for their organisation with authority, commit their organisation on policy and practice matters and hold their organisation to account. On the whole, they have also successfully determined their main priorities and maintained a focus on seeking to meet these. Increasingly professionals are embracing the notion that safeguarding children and promoting their welfare is a shared responsibility, rather than one confined to Children's Social Care. Progress has also been made in relation to inter-agency communication and the development of a shared language across agencies. Similarly, frontline professionals for the most part, understand their responsibilities in terms of safeguarding children from harm. Although developments in this respect are apparent it is far from clear that progress in relation to inter-agency working and communication is attributable to the work of LSCBs, as opposed to wider developments, such as the establishment of Children's Trusts and implementation of the Common Assessment Framework. While there is clear evidence of changes indicative of effective operation the findings also reveal a number of ongoing challenges and issues.

LSCBs have struggled to establish accountability mechanisms and the demarcation of roles and responsibilities between the Board and Children's Trust has not always been as clear as it should be. Changes in agency representation on the Board and levels of participation in its operation have also raised challenges. Lack of continuity of Board membership can make it difficult to maintain a shared vision and focus. It can also inhibit the establishment of relationships and trust, effective networking and operation. The size of the LSCB and the time and resources available to support the work of LSCBs are also influential; small boards may lack enough members able to invest enough time to meet the LSCB role and remit, while large Boards may become unwieldy and impersonal. Either way, effective communication channels between the LSCB and partner agencies are essential. Findings reveal, however,

that generally these links and mechanisms to ensure the effective dissemination of information to inform operational practice were relatively weak.

LSCBs identified that they struggled to fulfil all their functions. The time and resources required to undertake Serious Case Reviews, in particular, could inhibit capacity to move forward and meet other responsibilities. Attitudes differed about the extent that Boards could or should move beyond co-ordinating and ensuring the effectiveness of work to protect children from harm. While some interviewees questioned whether it was realistic or desirable for Boards to play a substantive role in preventative work, others expressed regret that in the wake of the Baby Peter case the preventative agenda was likely to be lost, with Boards concentrating all their efforts on child protection. Such issues need to be considered in the context of the financial and in-kind contributions that agencies receive to support their operation. In the absence of a funding formula Boards spent considerable time negotiating and securing contributions towards the operation of LSCBs and there were considerable variations in the resources each had available. Similarities and differences in the effectiveness of each of the case study LSCBs against key indicators of effectiveness are explored further below.

Did areas meet the criteria of conditions for effective operation?
In measuring the effectiveness of LSCBs the research team have assessed case study Boards against 13 effectiveness criteria. Selection of these was informed by research on ACPCs, inter-agency working and effective strategic partnerships (Ward et al., 2004; Percy-Smith, 2006; Horwath and Morrison, 2007). As outlined in the introduction these are *'proxy measures'* and not criteria for effectiveness in themselves. Table 25 below outlines the measures adopted and the scores each of the six case studies attained. A three point scoring system was adopted:

1 = clear evidence of challenges in operating effectively.
2 = evidence of adequate operation.
3 = clear evidence of effective operation.

Table 25   Conditions for effective operation of LSCBs

	Effectiveness Factor	Effectiveness Indicator	Area One	Area Two	Area Three	Area Four	Area Five	Area Six	Total (18)
1	Clarity of governance arrangements.	Clear lines of accountability for the Chair and Board.	2	1	2	2	1	2	10
2	Clarity of governance arrangements – management.	Clear management structures for the Chair and the Board.	2	1	2	2	1	2	10
3	Strong leadership.	Skilled Chair with authority who is able to keep partnership focused on core tasks.	3	2	3	3	2	3	16
4	Clear priorities and focus of the work.	LSCB have clearly defined aims and objectives that are strategic in their focus on safeguarding.	3	2	2	2	1	2	12
5	Clear planning and reviewing of work.	There is good planning and reviewing of progress.	3	2	2	2	2	3	14
6	Maintaining clarity of purpose, values and vision.	There is a clear vision amongst Board members about purpose of the LSCB.	2	2	2	2	2	2	12
7	Adequately resourced infrastructure.	The LSCB is supported by a Business Manager and appropriate level of staff and resources to help it function effectively.	2	1	3	2	2	3	13
8	Importance of having the appropriate levels of seniority.	The Board has a good level of seniority among its membership – the right people are present who can act on the behalf of their agency.	2	1	3	2	2	2	12
9	Stability of Board membership.	Attendance and participation in the Board and subgroups are stable and active.	2	1	2	1	1	2	9
10	Strong links exist between the LSCB and operation.	Clear conduits exist between the LSCB and professional practice.	1	1	2	2	1	2	9
11	Understanding of roles and responsibilities by Board members.	Members of the Board understand their roles and responsibilities in the LSCB and act upon them.	2	2	2	2	2	2	12
12	Need for open communication and shared language between professionals.	Open communication both between and within agencies that facilitates co-ordinated response.	2	2	2	2	2	2	12
13	Professional Practice Frontline professionals fully understand their roles in safeguarding.	Frontline professionals have a clear understanding of roles and responsibilities in terms of safeguarding.	2	2	2	2	2	2	12
		Total	28 (39)	20 (39)	29 (39)	26 (39)	21 (39)	29 (39)	153 (234)

The judgements and subsequent scores attributed for each LSCB against each effectiveness measure were determined by the research team based upon analysis of all the data collected on each area. As Table 25, shows the total 'effectiveness score' across the six areas was 153. Had every Board demonstrated clear evidence of effectiveness against all the measures a score of 234 would have been attained. As such, seen together, the LSCBs were performing at 65 per cent effectiveness. Across the case study areas scores on four effectiveness factors were low: Stability of Board membership (9); strong links exist between the LSCB and operation (9); clarity of governance arrangements (10) and clarity of management structures (10). These areas need more attention if Boards are to become more effective.

There were no criteria against which every Board performed well or badly, as such the difficulties each area encountered varied between areas. Four LSCBs scored a '1' in at least one aspect of their work (i.e. there was evidence that they were experiencing particular challenges in operating effectively). Issues concerning links between the LSCB and operational practice were identified in Area One. In Area Four the continuity of Board membership posed a challenge. Areas Two and Five were facing a larger number of issues identified as influencing the effectiveness of their operation. Both these Areas were deemed to have struggled to establish clear governance arrangements and secure stability of membership. In Area Two interviewees also raised concerns about the size of the LSCB (small and 'inclusive') and the seniority of representatives.

Positively, each area had secured effective leadership via the Chair (16). This also seems to facilitate the identification of clear priorities and focused activity (14). Area Three was found to be effective in this respect and all the other areas, with the exception of Area Five were rated as adequate. Effective (two areas) or adequate (four areas) systems were also in place to plan and review work. LSCBs were also developing a clear sense of purpose and shared vision. There were four measures of effectiveness that every Board was rated as adequate against (Indicators 6, 11, 12 and 13). These were areas in which there was scope for further development. The findings from in-depth case study work, as well as the national survey and mapping exercise, indicate that a number of issues warrant consideration in order to improve

the effectiveness of LSCBs further. Key messages for policy and practice are outlined below.

Messages for Policy and Practice

Role and remit

- The most effective LSCB case studies had been realistic about what they were able to achieve and had focused upon the core business of ensuring that work to protect children was properly co-ordinated and effective before seeking to develop their preventative work.

- Without adequate resources it is not viable for Boards effectively to fulfil all their functions. Perspectives varied as to whether it was feasible or desirable for LSCBs to have such a wide remit or whether they would be better placed to concentrate their efforts on child protection. The balance that LSCBs strike in this respect should inform decisions concerning membership and agency representation on the Boards.

Independent Chairs, leadership and accountability

- Boards have struggled to establish adequate accountability mechanisms. 'Mutual accountability' between the LSCB and Children's Trust is problematic given that a number of influential people are likely to sit on both. There is scope for the Chief Executive's Office and Local Members, through scrutiny committees, to ensure that the Chair and Board are held to account.

- It is important that the impartiality of the Independent Chair is not undermined by contractual arrangements and that the Chair is not unduly influenced by key figures, such as Directors of Children's Services. Separating out accountability from management is important.

- Consideration needs to be given to mechanisms to ensure that Independent Chairs are linked into local networks and structures.

- The authority of the Chair and the LSCB need to be acknowledged and respected by agencies so that they can engender changes in policy and practice to safeguard children from harm and to promote their welfare. The implications of non-compliance with Board recommendations should be clarified and systems should be put in place to support the resolution of differences of opinion.

Size and membership of the LSCB

- The findings suggest that medium Boards of around 20 to 25 members are workable. In determining the appropriate membership of the LSCB it is worthwhile to consider both seniority and the specialist knowledge and expertise that individuals may bring.

- Continuity of Board membership is important to the maintenance of a shared vision, to develop trust and dialogue and facilitate the timely assignment and completion of tasks.

- Understanding the roles and responsibilities connected to Board membership is critical to the effective functioning of LSCBs. Board Members should be working together and 'representing the Board' rather than their own agencie's interests. How this is achieved needs to be considered.

- Regular and consistent attendance at meetings is necessary to take forward the LSCB agenda. Increased active participation by Board Members and those on subgroups is required.

Communication between the LSCB and agencies

- Channels of communication were often implicit and assumed, with responsibility placed upon Board Members to facilitate information exchange and communicate information to their own agencies. The extent to which this took placed was often unknown. Arrangements in respect of communication between LSCBs and agencies need to be clarified and strengthened.

- Information exchange in large organisations such as Children's Services and Health is challenging. There was limited knowledge about the extent to which information reached the appropriate personnel to influence policy and practice and affect change. Questions were also raised about whether the diversity of views from the Health sector were heard. This warrants attention.

- Forums to engage with operational staff and ensure that their experiences inform strategic priorities and that the work of the Board influences practice are critical. Specific issues emerged in relation to communication with GPs, schools and the Third Sector and strategies to strengthen links with these groups would be useful.

Communication to the general adult public and children and young people
- This aspect of the LSCB is currently underdeveloped. Findings suggest that work to address public understanding of the work of LSCB is weak and has been inhibited by lack of resources.

- Findings suggest that children and young people are marginalised in the processes. They may be informed but not involved. LSCBs need to develop opportunities for children and young people to be more involved.

- There is scope for the LSCB to undertake activities aimed at counteracting the negative portrayal of the social work profession and raising public awareness of the role and contribution that Children's Social Care and other agencies play in improving outcomes for children and families.

Training and support
- The role of the Chair and Business Manager are both critical to the effective operation of LSCBs. Both would benefit from improved access to training and support to fulfil their responsibilities.

- Training for Board Members on their roles and responsibilities, and the operation of the LSCB, both at induction stage and on an ongoing basis would be valuable.

- Each case study area experienced a change of Business Manager over the course of the evaluation. It may be valuable to consider professional development opportunities and career pathways for this group.

- Inter-agency training is perceived to have had a positive impact upon working relationships between practitioners from different agencies and helped break down professional boundaries. However, frontline staff identify that inter-agency training should not be at the expense of single-agency training, which is also important.

- The findings suggest that tensions exist in the relationships between LSCBs and the Government Offices for the Regions. There is ambiguity about how the Offices can effectively 'support' Boards when they also have a role in 'challenging' them and monitoring performance.

- LSCBs would benefit from advice and guidance about how to judge the impact that they are having upon the effectiveness of their work.

Resources
- Without adequate funding and the release of staff to attend meetings and undertake activities to take forward work LSCBs are unable to operate effectively. Boards currently spend a considerable amount of time negotiating funding contributions from partners and the funding secured varies considerably. This can inhibit strategic planning and what an LSCB is able to achieve.

- Chairs, Business Managers and Board Members indicated that a funding formula would assist them. In the current financial climate they also identified that there was a danger that funding contributions would fall as agencies seek to reduce their budgets where they can. As such, LSCBs are vulnerable to funding cuts which would limit their capacity to fulfil their responsibilities.

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ANNEX

ANNEX A RESEARCH METHOD

Introduction

The overall goal of the study was to examine whether the new structures and processes established by LSCBs have overcome identified weaknesses of Area Child Protection Committees (ACPCs) and promoted inter-agency co-operation. A strong emphasis within the evaluation was on 'what works' well, in what context. The research was designed to examine effectiveness by assessing practice against an evidence base that already exists in the social sciences about strategic partnership working.

The aims and objectives were to examine and assess:

- if LSCBs are fulfilling their core functions to safeguard and promote the welfare of children;
- the working practices put in place and their effectiveness in securing effective operation of the LSCB functions and ensuring that all member organisations are effectively engaged;
- how LSCBs manage and evaluate their role in safeguarding and promoting the welfare of children and the effectiveness of lines of accountability;
- how LSCB partners transfer knowledge and information between member organisations;
- how LSCBs work alongside other local strategic bodies and partnerships;
- if the new systems and arrangements are 'fit for purpose' and whether they safeguard and promote the welfare of children in the local area;
- how far the new LSCB arrangements are influencing and improving frontline practice; and
- the estimated costs of the new LSCB arrangements.

A mixed method approach was adopted, including a national survey and mapping exercise of all LSCBs in England and in-depth case study work in six areas, including:

- face-to-face interviews with six LSCB Chairs and Business Managers and five[11] interviews with the Directors of Children's Services in each area;

- 49 telephone interviews with Board Members, these included partners from Health, Social Work, Education, Youth Justice, Police, Early Years and the Voluntary Sector;

- 132 telephone interviews with frontline professionals (holding both managerial and non-managerial responsibilities) with similar professional backgrounds as the Board Members;

- Content and thematic analysis of minutes of Board meetings;

- Social Network Analysis (SNA) was piloted in two case study areas, providing detailed micro information on practice and effectiveness. SNA facilitated examination of the relationships between individuals and groups within the LSCB structure in order to gain an insight into how the LSCBs were functioning; and

- A detailed analysis of costing of LSCB meetings was conducted in two of the case study areas.

The study was approved by the National Research Ethics Committee and where necessary, local research governance committees. It was agreed with DCSF and the Research Advisory Board that the areas would remain anonymous. Therefore the findings presented have been anonymised to protect the confidentiality of individuals and the LSCBs involved.

The National Mapping Exercise and the National Survey

A national survey (of LSCB Chairs) and a mapping exercise of LSCBs were conducted in order to provide an overview of the size, membership and organisational structures of LSCBs. The data collected through this process also contributed to Lord Laming's progress report on the protection of children in England (Lord Laming, 2009)[12].

For the *national mapping exercise* all 144 LSCBs were asked to provide detailed information about their structures of delivery. LSCBs were asked to supply the research team with an up to date LSCB membership list and an organisational chart

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[11] In one area the Chair is the Director of Children's Services.
[12] For an extensive discussion of the findings of this survey, please see France at al., 2009.

of the different subgroups that they had established to support the Boards work. The response rate was 86 per cent (124 out of the 144 Boards in England replied). Information on job titles was used to examine the seniority of Board representatives.

The *national survey of Chairs* was sent out after the events surrounding the 'Baby Peter' case. The response rate for the national survey was 72.9 per cent, with 105 LSCBs completing the survey (out 144). Further details on the LSCBs that completed the survey are provided in Table A1. The national survey requested factual information as well as asking respondents for their views and opinions on the operation of the LSCB. Full details of findings can be found in the interim report (France et al., 2009).

Table A1   Details of the LSCBs that completed the national survey

Type of Authority	Respondents to the survey		All LSCBs	
	Frequency	**Per Cent**	**Frequency**	**Per Cent**
Unitary	32	30.5	40	27.8
County	23	21.9	33	22.9
Metropolitan	28	26.7	35	24.3
London	18	17.1	31	21.5
Joint LSCBs	4	3.8	5	3.5
Total	**105**	**100.0**	**144**	**100.0**

Information about all LSCBs from the national mapping exercise. Joint LSCBs have been formed when two or more Local Authorities have formed one LSCB to cover their combined areas.

The Case Study Areas and Methods

Selection of case study areas

The selection of the six case study areas was based on criteria that included diversity of LSCB models, geographical areas, and levels of need. The models aimed to address theoretical propositions posed at the beginning of this study, exploring the conditions under which LSCBs work. As generalisation is not always possible with qualitative research, case studies are used to explore external conditions and see when and/or how they can produce similar results. The six detailed case studies provided an opportunity to understand, in detail, emerging challenges, good practice and what works in what context. This allowed exploration of how different factors may have influenced partnership working, and effectiveness.

The identification of the six case study areas was done with input from the Research Advisory Board, which included policy makers from the DCSF and DoH, academics and representatives from Health, Children's Social Care, Police and Third Sector. The identification of case study areas was aided by the use of web-based information. Local Authority, rural or urban, and population data was used and helped the research team select case studies based on their rural or urban distribution. The research used the Defra classification of Local Authority districts and Unitary authorities in England LA Classification Dataset[13] .

The ONS website was also used to help identify size of population and to find the area in km² and also to find the ethnic minority break-down and trends[14]. The research also drew upon the multiple deprivation index[15]. Six research sites that matched our criteria were selected and invited to participate. Only one LSCB declined and this was replaced with a similar Board.

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[13] http://www.defra.gov.uk/rural/ruralstats/rural-defn/LAClassifications_introguide.pdf
[14] http://neighbourhood.statistics.gov.uk/dissemination/LeadHome.do;jsessionid=ac1f930bce6f95bd73ffeae438a9e8f878181a1e01a.e38PbNqOa3qRe34SbxiQahaNc3z0n6jAmljGr5XDqQLvpAe?bhcp=1
[15] http://www.communities.gov.uk/archived/general-content/communities/indicesofdeprivation/216309/

Interviews with senior professionals associated with the LSCB

The Chair and Business Managers' interviews took place in two stages. At the start of the research, in-depth face-to-face interviews were conducted in all six case study areas. Interviews lasted for approximately one and a half hours. The interviews gathered data on the Chairs' and Business Managers' experiences of: set up and the transitional arrangements made from ACPCs; Board membership and who was involved in the Board; how Local Authorities were addressing issues of accountability; how Boards managed demands arising from LSCB business; and issues surrounding Serious Case Reviews and the Child Death Review Process. Five of the six first round interviews with Chairs and Business Managers were conducted prior to media attention surrounding the 'Baby Peter' case. Findings from the first round of Chair and Business Manager interviews also contributed to Lord Laming's Review and helped shape the national survey that was undertaken (see above).

Stage two consisted of *second interviews with Chairs of LSCBs and interviews with Directors of Children's Services.* These interviews took place 12 months into the research and explored themes that emerged from both the national survey and from the first round of interviews with Chairs and Business Managers. The focus was on how the new arrangements were working, what had been learnt in the process and how practice around evaluation and monitoring had been put into place. Attention was particularly given to how Children's Services were engaging with the LSCB. Issues emerging from the Laming Review on the relationship between Children's Services, Children's Trust and the LSCB were also explored in more detail. Board Members' engagement in the process was also examined. Interviews with Directors of Children's Services focused on themes of management, accountability and how they perceived the LSCB to be working.

Board Member interviews

The Board Members were selected once Boards had formally agreed to participate. Selection aimed to achieve a balance of professional groups who were either required to participate in the LSCB or had been invited by the Local Authority to take part. Making sure that the main agencies were represented was important but a number of non-statutory Board Members were also involved. A good balance was

achieved (see Table A2). In one area the research team was unable to get the Police (Area One) to respond to requests to be involved and in another area local Children's Service representatives refused to participate[16] (Area Three). Once selected Board Members were sent an invitation to take part in the study, and asked to respond within two weeks (a condition of the NHS Ethics Committee). Consent forms were sent out once members agreed to participate. A total of forty-nine semi-structured telephone interviews were completed, with Health and Children's Services, the Police, the Probation Service and the Third Sector. Other agencies such as Adult Social Care, Early Years, Fire and Rescue and Drug and Alcohol agencies were also represented (see Table A2 for a breakdown by area and type of agency included). Key themes investigated in the interviews included: definitions and understandings of safeguarding; experiences of being a Board Member; perspectives of how effective the Chair was; perceptions of inter-agency working; and challenges the Board faces including discussion on Serious Case Reviews and Child Death Review Processes. Interviews were spread across a six month period and over a third of them were collected after the Baby Peter case broke in the media.

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[16] The Chair was the DCS of this area and the main representative. They were interviewed as the Chair.

Table A2   Board Member Interviews by Area

	Area One	Area Two	Area Three	Area Four	Area Five	Area Six	TOTAL
Children's Services	2	1	0	2	2	2	**9**
Police	1	0	1	0	2	1	**5**
Probation/YOT	0	2	1	0	1	0	**4**
Health*	2	1	1	3	1	2	**10**
CAFCASS	0	1	0	0	0	1	**2**
Drug and Alcohol Services	0	0	1	1	0	0	**2**
NSPCC	1	0	1	0	0	1	**3**
Other Agencies	Safeguarding Adults	Legal Services Emergency Social Care Duty Manager	Children's Legal Services Housing Services Fire and Rescue Service	Borough Councillor LSCB Policy and Development Officer	Community Engagement Manager	LSCB Audit Officer	**10**
Local Voluntary Organisations	Catholic Diocese	Home Start	Safe in the City Project	0	Action for Children	0	**4**
TOTAL	**8**	**8**	**9**	**8**	**8**	**8**	**49**

*Strategic Health Authority and PCT, NHS Trusts and NHS Foundation Trusts.

Practitioners' interviews

How professionals were to be selected for the study was defined by the National Research Ethics Committee. Access to professional groups had to be negotiated through Board Members. They were required to identify relevant professional groups and ask them if they would be happy to participate. Once they agreed Board Members would release contact details to the research team. Direct contact could then be made. A consent form was then sent to participants who expressed an interest to participate and follow up approaches made by telephone and email to make appointment for interviews. A telephone interview was scheduled at the participant's convenience, as soon as the consent form was received. This was a challenging process[17] that made purposeful sampling difficult. However, the research team aimed (and succeeded) to try and ensure a broad representation. A total of 132 practitioners were interviewed (83 frontline staff with no managerial responsibilities and 49 frontline staff with managerial responsibilities). The study had a 73 per cent response rate from those who agreed to take part. Professionals from a broad range of agencies were interviewed. Again, as can be seen in Table A3 a larger number of professionals from statutory agencies were interviewed (24 from Health, 22 from Children's Services, 17 from Police). In one area (Area Four) the research team was unable to get anyone from Children's Services to respond (even though the DCS was approached and asked to help in the process). Access to Education representatives did not prove possible in four areas (as there was no representative on these Boards).

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[17] See discussion on strengths and weakness in this chapter (Annex A) on the impact this had on the research.

Table A3   Practitioner Interviews by Area

	Area One	Area Two	Area Three	Area Four	Area Five	Area Six	TOTAL
Children's Social Care/Social Work	5	5	1	0	3	8	**22**
Connexions	1	0	3	0	0	3	**7**
Health	6	5	3	4	5	1	**24**
Police	1	3	4	2	2	5	**17**
Probation	0	2	3	6	6	0	**17**
Adult Social Care	0	0	1	0	0	0	**1**
Third Sector	0	3	1	0	0	0	**4**
Youth Offending Services	2	3	0	0	0	4	**9**
CAFCASS	0	0	0	0	0	0	**0**
Housing	0	0	1	5	0	0	**6**
Education	3	0	0	0	0	6	**9**
Fire Service	0	0	1	0	0	0	**1**
NSPCC/Barnardos	0	0	6	0	0	0	**6**
Mental Health (incl. Drug &Alcohol Team)	0	0	2	0	5	0	**7**
Other	0	0	0	0	0	2	**2**
TOTAL	**18**	**21**	**26**	**17**	**21**	**29**	**132**

This section of the study explored how the strategic measures adopted by the LSCBs have been implemented in practice and how individual agencies feel equipped to protect and promote the welfare of children and young people. It provided an opportunity to explore practitioners' understanding of the procedures and requirements and how they manage issues of diversity and equal opportunities. Data was collected through telephone interviews and reported on a structured interview schedule. This allowed for collection of measurable data that has been produced in the report in percentages. Judgements were also made by the research interviewer on how much knowledge respondents showed in certain areas that were important to understand for the evaluation i.e. understanding of referral/LADO processes.

Social Network Analysis

Social Network Analysis (SNA) is a method of examining complex sets of relationships between members of social systems at all scales, from interpersonal (e.g. which individuals are friends with each other) to international (e.g. which countries trade with each other) (Scott, 2000). In the context of the evaluation, SNA was used to examine the relationship between individuals and groups within the LSCB structure, in order to gain insight into membership, relationships and participation. SNA was used as a way to explore in detail how partnerships operate at strategic and operational levels. Due to the complexity of this task and the volume of information produced (providing detailed micro information on relationships and partnerships between Board Members), this analysis was only carried out in two of the case study areas. The two areas were chosen because after visits to Boards and an assessment of the six case study models of delivery, the two identified offered contrasting methods. These different structures were thought to provide the most valuable insights into diversity of models of LSCB functioning.

A short questionnaire was sent to Board Members in the two selected areas asking for details on involvement in LSCBs and other relevant activities. The questionnaire aided understanding of how communication with colleagues from the LSCB unfolds and facilitated exploration of how this interaction contributes to the work of a particular organisation and that of the LSCB. Membership lists for the LSCB and

subgroups were also used, as well as LSCB meeting minutes. Data on influence was also collected using a questionnaire. The membership lists of the Board and subgroups were useful in establishing the connectivity and commonality between the LSCB and the subgroups and to identify levels of participation of individual members. Results from this work were cross triangulated with qualitative data and data from the minutes as a mechanism of understanding themes that emerged.

Board meeting minutes

In all case study areas content analysis of LSCB meeting minutes made available by areas was undertaken. The minutes covered discussions held at LSCB meetings held every three months over a period of one to three years, depending on availability, between 2006 and 2009 and in one case ACPC meetings from 2004-2006 (see Box A1). The discussions recorded within LSCB minutes were classified according to pre-determined categories: standing agenda items, recurring issues, safeguarding issues and other significant discussions.

Box A1 Number of minutes analysed and time period in each case study area

- Area One – minutes for two LSCB meetings from 2007-2008.
- Area Two – minutes for eight LSCB meetings from 2007-2008.
- Area Three – minutes for 21 LSCB meetings from 2006-2008.
- Area Four – minutes for 11 LSCB meetings from 2006-2008.
- Area Five – minutes for 11 LSCB meetings from 2004-2008.
- Area Six – minutes for eight LSCB meetings from 2007-2009.

Analysis of case study data

The case study data provided a number of diverse and rich data sets. Analysis of qualitative data was thematic and shaped by the key research questions outlined above. The effectiveness factors/indicators (see Introduction) were also critical in helping focus analysis on important themes and questions to be explored. This allowed for analysis to be standardised across a wide range of data sets i.e. Board

Member interviews, Chair Interviews and Practitioner interviews. Analysis was therefore based on theoretically established concepts on issues of organisational structure, vision and leadership, understandings of safeguarding, organisational effectiveness, professionalism, accountability and inter-agency work. Attention was given to similarities and differences in the responses of different strategic partners and practitioners. Variations within and between agencies were also explored as were variations at strategic and operational levels. Themes that emerged in one data set could be (and were) explored in others. This provided opportunities for the research to cross check and test out different theories and ideas. This was especially useful in areas identified by SNA and the analysis of participation data in minutes of LSCB meetings. Findings were further explored in the qualitative data from Chairs, Business Managers and Board Members.

Social Network data was analysed using the Pajek software programme. SNA analysis looked at the number of relationships each agent involved in partnerships had, whether the relationships between the agents were positive or negative and also how strong the relationships were. These observations were used to examine the existence and use of power within the network, the existence of conflict, how the structure is run and how problems are solved. Using SNA we also explored patterns of attendance. This shed light on the priorities/interests of the different agencies and it helped identify issues for further qualitative investigation.

Data on the costs of LSCB activity in case study areas

As a part of the evaluation the cost analysis of the new LSCB arrangements was undertaken. In two LSCBs (Areas Five and Six) time use event records were distributed to Board Members. The aim of distributing these was to estimate the implicit costs incurred by the employers of Board Members to allow the LSCB to operate. The approach is to value cost of operating the LSCB by valuing the time that Board Members spend on work that is related to the scheduled operation of the Boards and the associated subgroups in place of their normal duties. These costs are additional to the administrative costs of running Boards. The bottom-up costing methodology adopted (Beecham, 2000) has been successfully employed in a number of studies to explore the costs and outcomes of child welfare interventions (Ward, Holmes and Soper, 2008). Board Members were asked to complete a time

use event record to indicate the time they spent on different LSCB activities in the month preceding the LSCB meeting (see Annex C). Activities included: travel to and from meetings, preparation for meetings and provision of feedback to their agency. Data was collected in relation to the main LSCB meetings and subgroup meetings. Event record data was supplied by 15 Board Members from Area Five (71 per cent) and nine Board Members from Area Six (25 per cent) and then the average time spent on key activities was calculated. The time spent by individual Board Members was costed using appropriate hourly rates. These were derived from annual salaries plus on-costs assuming that 7.5 hours are worked per day and there are 217 working days in a year. Where available, agency pay scales were used to determine average salaries for staff with different levels of responsibility within their organisation. Otherwise, salary levels were informed by a web-based search for advertised jobs similar to those that LSCB members were undertaking. These were then averaged for each level of seniority in each agency. Annual salaries were increased by 26 per cent to allow for on-costs comprised of employer's National Insurance contribution of nine per cent for contracted out employees and employer's superannuation contribution estimated at 17 per cent. The method therefore links amounts of time spent to data concerning salaries, administrative and management overheads and other expenditure. A framework for costing overheads within Children's Services departments has been developed as part of the wider programme of research being undertaken at the Centre for Child and Family Research (CCFR) (Selwyn et al., 2009).

Data Strengths and Challenges

Strengths of the approach adopted

Challenges are likely to be encountered when undertaking studies of this size and complexity. The research team has been very successful in securing good samples and collecting robust data that have been focused on the key research questions. All data collection was quality assured at different time points during the evaluation. The use of multi-methods has provided opportunities to cross check and triangulate findings thus providing strong evidence which has helped understand the effectiveness of LSCBs.

The national survey offers a unique data set on the majority of LSCBs in England. With this data, it was possible to identify similarities and differences among various areas and thus complement and contextualise the information from the case studies. Response rates were very high (exceptionally so) because Lord Laming asked LSCBs to respond to our requests. This provided a very unique data set that allowed us to construct a detailed and reliable national picture of LSCBs. While the survey results reflected the views of the Chairs it did give us a benchmark data set in which to locate the case study work.

The diversity of the data collected through the qualitative interviews in the six case areas brings additional value, as it provides a range of perspectives, from different professionals, in various positions (frontline and managerial; strategic and operational) and from different agencies. This approach increases construct validity of the core concepts explored in this study, as multiple views were sought on similar issues (triangulation of research). Having both quantitative data (the national survey and SNA) and large and diverse qualitative data sets, collected over a 15 month time frame, allowed the research team to identify key themes and issues and to explore them in more depth at different time points. For example, interviews with Directors of Children's Services were conducted after the national survey and interviews with Chairs, which allowed the research team to explore key themes and concepts that were emerging. Similarly, the national survey of Chairs was shaped by first round interviews with case study Chairs and Business Managers.

Challenges: Securing a sample of Board Members and Practitioners
In terms of the qualitative interviewing, a number of issues arose which raised challenges for the research team. The National Research Ethics Committee required contact for approaching our proposed sample of professionals to be structured in a particular way. For example, access to practitioners had to be facilitated by Board Members rather than the research team contacting individuals directly. The research team was required to go through a number of stakeholders before they were permitted to talk directly to potential participants to obtain their informed consent to participate. The approved approach was complex and time-consuming and substantial effort was required to negotiate this. Workloads also made it difficult for professionals in some areas to take part in the research. This did

have an impact in two areas as it did not prove possible to secure representation from the Police (on the Board interviews) and Children's Services (on the Practitioner interviews). Attempts to encourage participation and engagement (by discussing with senior management of the organisations) were unsuccessful.

The difficulties of getting access to samples had two implications for the research. Firstly, samples of frontline professionals reflected those organisations on the Board. If the Board Member was unwilling or unable to facilitate access to staff then it was necessary to accept that it was not going to be possible to access that organisation. Secondly, the selection of potential participants was undertaken by Board Members (or the person to whom they delegated the process). Requests were made for four times the number of staff needed for interview, however, this number of names was not always forthcoming and it was necessary to accept limited options. The implications of this on sample bias are unknown but the approach employed is worth keeping in mind when reading the data.

Baby Peter and media coverage

One other important issue to consider was the news of the tragic death of 'Baby Peter'. This took place while we were collecting data from Board Members. Approximately a third of interviews took place after this event. All the practitioner interviews were also taking place while the case was unfolding in the media and during or after Lord Laming's review (Lord Laming, 2009). Most of first round interviews with Chairs and Business Managers took place before the event while second round interviews and interviews with DCSs took place afterwards. Data collected for the national survey with Chairs was framed around requests for information by Lord Laming. This clearly improved response rates (72.9 per cent). It is unclear whether knowledge that data would feed into Lord Laming's review influenced the responses to the questions, but it was emphasised that findings would be anonymous. The results appear to give a balanced view of how LSCBs were operating nationally.

The impact of the 'Baby Peter' case on other data also remains unknown. From the interviews some respondents highlighted the difficulties the media attention created for them in doing their job but it did not seem to restrict their participation in the

research. Others highlighted and discussed the impact it had on LSCBs and how practice was being affected by the negative media coverage. In some ways this created an interesting focus to many of the interviews and allowed researchers to explore the challenges of child protection. In the report, where appropriate, the potential impact of the 'Baby Peter' case on responses, and on policy and practice, have been highlighted.

Challenges of Social Networking Analysis

Difficulties were encountered in obtaining samples for the Social Network Analysis. In the two selected areas substantial work was done with Board Members to explain the process and what was required. Final response rates were lower than expected (35 per cent in Area One and 39 per cent in Area Three) although they are in line with average response rates for postal surveys. In our follow up discussions with non-respondents the main concern raised was that the questionnaire required respondents to identify themselves and to name other individual Board Members. This was a concern to some and therefore they refused to fill in the survey, even though they had been reassured that the data would be treated in the strictest confidence. Methodologically this information is needed as it is important to identify individuals and with who they have professional relationships. This is impossible if participants do not supply colleagues' names. Once the data were analysed findings were anonymised so that no individuals could be identified. Data that were collected was of a high quality and findings have been valuable, contributing to an understanding of relationships between members.

Assumptions and decisions concerning the costing exercise

Getting reliable and useful costing data required the research team to make a number of assumptions and to make decisions about definitions. The approach adopted to classify the seniority of Board Members builds upon the approach adopted for the national survey (France et al., 2009; see Annex B). For the purpose of the costing exercise, however, salary differentials between and within professions also become relevant. Staff at the same seniority level command different salary levels in different organisations, and there is considerable variation within certain seniority groupings in some organisations. To reflect this adequately, different organisations were costed separately and in some instances two salary bands were

assigned within a seniority level. For example, in Local Authorities and the Police those classified as seniority 2 (having overall responsibility for a large department within their organisation, or being accountable only to the head of their organisation) were re-classified into salary bands 2a and 2b, separating Directors, Assistant Chief Constables and Commanders from Assistant Directors and Police Chief Superintendents.

The task of classification, based on job titles was challenging as job titles are not universally consistent across areas. Job titles also differ according to agency which was usually, but not always, stated. Members were classified based on identification of key titles such as Chief Executive and Assistant Director and based on their level of responsibility. If the job title did not uniquely identify a salary band the one judged most likely by comparison with other Board Members was chosen, and if two bands seemed equally likely the lower band was chosen. A web-based search was undertaken to establish average salaries for key job titles within the seniority bandings in different agencies.

The time spent figures presented may underestimate the time spent on activities to contribute to the Board because members were not specifically asked whether or not they delegated preparatory work for the Board to colleagues for completion (see Annex C). Given the seniority of LSCB membership it could be hypothesised that those on the Board may ask staff to undertake work on their behalf to contribute to meetings and one survey respondent noted that he did this.

Conclusion

The mixed method approach adopted in the study brings several points of strength which enhance the validity and reliability of the data, with each data set contributing in a different way. The survey and mapping exercise provide an overview of how Boards have developed and allow findings from the case study areas to be contextualised. The mixed methods employed have facilitated exploration of similarities and differences in perspective concerning the effectiveness of LSCBs, according to agency and job role. Overall, the research methods employed have produced a strong evidence base for the report.

ANNEX B CLASSIFICATIONS OF SENIORITY

In order to establish the extent to which the LSCBs are meeting these requirements, the seniority of Board Members was examined. The task was challenging as job titles are not universally consistent across areas. Job titles also differ according to agency and so members were classified based on identification of key titles such as Chief Executive and Assistant Director and based on their level of responsibility.

- Members were coded **1** if they had overall responsibility for their entire organisation.
- Members were coded **2** if they had overall responsibility for a large department within their organisation, or if they were accountable only to the head of their organisation.
- Members were coded **3** if they had responsibility for a smaller sub-section of their organisation.
- Members were coded **4** if they were a manager or had responsibility for a small team within their sub-section.
- Members were coded **5** if they were below team manager level.
- Members were coded **6** if they were not from one of the statutory organisations as defined in section 3.58 of Working Together to Safeguard Children.
- Members were coded **7** if we were unable to ascertain their seniority from their job title, or if no job title was given.

ANNEX C TIME USE EVENT RECORD

EVALUATION OF THE EFFECTIVENESS OF THE NEW LOCAL SAFEGUARDING CHILDREN BOARDS IN ENGLAND

Time Use Event Record

CRSP
Centre for Research in Social Policy

CCfR
centre for child and family research

Loughborough University

LOCAL SAFEGUARDING CHILDREN BOARDS COST ANALYSIS

The LSCB cost analysis forms part of a study commissioned by the Department for Children, Schools and Families (DCSF) and the Department of Health (DoH) to evaluate the new LSCB arrangements. The aim of the cost analysis is to estimate the costs of operating LSCBs by valuing the time that Board members spend on work that is related to the scheduled operation of the Boards and their associated subgroups, as well as the administrative costs of running them.

Completion of Time Use Event Record

In order to obtain detail about the amount of time spent on LSCB and related activity we are asking Board members to complete an event record that records the amount of time spent on different activities in the **month preceding** the LSCB meeting. These activities are: travel, preparation for meetings, membership of LSCB subgroups and providing feedback to your agency.

We appreciate that demarcating time in this way is not always a straightforward task, but ask you to provide as accurate information as possible for the time you have spent on the identified activities. We are not asking you to record time spent actually in the meeting, since we have this information from the minutes secretary.

Confidentiality

The information provided in the event record will only be used to calculate the average cost of LSCB meetings. Data will be securely held and will not be shared outside the research team. We do not ask you to record your name on the event record.

Returning Event Records

Please return your completed event record to the researcher at the end of the LSCB meeting.

return it electronically to Rebecca Hand (R.J.Hand@lboro.ac.uk) or paper copies can be sent to Administrator, Centre for Research in Social Policy, Department for Social Sciences, FREEPOST Loughborough University, Loughborough, LEICESTERSHIRE LE11 0BR

If you have any queries please contact Matt Padley, Research Associate, M.J.Padley@lboro.ac.uk, 01509 223059

Many thanks for your time and cooperation in providing this information.

x

Section 1 asks about activities related to the main LSCB meeting and Section 2 refers to activities related to LSCB subgroups.

Name of LSCB _____

Which agency do you represent on the LSCB? _____

SECTION 1 LSCB MEETING

Please indicate the time spent in the activities listed below in the month preceding this LSCB meeting.

ACTIVITY	TOTAL TIME SPENT IN LAST MONTH	
	Hours	Minutes
Travel time (include journey to and from meeting)		
Preparation time (e.g. reading documents, preparing papers)		
Feedback time (to own agency and in relation to LSCB meeting)		

SECTION 2 LSCB SUBGROUP MEETINGS

For the LSCB subgroups of which you are a member, please name the subgroups and indicate the time spent in the activities listed below in the month preceding this meeting (if you are a member of more than three subgroups then please provide information on each – extra tables are provided in Section 3).

SUBGROUP NAMES						
ACTIVITY	TOTAL TIME SPENT IN LAST MONTH					
	Hours	Minutes	Hours	Minutes	Hours	Minutes
Travel time (include journey to and from meetings)						
Preparation time (e.g. reading documents, preparing papers)						
Feedback time (to own agency, in relation to subgroup meetings)						

SECTION 3   LSCB SUBGROUP MEETINGS (CONTINUED)
(Only complete this section if you are a member of three or more subgroups)

Please only complete these additional tables if you are a member of three or more subgroups. For the LSCB subgroups of which you are a member, please name the subgroups and indicate the time spent in the activities listed below in the month preceding this meeting

SUBGROUP NAMES					
ACTIVITY	TOTAL TIME SPENT IN LAST MONTH				
	Hours	Minutes	Hours	Minutes	Hours	Minutes
Travel time (include journey to and from meetings)						
Preparation time (e.g. reading documents, preparing papers)						
Feedback time (to own agency, in relation to subgroup meetings)						

SECTION 4   EXECUTIVE GROUP MEETINGS
(Only complete this section if you are a member of the LSCB Executive Group)

Please indicate the time spent on the activities listed below in relation to the last Executive Group meeting you attended.

ACTIVITY	TOTAL TIME SPENT ON LAST EXECUTIVE GROUP MEETING	
	Hours	Minutes
Travel time (include journey to and from meeting)		
Preparation time (e.g. reading documents, preparing papers)		
Feedback time (to own agency and in relation to LSCB meeting)		

ANNEX D COST ANALYSIS FOR LSCB MEETINGS AND SUBGROUPS

Area One

Table D1   Board Members (Area One)

Agency	1	2a	2b	3	Seniority 3b	4	4b	5	Total
Local Authority			2	5		2		2	11
NHS		1				3	1		5
Police					2	1			3
Probation				1					1
Fire and Rescue									0
CAFCASS						1			1
Connexions				1					1
YOT	1								1
Voluntary				1		2			3
Total	**1**	**1**	**2**	**8**	**2**	**9**	**1**	**2**	**26**

Table D2   Estimated Cost of Members Attendance per Board Meeting (Area One)

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority			£952	£1,828		£663		£459	£3,902
NHS		£689				£2,474			£3,163
Police					£680	£315			£995
Probation				£434					£434
Fire and Rescue									
CAFCASS						£272			£272
Connexions				£366					£366
YOT	£476								£476
Voluntary				£366		£663			£1,029
Total	**£476**	**£689**	**£952**	**£2,994**	**£680**	**£4,387**		**£459**	**£10,637**

Table D3   **Estimated Cost of Members Attendance per Meeting - Safeguarding in Employment Subgroup (Area One)**

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority				£645		£585		£203	£1,433
NHS						£728	£285	£233	£1,246
Police									
Probation									
Fire and Rescue									
CAFCASS									
Connexions									
YOT									
Voluntary				£323					£323
Total				**£968**		**£1,313**	**£285**	**£436**	**£3,002**

Table D4   Estimated Cost of Members Attendance per Meeting - Monitoring & Evaluation Subgroup (Area One)

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority			£420	£645				£203	£1,268
NHS							£285		£285
Police						£278			£278
Probation									
Fire and Rescue									
CAFCASS									
Connexions				£323					£323
YOT									
Voluntary				£323					£323
Total			**£420**	**£1,291**		**£278**	**£285**	**£203**	**£2,477**

Table D5   **Estimated Cost of Members Attendance per Meeting - Learning & Development Subgroup (Area One)**

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority						£585		£405	£990
NHS						£728		£698	£1,426
Police								£195	£195
Probation						£203			£203
Fire and Rescue									
CAFCASS									
Connexions									
YOT									
Voluntary						£293			£293
Total						**£1,809**		**£1,298**	**£3,107**

Table D6   Estimated Cost of Members Attendance per Meeting - Policies & Procedures Subgroup (Area One)

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority				£323		£1,463			£1,786
NHS						£728	£285		£1,013
Police						£555			£555
Probation									
Fire and Rescue									
CAFCASS						£240			£240
Connexions									
YOT	£420								£420
Voluntary									
Total	**£420**			**£323**		**£2,986**	**£285**		**£4,014**

Table D7   Estimated Cost of Members Attendance per Meeting - E-Safety Subgroup (Area One)

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority				£645		£878		£810	£2,333
NHS								£233	£233
Police									
Probation									
Fire and Rescue									
CAFCASS									
Connexions									
YOT									
Voluntary						£293			£293
Total				**£645**		**£1,171**		**£1,043**	**£2,859**

Table D8   Board Members (Area Two)

Agency	1	2a	2b	3	Seniority 3b	4	4b	5	Total
Local Authority		1		2		1			4
NHS		2		1			1		4
Police		1	1					1	3
Probation						1			1
Fire and Rescue									0
CAFCASS						1			1
Connexions									0
YOT		1							1
Voluntary				1		1			2
Total	**0**	**5**	**1**	**4**	**0**	**4**	**1**	**1**	**16**

Table D9   Estimated Cost of Members Attendance per Board Meeting (Area Two)

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority		£646		£731		£332			£1,709
NHS		£1,377		£459			£323		£2,159
Police		£612	£493					£221	£1,326
Probation						£230			£230
Fire and Rescue									
CAFCASS						£272			£272
Connexions									
YOT		£255							£255
Voluntary				£366		£332			£698
Total		**£2,890**	**£493**	**£1,556**		**£1,166**	**£323**	**£221**	**£6,649**

Table D10   Estimated Cost of Members Attendance per Meeting - Public Awareness Subgroup (Area Two)

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority						£293		£203	£496
NHS		£608							£608
Police						£278			£278
Probation									
Fire and Rescue									
CAFCASS									
Connexions									
YOT									
Voluntary				£323					£323
Total		**£608**		**£323**		**£571**		**£203**	**£1,705**

Table D11   Estimated Cost of Members Attendance per Meeting - Monitoring & Evaluation Subgroup (Area Two)

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority						£293		£405	£698
NHS				£405					£405
Police						£278		£195	£473
Probation						£203			£203
Fire and Rescue									
CAFCASS									
Connexions									
YOT		£225							£225
Voluntary									
Total		**£225**		**£405**		**£774**		**£600**	**£2,004**

Table D12   Estimated Cost of Members Attendance per Meeting - Training Subgroup (Area Two)

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority						£585		£203	£788
NHS									
Police						£278			£278
Probation									
Fire and Rescue									
CAFCASS									
Connexions									
YOT									
Voluntary						£293			£293
Total						**£1,156**		**£203**	**£1,359**

Area Three

Table D13   Board Members (Area Three)

Agency					Seniority				
	1	2	2b	3	3b	4	4b	5	Total
Local Authority		2	3	4				1	10
NHS		3		5		3			11
Police				3		1			4
Probation				1					1
Fire and Rescue	1	1							2
CAFCASS				1					1
Connexions				1					1
YOT	1								1
Voluntary		1		1					2
Total	**2**	**7**	**3**	**16**		**4**		**1**	**33**

Table D14   Estimated Cost of Members Attendance per Board Meeting (Area Three)

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority		£1,292	£1,428	£1,462				£230	£4,412
NHS		£2,066		£2,295		£2,474			£6,835
Police				£1,301		£315			£1,616
Probation				£434					£434
Fire and Rescue	£434	£332							£766
CAFCASS				£366					£366
Connexions				£366					£366
YOT	£476								£476
Voluntary		£476		£366					£842
Total	**£910**	**£4,166**	**£1,428**	**£6,590**		**£2,789**		**£230**	**£16,113**

Table D15   Estimated Cost of Members Attendance per Meeting - Policy, Procedures & Practice Subgroup (Area Three)

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority						£2,048		£608	£2,656
NHS						£728	£285		£1,013
Police								£390	£390
Probation				£383					£383
Fire and Rescue									
CAFCASS									
Connexions									
YOT		£225							£225
Voluntary						£293			£293
Total		**£225**		**£383**		**£3,069**	**£285**	**£998**	**£4,960**

Table D16   Estimated Cost of Members Attendance per Meeting - Quality Assurance Subgroup (Area Three)

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority				£323		£878			£1,201
NHS						£728	£285		£1,013
Police								£195	£195
Probation				£383					£383
Fire and Rescue									
CAFCASS									
Connexions									
YOT	£420								£420
Voluntary									
Total	**£420**			**£706**		**£1,606**	**£285**	**£195**	**£3,212**

Table D17   Estimated Cost of Members Attendance per Meeting - Performance Management Subgroup (Area Three)

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority				£323		£1,170		£810	£2,303
NHS				£405			£855		£1,260
Police								£390	£390
Probation				£383					£383
Fire and Rescue									
CAFCASS				£323					£323
Connexions				£323					£323
YOT		£225							£225
Voluntary				£323		£293			£616
Total		**£225**		**£2,080**		**£1,463**	**£855**	**£1,200**	**£5,823**

Table D18   Estimated Cost of Members Attendance per Meeting - Voluntary & Community Sector Subgroup (Area Three)

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority									
NHS									
Police									
Probation									
Fire and Rescue									
CAFCASS									
Connexions									
YOT									
Voluntary		£420		£2,580		£2,925			£5,925
Total		**£420**		**£2,580**		**£2,925**			**£5,925**

Table D19   Estimated Cost of Members Attendance per Meeting - Workforce Development Subgroup (Area Three)

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority			£420	£645		£878		£608	£2,551
NHS							£285	£465	£750
Police								£195	£195
Probation				£383					£383
Fire and Rescue									
CAFCASS									
Connexions				£323					£323
YOT		£225		£203					£428
Voluntary				£323		£585			£908
Total		**£225**	**£420**	**£1,877**		**£1,463**	**£285**	**£1,268**	**£5,538**

Table D20   Estimated Cost of Members Attendance per Meeting - Safe Staffing Task Group (SSTG) Subgroup (Area Three)

Agency					Seniority				
	1	2	2b	3	3b	4	4b	5	Total
Local Authority		£570		£323		£293		£1,215	£2,401
NHS		£608		£405			£570	£930	£2,513
Police								£390	£390
Probation				£383					£383
Fire and Rescue									
CAFCASS				£323		£240			£563
Connexions				£323					£323
YOT	£420	£225		£203					£848
Voluntary		£420		£645					£1,065
Total	**£420**	**£1,823**		**£2,605**		**£533**	**£570**	**£2,535**	**£8,486**

Area Four

Table D21   Board Members (Area Four)

Agency	Seniority								
	1	2a	2b	3	3b	4	4b	5	Total
Local Authority	4	1		3		6			14
NHS	1			3		2	1		7
Police			1						1
Probation				1					1
Fire and Rescue									0
CAFCASS				1					1
Connexions	1								1
YOT		1							1
Voluntary		1		2					3
Total	**6**	**3**	**1**	**10**	**0**	**8**	**1**	**0**	**29**

Table D22   Estimated Cost of Members Attendance per Board Meeting (Area Four)

Agency	Seniority								Total
	1	2	2b	3	3b	4	4b	5	
Local Authority	£3,060	£684		£1,161		£2,106			£7,011
NHS	£909			£1,458		£1,746	£342		£4,455
Police			£522						£522
Probation				£459					£459
Fire and Rescue									
CAFCASS				£387					£387
Connexions	£459								£459
YOT		£270							£270
Voluntary		£504		£774					£1,278
Total	**£4,428**	**£1,458**	**£522**	**£4,239**		**£3,852**	**£342**		**£14,841**

Table D23   Estimated Cost of Members Attendance per Meeting - Procedures Subgroup (Area Four)

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority				£968		£585			£1,553
NHS						£728	£855		£1,583
Police									
Probation									
Fire and Rescue									
CAFCASS									
Connexions									
YOT									
Voluntary									
Total				**£968**		**£1,313**	**£855**		**£3,136**

Table D24   Estimated Cost of Members Attendance per Meeting - Quality of Practice Subgroup (Area Four)

Agency					Seniority				
	1	2	2b	3	3b	4	4b	5	Total
Local Authority				£645		£1,170			£1,815
NHS						£1,455	£1,140		£2,595
Police						£278			£278
Probation									
Fire and Rescue									
CAFCASS									
Connexions									
YOT									
Voluntary									
Total				**£645**		**£2,903**	**£1,140**		**£4,688**

Table D25   Estimated Cost of Members Attendance per Meeting - Training Subgroup (Area Four)

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority						£878		£203	£1,081
NHS						£728	£855	£465	£2,048
Police								£195	£195
Probation						£203			£203
Fire and Rescue									
CAFCASS									
Connexions				£323					£323
YOT									
Voluntary						£585			£585
Total				**£323**		**£2,394**	**£855**	**£863**	**£4,435**

Table D26   Estimated Cost of Members Attendance per Meeting - E-safety Anti-Bullying Subgroup (Area Four)

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority				£1,935		£1,170		£810	£3,915
NHS							£285	£233	£518
Police						£278			£278
Probation									
Fire and Rescue									
CAFCASS									
Connexions									
YOT									
Voluntary		£840		£645					£1,485
Total		**£840**		**£2,580**		**£1,448**	**£285**	**£1,043**	**£6,196**

Area Five

Table D27   Board Members (Area Five)

Agency	Seniority								
	1	2a	2b	3	3b	4	4b	5	Total
Local Authority		4		1		4		1	10
NHS	1	1		2				1	5
Police					1	1			2
Probation				1					1
Fire and Rescue									0
CAFCASS				1					1
Connexions									0
YOT									0
Voluntary				1		1			2
Total	**1**	**5**	**0**	**6**	**1**	**6**	**0**	**2**	**21**

Table D28   Estimated Cost of Members Attendance per Board Meeting (Area Five)

Agency	Seniority								
	1	2	2b	3	3b	4	4b	5	Total
Local Authority		£2,432		£344		£1,248		£216	£4,240
NHS	£808	£648		£864				£248	£2,568
Police					£320	£296			£616
Probation				£408					£408
Fire and Rescue									
CAFCASS				£344					£344
Connexions									
YOT									
Voluntary				£344		£312			£656
Total	**£808**	**£3,080**		**£2,304**	**£320**	**£1,856**		**£464**	**£8,832**

Area Six

Table D29   Board Members (Area Six)

Agency	1	2a	2b	3	Seniority 3b	4	4b	5	Total
Local Authority	1	1				5			7
NHS		2		2		3	1	1	9
Police			1		1				2
Probation		1							1
Fire and Rescue									0
CAFCASS				1					1
Connexions									0
YOT	1								1
Voluntary		4		9		2			15
Total	**2**	**8**	**1**	**12**	**1**	**10**	**1**	**1**	**36**

Table D30   Estimated Cost of Members Attendance per Board Meeting (Area Six)

Agency	1	2	2b	3	Seniority 3b	4	4b	5	Total
Local Authority	£680	£608				£1,560			£2,848
NHS		£1,296		£864		£2,328	£304	£248	£5,040
Police			£464		£320				£784
Probation		£448							£448
Fire and Rescue									
CAFCASS				£344					£344
Connexions									
YOT	£448								£448
Voluntary		£1,792		£3,096		£624			£5,512
Total	**£1,128**	**£4,144**	**£464**	**£4,304**	**£320**	**£4,512**	**£304**	**£248**	**£15,424**

ANNEX E RESEARCH ADVISORY GROUP MEMBERS

Name	Organisation
Janice ALLISTER	Royal College of General Practitioners
Jane APPLEBY	NHS East Midlands
Jane APPLETON	Community Practitioners' and Health Visitors' Association
Sue BAILEY	Royal College of Psychiatrists
Jennifer BEECHAM	London School of Economics
Judy BIZLEY	Royal College of Nursing
Sue CART	Head of Safeguarding, Adult and Children, West Sussex County Council
John COUGHLAN	Association of Directors of Children's Services
Isabella CRAIG	Department for Children, Schools and Families
Nick CROSSLEY	University of Manchester
Brigid DANIEL	University of Stirling
Carolyn DAVIES	Institute of Education
Sue DUNSTALL	NSPCC
Alan FRANCE	Centre for Research in Social Policy
Nick FROST	Leeds Metropolitan University
Janet FYLE	Royal College of Midwives
Jenny GRAY	Department for Children, Schools and Families
John HAKES	National Association of Head Teachers
Christine HUMPHREY	Department of Health
Joe LEVENSON	National Council of Voluntary Child Care Organisations
David McDONALD	Home Office
David MONK	Youth Justice Board for England and Wales
Emily MUNRO	CCFR, Loughborough University
Rosalyn PROOPS	Royal College of Paediatrics and Child Health
Kevin WALTON	Association of Chief Police Officers
Harriet WARD (Chair)	CCFR, Loughborough University
Jo WEBBER	The NHS Confederation
Peter WESTON	Government Office for the South-East