Author:
Monk, Claire

Title:
An examination of how child neglect guidance is communicated and implemented from Government to Local Safeguarding Children Boards to frontline statutory services

Dissertation

Doctorate of Social Science

An examination of how child neglect guidance is communicated and implemented from Government to Local Safeguarding Children Boards to frontline statutory services.

Claire Monk

Date submitted: April 2019

A dissertation submitted to the University of Bristol in accordance with the requirements for award of the degree of Doctorate of Social Science (Policy Studies) in the Faculty of Social Sciences and Law

,

,word count: 47,848

Abstract

Previous research has highlighted that child neglect is a significant factor in child deaths, and should therefore be taken as seriously as other forms of abuse. Child neglect is a multifaceted, 'wicked' issue, which requires a multi-dimensional response from many professionals. With such multi-dimensional perspectives, however, arise difficulties in defining the problem and agreeing solutions.

The aim of this study was therefore, to examine how guidance about child neglect is passed from government to the Local Safeguarding Children Boards (LSCBs) for local implementation and coordination. The study adopted a qualitative, multiple case study approach, and used semi structured interviews. It used a governance network model to discuss and present the findings.

Research findings indicate that child neglect messages coming out from government are disjointed, inconsistent and often unclear, making it difficult for LSCBs to develop a clear and informed understanding of the policy problem. In turn, LSCBs do not have a dissemination strategy for transferring their neglect messages to operational and front-line practitioners. This is often an *ad hoc* process, and responsibility for disseminating guidance disappears once the send button has been pressed. Furthermore, front-line practitioners did not perceive email as being the most effective format for communicating guidance, preferring instead face-to-face forms of knowledge transfer.

Key Words: Child neglect, wicked issues, LSCB, governance network, effectivity criteria.

Acknowledgements

There are many people to thank, without whose support I would not have completed this Doctorate. Firstly, I thank my First Supervisors – Professor Elaine Farmer (2013-2017), Dr. Danielle Turney (2017 to 2018) and Professor Geraldine Macdonald (2018 - 2019). Secondly my second supervisor, Dr. Sarah Ayres, who has not only been a constant source of support for the past 5 years on this dissertation, but also supported me through a negotiated module prior to starting the dissertation. Your support and patience know no bounds!

I must thank my family. My parents who have helped out whenever, and wherever they can, in order to give me the time and space to write. My husband, Sam, whose calmness and groundedness has helped me through the stressful times, when I lost faith that I could do it. And, of course, my children, Samuel now aged 4 and Oscar now aged 3, who have only ever known 'stressed mummy'. I promise that will now change!

I must thank my employer, Newman University, for funding my Doctorate, and for giving me time to carry out my research. In particular I must thank my close colleagues, Graham, Terry, Keith, Sharon, Maureen, Dan, Femi, and Karen for your support, for offering advice, or posing useful questions when I was stuck. In particular thanks go to Charlotte who has travelled the last 18 months of this Doctorate with me, in trying to complete her own PhD, running for the same deadline. Our conversations about a stress-free, post-doc life have kept me laughing.

Of course, I must also thank my research participants – without whom there would be no research. Your time, insight and interest in the study are very much appreciated.

Author's declaration

I declare that the work in this dissertation was carried out in accordance with the requirements of the University's *Regulations and Code of Practice for Research Degree Programmes* and that it has not been submitted for any other academic award. Except where indicated by specific reference in the text, the work is the candidate's own work. Work done in collaboration with, or with the assistance of, others, is indicated as such. Any views expressed in the dissertation are those of the author.

SIGNED: ..... DATE:.....

Contents Page

List of figures

Chapter One: Introduction

1.0 INTRODUCTION

The aim of this study was to explore how Government guidance about child neglect is communicated to, and implemented by, Local Safeguarding Children Boards (LSCBs) and subsequently by frontline statutory services. Social Work in England and Wales is a state-governed activity. It deals with many multifaceted problems, such as child protection practice, for which there are rarely simple answers to complex questions. There is, therefore, a question as to how practitioners are guided in their practice by guidance provided by government around such complex issues.

Child neglect is difficult for practitioners to assess because it encompasses many issues. For example, parental failure to provide for a child's basic needs might either be a result of living in poverty, lack of parental education around caring for a child, or even a deliberate act of withholding basic needs such as food or care from a child, or multi-causal (Devaney and Spratt, 2009). Such complex issues require practitioners to call on their professional judgement to assess the case carefully and make *informed* judgements. *Informed* judgements require practitioners to keep up to date with policy to inform their practice. Despite recent research in the field (for example, Brandon *et al.*, 2008, 2009; France *et al.*, 2010; Davies and Ward, 2012; Baginsky and Holmes, 2015), we know comparatively little about how practitioners keep abreast of developments in child neglect policy research.

Within this study, government guidance is taken to mean guidance from government funded research. One mechanism for conveying such guidance from government to front-line practice is the Local Safeguarding Children Boards (LSCBs). LSCBs are multi-agency networks whose core function is to establish child protection priorities within their areas, develop multi-agency policies, and to~~,~~ challenge and scrutinise multi-agency child protection practice to ensure that policy is implemented. Yet, to date, little research has been carried out on the role of the LSCBs as communicator, and policy implementer. This study aims to address this gap.

Within this study, the term practitioners (unless otherwise stated) is taken to refer to all those who work with children and young people in a range of disciplines (including Social Work, Health, Education), and their managers, who may be in a position to identify child neglect, make a referral for additional family support of some sort, or – in the case of front-line Social Work – need to make an assessment of possible neglect.

1.1 BACKGROUND TO THE RESEARCH

Commissioned by the previous Labour government, Lord Laming (a former Social Worker and advisor to the government) carried out reviews of the deaths of Victoria Climbié (who, aged 8, died in 2000 at the hands of her great aunt and great aunt's partner) and Baby P/Peter Connolly (who, aged 18 months, died in 2007 at the hands of his mother and her boyfriend). Lord Laming made 108 recommendations for changes to practice in his first report following the death of Victoria (Laming, 2003) and a further 58 recommendations in his subsequent report following the death of Peter Connolly (Laming, 2009). Yet, despite his many recommendations to improve practice, government concerns remained about current child protection practice in England and Wales, which highlight the difficulties of putting recommendations into practice. The Coalition government (2010-2015), noted concerns in child protection following the deaths of Victoria Climbié in 2000, and Peter Connelly in spite of Laming's reports. The Coalition Government's response was to commission Professor Eileen Munro (a Professor in Social Work at the London School of Economics) in 2010 to carry out a further review of child protection practice in England and Wales. Munro's view was that there was an imbalance between bureaucratic processes and professional judgement in which the former seemed to take precedence. Her findings (Munro, 2011) were intended to reform practice, such that practitioners were enabled to make professional judgements based more on professional practice and expertise, with less reliance on bureaucratic processes.

Subsequently, the DfE and the DoH (also under the Coalition government) funded a major research initiative on safeguarding children from neglect and abuse in England and Wales, the findings of which were brought together in an overview report, authored by Davies and Ward (2012). This report provided an accessible account of the evidence base on which to develop policy and practice in order to improve child protection

practice. Yet what is not known is how effectively the findings from any of these reports were communicated to a local level, and how – or even if – these were interpreted and translated into local policy. To my mind, the government's response to a high-profile child death is to respond with more policy guidance, but without ever checking whether the messages from research, guidance or policy are actually being transferred effectively to front-line practice.

1.2 THE DEVELOPMENT OF LSCBs

The public inquiry into the death of 6 year old Maria Colwell in January 1973 by her step father, William Kepple, concluded that it was the child protection system – as opposed to individual practitioners - which had ultimately failed her (see Butler and Drakeford, 2012). The system at that time did not encourage partnership working, clear communication or guidance on sharing information. One of the recommendations from the Colwell Inquiry was that local authority areas should establish Area Review Committees (ARCs) (DHSS, 1974) in order to improve *information sharing*, policy making and *communication*, as well as establishing interagency child protection conferences and child protection registers (Horwath, 2010). ARCs were non-statutory bodies, meaning that local authorities did not have to set up a joined-up committee if it did not deem it necessary in their area.

By the late 1980s, interagency working within the field of child protection remained problematic (Lonne *et al*., 2009; Parton, 2014). Under the Children Act 1989, it was recommended that ARCs be replaced by Area Child Protection Committees (ACPCs). These were established by 1991. The shift to ACPCs was supposed to embed the notion of formal coordination between the agencies, rather than just '*coming together*' (Horwath, 2010, p38), but they remained non-statutory entities (DoH, 2002). There was a requirement that those in management positions should represent their agencies on the Committee, in order to improve the level of engagement, commitment and improve decision-making processes and communication sharing within and among agencies.

Unfortunately, this change failed to realise significant improvements. In 2003, the Joint Chief Inspectors report (DoH, 2002) found that, in some local authorities, ACPCs were not responding adequately to concerns over referrals between agencies; they were

judged to be poorly equipped to safeguard children and young people because of poor leadership, and lack of commitment from local agencies to support the work of the ACPC. Furthermore, in some areas, local agencies did not feel accountable to the ACPC for safeguarding children and the ACPC did not have sufficient authority to command agencies to report to them (DoH, 2002; Horwath, 2010).

Following, the publication of the Every Child Matters green paper (DfES, 2003) and the implementation of the Children Act 2004, the Labour Government made a legislative change in transforming the *non-statutory* Area Child Protection Committees (ACPC) into *statutory* Local Safeguarding Children's Boards (LSCBs), to be established in every local authority by 1st April 2006 (Local Safeguarding Children Board Regulations, 2006). The Children Act 2004 states that the role of LSCBs is to:

> *(a) 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 by which it is established; and*
> *(b) ensure the effectiveness of what is done by each such person or body for those purposes.* (HM Government, 2004, p13)

The functions of the LSCBs are set out in section 5 of the Local Safeguarding Children Board Regulations 2006 (see Appendix 1). These objectives create a vast remit for the LSCBs, compared with its preceding bodies. According to the Working Together to Safeguard Children guidance (HM Government, 2006, which was the version that was current at this time) the aforementioned LSCB objective (a) to 'coordinate' local work was to be achieved through developing policies and procedures, planning children's services, communication and responding to unexpected child deaths. Ensuring effectiveness (objective b) was to be achieved through monitoring safeguarding practice, conducting SCRs and analysing information collected on unexpected child deaths.

In terms of developing policy, the LSCBs were given a wider remit than their predecessors (Davies and Ward, 2012), now including issues such as preventing sexual exploitation, child trafficking or online abuse. The remit for Serious Case Reviews (SCRs) carried out by the former ACPCs was expanded. Whilst the role of the ACPC was

simply to monitor the SCR process, this became a core function of the new LSCBs (Brandon *et al.,* 2008). In addition to investigating child deaths from suspected maltreatment, LSCBs were to conduct SCRs in cases where children commit suicide, or are killed as a result of domestic violence, homicide by a parent with a mental illness, or other causes of death not directly as a consequence of maltreatment such as Sudden Infant Death Syndrome (SIDS), (Brandon *et al.,* 2008; Rose and Barnes, 2008). In addition to child protection, the new LSCBs had responsibilities to promote safeguarding and child welfare. For example, LSCBs are required to *develop policy* in relation to:

- children's safety and well-being, including the safety of children who are privately fostered (seemingly a reaction to the death of Victoria Climbié who was in the kinship care of her great aunt albeit this relationship was not known until after her death);
- training practitioners working in children's services;
- recruitment;
- investigation of allegation;
- working with neighbouring children's services authorities

(France *et al.,* 2010; Davies and Ward, 2012; Munro, 2010a; Morrison, 2010).

Furthermore, representation on the LSCBs was also mandated. In line with the Children Act 2004, LSCBs *must* have a representative from the Local Authority, Police, local probation board, Youth Offending Team (YOT), Health (Strategic Health Authority, Primary Care Trust, and/or NHS [foundation] Trust), and from the Children and Family Court Advisory Support Services (CAFCASS), (HM Government, 2004, section 13). Since 2009, LSCBs have been required under the Apprenticeship, Skills, Children and Learning Act 2009 to recruit two lay members to the Board, and to produce an annual report (Preston-Shoot, 2012). Similarly, as part of the Local Safeguarding Children Boards (Amendment) Regulations (2010), schools and Further Education colleges should have a representative on each Board (Preston-Shoot, 2012). The members of the LSCB are, however, unlikely to be involved in front-line practice and may not necessarily have a background in safeguarding (Morrison, 2010).

The move to a *statutory* body was significant because it signalled a strengthening in executive authority, strategic responsibilities, and accountability of Board members. This, in turn, was expected to bring about improvements in information sharing, communication and joined-up working across organisations involved in the child protection process to front-line practice (Laming, 2003; Lonne *et al*., 2009). However, few studies have examined the role of LSCBs as a strategic body, or how effective they have been in transferring and translating Government level policy to local level policy.

1.3 THEORETICAL LENS

The theoretical lens chosen for this study is governance theory, as it focuses on multi-agency policy making in the context of complexity and uncertainty in the policy arena (Koppenjan and Klijn, 2004). Specifically, the study draws on governance network theory (Kickert *et al.,* 1997; Sørensen and Torfing, 2007; Torfing *et al.*, 2012; Klijn and Koppenjan, 2016), as this provides a framework for exploring the complex interactions between public, private and voluntary sector actors. It is, therefore, appropriate to explore the role of LSCBs in negotiating multi-agency responses to child neglect, (Devaney and Spratt, 2009; Klijn and Koppenjan, 2016). In particular, it enables the policy *negotiation* process to be explored, how LSCBs learn about child neglect guidance from government, and how they translate into local policy to be implemented by front-line practitioners.

The governance network theory proposed by Torfing *et al.* (2012) includes six criteria against which the effectiveness of a governance network can be assessed. These so-called 'effectivity criteria' (EC) help to identify how well a network: i) defines the policy problem in question; ii) is creative and innovative in practice development to match the policy problem; iii) has the ability to make joined-up decisions; iv) ensures a smooth implementation of the policy; v) responds flexibly to feedback; and vi) creates favourable conditions for further cooperation and coordination. I judged this as a suitable model to explore knowledge transfer from government to front-line practice via the LSCB because it allows the complexities of the policy process to be analysed, not just a focus on policy and practice outputs.

STRUCTURE OF THE DISSERTATION

In Chapter 2 I first examine why child neglect is best conceptualised as a wicked issue, and the multifaceted parameters of a child neglect policy framework. I then summarise the literature on the role of LSCBs and their importance as a conduit for disseminating government guidance.

In Chapter 3, I critically appraise governance network and Torfing *et al.*'s (2012) model of effectivity criteria and defend its use in this study.

In Chapter 4, I detail the research methods adopted, offering a rationale for their use, before describing the two LSCB case study areas from which the data were drawn. I then explore the ethical implications of the study and set out my approach to data analysis.

In Chapter 5, I present the findings, using Torfing *et al.*'s (2012) effectivity criteria as a framework for analysis. I draw out the differences between Education, Health and Children's Social Care across two LSCBs.

In Chapter 6, I discuss and analyse the findings in relation to my four research questions.

In chapter 7 I make recommendations for further research.

Chapter Two: Literature review 1 – Child neglect as a wicked issue.

2.0 INTRODUCTION

This chapter examines child neglect as a wicked–issue, and the role played by Local Safeguarding Children Boards (LSCBs) in tackling it. I adopted a systematic approach to the literature search (see Appendix 2).

2.1 PREVALENCE OF NEGLECT

Based on annual returns of local authorities, the DfE statistics indicate that, in 2016-2017, 48% of the children who were the subject of a child protection plan in England, were registered because of neglect, in comparison with 34% for emotional abuse, 8% for physical abuse, 4% for sexual abuse, and 6% for more than one category (DfE, 2017). This has been a consistent pattern since 2009-2010 (DfE, 2017). Whilst neglect is the most common reason why children are subject to a child protection plan, it is important to highlight that the day-to-day nature of neglect as experienced by children is far more complex than statistics convey. Furthermore, whilst the idea of safeguarding is a responsibility for all children's services, the notion of *thresholds* (which families have to reach in order to have access to those safeguarding services) causes further confusion amongst professionals in universal and voluntary services (Horwath, 2007; Warner, 2015). This all adds to the complexities of the issue.

2.2 IDENTIFYING CHILD NEGLECT

Several studies and inquiries about child protection practice in the UK take as their starting point (alleged) failings within practice (for example, DHSS, 1985; DoH, 1995; Laming, 2009; Munro, 2011; Davies and Ward, 2012). Each subsequently explores changes for practice, usually resulting in further processes being introduced. Typically, they call for practitioners working with children and families to intervene early as soon as they identify cases of need or risk, or more specifically for this study, neglect. Yet, what is not so clear is how, when, or even if, practitioners are fully aware of what constitutes *neglect*. This section, therefore, examines the recent literature around identifying child neglect, what is known about its complexities today, and how this differs between practitioner disciplines.

Defining child neglect has been a longstanding challenge within children's services (Zuravin, 1999). Some attempts have been made to develop definitions of neglect and these include physical neglect (caregivers failure to provide a home, adequate personal hygiene, clothing, or medical care), educational neglect (poor school attendance and behaviour) and emotional neglect (care linked to the child's emotional well-being) (Duerr Berrick, 1997; Rose and Meezan, 1997). But even these definitions, whilst a starting point, are viewed as problematic in respect of identifying whose responsibility it should be to respond. For example, should a child regularly missing or turning up late for school be the responsibility of the school, as an educational issue, or Social Services, as a neglect issue? (Duerr Berrick, 1997). But this becomes more complicated when we delve beneath the surface of the problem, because there may be wider factors at play for example a parent might not ensure a child gets to school for many reasons, such as economic factors, health factors, or other social factors (Stevenson, 1999). Determining when the parental neglect is intentional or unintentional is another challenge which may influence society's response (Rose and Meezan, 1997; Stevenson, 1999). I think that this highlights the significant number of factors that any practitioner needs to work through to get to the source of the problem. Added to this is the notion of *thresholds*, or measurements, of neglect which determine how serious an issue needs to be in order to trigger a statutory response (Stevenson, 1999) which is problematic when we consider that different practitioners will have a different understanding of the problem and the reason for neglect (Duerr Berrick, 1997; Horwath, 2007).

Daniel *et al.* (2011) carried out a systematic literature review focusing on whether or not practitioners are equipped to recognize and respond to the indications that a child's needs are being neglected. The authors did not apply a specific definition of neglect to their search but instead focused on 'unmet developmental need' (*ibid,* p31) in order to cast the literature search net as wide as possible. Sixty-three empirical studies, including international work, were included in the review. The authors identify a lack of multi-disciplinary research in their literature search, and research focused more on health professions. Both of these points should be regarded with caution, therefore, in terms of how non-UK based research and research from one discipline can be applied to other disciplines within the UK.

Within their findings, the authors make a distinction between a generalised definition and more practice-based definitions, acknowledging the varied perspectives, of such an issue. Daniel *et al*.'s research sheds light on both the complexities not just of the breadth and depth of the definitional aspects of neglect, by positioning it within a wider politico-socio-economic landscape which also determines both the caregivers' neglectful behaviour, but also the practitioners' location of the neglectful behaviour and responses to it. Furthermore, Daniel *et al.* (2011) note that the complexity of what constitutes neglect can cause confusion for all practitioners working with children. This is in line with the findings from the Joint Chief Inspectors Report (2005), which highlighted that practitioners within non-social care services were unsure about how to recognise signs of abuse or neglect, and when - or how - to make referrals when concerned about a child. Furthermore, practitioners need to be able to identify child neglect within the context of other family problems such as poverty, substance abuse, mental health issues, domestic violence (Rose and Barnes, 2008; Daniel *et al.,* 2011). In my opinion, it is important to make these differentiations because they might lead to different policy and practice responses being put into place such as the thresholds for services to offer intervention.

2.3 ASSESSING AND DECISION MAKING IN CHILD NEGLECT CASES

Brandon *et al.* (2008, 2009) carried out two biennial reviews examining the findings from published Serious Case Reviews. A sample of all SCRs carried out within the stipulated two-year timeframe, were selected for inclusion in each review. These biennial studies are useful because they draw together the findings from a number of SCRs in order to identify key learning which has potential to improve (multi-agency) practice and learning when transferred into everyday practice. Brandon *et al.* (2008, 2009) locate the SCRs in context of the policy and legislation of the day. A couple of caveats need to be borne in mind when considering the findings. Firstly, their findings do not just relate to child neglect, but rather include all forms of abuse and neglect. Secondly, SCRs are only carried out when a child dies in suspicious circumstances or is seriously harmed, therefore, the findings offer insights into extreme cases of abuse, and do not include findings for children living in low level or non-life-threatening neglect. Also, as with any systematic review, the analysis is dependent on the quality of the original data. Within their findings, however, Brandon *et al.* (2008) noted that

practitioners (including all those within universal services for children and families) often felt helpless and overwhelmed by past information in relation to a family's circumstances. In such cases, where children were known to have been removed because of neglect, Social Care practitioners found it difficult to understand and analyse past information in order to help them gauge whether or not a parent was currently able to look after their child, instead they simply started the assessment process again from the current point in time, referred to as the 'start again syndrome' (Brandon *et al.,* 2008, p5). This *syndrome* 'prevents practitioners and managers having a clear and systematic understanding of a case informed by past history' (*ibid*). In addition, Brandon *et al.* (2009, p45) noted that 'in spite of a raft of procedural guidance, practitioners and managers were often unclear about what they could or could not do, or should or should not do, in these cases. Assumptions were frequently made that other people were visiting the family or seeing the child or taking charge of the case as the lead professional'.

Brandon *et al.* (2008; 2009) noted that neglect was a significant factor within their analyses and were subsequently commissioned by the NSPCC to conduct a systematic analysis of SCRs conducted in England between 2003 and 2011 (Brandon *et al.,* 2013). It specifically explored how child neglect can lead to fatal outcomes, and the authors identified 46 neglect related SCRs from the specified 8-year timeframe. The authors found that neglect occurred in 60 per cent of the included SCRs, suggesting that it is a far more significant factor in child deaths than previously thought. They argue that neglect is 'life threatening' (*ibid,* p7) and should 'be treated with as much urgency as other categories of maltreatment' (*ibid*, p7). That said, they point to the fact too that only a very small number of child deaths are directly attributable to child neglect alone, which is why it is described as a *contributory* factor rather than a sole factor. Brandon *et al.* (2013) note that practitioners can often miss 'life threatening risks' (*ibid,* p15) in cases where parent-child relationships are already poor, and where children are often hidden from the view of practitioners in children's services for example, Kimberley Carlile (Reder *et al.*, 1993) and Khyra Ishaq (Radford, 2010). In addition, within universal services 'professional disagreement about the extent and impact of neglect can allow over-optimism about parental capacity to dominate' (Brandon *et al.,* 2013, p78). Again, though, I must emphasise that this systematic analysis drew on data from

extreme cases in which a child died, so the findings might not be applicable to less severe cases of child neglect, in which the signs might be differently understood.

Brandon *et al.* (2013) note reasons why professionals may overlook certain factors in relation to child neglect, including staff workload and staff confidence but they do not explore thoroughly the reasons behind *why* or how this may occur. For example, they note that there might be 'a pattern of professionals failing to recognise' factors (*ibid,* p47), that there might be 'a lack of awareness' (*ibid,* p53) and that there 'was a lack of skill, confidence and experience in dealing with the challenges' presented' (*ibid,* p68), but they do not explore *from where* or *how* professionals learn about policy and practice on neglect, or *how* this knowledge is *communicated* and *interpreted* within day-to-day practice. In my opinion, it is important to understand the *knowledge transfer* processes *before* evaluating and understanding knowledge translation, dissemination and implementation. Knowledge is no longer simply possessed by organisations but rather – with the growth of networks – it is the interactions between network actors that facilitates the flow of knowledge between sectors, organisations and professionals in order to improve innovation and performance (Huggins *et al.*, 2012; Sohi and Matthews, 2019). I have therefore interpreted knowledge transfer in this study to mean the sharing, distribution and dissemination of knowledge that might be used in tackling complex issues. Furthermore, *Knowledge* in this study refers to policy guidance and research messages relating to child neglect. Subsequently the notion of effective communication in this study refers to the practice of successfully transferring messages, or *knowledge*, to another party within the network. Both knowledge transfer and effective communication require a culture of open access and the sharing of messages both top down and bottom up (Minshall, 2009). Only once the knowledge transfer processes are understood should any attempt be made to assess knowledge translation, dissemination and implementation.

Farmer and Lutman (2010) conducted a longitudinal (5 year) study of the case management of neglected children who had been looked-after and returned home. The study followed 138 children in seven local authorities in England. Farmer and Lutman collected data from case files as well as interviews with social work practitioners, parents and children, therefore, bringing an in-depth original perspective of the issue.

They examined details of neglect, the services involved and the management of the case over the 5 year period (Lutman and Farmer, 2013). They found that those working with abused and neglected children often minimised the level of harm or abuse, which in turn led to insufficient interventions and, in cases where families had multiple issues, neglect was often overlooked. Furthermore, in cases manifesting neglect, action was often only taken when triggered by a more severe or violent incident such as physical or sexual abuse, or domestic violence. Farmer and Lutman point out variations in proactive practice between different local authority areas, which creates disparities in outcomes for children, who, I would argue, are therefore, subject to a *postcode lottery* in relation to services received. Such differences need to be addressed to ensure all areas are delivering the best possible practice to improve the long-term outcomes for neglected children (Farmer and Lutman, 2012).

On behalf of Action for Children, Burgess *et al*. (2013) carried out a review of child neglect in the UK. This research explored 'the views of children and parents about seeking and receiving support' (*ibid,* p1) in relation to neglect, as well as the views of professionals encountering child neglect. This was the second annual review of child neglect commissioned by Action for Children, with the aim of increasing the evidence base on the impact of child neglect. This UK-wide, mixed methods study is the only empirical study that I found that examines the views of practitioners across universal services. It includes a breakdown of some of those results by different practitioner groups. Within their findings, Burgess *et al.* (2013, p4) reported that 'neglect remains the most common initial category of those made subject to a child protection plan, or reason for registration' and that definitions of neglect were often open to interpretation. This may, therefore, cause signs to be noted too late, or, on the other hand, practitioners working with children and families may 'over-identify' (Brandon *et al.,* 2008, p20) neglectful and abusive behaviour in some cases in order to 'reach a threshold to attract services' (*ibid*). I would argue that this might cause conflict if other social care professionals feel that referrals have been made prematurely and the referral is rejected on the basis that it does not meet the intervention threshold (which is itself a moveable target depending on the politics-of-the-day and budget restraints). Such a refusal, therefore, can discourage the professionals in universal services from making a referral for extra support (Burgess *et al.,* 2013; Gardner, 2008).

2.4 MULTIDISCIPLINARY PERSPECTIVES OF CHILD NEGLECT

Daniel *et al.* (2011) identified that perceptions of neglect differ between professionals and the general public, with professionals having higher thresholds of what constitutes neglect. Within their literature search, Daniel *et al.* (2011) found that health staff, especially health visitors, were more likely to take action in cases of neglect than school staff and police, who were least likely to intervene. That said, Burgess *et al.* (2013, p9) found that 'primary school staff were more likely to notice the negative effects of neglect among children than their nursery school colleagues'. I think that this was because primary school staff were more likely to encounter neglect, because it is a legal obligation for all children to attend school regardless of a family's economic situation. Furthermore, within their research, concerns were raised by participating professionals that staff within private nursery provision was much less aware of and unable to identify child neglect. Of course, it would be easy to argue here that children attending private nursery provision are more likely to be from higher socio-economic backgrounds and therefore less likely to be subjected to neglect. The assumption is generally that neglect and economic deprivation go hand-in-hand (Bywaters *et al*., 2016; Bernard, 2018). There is research, however, which evidences that children from higher socio-economic backgrounds are more likely to be subjected to emotional neglect, rather than physical or emotional neglect, and emotional neglect is much more difficult for practitioners to identify (Luthar and Becker, 2002; Bernard, 2018).

2.5 CHILD NEGLECT AS A WICKED ISSUE

In contrast to 'tame problems', (Australian Public Service, 2007, p3) which are more definable and resolvable, wicked issues (W.I) are those which are difficult to define, difficult to resolve, or prevent and which require multifaceted policy and practice solutions (Rittel and Webber, 1973; De Corte *et al*., 2017). In discussing planning problems in public services as 'wicked', Rittel and Webber (1973, p160) use words such as 'malignant', 'vicious', and 'tricky' to describe them. Some scholars (for example Peters, 2017; Alford and Head, 2017; Turnbull and Hoppe, 2018) have questioned the relevance of wicked issues as a contemporary concept in public policy. In particular, Turnbull and Hoppe (2018) hold a rather disparaging view about Rittel and Webber's concept, arguing that the concept of wicked issues is 'fundamentally flawed' (p321). They argue that, within Rittel and Webber's W.I concept, there are only tame problems

or wicked problems, rather than a sliding scale of *wickedness,* which might be more plausible, and conceptually useful, than a binary alternative. In response to this, it does need to be remembered that this concept was constructed in the 1970s, before – as Peters (2017) points out – levels of *complexity* in social problems were more considered. That said, I think that that notion of wicked issues is still useful and pertinent today for arguments which I set out hereonin.

Turnbull and Hoppe (2018), Alford and Head (2017) and Peters (2017) all allude to changes in public administration which may have altered the definition, and perceived complexities, of wicked issues. For example, the shift in the public administration systems of the 1970s to today's decentralised complex governance structures makes dealing with most social ills less linear, more interactive and complex. Alford and Head (2017) and Peters (2017) do not dismiss the concept of W.I as Turnbull and Hoppe seem to. Peters (2017) argues that growth in complex policy making has turned W.I into a 'fad' (*ibid* p386), whilst Alford and Head (2017 p398) consider the term to be 'applied indiscriminately'. They both highlight that although there are a number of difficult problems facing the public sector in contemporary society, many of these are not 'wicked' in the way that Rittel and Webber had intended the term to be applied. Instead, quite often the concept is now stretched to fit a difficult problem, to categorise it as *wicked* and this is where the problem now lies because it is over-used and difficult to ascertain what truly is a wicked issue, in today's society.

Turnbull and Hoppe (2018 p317) argue that the term wicked issue is 'appealing because it resists precise definition' but I disagree with this argument. I think wicked issues can be defined. The term can be applied to socially constructed problems. Such problems are complex (not simple or straight forward) and multifaceted (that is to say that they can be viewed from various angles and require multiple organisations to work together). More importantly, however, such problems either have no solution or are resistant to a solution. Potential solutions may create further problems, as the issue transpires or morphs in other complicated ways. Therefore the problems need to be managed more so than resolved. Wicked issues therefore are not cyclical (which suggests a start and end point) but rather progress in a helical manner which suggests a

rolling continuum with no end point (because of the social constructivist nature of the issue). The term therefore is not and should not be redundant.

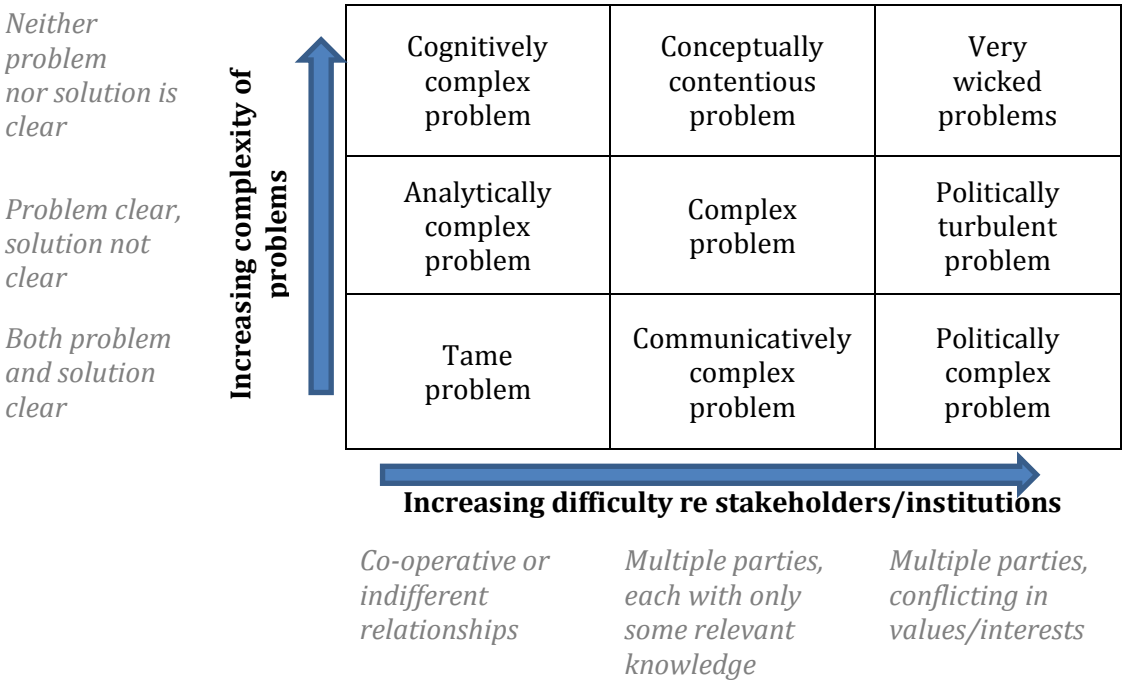
Turnbull and Hoppe also argue that the term W.I is unhelpful in terms of analysis. But Rittel and Webber did not structure their ten features as an analytical model, it was simply a list of features to enable a problem is be identified as wicked or not. Such categorisation could then assist in beginning to understand the problem and respond to it as a W.I. That said, others (Peters, 2017; Alford and Head, 2017 and Turnbull and Hoppe, 2018) have attempted to develop alternative models for discussing complex, or wicked, problems. Turnbull and Hoppe (2018 p315) reconceptualise W.I as 'problematicity', defined as 'the distance between those who question or inquire into the problem'. They call this model the 'questioning-distance framework' (*ibid* p322). For example, within this model a policy maker might argue that child neglect policy is about parental unemployment not about maltreatment. Such a response represses the multifaceted nature of the problem by repressing the scope, and putting a ring-fence around (part of) the problem. But this is by no means the full scale or nature of the problem, and therefore invites other policy makers to question this context, and examine other angles of the issue. The issue may be closer to some policy makers interests than others, such that they will all be at relational odds.

There are a number of problems with this model. Firstly, it assumes that there is more than one person working on a problem because there needs to be more than one 'questioner' (*ibid* p324); each *questioner* assesses the problem from their own experiences, compares this to other questioners in order to gauge the *distance*. Secondly, Turnbull and Hoppe criticised Rittel and Webber's W.I model for not being a useful analytical model, but I do not think that this 'questioning-distance' model is any better at analysing the degrees of wickedness of a problem. It seems overly complicated. I am unsure how this might be applied systematically to various problems or between different policy makers because it is difficult to see at what point agreement might be reached and action taken. Within networks such discussions naturally occur as part of the nature of the network's remit so it is unclear how much this model adds to something which, I think, occurs on a regular basis anyway within organisations.

Alternatively Alford and Head (2017) developed a typology of problems matrix (see figure i) which centres on two key elements of a wicked issue: the problem (the *y* axis), and the actors involved (the *x* axis). The matrix should be viewed as a continuum, starting from tame problems in the bottom left, progressing to the most complex problems – wicked problems – in the top right corner. This model appears more user-friendly and has clearer, more specific degrees of 'wickedness', which is what Turnbull and Hoppe (2018) seemed to be aiming for but did not quite achieve in my view, certainly not with any distinctiveness or ease of applicability.

Both models, however, seem overly complicated if the purpose of the argument is to identify whether or not something is a wicked issue in the first place. Furthermore, it might be quite difficult to apply broad categories of problems (e.g. climate change, or poverty, or child neglect) to these models. Such broader umbrella terms would need to be broken down to its smaller components (e.g climate change is caused by an increased use of fossil fuels, poverty is lack of education, child neglect is caused by lack of good parenting) and those smaller components applied for more detailed identification of the degrees of wickedness.

Figure i) Alternative types of complex problems



(Alford and Head, 2017 p402)

Rittel and Webber (1973 pp161-167) proposed ten features (see figure ii) which can be applied to any issue to identify whether or not it is a wicked issue. When all ten features apply the problem is classed as *wicked*. Rather than reconceptualising Rittel and Webber's model, Peters (2017) expanded it with three further elements which he felt were missing, yet crucial in the decision-making around complex issues. These were multiple actors, social features and political features. He stated that 'wicked problems involve multiple actors and are socially and politically complex' (Peters, 2017 p388). I think that these two models can be drawn together into a single matrix, with Peters's (2017) three features adding extra depth to those of Rittel and Webber's (see figure ii).

Using figure ii, I will apply Rittel and Webber's (*ibid*) ten distinguishing features, within which I will also apply Peters' additional characteristics of multiple actors, social and political complexities to the umbrella term of child neglect (rather than breaking it into constituent parts) in order to explain why child neglect, in broad terms, should be conceptualised as a wicked issue.

Figure ii: Applying Rittel and Webber's (1973) ten features of a wicked issue with Peters (2017) further features to child neglect.

Rittel and Webber's (1973) ten features of a wicked issue	Peters (2017) Further features		
	Political	**Social**	**Multiple actors**
1. There is no definitive formulation of a wicked problem.	Politically, there is no single Government department dealing with the root causes of child neglect. Depending on how it is defined then depends on whether it is dealt with by DoH, DfE, DWP, or even the Home Office. This further adds to the complexities when trying to respond to its issues.	Describing neglect may cause operational difficulty because definitions often fall into the category of broader family needs such as parenting (in)capacity making it socially complex (see section 2.2)	Child neglect is multifaceted and its complex nature makes it difficult for multiple actors to identify, or understand what constitutes child neglect.
2. Wicked problems have no stopping rule	Child neglect has been a long-standing political and social (Peters, 2017) issue and will continue to be an issue for years to come because wicked issues are difficult to define, therefore there is no clear, definitive end to the problem: the parameters of the notion of child neglect will shift.		Those dealing with the problem will, more often than not, find that it is an endless, unresolvable spiral because as one solution is found a further problem occurs. Multiple actors working on the issue, will draw to an end (either temporarily or permanently) because they run out of money, time, or find that they have done the best that they are presently able to with the resources that they have.
3. Solutions to wicked problems are not true-or-false, but good-or-bad.	There is no true or false answer to resolving child neglect. Political responses to it will depend on the politics of the day, and what the political priorities are. Such political responses will either be good (and well received) or bad and poorly designed. Equally as politics changes (e.g. through general election) policy responses can change or disappear, thus changing the outcomes for children facing neglect.	Child neglect is a socially constructed concept and therefore its definition changes with society. True or false solutions cannot be applied to concept which is fluid. What works (good solution) today might not be a suitable solution for child neglect in the future, and therefore becomes a bad solution.	Given the multiple actors involved with dealing with child neglect, each will judge any proposed policy solutions, based on their own experience, values, knowledge. This will vary amongst the actors who will then need to negotiate a solution because there will be no single true/false answer within such a political and social issue.
4. There is no immediate and no ultimate test of a solution to a	Governments cannot predict the outcomes of any policy solutions to child neglect. Often it may take	Within child neglect, the variables cannot be controlled, therefore a policy	Whilst the merits or consequences cannot be appraised immediately,

wicked problem.	many years for any effects to be seen. The outcomes may not necessarily be as intended.	solution may work in one area but not another. This might not be predictable upon implementation and may take time to evidence.	they may be appraised differently by the different actors involved. A successful solution to one may not be seen as such by another.
5. Every solution to a wicked problem is a "one-shot operation"; because there is no opportunity to learn by trial-and-error, every attempt counts significantly.	On the one hand it might be argued that the government does pilot initiatives, but even then the consequences from these pilots or trailblazers leave 'traces' that might have irreversible consequences.	There is no room for trial-and-error because every solution, no matter how small, 'leaves "traces" that cannot be undone". This is applicable to child neglect; because solutions are dealing with children's well-being, and may therefore, have catastrophic consequences.	The multiple actors involved in child neglect need to carefully consider and negotiate any policy being implemented locally in order to minimise harmful consequences
6. Wicked problems do not have an enumerable (or an exhaustively describable) set of potential solutions, nor is there a well-described set of permissible operations that may be incorporated into the plan.	In political terms, at any given time there could be any number of potential solutions to child neglect.	In social terms, there could be any number of social ills or complexities impacting on child neglect at any given time, and these will always change over time.	The multiple actors involved in child neglect need to judge which solutions should be pursued at which time. But given the varied professional background of the multiple actors, each will have their own view on what should be done, when and how which adds another set of issues to resolving the issue.
7. Every wicked problem is essentially unique	Political responses to child neglect are not a one-size fits all. The root causes of child neglect vary, and the problem changes over time. Therefore there political equations or rules cannot be applied to child neglect to formulate a policy response. Each problem needs a different political response.	Each child's experiences of neglect and how they respond to their circumstances, will differ. The solutions to those problems, therefore, need to be tailored to the individual child or family.	The multiple actors involved with child neglect cases will be responding to different elements of the causes of child neglect.
8. Every wicked problem can be considered to be a symptom of another problem.	The multi-dimensional elements of child neglect are essentially the symptom of a State regulated problem. Solving one element highlights deficiencies or problems in another (or several other) areas. A physically neglected child may be hungry and dirty because the parents have no money for groceries. This might lead to the question of whether or not one or both parents are employed; if yes, then is there a wider issue of minimum wage? Do the parents need extra benefits to supplement their salaries? If only one, or neither parent is in employment, does this lead to a bigger question of a) state welfare benefits (are these fit for purpose and so on.) or b)		Unfortunately, practitioners at the operational level cannot resolve the bigger problems on a day to day basis and are often, fire-fighting the fallout for example, the child who is hungry, or the parent trying to access benefits.

	the State needs to increase employment opportunities. The symptom of child neglect always leads to another, bigger problem.		
9. The existence of a discrepancy representing a wicked problem can be explained in numerous ways. The choice of explanation determines the nature of the problem's resolution	Child neglect might be explained by poor parenting skills, poor education, poor economy (low-paid, or not enough, jobs), inadequate state benefit system, health problems (child or parent) or disability (child or parent), but not one of these is the single known cause for neglect, and any one of these may lead to any of the others. They do not occur in any identifiable sequence either.		Those working to find solutions to the problem will lean towards one of these as a cause, and they will err towards the one which makes most sense to them. This, however, is where a network approach is useful in seeing the problem from multiple perspectives.
10. The planner has no right to be wrong	In political terms, bad policy decisions or poor policy outcomes can be costly and damaging to a political party's reputation.	As identified through the previous 9 features, ill-thought out policy solutions can have lasting, irreversible effects on the political party, and within society.	The word "planner" could easily be changed in my context with practitioners in children's universal services. That is to say social workers, early years' practitioners, teachers, police officers, health staff and so on, and the meaning would still apply. This has clearly been evidenced in child abuse and neglect cases when practitioners have missed symptoms of abuse or neglect.

Wicked issues require strategic coordination which might take the form of a network, or partnership, between relevant agencies that are able to respond to its consequences (Koppenjan and Klijn, 2004). Wicked issues, such as child neglect, cut across both the many layers of government (government to front-line level) as well as being cross-sectoral (Ferlie *et al.,* 2010; Klijn and Koppenjan, 2016). Network approaches offer benefits as ideas, resources and expertise can be drawn from several relevant sources in order to tackle a problem from many different angles. Such collaborative problem solving fosters an ethos of joint ownership of the problem and, therefore, joint responsibility for alleviating it (Sørensen and Torfing, 2007a; Torfing and Sørensen, 2014). In relation to child neglect, having a network consisting of actors from Health, Housing, Education, and Social Services (amongst many others) enables it to explore a variety of causes, and develop the multifaceted responses, drawing on the varied knowledge, expertise, skills and resources.

The next section moves on to examine the role of the LSCB as a specific network for responding to wicked issues such as child neglect.

2.6 IMPACT OF LSCBs

France *et al.* (2010) carried out an in-depth empirical study which examined 'the extent to which LSCBs have overcome the weaknesses of Area Child Protection Committees, and the effectiveness of the Boards in meeting their objectives' (France *et al.*, 2010, pi). The researchers used a mixed methods approach across six areas in England, involving: i) a quantitative survey to gather extensive data across England; ii) a content analysis of minutes from various meetings, and iii) qualitative interviews (a mix of face to face and telephone) with LSCB members and front-line practitioners. This evaluation focused on leadership and governance, board membership, participation of core agencies and inter-agency working, training and performance, communication between bodies involved, resources and costs and the impact on professional practice, all of which had been identified as weaknesses in previous multi-agency arrangements. However, it did not focus on how guidance from policy are accessed and shared in practice.

France *et al.* (2010) concluded that LSCBs had effected some improvements on their predecessors. They noted that LSCBs had succeeded in achieving acknowledgement

from practitioners, at strategic and operational level, that safeguarding children is a shared responsibility, thus enhancing the notion of joined-up working. However, weaknesses continued to exist in their 'Governance arrangements' (France *et al.*, 2010, pi), and differences in opinion were apparent in terms of the wider remit given to LSCBs, as some Board members felt that their role should be narrowly focussed on protecting children from harm. The research uncovered uncertainty from the LSCBs in terms of *whether or not they were informing and affecting operational practice* in terms of safeguarding children.

There may be a number of reasons for this. France *et al.* (2010, p113) note that 'differences in organisational culture and differences in language and terminology can raise challenges ... Large and complex structures involving a wide range of partners can also be problematic'. This point reflects that made by Pressman and Wildavsky (1984, pxxiv) who, in relation to discussing policy implementation, noted that 'the longer the chain of causality, the more numerous the reciprocal relationships among the links and the more complex implementation becomes'. France *et al.* (2010) argue that, because some Boards were trying to cover a remit which was deemed to be too wide (addressing child protection policies, carrying out SCRs, preventative work and implementing new wider business requirements) they were struggling to be effective.

In addition, strategic level decision-making and policy making are never conducted in a neutral environment; such decisions are made in a social and political context and are influenced by a range of professional perspectives whose organisations have competing political agendas in terms of the best practice for safeguarding children (Corby and Cox, 2000). This may also impact on whether, and how, services interpret and implement particular policies and procedures. The influence generated at operational level is likely to depend on how well the LSCBs exercise their statutory powers, understand local infrastructure, inter-agency relationships and the influence and stature of key individuals such as the Director of Children's Services. That said, while the LSCB is a statutory body, they '… do not have any statutory powers to insist on changes to policy or practice' (France *et al.,* 2010, p129), which was also a core criticism of its predecessors (Horwath, 2010). However, the Working Together guidance (2013, p60)

stated that LSCBs, while not having the authority to 'direct other organisations', do have a duty to make clear 'where improvement is needed'.

Munro (2010a, 2010b, 2011), and Ofsted (2011) took a more positive view of the LSCB role. Munro's (*ibid*) three-part review took a 'systems approach' (Munro, 2010a, p10) to assessing the child protection system as a whole. The review analysed previous data as its main method of assessment. As this review was heralded as a turning point in reducing bureaucracy and targets in social work, and giving professional judgement and decision making back to practitioners, it is an important review. In relation to LSCBs, Munro highlighted the role which LSCBs took in managing the 'holistic approach to child protection' (*ibid,* p10), and ensuring coordination, communication between agencies and performance management in early help provision (see Green, 2012). Thus, Munro was keen to suggest strengthening the responsibilities which the LSCBs hold in relation to monitoring the impact of training, practice and learning, as well as being able to 'identify emerging problems in the system' (Munro, 2010b, p77).

Building on from Munro's comments about the important role that LSCBs have in monitoring working together practices, Ofsted (2011) published a report to help LSCBs reflect on their practice and improve through sharing good practice. Ofsted used evidence from their own inspections carried out from 2009 to 2011, visits, interviews and requests for examples of good practice from five chosen areas (from which they received 12 examples). They gained the views from a number of professionals across universal services, not just social care. The 2011 Ofsted report evidenced much good practice in LSCBs, in terms of leadership, business planning, partnership working, including engaging front-line practitioners and children, as well as developing relationships with other networks such as the Children's Trusts. In particular, it noted the shift from a compliance culture to a learning culture in all areas. It highlighted that LSCBs are learning from Serious Case Reviews and disseminating this learning - through training - to professionals (Ofsted, 2011). Whilst this report relays useful findings in relation to the work of LSCBs, it seems as though the report was produced in light of the success of Munro's review, about developing a learning culture rather than a compliance one, which is ironic because Ofsted is not generally perceived as promoting

a learning culture (but rather a fault-finding culture) (see, for example, Jeffrey and Woods, 1996; Clarke, 2012).

Furthermore, Preston-Shoot (2012) and Green (2012) contributed to an important and timely debate deliberating the chances of a successful implementation of the reforms set down in the Munro review (2011). Preston-Shoot (2012) focused his view on the effects of a changing political landscape and the role of LSCBs. In his opinion, whilst acknowledging positive elements of LSCBs in their role in safeguarding children, (such as being crucial in terms of promoting good practice, developing learning, monitoring outcomes and overseeing multi-agency practice to minimise duplicate service provision), all of this needs to be achieved within the local authority austerity measures which are being implemented by Central Government. This is potentially problematic given that LSCBs are funded by contributions from Local Authorities, Health, Police and other public services, all of which are having their budgets cut and are being forced to make savings, which might be detrimental to the sustainability of LSCBs in some areas. Similarly, Green (2012) noted that partner organisations are expected to contribute financially to the running of their LSCB; however, the funding provided by agencies varies. In the current climate of austerity cuts, it might be assumed that one of the savings that organisations are likely to make, might be their contributions to the LSCB, for example Green (2012, p18) claimed that 'the absence of a statutory duty [for financial prescription] will make contributions less'.

In addition, LSCBs are also criticised for being another expensive, bureaucratic tool of government, which duplicates the work of other joined-up mechanisms such as Children's Trusts and Health and Well-Being Boards and consumes financial and staff resources which might be better used elsewhere. This leads to a question about how well such joined-up entities are working in transferring knowledge and changing practice.

2.7 THE GOVERNMENT'S SAFEGUARDING CHILDREN RESEARCH INITIATIVE

The Coalition government sponsored *Safeguarding Children research initiative* (Davies and Ward, 2012) was to shape the day-to-day practice of strategic and operational managers, policy makers, front-line practitioners and service providers working to

safeguard children from neglect and emotional abuse. This included those in Health, Education, the Police, and Family Justice and was *not* just limited to Children's Social Care. This statement of intent from page 12 clearly stipulates that:

> 'Safeguarding Children across Services: Messages from Research provides an Overview of the key messages from 15 studies, *distilled to meet the needs of those professionals who seek to utilize such research findings to shape their day-to-day work.* These include strategic and operational managers and practitioners, commissioners and providers of services, and policymakers in all those agencies *that are required to work together to safeguard children*: although these are primarily those who work in Children's and Adults' Social Care, Health, Education, the Police and the family justice system, *the messages are relevant to staff in many other agencies in both the statutory and independent sectors*.'

Therefore, within this 'safeguarding children' research initiative, the Government identified a core research focus of exploring neglect and emotional abuse (the main factors in Victoria Climbié's case), within which three specific areas were identified as:

- *'Identification and initial response to abuse*
- *Effective interventions after abuse or its likelihood have been identified*
- *Effective inter-agency and interdisciplinary working to safeguard children'* (Davies and Ward, 2012 p12).

Eleven of the fifteen studies within the Review (Davies and Ward, 2012) were specifically commissioned as part of this initiative. Of the remaining four, therefore, two biennial analyses were included from an on-going programme of government funded biennial analyses of SCRs; two further studies were included in the research initiative because they were reporting during the same time frame (Davies and Ward, 2012). Three out of these 15 studies focused specifically on child neglect (Daniel, Taylor and Scott, 2009; Farmer and Lutman, 2010; Stein, *et al*., 2009) and the two biennial analyses of SCRs had many findings relating to the presence of child neglect prior to a child death (Brandon *et al.*, 2008; Brandon *et al.,* 2009). Therefore, given the intention of the research initiative, those it aimed to influence, this research initiative seemed a good test case to use to evaluate how well LSCBs are in disseminating and operationalizing government sponsored research into everyday practice.

2.8 SUMMARY

This chapter has examined existing literature around the complexities which practitioners have in defining, identifying and assessing child neglect. The chapter then conceptualised child neglect as a wicked issue, and why a network response is one suitable approach to tackling such issues. It also examined the impact of LSCBs from current literature. What this chapter highlighted was that what we do not presently understand is how guidance around child neglect is transferred to front-line practice and the processes that that guidance passes through before informing practice.

Chapter Three: Literature Review 2 – Governance Networks

3.0 INTRODUCTION

Part two explores governance network theory and then explains Torfing *et al.*'s (2012) *effectivity criteria* (EC) in order to assess if LSCBs are fit for purpose in terms of being a means for knowledge transfer to front-line practitioners.

3.1 SELECTING THE THEORETICAL FRAMEWORK

There were several theoretical frameworks that I could have adopted to examine the issue of the operationalization of LSCBs. I considered policy communication theory, Implementation theory, and Governance theory (see Appendix 2). I was drawn to policy communication theory first because initially I thought that what I was examining was *how* child neglect guidance was communicated. This would have required documentary analysis as well to examine the content of particular policies. I discounted this theory, however, because I thought this would not enable me to examine the wider social factors around knowledge transfer, for example, policy negotiation. In terms of the documentary analysis as well, it proved difficult to find comparable policy documents across participating areas.

Dissemination and Implementation (D.I) science theory was a strong contender because this would have enabled me to examine how (or if) the guidance filters into practice. D.I science draws on the works of Lewin's action research, Cochrane's systematic reviews (1970s) and Rogers's ideas of innovation and adoption (1960s) (Estabrooks *et al.,* 2018). However, I discounted this because in my mind there was a step before this that needed to be examined, and that is how the guidance, or knowledge, is transferred from top (government) to bottom (front-line practitioner), and what are the decision-making processes that are involved in whether or not something is transferred. Therefore, I selected governance theory because this enables such processes to be examined from the more human element of working together to operationalize policy guidance. Governance theory enables an exploration of the operationalization and coordination of

networks. The next section examines governance theory and its application to this study in more detail.

3.1.1 Governance theory

- *The shift to governance structures and the definition of governance*

The ideas that dominated traditional forms of government and public administration centred around the fact that central government should dominate society and the economy. Yet, such public administrative forms have been criticised for being too 'formalistic, narrow-minded, exclusive, conservative, inflexible, uncoordinated, undemocratic, and, more importantly, out of step with reality' (Torfing and Sørensen, 2014, p330). Expectations of the electorate on the delivery of public services, the limitations of the public sector services and the shift from a sense of society to a sense of individualism with the leap to neoliberalist values (which began to emerge with the Conservative government of the late 1970s and 1980s), lead people to question whether or not the government was overloaded. With this shift to neoliberalism, the 1970s also saw the increase in private sector contracts to deliver public services, and the increasing privatisation of public services, (Ling, 2000; Torfing and Sørensen, 2014; Ojo and Mellouli, 2016). Central Government was becoming decentralised, moving to a position of steering policy-making, or *governance*, rather than leader or director. With such moves, the emphasis shifted from macro (national) level policy making to meso (regional, or middle level) policy and decision making.

Governance can be seen to be a way to *coordinate* or *steer* independent actors, with common goals or purpose, from the public, private and voluntary sectors for the benefit of society (Torfing and Sørensen, 2014; Ojo and Mellouli, 2016; Kapucu *et al.,* 2017). Governance theory suggests that such steering or coordination is deemed to be horizontal, rather than vertical, or top-down (Ojo and Mellouli, 2016; Kapucu *et al.,* 2017). Governance is a '*process* of governing' (Klijn and Koppenjan, 2016, p5) rather than a structure, in which governments shift from the stance of *imposing* solutions, or practices, to allowing actors to be more creative or innovative in terms of *how* or what they deliver, as long as the outcomes are achieved. This suggests meso-level action and initiative to take charge at a local level, rather than leading from the top. Yet, with this

neoliberalist approach to public services delivery, and the increase of decentralisation, services still needed to be coordinated, more so than governed.

For the purpose of this study, with a focus on Local Safeguarding Children Boards, governance is taken to mean government steering and coordinating policy development, but enabling LSCBs to respond to their own local level needs and demographics, in terms of how and what is delivered, as long as it is within the Government's policy agenda.

- *Models of governance*

The concept of governance can be divided into four perspectives of governance:

- Good governance or corporate governance
- Multi-level governance
- New Public Management (NPM)
- Network governance

Each of these implies a slightly different way of *steering*. Therefore, I needed to identify a relevant model of governance that would support an investigation of the operationalization of LSCBs.

Good governance / corporate governance is concerned with 'the principles of a properly governed state and how government operates' (Ojo and Mellouli, 2016). Multi-level governance emphasises the use of networks to transect agency boundaries and hierarchies (Ojo and Mellouli, 2016; Klijn and Koppenjan, 2016). I discounted these two models because this study is neither exploring how the government operates, nor how LSCBs transects boundaries and hierarchies. Rather it aimed to explore the communication and interactions within and beyond the LSCB as a network to transfer policy.

Both NPM and network governance could have been selected as the model for evaluation of LSCBs. New Public Management (NPM) employs private sector performance and monitoring tools in combination with traditional public administration (Andresani and Ferlie, 2006; Cairney, 2012; Torfing and Sørensen, 2014; Ojo and Mellouli, 2016), to enable the government to be hands-off, and steer from afar

whilst still holding the delivering agencies (public, private or voluntary sector) to account through performance targets. As Andresani and Ferlie (2006, p416) state 'NPM reforms are typically "top-down" in nature, driven by a "reformist" central government trying to squeeze more value out of large operational agencies and functions'. NPM uses a model of consumer choice, and stakeholder voice, to hold delivering agencies to account by the service user, and the government, (Torfing and Sørensen, 2014). One key element of the NPM regime is the emphasis on management through performance measurement, monitoring and evaluation, and having an audit trail whose ultimate focus is on value for money or best-value, rather than service quality.

NPM was discounted as the most useful model of governance, because NPM based models of effectiveness (that is to say, working together for, and reaching, a common goal) and efficiency (doing more with less) are not always the best ways for measuring the performance of networks because they are output and economically driven as opposed to thinking about processes and stakeholder satisfaction (Klijn and Koppenjan, 2016; Greenwood, 2016). But more importantly, for my study, NPM is not a good model for exploring how practitioners deal with wicked issues such as child neglect, or for exploring the implementation of policy. NPM's focus on performance monitoring – whilst relevant to a degree here – detracts from the complex nature of child neglect. I therefore selected Governance networks as the governance model for this study.

3.1.2 Governance Network theory

The first wave of governance network research is very much connected to works by Rhodes (1981, 1990, and 1997) and Marsh and Rhodes (1992). These researchers talked more of *policy networks* than governance networks, but highlighted the changes taking place within public administration and the shift towards a network-based approach to government and policy-making. They sought to explain why and how governance networks are formed, the impact of the market in such set ups, and 'linking the rise of network governance to new societal trends' (Sørensen and Torfing, 2007a, p14).

Later theorists argued that governance networks should be examined through different theoretical perspectives. The theories of network governance (for example, Sørensen

and Torfing, 2007; Torfing *et al*., 2012; Kickert *et al.,* 1997; Koppenjan and Klijn, 2004, 2016) are concerned with the levels of *complex interaction* between the actors. Such interactions include (but are not limited to) interactions across the sectors (public, private and voluntary) and organisations within them, interactions between network actors regarding developing and disseminating policy guidance; all with the purpose of delivering a particular agenda for the benefit of a local community which those agencies or actors serve (Greenwood, 2016; Kapucu *et al.,* 2017). Within this model, the government plays more of an *influencing* role than a directing role, and *power* is shared among the network actors to enable them to coordinate their agenda. Andresani and Ferlie (2006, p417) articulate how network governance 'may be a post-NPM form, better able to cope with higher levels of social complexity and uncertainty than the top-down and state-centred approach now strongly associated in some jurisdictions with the NPM model'.

To me, writers such as Goldsmith and Eggers (2004) and Peters (2013) seem to approach the notion of governance networks through balancing the traditional top-down policy making approach with emerging horizontally coordinated networks. In my opinion, they argue that for governance networks to function successfully, an element of the traditional public administration model is still needed in order to guide the networks. This adds a further element to the complex interactions noted in the previous paragraph, in that, along with the complex horizontal interactions, one needs to include the interactions from the top into the networks. In relation to understanding LSCBs, I am inclined to agree that the arguments of Goldsmith and Eggers, and Peters is perhaps a more accurate picture of the governance environment in which LSCBs are operating. This is because LSCBs are operating alongside other meso-level strategic networks (such as Children's Trusts, Health and Well-Being Board and so on) but they are strategically determined, and accountable to, Central Government departments. They are an entity that was devised by Central Government, to carry out the strategic work of central government and they are, therefore, very much beholden to targets set by Central Government. As Sørensen and Torfing (2007) explain network governance operates in a political and economic climate over which those involved in the network have no control, and such political, economic and social processes can affect how successful (or not) a governance network might be at any given time. Such factors may

affect the motivation and participation of relevant network actors because of an actor's inability 'to gain real political influence' (Sørensen and Torfing, 2007b, p96).

A Governance network, therefore, can be defined as a particular form of multi-agency steering, which can usefully be applied to the policy development and execution of the LSCBs. Governance networks consist of organisations who are 'operationally autonomous' from each other yet 'dependent' on each other's resources (Sørensen and Torfing, 2007a, p9). In theory, the actors within a governance network operate within a self-regulating, implied framework rather than a fixed structure, and operate through negotiations and bargaining. They have been set up for a public purpose or function within a certain geographical area (Sørensen and Torfing, 2007a). This, therefore, makes them ideal for dealing with wicked issues (Ferlie, *et al*., 2010). Figure iii summarises the ways in which LSCB can be described as a governance network.

Figure iii: linking the governance network description to LSCBs

Core features of a Governance network	LSCBs
Multi-agency steering	Must have representatives from multiple agencies.
Operationally autonomous from each other	Each agency has own strategic plan, organisational structure, etc.
Dependent on each other's resources	Staffing, financial contributions, expertise
Established for a public purpose	Safeguarding children within their area.
Implied framework developed through negotiation	Business Plan is consulted with representatives and service users in the area (e.g. children)
Geographically set	Usually the same parameters as the local authority.

3.2 EVALUATING GOVERNANCE NETWORKS

The growth in governance networks raises the question of evaluating their effectiveness in *steering* and *coordination* across sectors, and how to measure their effectiveness in improving performance (Sørensen and Torfing, 2009; Torfing *et al*., 2012; Klijn and Koppenjan, 2016; Greenwood, 2016). Of course, what an *effective* governance network looks like, and by whose judgement is it *effective* also needs consideration. Given the multi-sectoral and multi-professional nature of many governance networks, what is

classed as effective or impactful by one member, might not necessarily be the same for another (Klijn and Koppenjan, 2016).

I mapped the layers of communication through my chosen network (see Figure iv), in order to illustrate the complexities in knowledge transfer that often become enmeshed within a wicked issue, such as child neglect. I therefore needed to find an evaluation model that would help me to capture such complexities and issues in the knowledge transfer process.

Within governance network theory, I identified two evaluation methods that could have been adopted as part of this study to support my investigation of the operationalization of LSCBs in communicating and disseminating government sponsored research messages: Koppenjan and Klijn's (2004; 2016) actor, game and network analysis model, and Torfing *et al.*'s (2012) Effectivity Criteria (EC) model.

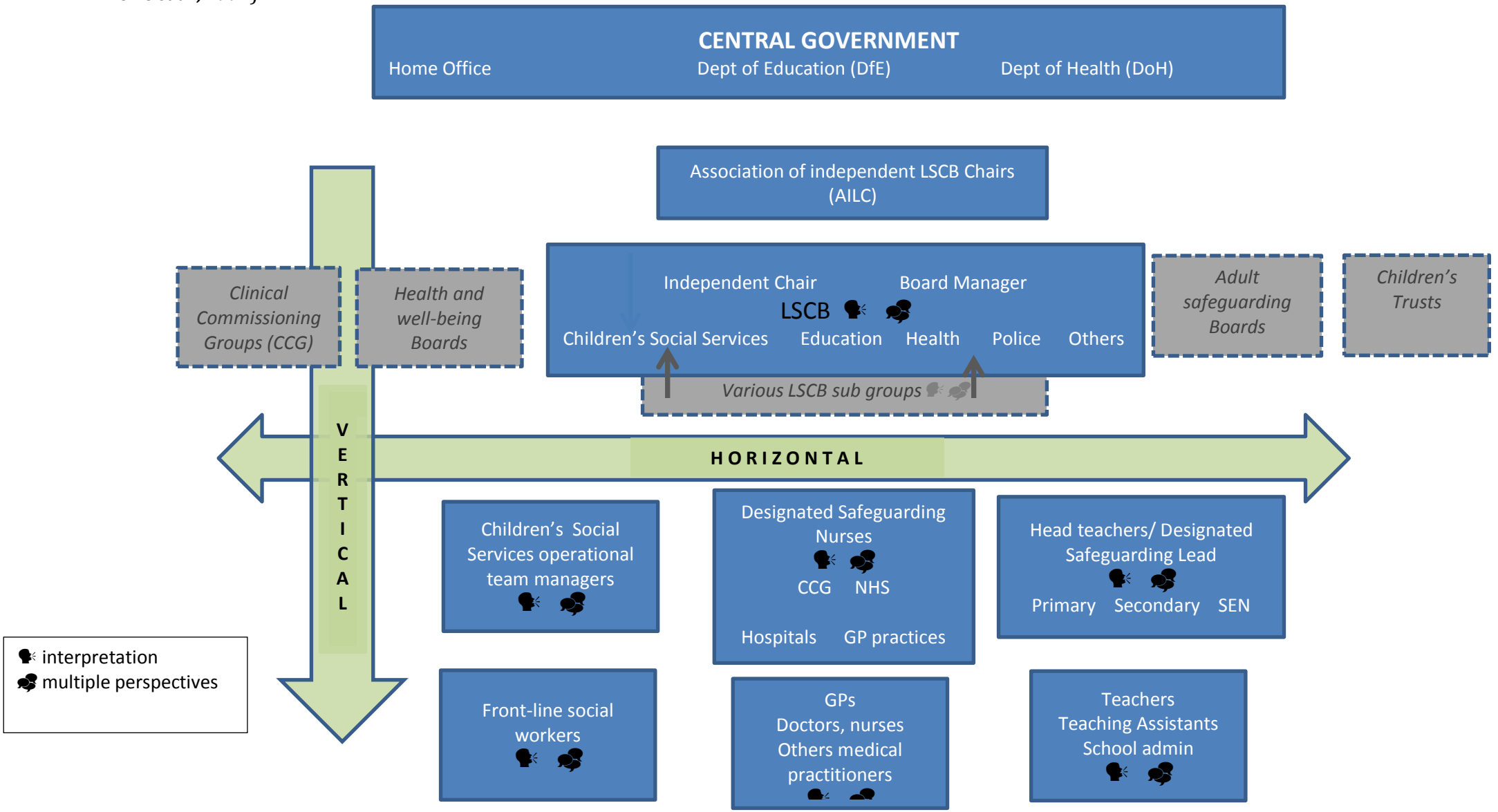
- *Koppenjan and Klijn's (2004; 2016) actor, game and network analysis model*

In relation to this 3-step analytical model, Koppenjan and Klijn (2004, p133) state that 'the actors, game and network analysis must provide an overview of the conditions and circumstances under which complex decision-making processes of wicked problems take place'.

Step one is the *actor* analysis. In short, this step aims to assess 'who the most important actors are, what problem perceptions they hold, and what their position is with respect to the problem situation' (Koppenjan and Klijn, 2004, p135). This helps to identify the different actors' perceptions of the problem or issue.

Step two is the *game* analysis. This explores how decisions are arrived at and solutions are devised.

Figure iv; Mapping the lines of communication and policy interpretation, horizontally and vertically, in relation to this study (based on Goggin *et al.* and Bowe *et al.*, 1992)



Step three, the *network* analysis, focuses on the background of the network actors (for example, home organisation, membership of other networks) which enables a cross analysis to be carried out on such relations and the impact on the rules of the network being analysed.

This model was designed to identify and deal with uncertainties within the network. In this context, uncertainties are more than a lack of knowledge, but include 'strategic and institutional characteristics of the interactions' (Koppenjan and Klijn, 2004, p133). This model cannot remove the uncertainties, but rather, helps to map them out in order that they can be dealt with more effectively within the network, if and when they arise.

In their later publication, Klijn and Koppenjan (2016) refer to process analysis and institutional analysis, rather than game analysis and network analysis respectively, but the important questions posed under these headings are, to all intents and purposes, the same as the 2004 model. I think 'game' and 'network' give a clearer indication of the phases and purposes of the analysis, and so refer to these terms in this thesis.

Although the model is designed to be used sequentially as a 3-stage model, there does not appear to be any reason why just one section of the model could be used, if so required. For example in a study on professionals awareness, or perceptions, of a given issue (for example child sexual exploitation), step one might only need to be used.

One problem of the model that I perceive is that more often than not, governance networks have more than one goal that they are working towards at any one time (for example, LSCBs are not just working towards prevent child neglect, they will have many other aspects of safeguarding work that are taking place simultaneously). These goals can often change, each actor may hold different goals as their priority in comparison with other actors, and the effects may not necessarily be measurable. Therefore, in this scenario, using this model, the researcher would need to be quite specific about what they were setting out to measure within the governance network, rather than allowing the actors to identify the starting point.

This model of governance network analysis could have been adopted for this study because it explores interactions between the actors, including examining how decisions

are arrived at. The game analysis phase might have enabled me to explore the background of the actors, and enabled cross-sector differences (Health, Education, and Children's Social Care) to be drawn on. The network analysis phase might have enabled me to draw on interactions, positive and negative relationships. However, the model (Koppenjan and Klijn, 2004, p136-137, or Klijn and Koppenjan, 2016, pp261-262) is very detailed and poses some specific questions which could be answered using both quantitative or qualitative data, depending on whether what was required was breadth or depth, or both. Therefore, I discounted this model because it would not have allowed me to examine the knowledge transfer beyond the network (from Government into the network and from the network out to front-line practitioners) because it focuses on the internal workings of the network, and not beyond the network.

- *Torfing et al.'s (2012) model of Effectivity Criteria (EC)*

Torfing *et al.* (2012, p172) established a set of six criteria (see Figure v) which could be applied to a governance network in order to evaluate the extent to which it was producing and implementing better policy solutions.

Figure v) Sørensen and Torfing's (2009, p242; 2012, p172) *effectivity* criteria: a model for evaluating effectiveness in networks

1. Produce a clear and well-informed understanding of the often complex and crosscutting policy problems and policy opportunities at hand;
2. Generate innovative, proactive and yet feasible policy options that match the joint perception of the problems and challenges facing the network actors;
3. Reach joint policy decisions that go beyond the least common denominator while avoiding excessive costs and unwarranted cost shifting;
4. Ensure a relatively smooth policy implementation based on a continuous coordination and a high degree of legitimacy and programme responsibility among all the relevant and affected actors, including target groups, client advocacy groups, stakeholder organizations, public administrators and politicians;
5. Provide a flexible adjustment of policy solutions and public services in the face of changing demands, conditions and preferences;
6. Create favourable conditions for future cooperation through cognitive, strategic and institutional learning that construct common frameworks, spur the development of interdependency and build mutual trust.

These criteria help the researcher to establish whether or not a governance network delivers in the way the literature on governance networks promises that they should, as well as enabling the procedural elements of the governance network to be explored. Greenwood (2016, p37) offers a post-positivist discussion on the coordination challenges in evaluating governance. He identifies Torfing *et al.*'s effectivity model as a suitable evaluative model if the purpose of the research is to enable 'the discovery and drawing together of knowledge dispersed across various actors and closely inter-twined with policy actors' incentives to act effectively on the basis of this knowledge'. Greenwood praises Torfing *et al*. for recognizing 'the epistemological dimension' (*ibid*, p37) in evaluating complex interactions in networks, (in contrast to traditional positivist methods) and for leaving open the operationalization of their effectivity criteria. I interpret this to mean getting to the crux of how complex interactions operate and how they are subjectively worked through, rather than simply accepting that complex interactions occur within networks. But rather than being prescriptive in how to apply the model, Torfing *et al.* have simply offered guidelines to be adapted.

From the two evaluation models I selected Torfing *et al*.'s effectivity criteria model because, as my study aimed to examine where guidance about child neglect originate, and how such guidance was passed through the LSCB network to front-line practitioners, this model seemed to provide a good model within which to inform my data collection and examine my research findings (see Figure vi). The criteria, therefore, require a qualitative approach in order to gauge network actors' personal and professional judgements and experiences on the issues being addressed, rather than a quantifiable measure which might enable more exact comparisons between networks to be drawn up (Torfing *et al*., 2012).

Figure vi) Mapping my requirements against the two evaluation models

My requirements from the model	Koppenjan and Klijn's (2004, 2016) actor, game and network analysis model	Torfing *et al.*'s (2012) model of Effectivity Criteria
Allows procedures to be explored	✔	✔
Allows network actors experiences to be explored	✔	✔
Allows multiple perspectives to be explored	✔	✔
Allows researcher to look beyond the network		✔
Malleable to own study		✔
Allows complex issues to be explored		✔

3.3 THE 6 CRITERIA

EC 1. Produce a clear and well-informed understanding of the policy problems.

Torfing *et al.* (2012) link this first criterion to the idea that governance networks are useful for dealing with wicked issues. Due to the complex nature of wicked issues, a complicated and complex discussion process is required of the root causes of the problem, how it should be tackled, and who is accountable and for what. Therefore, before the LSCB can devise a 'clear and well informed' policy and implement it, the actors in the network need to agree on a shared understanding of the problem (Ojo and Mellouli, 2016).

This leads to another problem which might be working through the multiple 'perceptions' (Klijn and Koppenjan, 2016, p46) of a complex problem. This, therefore, requires those within the network to be able to negotiate, discuss and manage conflict that may arise. Attached to this notion are issues around power and influence in terms of policy negotiation and formulating an agreed definition or agreed policy. I will use Torfing *et al.'*s (2012, p48) definition of power which they refer to 'as the *ability to shape* and secure particular outcomes' [my added emphasis]. They closely align this to politics – with a small p – which they class as 'conflict-ridden decisions that are structuring and shaping social and economic relations', and the two are interconnected

in the arena of multiple actors coming together in a networked environment. C*onflict-ridden* here refers to *conflict* as uncertainty and lack of consensus. Despite arguments (for example, Stoker, 1998; Skelcher *et al.,* 2005) to the contrary, networks are *not* without conflict and power struggles and these need to be managed (Torfing *et al*., 2012).

Conflict might be closely linked to power, influence and authority as a challenge to the ability of networks to resolve wicked issues. But conflict may also arise as a contrast to *consensus* (Koppenjan, 2007) and *uncertainty* (Klijn and Koppenjan, 2016). In relation to conflict, Koppenjan and Klijn (2004) note that conflict regulation mechanisms can halt opportunistic behaviour (that is to say, one network actor using their position to further their own or their organisation's interests), especially among newer partners or in newer, less well-established partnerships. Koppenjan (2007) argues that consensus – whilst being viewed as harmonious behaviour within a network - has drawbacks. He argues that a consensus culture and avoidance of conflict, reduces excellence, innovation, creativity and competition in policy design and implementation. Network actors become complacent and do not challenge the choices being made. By contrast, conflict can demonstrate the importance that actors place on certain issues and this can drive discussion, debate and possibly the gathering of information or research on a certain issue in order to find new solutions. Both points are valid in my view. I interpret conflict, lack of consensus and uncertainty as positive elements of networks, in as much as they ensure that policy problems and decisions are examined from all angles, and that no network actor is being enabled to use their position for their own gain.

Conflicts may also arise when network actors are operating across other governing structures. For example, each actor within the network has to balance the needs of the network with the remit of their own home agency, or other networks to which they also belong. This can lead to the individual having to grapple with different ideologies and values from various angles. That said it is important to note that a certain level of conflict can be beneficial in terms of turning autocratic adversaries into mutually respectful collaborators who may sometimes disagree, when the disagreement enables more constructive discussion and innovative ideas to emerge (Mouffe, 2005 as cited by Torfing and Sørensen, 2014). This is drawn on in the research in terms of exploring how

LSCB representatives balance the remit of the LSCB with that of their home organisation.

In theory, there is no hierarchy between the participating members within the LSCB, as each participating member is horizontally interdependent and autonomous, guided by an Independent Chair. This does not necessarily mean that each actor is 'equal in terms of authority' within the LSCB (Mayntz, 1993b as cited by Sørensen and Torfing, 2007a). Some partners may have greater influence due to length of time in post or time served on the Board, which means they might carry greater *sway* than others, but this may equally come down to professional status and professional confidence upon discussing certain issues such as challenging child neglect.

In relation to managing conflict in horizontal networks, it is suggested that the manager or chairperson of the network should take on a facilitator-type role rather than one of leader or director. Koppenjan and Klijn (2004, p11) describe them as being 'mediator and stimulator of interaction and not one of central director'. That said, they need to be careful not to get drawn into conflicts between the actors and to remain impartial. This could be seen within the LSCBs with the shift towards having an Independent Chair following the Laming report (2009).

EC 2. Generate innovative, proactive policy that match the perception of the problems facing the network actors

Torfing *et al.* (2012) refer to the extent to which the actors engaged in a governance network bring together different ideas and perspectives which enable creativity, innovation and proactivity to be utilised in the policy making process. Of course, this depends on how much freedom networks are given to be self-organising and self-governing.

At the macro level, some argue (Rhodes, 1997, 2017; Cairney, 2009) that with the shift from government to governance, government's power has been depleted. In the UK, the key example is decentralisation, whereby government powers are devolved to local organisations through contracting out services. This, in turn, renders the government as *inspector* of services, rather than *deliverer* (Rhodes, 1994; Bell and Hindmoor, 2009),

thereby enabling local-level policy makers to be more innovative, proactive and creative in how they design and implement policy at the local level.

Others (Newman, 2005; Torfing *et al*., 2012; Torfing and Sørensen, 2014) argue that government's power and authority has not been depleted, but it has simply shifted. This, therefore, means that the government – as *inspector* - exerts power over the networks by 'regulating and controlling the political agenda' (Torfing *et al*., 2012, p55), potentially eroding the opportunities for innovative and proactive policy-making. I am more inclined to agree with this latter view because of the evidence around the increase in managerialist measures (such as performance targets) and inspection measures (such as Ofsted) which the government has implemented as a way to control local strategic and operational practice.

According to Torfing and Sørensen (2014), central government's power remains, but it has been transformed into that of *metagovernor* of the governance networks (Newman, 2005; Sørensen and Torfing, 2007a; Klijn and Edelenbos, 2007), that is to say, the coordinator and, what I view to be the *puppet master,* holding the strings of the vast array of growing networks and partnerships across society. With the growing number of networks, there needs to be an overarching authority (that is to say, the government) to be able to regulate their activities if they are to be an efficient asset to public life in terms of delivering more (service) for less (resources) (Sørensen and Torfing, 2007a; Rhodes, 2017). This can reduce creativity, innovation and proactivity in policy-making networks, by retaining control of their agendas.

Flinders (2005, p86) makes an observation which is highly relevant to this argument. He questions how a government could be committed to *devolving power* yet was viewed as 'having a strong centralising and controlling approach to governing'. My interpretation of this is that government on the one hand shifted power from itself to local strategic bodies, but at the same time still wanted to have some control over what those strategic bodies were doing locally. This might be viewed as the government absolving itself of responsibility by pushing strategic bodies centre stage, whilst it retreats and controls from backstage. This is very applicable to the role of the LSCB which, on the one hand, was charged with steering safeguarding policy, yet at the same

time was not given the '*teeth'* to do so (Horwath, 2010), and therefore, the opportunities for innovation, creativity, and proactivity, with which to commit that policy into practice.

Managerialist measures are interesting in relation to this criterion on 'innovative' and 'proactive' policy. On the one hand, managerialism is the development of performance targets and indicators in order for government to be able to *monitor* and *control* front-line practice, in an attempt to create a *compliant* culture (Munro, 2011). On the other hand, however, this notion of performance targets and monitoring conflicts with the ideas of innovation, proactivity and creativity that emerged with governance networks because neglect is subjective, not easily categorised, and is difficult to translate into a checklist of targets (Morrison, 2010), or an audit trail for monitoring purposes.

Peters (2013) offers an interesting perspective on policy coordination, in terms of trying to balance out the vertical, hierarchical dominance from horizontal utilitarian approach to policy coordination and implementation. He seems to approach the issue of policy and 'collective action' (Peters, 2013, p570) from a utilitarian perspective. Within this, he assumes that network actors will cooperate in order to collectively achieve better outcomes for their service users. Yet, at the same time he recognises that government is still trying to maintain some control in order to manage a coherent approach to delivering policy. This can have a positive outcome in that, as Peters (2013) argues monitoring practice can sometimes lead to strategic level leaders learning from front-line practices, because practitioners may have found more innovative and creative ways for implementing a given policy and dealing with clients. He states, 'Public servants in the field charged with implementing programmes when faced with real clients with multiple needs may find better ways of addressing the issues than would senior public servants back in the national capital' (*ibid,* 2013, p578). There are some flaws with this view in that, firstly, this suggests that senior managers are taking an interest in what front-line practitioners are doing and with what effect, and secondly that they are open to learning from what seems to be working in their area. The other factor to consider might be the cost implications involved in practitioners innovative and creative methods, and whether or not it is financially sustainable.

EC 3. Reach joint policy decisions that go beyond the least common denominator while avoiding excessive costs and unwarranted cost shifting

This criterion predominantly reflects the dilemma that governance networks have in terms of reaching joint decisions and their financial implications in terms of footing the bill for a policy solution. It focuses on seeking the extent to which network actors are prepared to pay for initiatives upheld within a policy decision and to what extent are those costs pushed outside of the governance network to unwitting organisations. Whilst both aspects are relevant to the effective operation of LSCBs, only the focus on reaching joint policy decisions was directly relevant to this study, which was concerned with knowledge transfer and communication.

Networks may need to operate within and across other networks, and these should be viewed on a horizontal, level playing field rather than within a hierarchical structure. This is what makes governance networks different to other forms of governance, and why this is wholly relevant to the discussion of LSCBs and wicked issues such as child neglect.

Furthermore, the horizontal structure of networks has seemingly replaced hierarchies (Koppenjan and Klijn, 2004). But this has caused fragmentation of service delivery as universal services are provided by public, private and voluntary sector services. Therefore, despite arguments to the contrary, the government's role as metagovernor might be deemed necessary in order to coordinate the parts of the jigsaw and monitor the budgets/costs.

EC 4. Ensure a smooth policy implementation based on continuous coordination among the actors involved.

Given the web of governance networks and fragmented service delivery, policy implementation and coordination through a network is not an easy task. Accountability can be closely aligned with notions of continuous coordination, implementation and program responsibility. These concepts have led to a stronger emphasis on organisations as a whole, as well as individual practitioners being held responsible, or accountable, by other people for their actions (Esmark, 2007; Klijn and Koppenjan, 2016; Jacobs and Schillemans, 2016). In this respect, accountability may flow vertically

(that is to say, bottom up) or horizontally across the network. In order to be held accountable, someone (within government, or a network, or an organisation) needs to set the benchmarks for the goals, or behaviour and expectations that are required to be met, and by which an actor is scrutinized for adhering to, or not (Esmark, 2007; Klijn and Koppenjan, 2016).

There is a close alignment between accountability for one's actions, and being scapegoated when something goes wrong (Esmark, 2007; Jacobs and Schillemans, 2016) and nowhere is this more evident than in media reporting in the area of social work. Peters (2016) examined how network actors change their behaviour because of the media. On the one hand, the increase in media encroachment into governance and policy making has opened up the policy agenda to scrutiny and accountability.

Furthermore, print media closely aligns itself to a particular political party (Peters, 2016). In the UK, most newspapers (especially tabloids) are right wing, and three companies (News UK, Daily Mail and General Trust [DMGT], and Trinity Mirror) control almost 70% of national newspaper circulation. This exposes the readership to exceedingly biased information. Nowhere is this more obvious than with child protection cases where a child tragically dies, and there follows a media witch-hunt for those practitioners involved with the case. This was particularly evident in the case of Victoria Climbié in which the social worker, Lisa Arthurworrey, was put on the Protection of Children Act (PoCA) list which banned her from working with children (Davies, 2014). Sharon Shoesmith, the Head of Haringey Children's Services at the time of the death of Baby P was also publicly castigated, and seemed to have a trial by media, with only the Guardian publicly defending her, and the work of social workers. Following the death of Daniel Pelka in 2012 there was a media drive behind David Cameron's call to jail social workers in cases where children are killed by their parents or carers, and social workers allegedly failed to intervene. Peters (2016, p16) likened this to being in a 'goldfish bowl' and 'knowing that every action will be subjected to close inspection and media coverage'.

Such media *scapegoating* drives up and reinforces accountability of actions. Media coverage of such high-profile cases, it might be argued, has driven up standards within

children's child protective services in recent years. As Jacobs and Schillemans (2016, p23) stated 'the media are an important trigger that "activates" formal accountability institutions, that is, parliaments and regulators, and can also be an instrument of accountability in itself'. Peters (2016, p16) discounts this argument, stating that all this does is 'produce safe decisions that may not produce the type of policy change required', which is not useful or productive when dealing with wicked issues which require more complex, and innovative policy solutions.

Accountability within governance networks is problematic for a number of reasons. Firstly, the number of organisations involved in a network and their interdependence may mean that organisations resist the responsibility, and therefore, not accepting joint-accountability for elements that are delivered by someone else within the network, (Esmark, 2007; Klijn and Koppenjan, 2016). Bache *et al*. (2015, p65) refer to an 'accountability vacuum' in governance structures, which in turn leads to 'fuzzy governance' (*ibid*) and 'fuzzy accountability' (*ibid*). Whilst their research is discussing climate change, these terms are also useful in explaining what is occurring here. They argue that politicians favour a complex governance architecture because it is easier to lose the 'socio-political challenges' (*ibid*) in the complex structures and place the blame for unpopular actions, and accountability for that onto someone, or something, else. Within their research, Bache *et al.* (2015) identified that, in the area of climate change policy, a combination of multiple organisations, a lack of quality concerns, and the government's drive to push down responsibility and accountability, has designed governance structures rife with blame games and blame avoidance. This applies to understanding LSCBs and how they operate.

Furthermore, those actors sitting on the network and representing their home organisations can represent, speak for and commit (financially, strategically) their home organisation to the values and remit of the network. Similarly, networks may need to operate within and across other networks, and these should be viewed on a horizontal, level playing field rather than within a hierarchical structure. This is what makes governance networks different to other forms of governance, and why this is wholly relevant to the discussion of LSCBs and wicked issues such as child neglect.

EC 5. Provide a flexible adjustment of policy solutions in the face of positive and negative policy feedback and changing conditions.

Governance networks in theory should reduce implementation resistance (Sørensen and Torfing, 2007a). Goggin *et al.* (1990) aimed to establish a 'communications model' (Goggin *et al.,* 1990, p19) in order to analyse policy implementation within inter-governmental partnerships in the U.S. They explored what influences the acceptance or rejection of a new policy between each *level* of government. While the examples used by Goggin *et al.* relate to American federal/State relations, the notion of levels, or layers of Government, and the difficulties of policy flow between these layers have wider applicability. It can be applied to the field of child protection within England, where – I would argue - the flow of policy guidance through diverse layers suggests a compliance model is needed for successful policy execution which discounts elements of policy resistance or even misinterpretation of policy guidance.

Bowe *et al.* (1992) draw on the qualitative notion of communicating and interpreting 'policy texts' (that is to say, official policy documents including speeches and commentaries). They claim that policy texts are not necessarily clear and may be misunderstood. Crozier (2008) makes a similar point, noting that guidance is transformed as recipients of that information re-interpret it in ways not intended by the sender. Their point is that, policy documents will evolve through (re)interpretation by agencies and individuals along the communication and dissemination continuum. They state that 'policy is not simply received and implemented ... rather it is subject to interpretation and then "recreated"' (Bowe *et al*., 1992, p22) and this will occur in a governance network with actors approaching an issue from different perspectives (as was identified under criteria 1). Lupton *et al.* (2001, p49) concur stating that 'the transition from "knowing" to "doing" is a complex and unpredictable process, affected by a range of factors at the individual, group and social level'.

Goldsmith and Eggers (2004) discuss how to communicate through networks, using technology to connect network actors. They (2004, p94) highlight the importance of 'a digital backbone' to support a successful network and ensuring good electronic links to all of the actors within the network. But equally they highlight the disadvantages of the demise of face to face communication as working together moves beyond a single

organisation into networks beyond the organisation. In today's digital society, there has been a switch from face to face communication to a bombardment of email or other electronic communication, which can become unmanageable (Goldsmith and Eggers, 2004; Korkki, 2013; Batista and Figueiredo Marques, 2017). Similarly, electronic communication may cause confusion about what is being required as meaning may not be clear. Goldsmith and Eggers (2004) are right to argue that a governance network needs coherent electronic links to the relevant network actors, but in relation to LSCBs, meetings of the network actors will be held face to face on a regular basis, and certain information between meetings may be circulated electronically, as a secondary communication medium.

Of course, this all makes the assumption that front-line practitioners are able to keep up to date with policy and regulation changes. Many practitioners are already overwhelmed with workload pressures and either do not have time to locate relevant policy documents or do not have the time and space to read and comprehend such documents. Klijn and Koppenjan (2016) refer to an information overload and ambiguity of messages, as information in a variety of formats from various perspectives rains in on micro level actors. As Laming (2003, section 1.26, p5) noted when conducting the inquiry into the death of Victoria Climbié, the greatest defence of front-line practitioners was "no one ever told me", as senior managers distanced themselves from the reality of practice.

Lupton *et al.* (2001, p40) made the connection between regulation and communication, noting that replacing professional knowledge and judgement with evidence-based practice makes two assumptions. Firstly, it assumes that judgement can be 'codified' (*ibid*) and, therefore, generalised and communicated across sectors or professions. Secondly, there is an assumption that once the recipient has received such codified information; they will *know* to act on it, and *how* to take an appropriate, unhindered course of action. This again assumes a compliant culture and does not consider – as noted by Cooper (2013) - that busy front-line practitioners may find it difficult to keep up to date with the latest practice recommendations and changes.

Lupton *et al.* (2001, p45) highlighted that communication and information sharing are also likely to prove problematic when organisations are undergoing change, 'especially

when professionals do not feel in control' (*ibid*). Restructuring causes feelings of uncertainty which impacts on knowing how to, or being willing to, share information, especially if restructuring creates job insecurity, increased workload, or if there are feelings of competition between agencies fighting for survival or competing for the same funding streams.

EC 6. Create favourable conditions for building mutual trust.

Both trust and shared values are an attribute of successful governance networks. Bevir and Rhodes (2007, p79) state that 'trust is essential for co-operative behaviour', whilst shared values act 'as the glue that holds the complex set of relationships in a network together'. Successful governance networks will develop protocols and rules within the network for sustainable joined-up working that stands the test of time. This is the development of network cohesion, a sense of mutual responsibility and, of course, trust which arises through continuous working together for a common goal. Trust must be mutually beneficial and advantageous for each of the partners in the network. Trust is defined as 'the perceptions of the good intentions of another actor' in the network, and 'the expectation that the other actor will respect the interests of the "trusting" actor' and refrain from opportunistic behaviour' (Koppenjan and Klijn, 2004, p83). Actors trust that other actors will deliver as expected. Governance networks which can foster an atmosphere of positive conflict in terms of open debate and discussion will build a trusting environment in which actors feel safe and valued enough to openly air their views, concerns and ideas about wicked issues (Koppenjan and Klijn, 2004; Klijn and Edelenbos, 2007).

That said, trust does not just happen within a network. It needs to be fostered over time, (which is very often resource intensive) and this will happen as people's social and political experiences within the workplace and indeed within partnership working is nurtured and developed, (Sørensen and Torfing, 2007b; Davies, 2011; Klijn and Koppenjan, 2016). Therefore, the longer a network exists the greater the level of trust is likely to be, and the more successful the governance network. Interactions are built on and rooted in mutual trust of fellow members rather than being contractually connected. Of course, where this notion fails is that, whilst governance networks have a degree of autonomy from the government, it still controls the overall structure in which

networks operate (as explored as part of the second criterion), and have ways to stop, or change, the operation of some networks should it so wish. This creates an uncertain operating environment for the actors in the network, but also affects trust-nurturing and trust-building within the network, which may suddenly be required to change tack.

Conversely, trust can easily become mistrust. If one partner fails to deliver on one occasion, then previous experience and perceptions may prevail and the actor may be given the benefit of the doubt. But if the partner continuously fails to deliver, trust is eroded and the future stability of the network may be in jeopardy (Koppenjan and Klijn, 2004). Furthermore, trust may leave newer members of the network more vulnerable to more confident, autocratic network actors, and more susceptible therefore, to their *professional sway*. This can equally result in exploitation of the newer professional's views which may ultimately lead to misplaced trust as their experience and confidence as a network actor grows.

Whilst Koppenjan and Klijn, (2016), Torfing *et al*. (2012) and Sørensen and Torfing (2007b) are emphatic about the need for trust within governance networks, not all research on governance networks is quite so optimistic about the need or requirement for trust within the network (Davies, 2011). In such cases, trust was either seen as not a strong enough concept on which to build and sustain a governance network, being resource interdependent was a stronger bond than trust, and even that low-levels of trust did not necessarily lead to network failure if the partners operated pragmatically (Davies, 2011).

In my view, in relation to wicked issues, such as child neglect, those practitioners working in such fields are doing so for utilitarian purposes; they generally want to make a difference to society in some way. Therefore, those operating within governance networks in order to resolve a wicked issue will put to one side their own individual ideologies and values in order to create a joint, agreed ideology and values base which will be for the greater good. In order to do this, they will automatically trust the other network actors, until a point when someone gives them some reason to question that trust.

3.4 SUMMARY

Governance network theory was identified as being a useful lens through which to examine multi-agency network arrangements dealing with wicked issues, such as child neglect. It is useful in this context because it takes into account multiple perspectives of the network actors, and how they interact in order to produce and disseminate policy and practice guidance. Further to this Torfing *et al.*'s effectivity criteria were explored as being a useful analysis framework for this research.

In short, this research offers a timely opportunity to explore views on the role of the LSCB from a practitioner level, in order to offer an argument for the necessity and importance of LSCBs, as a governance network to steer child protection policy and practice in local areas.

The next chapter will move on to examine and justify the choice of research methods being used within this study.

Chapter Four: Methodology

4.0 INTRODUCTION

This chapter discusses the rationale and justification for the methods chosen within this qualitative study. Details on ethics issues and approval are also discussed.

4.1 THE RESEARCH AIM

Through the literature review I identified the need to examine:

- How government guidance is operationalized, communicated and filtered through to front-line practice.
- How effective the LSCB is as a mechanism for transferring such guidance.

Understanding such processes should help LSCBs identify gaps in their joined-up working and communication practices to front-line practitioners.

In order to do this, I chose to focus on how government guidance about child neglect are communicated to, and implemented by, Local Safeguarding Children Boards (LSCBs) and then down to frontline statutory services. The research was guided by the following research questions:

1. How does the Government interact with LSCBs to disseminate and drive forward its child protection guidance?
2. How does the LSCB identify or learn about the child protection (neglect) guidance from Government?
3. How does the LSCB communicate child protection (neglect) guidance to operational teams within statutory services?
4. When developing local child neglect policy, what factors help or hinder policy implementation from LSCB strategic level to operational practice?

4.2 THE METHODOLOGICAL PARADIGM

There are two major research paradigms: positivist research and interpretivist research. The positivist paradigm is associated with the works of Auguste Comte who believed that only that which can be experienced by the senses, and measured in an objective, quantitative way is real knowledge. Everything else should be rejected (Babbie, 2001, 2017; Bryman, 2008). In this paradigm, research should be value neutral

and the researcher completely impartial. This paradigm has been criticised because the observer is not 'value-free' (Robson and McCartan 2016, p21). Therefore, post-positivists accept that the researcher can influence what is seen and how it is recorded. Within this, however, they still align themselves with an objective, theory-testing approach, rather than theory building. Within my study, the positivist and post positivist paradigm were not appropriate because such rigid and randomised design requirements, needed within objective theory testing research, are impractical when exploring aspects such as human interaction, views and opinions (Robson, 2011, Robson and McCartan, 2016).

The interpretivist paradigm was appropriate because this is concerned with people's perspectives, experiences and understandings of particular issues in their natural settings, for example where they live or work (Denzin and Lincoln, 2005; Ormston *et al*, 2014; Robson and McCartan, 2016).

4.2.1 *Interpretivist data collection*

Qualitative methods of data collection were used to collect thick descriptions (Lewis *et al*, 2014; Bryman, 2008; Thomas, 2009) of practitioners' understandings of policy and research guidance in relation to child neglect. Thick description within interpretive research requires the researcher to not just proffer simply what was observed/said (which would be thin description) but requires the researcher to give more context to the findings (such as mannerisms, reactions, environment). This extra context allows the reader to judge the meanings *as interpreted by the researcher* in order to gauge the *validity, credibility* and transferability of the findings to other similar settings (Bryman, 2008; Thomas 2009). Within this study, , my role as the qualitative researcher was to collect thick descriptions from my research participants, and interpret the meanings attached to the issues being studied (Denzin and Lincoln, 2005; Robson, 2011), using a governance network framework through which to analyse and assess the findings, as opposed to trying to prove a theory or hypothesis.

4.3 THE RESEARCH METHODS

4.3.1 Designing the qualitative case study

A case study is a flexible, empirical approach that is appropriate for exploring a phenomenon or policy implementation and processes of change within real life situations, or organisations (Hakim, 2000; Yin, 2009). What makes the case study approach popular within interpretive research design is the variety of research tools that can be used within it (for example, interviews, observations, documentary analysis, focus groups and so on) in order to examine something in depth, gaining a multiplicity of views (Hakim, 2000; Denscombe, 2017; Lewis and McNaughton Nicholls, 2014). Hakim (2000, p59) likened the case study approach to the 'social research equivalent' of a microscope in other scientific experiments. I interpret this to mean that it puts an intense spotlight on something which needs to be scrutinised in varying magnifications.

There are criticisms of the case study approach, such as generalisations cannot be made to the wider population from one (or even multiple) case studies (Denscombe, 2017; Bryman, 2008; Gilbert, 2008). Others (Yin, 2009; Thomas 2011; Flick 2014) argue, however, that theoretical generalisation, or theoretical replication, can instead be applied to case study research (see below). But, sometimes within a case study, the purpose is not to be able to draw generalisations, but to research an instance because of its uniqueness. Positivists argue that case study research does not provide hard data and lacks scientific rigour that quantitative methods provide. Yet the counter argument to this are that the purpose of the case study is to provide an in-depth examination of a particular phenomenon which cannot be gained through statistical measures alone (Denscombe, 2017). Furthermore, the fact that a key element of case studies is the in-built triangulation achieved by drawing on a variety of methods as part of its design, and the multiplicity of views gained, strengthens credibility of the research (Hakim, 2000). In relation to their use of multiple methods and in-built triangulation, Yin (2009, p117) highlights that 'those case studies using multiple sources of evidence were rated more highly, in terms of their overall quality, than those that relied on only single sources of information'.

I decided that the case study approach was relevant in my study because I wanted to put under the social *microscope*, the knowledge transfer processes of the LSCBs, by gaining a multiplicity of perspectives.

Case study research may include single or multiple cases. A single case study might be relevant if:

- The case represents a critical case, or test case, of a particular theory
- It is an extreme, unique, deviant or outlier case, or is a typical, or critical case.
- The case is longitudinal.

(see Hakim, 2000; Denscombe, 2017; Yin, 2009; Thomas, 2011)

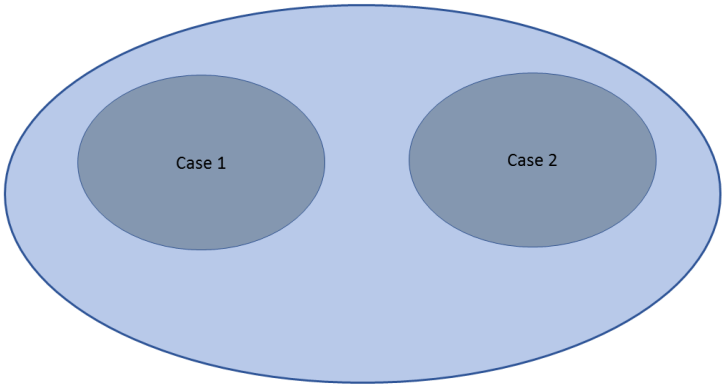
By contrast multiple case studies may be relevant if the purpose of the study is more specifically the *phenomenon* (in this study the LSCBs as a means for knowledge transfer and policy implementation) being studied rather than the *case* (a specific LSCB) within the study. Within this approach each case serves to offer a comparison of the phenomenon in contrast to other cases, to generate a 'cross-case analysis' (Thomas, 2011, p141).

For this study, I had initially anticipated that a single case study, carried out on one LSCB area, would be appropriate. I carried out a mapping exercise of LSCB membership within all West Midlands LSCBs in order to try and find an element of parity between LSCB membership in terms of roles or agencies involved, but it was clear that there was no standard set up across the different LSCBs. Therefore, given, that I found no *model* LSCB, I felt that trying to assess and interpret knowledge transfer in one LSCB might not offer sufficient useful insight. I decided that a multiple case study approach of two LSCBs, would generate more useful data.

Upon selecting a multiple case study approach, two further decisions needed to be made: whether or not to nest the case studies, and whether or not to carry them out sequentially. The two case studies were selected from one region, but this was a choice of logistics rather than being a key focal element of the phenomenon in question. Therefore, the case studies were not nested within the wider case (the region) (Thomas, 2011) (see Figure vii). I could have selected two case studies from different regions but in order to offer a more useful basis of comparison, it was more useful to select two case

studies working within the same regional demographics. Fieldwork within the case studies was carried out in parallel rather than sequentially. The fieldwork of the second case study was not dependent on the findings from the first case study; therefore, I did not need to complete one case study before beginning research in the other.

Figure vii: Illustrating the multiple case studies.



4.3.2 *Selecting the multiple case studies: one region and two local areas*

- Firstly, selecting the region

As child neglect is deemed to occur most often in families living in areas of poverty and deprivation, this was a good indicator to use when selecting the region**.** In terms of child neglect, the West Midlands region has the fourth highest rate of child neglect at 12.7% of the national figure, (see Figure viii).

Figure viii: No. of children who were subject to a child protection plan because of child neglect at 31st March 2013.

	No.	%
England	17930	100
London	2,620	14.6
South East	2,480	13.8
North West	2,380	13.3
West Midlands	**2,280**	**12.7**
Yorkshire & The Humber	2,030	11.3
East of England	1,730	9.6
South West	1,640	9.1
North East	1,560	8.7
East Midlands	1,210	6.7

Source: www.education.gov.uk

The Department for Communities and Local Government (2011) indicated that the West Midlands region had consistent levels of multiple deprivation as opposed to other regions which fluctuate between the one percent and 20% most deprived. As illustrated in Figure ix, the West Midlands region had the fourth highest percentage (at 9%) of the very highest index (1%) of multiple deprivation ranks and has the third highest (15%) of the top 20% of multiple deprivation ranks. Other areas (for example, East of England and South West) also had fairly standard levels of deprivation but the percentages were much lower than the West Midlands overall. Yorkshire and the Humber had consistent levels with a greater percentage of deprived areas falling in the one percent most deprived category, but as shown in the previous table its child neglect rates were lower than the West Midlands.

Figure ix: Regional breakdown of levels of deprivation

Region	1% most deprived	5% most deprived	10% most deprived	20% most deprived
North East	12%	10%	9%	8%
North West	52%	35%	28%	22%
Yorkshire and The Humber	17%	18%	17%	14%
East Midlands	5%	5%	6%	7%
West Midlands	**9%**	**17%**	**17%**	**15%**
East of England	2%	2%	3%	4%
London	0%	7%	12%	19%
South East	3%	4%	4%	6%
South West	2%	3%	4%	4%

(Source: Department for Communities and Local Government 2011 p7)

- *Secondly, selecting the LSCBs*

Ofsted (2014) reported that some LSCBs do not grasp the extensiveness of child neglect within their areas which makes it difficult to evaluate their effectiveness in responding to it. It also reported that the areas 'providing the strongest evidence of the most comprehensive action to tackle neglect were more likely to have a neglect strategy and/or a systematic improvement programme addressing policy, thresholds for action and professional practice at the front-line' (Ofsted, 2014, p5). As this research focused on how child neglect guidance was communicated and implemented, it was necessary to purposively select LSCBs in the West Midlands who had identified child neglect as a key priority for action within their current Business Plan and Work Programme, in order that there was neglect guidance to follow through the transfer and communication processes.

I conducted a mapping exercise of the priorities of each of the LSCBs in the West Midlands region in order to identify which two had the strongest emphasis on child neglect,. Despite the role of LSCBs in overseeing child protection practice and training within their areas, not all LSCBs in the West Midlands classed child neglect as an area of priority for their strategic work. At the time of selecting areas, both Area A and Area B had developed, or were, developing policies related to child neglect which was the reason they were selected for this study.

4.3.3 *Sampling of research participants*

The sampling of participants was achieved using a purposive method (Babbie, 2001, 2017; Denscombe, 2017). This required the sample to be 'hand-picked' (Denscombe, 2017 p41) based on prior knowledge of the specific population in question and in relation to the aims of the research project (Babbie, 2001, 2017).

Through the mapping exercises conducted for the purposes of selecting LSCBS, I found that LSCB membership varied substantially. That said, however, there are some core sectors which are covered: Education, Local Authority (including Social Services), and Health. These are also the core funders of the LSCB (Davies and Ward, 2012). In terms therefore of 'hand-picking' the participants, I decided that I needed to include:

- The Assistant Directors of Children's Social Services (rather than the Director) because they have responsibility for safeguarding children in their area (whereas the Director is also responsible for education services as well).
- The Independent Chairs of the participating LSCBs because they are independent from any of the other organisations (often are not from the area), and they have a key role of managing and facilitating the discussion, and decision-making processes.
- LSCB representatives from Health, Education and Children's Social Care because these sectors are the core funders of the LSCB and, for comparative purposes, I could ensure that there would be a representative from each of these on the participating Boards (given the disparity of Board membership).
- Designated Safeguarding Managers from Health, Education and Children's Social Care but managers who had never sat on any LSCB because I wanted to explore the views of those with no previous experience of the Board and how it functions. I wanted managers from Health, Education and Children's Social Services though because I wanted to trace guidance filtering through these sectors.
- Front-line practitioners from Children's Social Care because these are the practitioners dealing with child neglect on a daily basis and for whom the transfer of child neglect guidance is particularly important. It might have been useful to speak to front-line practitioners within Education and Health, but I

think that the standard answer (which is the right answer in these cases) is that "I would speak to the designated safeguarding lead".

At this stage, I excluded other LSCB-related roles (for example the Board Manager, the Training Coordinator) because I did not consider them to have a specific role in the decision-making and policy implementation process. They were also not clearly spanning organisational boundaries in the same way that board representatives from health, education and children's social care were, therefore the knowledge transfer processes would have been different.

For the purposes of this research, I organised the interviewing process into four phases, essentially following the policy implementation and communication process crudely from top to bottom. These phases were divided as detailed in Figure x. The actual number of participants is detailed in Figure xi.

Figure x: Proposed participants

Phase 1	**Phase 2**	**Phase 3**	**Phase 4**
Children's Social Services	**LSCB participants**	**Designated Safeguarding lead, (non-LSCB)**	**Front-line practitioners,**
Relevant to research questions 1, and 2	*Relevant to research questions 1, 2,and 3*	*Relevant to research questions 3, and 4*	*Relevant to research question 4*
1 CSC Assistant Director	1 Independent Chair 1 Health 1 Children's Social Services 1 Education	1 Health 1 Education 1 Children's Social Services	1 group of 6-10
x 2 case studies			
Total; 2 Assistant Directors	8 LSCB representatives	6 safeguarding managers	2 group discussions of 12-20

Figure xi: Number of participants in the research.

	ROLE	**Area A**	**Area B**	**TOTAL**
Phase 1	CSC Assistant Director	1	1	2
Phase 2	LSCB Representatives	4	4	8
Phase 3	Non-LSCB designated safeguarding leads	4	3	7
Phase 4	Front-line practitioners	11	5	16
	TOTAL PARTICIPANTS	20	13	**33**

Whilst the fieldwork in each case study was carried out in parallel, the interviews within each case were conducted sequentially. Fieldwork from phases one and two were completed before moving onto phase three. Phase three was completed before commencing phase four. This enabled me to check information given in phases one and two by following up responses with participants in phases three and four. For example, by asking participants in phases one and two, how they disseminated certain information, I could then ask participants in phases three and four if that was how they viewed it, and gain perspectives on effectiveness.

4.4 DATA COLLECTION

4.4.1 *Semi-Structured Interviews*

I used semi structured interviews. These enable the interviewer to gain in-depth information from the interviewee with some flexibility in running order, whilst ensuring that key ideas or questions are covered in each interview (Fielding and Thomas, 2008; Thomas, 2009; Robson and McCartan, 2016). The semi-structured interviews in this research were carried out either face-to-face (phases one and two), by telephone (phase three) or in groups (phase four). Data were collected between March 2015, and August 2015 (with one group interview being carried out in summer 2016). All interviews were recorded using a Dictaphone (with participants' consent, which will be discussed under the Ethics section). In addition, handwritten notes were made during each interview. Each interview was transcribed verbatim for data analysis purposes.

i) Face to face interviews

In phases one and two, I used face to face interviews to gain the perspectives from the Assistant Director of Children's Services and representatives of the LSCBs. Flick (2014, p230) discusses 'elite' interviews as interviews with people occupying senior posts in institutional hierarchies who can offer an insight into institutional systems and routines. Requesting an individual face to face interview places importance on the issue in question inasmuch as the researcher has specifically sought individuals with knowledge of a particular phenomenon and demonstrates to that participant that you are placing value on their views in relation to this phenomenon (Cohen, Manion and Morrison, 2011). Furthermore, a face to face interview enables the researcher to pick up

on non-verbal cues such as body language, which adds to the level of thick description being collated.

In interviewing such senior, or 'elite', persons, Flick (2014, p231) highlights that the researcher needs to take the position of the '*informed* outsider' [my added emphasis] if they want to be taken seriously and be deemed as a 'competent exchange partner' (*ibid*). Several of my research participants made comments within their interviews which lead me to assess that the face to face interviews were deemed successful by the participants. One participant said that the interview was "cathartic" [Area B, LSCB member, Health], whilst another described it as being "a mutually beneficial taped interview" [Area B, Independent Chair] because it would focus the Board's discussions in the future on child neglect policy.

These initial 'elite' interviews required more time than subsequent interviews in order to establish a solid basis for further exploration within the manager and practitioners elements. I calculated that these interviews needed about 1 hour, and 1 hour was a realistic amount of time to request of senior professional (Flick, 2014). Robson (2011, p281) notes that 'anything under half an hour is unlikely to be valuable; anything going much over an hour may be making unreasonable demands on busy interviewees. All face-to-face interviews were recorded using a Dictaphone, along with field notes recorded by the interviewer. The shortest interview lasted 40 minutes and the longest was 70 minutes.

ii) Telephone interviews

I had initially planned to conduct face-to-face interviews with safeguarding managers in phase three, but due to issues of time (on my part and the on the part of the participating safeguarding managers), cost and, in an attempt to increase participant numbers, I decided that telephone interviews would be appropriate. The telephone interviews had some of the same benefits as the face to face interviews (in terms of only talking to one person at a time, and therefore being confident about whose opinions are gained from whom, being able to follow-up interesting points, demonstrating a value in the interviewee's knowledge and experience of a particular phenomenon by purposively seeking out specific individuals with certain expertise). One disadvantage

to undertaking telephone interviews, though, was the inability to gain non-verbal responses to their questions which could add to the thick description being collated. Furthermore, the qualitative telephone interview was likely to be shorter than the face-to-face interview (Bryman, 2008; Robson and McCartan, 2016), with Bryman (2008) noting that it might potentially last on average 20-25 minutes. The shortest telephone interview lasted 15 minutes and the longest was 40 minutes.

The telephone interviews were an appropriate tool to use. One participant stated "*I'm glad you asked me to do this because it has forced me to actually find out what the business plan was because I was so used to, just-tell-me-what-I-need-to-do*" [Area B, Designated Safeguarding Lead, Education] and another said "*it has been really interesting to kind of reflect really, I don't get to do that too often*" [Area A, Designated Safeguarding Lead, Health].

iii) Group interviews

Group interviews are used to gain a range of views simultaneously to see how individuals react to others' views, and to identify group behaviour and processes within an institution. I opted for this mode of data collection as an efficient means of securing the views of front-line social work practitioners. Group interviews are inexpensive to organise and run, they produce rich data, and the group process and stimulation can aid memory recall in group members (Fontana and Frey, 2003; Fielding and Thomas, 2008). Group interviews can also help to increase the number of people included, thereby augmenting the diversity of the responses (Gomm, 2008). Group interviews are not, however, without their difficulties. The researcher needs to ensure that there are no dominant voices within the group that might silence others and that each participant can voice an individual opinion (Fontana and Frey, 2005; Gomm, 2008). Equally individual responses may be subsumed by the group as there is pressure to conform within a group situation. Despite this, I thought that for this study, the benefits outweighed the disadvantages, and that group interviews would be useful to gain front-line practitioners collective experiences.

Initially I had intended to use teams for my group interviews, and to tag my questions onto the end of a team meeting. It is useful to use such 'pre-existing groups' (Finch *et al,*

2014 p233) if the research concerns work-related matters, because pre-existing groups can discuss shared situations and explore shared meanings. This was crucial to this research which was designed to explore policy implementation and how policy translated into practice. Kitzinger and Barbour (1999, p8-9) highlight that pre-existing groups are 'the networks in which people might normally discuss (or evade) the sorts of issues likely to be raised in the research session and the "naturally occurring" group is one of the most important contexts in which ideas are formed and decisions made'. However, in reality this did not happen as intended because I was reliant on a given contact within children's social services finding participants. Subsequently it came down to finding interested front-line practitioners, and not necessarily teams. That said, however, they were practitioners who knew each other from the same offices, and worked with neglect cases. In hindsight, this was perhaps better because it gave me a broader scope of views from within the organisation, rather than just from one team. When recruiting group participants from the same organisation, the participants can provide insight into an everyday issue simply in the way that they discuss the issue. Gomm (2008, p228) noted that 'in the group they may "talk the talk" of the organisation, in ways that would not happen in one-to-one interviews'.

In Area A, two group interviews took place. Due to the geography of the county and the difficulties in getting front-line practitioners together, I was advised that it would be easier to convene two separate group interviews; one in the north of the county and one in the south. Three participants took part in the first group discussion in the morning, and eight took part in the second one later that same day.

Area B posed more difficulties in getting front-line practitioners together. A group interview was arranged but only one out of the expected five participants attended. He agreed to an individual interview instead. I deemed this to be appropriate because he had been interested enough in the research to agree to participate in a group interview, and because, given his experience, I thought he could offer useful and meaningful insights. One of the other expected participants emailed me later that day to say that she wanted to participate but had told her manager that she could not do that date and time. Again, because of her considerable experience of working with child neglect cases, I thought she would have some insightful views, and she agreed to meet me for an

individual interview. Whilst useful, these individual interviews were not a replacement for a group interview, and I subsequently needed to re-arrange a group interview.

I persevered to re-arrange the group interview, but this took a further twelve months to arrange because continued organisational restructuring resulted in my named contacts either leaving or being deployed into other posts. I finally had three front-line practitioners take part in a group discussion.

Despite the difficulty in setting up the group interviews and being reliant on someone else to assist in finding participants, I am confident this was the right method to choose. Prior to deciding on group interviews, I had considered using online questionnaires with frontline practitioners because I thought that this would reach a greater number of participants and I had used online questionnaires in previous research with practitioners. In the course of the interviews and group interviews, it became evident that a questionnaire would not have been appropriate because some practitioners identified themselves as "form exasperated" and categorically stated that had the research been a questionnaire they would not have taken part. Instead they appreciated the fact that I had taken the time to go and talk with them in person.

iv. The Interview Schedules

Interview schedules were devised to enable consistency between interviews in order that a comparison could be made between the different professional groups. Separate interview schedules were drafted for the Assistant Directors of Social Services (phase one), and members of the LSCB being interviewed face-to-face (phase two), the safeguarding managers being interviewed by telephone (phase three), and a further separate topic guide for the group interviews with social work practitioners (phase four).

I had also anticipated using national and local research / policies to focus some discussion within the study. In terms of national guidance, I focused on the government's safeguarding children research initiative (Davies and Ward, 2012), as detailed in Chapter 2. The studies were subject to 'rigorous peer review' (*ibid*), and findings from the research were discussed 'by the Advisory and Implementation Group'

(*ibid*). The role of this group was to ensure that findings and presentation of material would be accessible to its intended audience, that is to say professionals with a responsibility to work together to safeguard children.

In terms of my selection of local policies, however, this did not work out as planned, because:

- Area A should have had a new child neglect policy implemented by December 2014, but at the time of starting the fieldwork (March 2015) this had still not been written. Therefore, instead I focused on the dissemination of the *Threshold for Services* document which had been rewritten and implemented. The focus of this document was to re-route needed services towards early intervention services to divert families from an already overburdened social work services.
- In Area B, the *Failure to Thrive* policy was used to focus the discussion on local policy implementation. This policy came out of a serious case review across two LSCB areas, in which a child died as a result of neglect because the markers of growth had not been used effectively to acknowledge the child's failure to grow.

With this guidance in mind, each interview schedule was structured thematically, as shown in Figure xii. Some themes occurred in more than one interview schedule, and some were specific to a particular phase.

As part of the interviews in phases one and two, I wanted to explore possible influences in developing child neglect policy within LCSB and the local authority. Therefore under the theme *identifying and developing child neglect policy guidance*, I gave the research participants a list of possible influences in child neglect policy (government, messages from research, serious case reviews, views of your policy lead, front-line practitioner voices, and media) and asked them to place them in order of the most important/most influential. This list was informed by the literature review (see Figure xiii).

Figure xii: themes of each interview schedule

Theme	Relevance to research question	Interview phases			
		1	2	3	4
The role of the LSCB and its priorities	2	✔	✔	✔	✔
Government policy guidance	1	✔	✔		
Identifying and developing child neglect policy guidance	2	✔	✔		
Policy implementation problems	1	✔			
Interpreting and communicating to operational level	3		✔		
Identifying, developing and communicating child neglect	3			✔	
Factors that help or hinder policy implementation	4			✔	✔
Policy monitoring	3			✔	
Political context	4			✔	✔
Learning about child neglect priorities in your area	4				✔

Figure xiii; possible policy influences as derived through the literature review.

Policy influencer	Reason for inclusion
The government	Child neglect is a politically driven activity. It was necessary to compare with other influencers whether this was the main policy driver.
Messages from research	Following the publication of the Davies and Ward report, (2012), (as discussed in Chapter 2).
SCRs	To identify how much of an influence SCRs are in the policy making arena.
The media	To explore if increased media reporting is driving pressure to intervene in cases, and to identify if the media is an influencer in policy making.
Views from the policy lead	To identify how much authority was given to this role as many – but not all - LSCBs have a *policy lead* as a stipulated position.
Front-line practitioner voices	To identify if policy was driven by everyday practice, and how much weighting was given to such local and current experience in comparison with other factors.

4.5 DATA ANALYSIS

Twenty-two semi-structured interviews were completed with over 16 hours of recorded material. Qualitative research produces a vast amount of data which can feel unwieldy (Gibbs, 2002; Spencer *et al.,* 2014a; Robson, 2011; Robson and McCartan, 2016), therefore care needs to be taken over choosing the right analysis method to 'maximise the potential of a full qualitative analysis' (Spencer *et al.*, 2003, p210). I used NVivo to assist with the data management and analysis. There are a number of criticisms levelled at qualitative software programmes such as NVivo for example the software cannot do the actual analysis in the same ways that quantitative software tools can; it cannot comprehend qualitative texts; the researcher cannot be as close to the material in an e-format; it takes too long to learn how to use the software; problems of compatibility and so on (Gibbs, 2002; Flick, 2014). However, for me it provided a good tool with which to manage the large amount of data generated and helped me to apply a systematic approach to analysis.

4.5.1 Selecting a thematic data analysis strategy.

I adopted a thematic coding analysis strategy (Braun and Clarke, 2006; Flick, 2014). This strategy combines elements from other qualitative analysis approaches such as narrative analysis, discourse analysis and grounded theory analysis. Broadly speaking, this method is useful for helping the researcher to identify themes, or concepts, and analysing patterns in the rich data (Spencer *et al.,* 2014b; Braun and Clarke, 2006).

Whilst being praised for having a flexible approach to tackling qualitative data analysis, the strategy is not without its limitations and criticisms. Braun and Clarke are criticised for drawing a qualitative data analysis approach based only on their experiences of analysing interview data, and therefore not applying the approach to other forms of qualitative data (Flick, 2014). Furthermore, the analysis may not sufficiently detract itself from theory or literature and may be constrained by these. Whilst I acknowledge these criticisms, this would not affect my study which was based on interviews, and designed around the governance network model, therefore I decided that a thematic analysis strategy would be relevant to this study.

Braun and Clarke (2006) state that there are six decisions to be made when selecting thematic analysis and these should be explicitly discussed in the methods section, and I now turn to this, and the decisions I made.

1. *What counts as a theme?*

For Braun and Clarke (2006, p82) 'a theme captures something important about the data in relation to the research question and represents some level of *patterned* response to meaning within the data set'. I think it is important to note that Braun and Clarke do not 'buy into the notion' of themes *emerging* from the data. Instead, they are advocates of the researcher being an active part of the analysis process and making active choices about what is and is not applied to the data. For them, analysis is the *act of interpretation* rather than a passive act of waiting for something to *emerge (*Braun and Clarke, 2006; Saldaña, 2013). For Braun and Clarke something should be drawn out as being a theme if it is relevant to a research question. Within this study, the thematic analysis was relevant because the interview schedules were structured using subheadings which linked back to the main research questions.

2. *A rich description of the dataset or a detailed account of one particular aspect?*

The former is useful if the purpose of the research is to give the reader a thick description of the entire dataset, and length is not an issue, whilst the latter is more relevant if the researcher wants to concentrate more specifically on the themes within the data. As I have identified Torfing *et al.'*s effectivity criteria as a model with which to evaluate the performance of my selected governance network, providing a detailed account of particular aspects within the case studies was evidently more appropriate.

3. *Inductive versus theoretical analysis?*

Within the inductive approach, themes are driven from the bottom up and strongly linked to the data, and thus the themes in the data may bear little resemblance to the questions posed to participants. Conversely the theoretical analysis is driven by the researcher's theoretical interest in the subject matter (in the case of this study, governance network theory) and equally maps onto specific research questions (Braun and Clarke, 2006). This study adopted a theoretical analysis of the data inasmuch as it was drawing on a governance network model.

4. *Semantic or latent themes?*

Taking a semantic approach to themes requires the researcher to name themes using the exact phrasing that the participant said, and not looking beyond what the participant said. By contrast the latent themes go beyond what has simply been said to 'examine underlying ideas, assumptions, and conceptualisations – and ideologies - that are theorized as shaping or informing the semantic content of the data' (Braun and Clarke, 2006, p84). What this suggests is that, rather than just providing a description of what someone has said, the latent approach also looks at further factors to explain *why* they might have said it, and *what* drove them to have such an opinion (see also Saldaña, 2013). Within this study I focused on the political environment in which the practitioners were operating which also put their semantic responses, into a more in-depth contextualisation and interpretation.

5. *Epistemology: essentialist/realist versus constructionist thematic analysis?*

Braun and Clarke (2006) argue that the essentialist/realist approach leads to a straightforward theorisation because the relationship between experience, language and meaning is fairly straightforward and one dimensional. By contrast, the constructionist thematic analysis ties in closely with the thematic analysis at the latent level. Within this constructionist framework, the thematic analysis is a moveable feast, as individual accounts are situated within a social constructivist context which may change over time. In this particular study, social work is a State dominated service, therefore structural and political elements will have affected individuals' responses (see Chapter 1).

6. *The many questions of qualitative research?*

Braun and Clarke (2006) remind the reader of the various stages and types of research questions involved within a qualitative study. As well as the broad research questions which drive the overall study, there are more refined questions posed to participants and questions being driven by the data. They argue that it is important to be cognisant of these questions, their role within the study and the weighting that they are given.

Therefore, in summary this study considered specific aspects, using latent themes within a constructivist approach driven by the theoretically informed research questions.

4.5.2 My thematic analysis.

Having worked through the six decisions, I set out to analyse my data. Firstly the raw data needed to be made more manageable through identifying 'themes and concepts' (Spencer *et al.,* 2003, p214) which could then be applied as labels to the data in order to organise them (using NVivo helped me to do this), As I had identified Torfing *et al*.'s effectivity criteria as a model to assist with the analysis, I had some preconceptions on some themes that I would be looking for within the data (for example in stages 1 and 2, I was anticipating themes on communication from Government to LSCB. In stage 3 I was anticipating a theme on communication from the LSCB to Designated Safeguarding Lead). I used these anticipated themes as a starting point to apply to the data. This enabled me to become more submerged in the data, which in turn allowed other themes to emerge that I did not anticipate (for example, the role of Multi-Agency Safeguarding Hub [MASH], the visibility of the LSCB to front-line practitioners, and inclusivity of Board members).

I adopted a systematic approach to the data analysis. That is to say, I examined the transcripts from stage 1 before moving onto stage 2 etc. In my mind this was following the theoretical thematic analysis in a top-down manner. For the most part, I had themes as derived from the theory and from each stage of the fieldwork process (for example, codes that started with L1 [for example L1.MSGS.GOVT] were the assistant directors responses in both case studies, and codes starting L2 [for example L2.EFFCOMM.LSCB-REP] were responses from the LSCB representatives etc.). This enabled comparisons to be made across the two case studies.

During this phase of the data analysis, I maintained the language and expressions used by the participants, rather than abbreviating or paraphrasing at this stage (see Ritchie *et al*., 2003). This was important to maintain the original meaning of the text and avoid a process of *Chinese whispers* occurring between data analysis and writing up the findings.

As the number of themes grew, I began to merge them under broader headings (Spencer *et al* 2014a; Saldaña, 2013) as I moved from first level coding where codes are formulated close to the original text, to second level coding, in which my codes were more abstract (Flick, 2009). For example, 'austerity', 'CSE', 'poverty', 'MASH', 'neglect' were merged under a broad theme of *government priorities*. Similarly, 'blind faith', 'expectation that guidance are shared', and 'quality assurance' were merged together under the broad them of *tracing the through flow of messages*.

I first applied the themes before exploring comparisons between the cases because within a thematic approach of data analysis, (Flick, 2014), through carefully and systematically carrying out these preparatory stages, I was able to move onto a thematic analysis applying latent themes which enabled a better, more enriched data analysis. As Ritchie *et al.* (2003, p237) state 'the very process of labelling, sorting and synthesising brings deep familiarisation with the evidence available. This gives the analyst a full and detailed picture of what has to be portrayed in the later analyses'.

Having applied the themes and subsequently the labels to manage the data, I then developed 'descriptive accounts' (Spencer *et al.,* 2003, p214) through the research phases. Whilst this led to descriptive analysis, this approach helped me to make more sense of the data in a narrative form (that is to say, 'what's the data telling me?'). This enabled me to identify more clearly comparisons across cases (Robson, 2011; Robson and McCartan, 2016) from which I could build up to a more 'explanatory accounts' (Spencer *et al.,* 2003, p215) in which I identified patterns and connections emerging from the data, (Spencer *et al.,* 2003, 2014). This approach also highlighted gaps in the data analysis, so I was able to go back to the NVivo database and draw out further details. For me, this was a cyclical process (see Figure xiv) until I felt that I had saturated the analysis process.

Figure xiv; my cyclical approach to data analysis

I was then able to apply Torfing *et al.*'s (2012) model to the findings. This enabled me to move away from a descriptive, narrative approach to the findings and apply criticality (the "so what?" question) to the data.

4.5.3 Ensuring quality within the study

- *Triangulation and research credibility*

The credibility of the research can be enhanced through measures taken in the data collection and data analysis stages. One of the best ways of ensuring the trustworthiness (Glaser and Strauss, 1967), or consistency (for example, Hammersley, 1992; Robson 2011; Robson and McCartan, 2016) (that is to say, validity) of qualitative research is through triangulation of the findings (Lewis *et al* 2014). Triangulation involves the use of several methods to strengthen the findings (Denzin and Lincoln, 2005; Stake, 2005; Bryman, 2008; Robson and McCartan, 2016). Triangulating the multiple research methods enables the researcher to find patterns or discrepancies within the findings, which may increase (or decrease) confidence in the validity of the research (Robson and McCartan, 2016).

There are four approaches to triangulation (Robson and McCartan, 2016; Yin 2009; Flick, 2014)

- Data triangulation: using more than one data collection source within the study in order to support a phenomenon
- Observer, or investigator, triangulation: using more than one observer or researcher.
- Methodological triangulation: adopting a mixed methods approach, using quantitative and qualitative elements.
- Theory triangulation; using more than one theory or perspective.

Data triangulation was the only option for this study because it was conducted by one researcher and collected only interview data. Data triangulation was achieved through interviews with different categories of people (the Assistant Directors of Children's Services, the LSCB representatives, the safeguarding managers and the teams of front-line practitioners), in order to gain perspectives from along the knowledge transfer continuum.

The *dependability* (for example, Lincoln and Guba, 1985) of the data is achieved through an auditing process. Careful and systematic data management is also crucial to the dependability of the study. This has been achieved here through clearly explaining the steps taken in carrying out the research and justifying the decisions made. This enables the reader to make their own assessment on whether elements (such as sampling is appropriate, data analysis strategies) have been correctly applied.

- *Generalisability*

Within the interpretative paradigm, qualitative researchers need to be concerned with the 'transferability' and 'fittingness' (Flick, 2014, p495) of their findings to other comparable situations or scenarios. Generalizability from small-scale qualitative studies to the wider population beyond the cases involved (external generalisability) is not feasible. Instead, however, what such studies should be concerned with is ensuring *internal generalizability* (Robson and McCartan, 2016). This relates to generalizability, or transferability and fit, of the findings in relation to the setting studied.

Ensuring internal generalizability relies on how the sampling was carried out, and the parameters that were establish in the sampling framework. The internal generalisability of this study can be applied to other LSCB areas with a similar demographic to those which participated in the research and have a focus on child neglect within the business priorities (Lewis *et al*, 2014; Flick, 2014). Through the use of thick descriptions generated in this study, the reader should be able to assess a 'degree of similarity, or congruence' (Ritchie and Lewis, 2003, p268) between the participating LSCB and their own LSCB area.

- *Researcher Reflexivity*

It is good practice for a researcher to state their particular position in relation to the topic being examined because our experience, values and understandings help us to make sense of social issues and the meanings we attach to them. This implicates the researcher in the analysis of their data, and the construction of knowledge derived from it (Gibbs, 2002; Denscombe, 2017; Bryman, 2008). By making explicit one's own position the reader is able to assimilate how and why a researcher may have reached the conclusions they did.

In relation to my study, I was able to maintain a certain level of objectivity because I am not a representative of any LSCB, nor am I employed within the children's services or child protective services. As a consequence, I do not have any direct insight or previous experience of the policy operations of the LSCB or policy development within children's social or protective services; and I was not drawing on any knowledge or experience gained prior to undertaking this research. I hoped that by being a neutral body in this sense, the participants felt both that I carried out the research with no prior (mis)conceptions of the policy workings of the LSCB, and therefore, that they felt they could be open and honest without feeling that they were being judged.

I am, however, employed as a Senior Lecturer within a Higher Education Institution in England; I teach on the BA (Hons) Working with Children, Young People and Families programme, and am course coordinator for BA (Hons) Applied Social Science. Previously I was also a secondary school teacher. I have knowledge and understanding of theory surrounding child protection policy and practice gained from these roles, both

of which may have influenced the questions I asked of the participants or the way I interpreted the research findings (Flick, 2009, 2014). Such a position may conversely hinder the research as participants may have felt that without the actual working experience of children's services, I had no legitimate cause to question and analyse those working within the field.

4.6 ETHICS

Ethical approval was granted in September 2014 from the School for Policy Studies Research Ethics Committee at the University of Bristol (see Appendix 3). I was also granted ethical permission from the Research Governance Frameworks within both local authorities. This section now examines those ethical issues of most relevance to this study.

- *Informed consent and confidentiality*

Contacting participants in phases one and two of the study was straightforward because those contact details were easy to find on websites. This was more difficult in phases three and four (with the exception of schools, who publish the name of the Designated Safeguarding Lead on their website) because such details were harder to find. For phase three, in the case of Health, I asked the LSCB representatives in the research if they had any useful contacts. In the case of social services for phases three and particularly phase four, I was reliant on being given a named contact who might help me to find relevant participants.

In order to gain informed consent (Webster *et al*, 2014; SRA, 2003; Robson and McCartan, 2016) the participants needed to know: what the study was about; what their role would be in the research (including an approximate time scale); what would be done with the research findings, and that their participation is voluntary (Webster *et al*, 2014). Participants also needed to be informed that their identity would remain anonymous (SRA, 2003; Webster *et al*, 2014), and any information which they imparted would remain confidential inasmuch as it would not be traceable to an individual, unless they imparted something which indicated that either they or someone else is at risk of harm (Webster *et al*, 2014). This was particularly crucial for those participants (for example, at phase four) who had been put forward by a manager. Equally another

participant at phase two was also anxious about this because of saying some controversial points which they thought might identify them. I reassured participants that the areas involved would not be named, and job titles would not be used, only broad sector names.

All participants were asked for permission (and agreed) to be audio recorded. Lewis (2003, p67) notes that 'consent is not absolute', therefore whilst informed consent may have been gained in advance of the interview process, I reiterated the key ethical points noted above prior to commencing an interview in case consent needed to be 'renegotiated' (*ibid*).

- *The Right to withdraw*

All participants were informed that they could withdraw from the research up to four weeks after completing the interview (Denscombe, 2017) and that any information which they had given in the study would not be used (SRA, 2003). All participants were given my contact details in case they needed to contact me following their participation. No participants withdrew from the study.

4.7 SUMMARY

This study adopted a qualitative, multiple case study approach to examine how government guidance about child neglect are communicated to, and implemented by, Local Safeguarding Children Boards (LSCBs) and then down to frontline statutory services. A purposive sampling method was used to identify 33 participants within each case study. Using a semi structured interview approach; the study gained the views of CSC assistant directors, LSCB representatives, designated safeguarding leads, and front-line practitioners. A thematic data analysis strategy was used to analyse the findings, which will be presented in the next chapter.

Chapter Five: Findings

5.0 INTRODUCTION

This chapter uses Torfing *et al.*'s (2012) model of *effectivity* criteria as a frame in which to present the research findings. After detailing the context of the two case studies, the chapter examines the procedural elements of policy interpretation, communication, knowledge transfer, through exploring findings by area, sector and, in some cases, professional group (see the research phases in Chapter 4, p67).

5.1 CASE STUDY CONTEXT

The study had 34 participants: 20 participants in Area A, and 14 in Area B. The majority of participants (N=28) were female.

- *Area A*

Area A has 14 members on the LSCB. In phases one and two of the research I undertook five face to face interviews with the Assistant Director of CSC, the Independent Chair and three LSCB representatives, whose job titles were Service Manager, Education Safeguarding Manager and Designated Nurse for child protection in Area A. These participants had experience of working in children's services ranging from 23 years to 41 years and had been working in Area A from three years to 15 years. They had a mean of 3.5 years of serving on Area A's LSCB. Two of them had experience of serving on another LSCB elsewhere.

The Independent Chair had a background in the police force in which he had gained safeguarding experience through being the Head of Child Abuse Investigations. He had been chairing LSCBs since 2012 and had been the Independent Chair of Area A since July 2014 (eight months at the point of the interview taking place). At the time of interviewing he was also the Independent Chair for another LSCB.

In phase three I conducted telephone interviews with four Designated Safeguarding Leads (an operations manager, a GP partner, a Head teacher, and a lead nurse for safeguarding children). These participants had experience of working in children's services ranging from 20 to 38 years, and between 14 and 27 years of working in Area

A. These participants managed teams of staff ranging from seven to 45 people. One person had experience of being part of an LSCB subgroup; these are constituted with a key focus, for example signs of safety subgroup, multi-agency training subgroup, performance analysis subgroup. The subgroups may vary from LSCB to LSCB depending on the LSCB priorities.

In phase four (group interview with front-line practitioners), there were 11 participants (all social workers) with work experience ranging from 18 months to over 15 years. One person had some experience of sitting on an LSCB subgroup.

- *Area B*

Area B has 34 members on its LSCB. In phases one and two of the research I undertook five face to face interviews with the Assistant Director of CSC, the Independent Chair and three LSCB representatives, whose job titles were Divisional Lead in Social Work, Designated nurse in Safeguarding Children, and Head teacher. These participants had experience of working in children's services ranging from 23 to 40 years and between one and 25 years working in Area B. They had served a mean of six years on Area B's LSCB, and three participants had experience from being representative on other LSCBs.

The Independent Chair of Area B also had a background in policing, this time as a Child Abuse Investigator. He was also Head of the Public Protection Unit (which was a multi-agency single site for police officers, social workers, nurses, probation officers and other similar roles) during which time he sat on adult and children's safeguarding boards. He had previous experience of chairing the Adult Safeguarding Board (outside of Area B) and had been the Independent Chair of Area B's LSCB since May 2013 (nearly two years at the point of interviewing for this study).

In phase three, I conducted telephone interviews with three Designated Safeguarding Leads whose job titles were named nurse for safeguarding children, Vice Principal, and Divisional lead. These participants had experience of working in children's services ranging from 19 to 39 years, and between eight and 16 years within Area B. They managed teams ranging from one person to 200 people. One person had experience of

substituting for their manager on the LSCB and two participants had experience of sitting on an LSCB subgroups.

In phase four, there were five participants (all social workers) with work experience in children's services ranging from six months to over 15 years. One participant had experience of sitting on an LSCB subgroup.

5.2 THE FINDINGS EXPLORED THROUGH TORFING *ET AL.*'S (2012) EFFECTIVITY CRITERIA (EC).

EC 1: Produce a clear and well informed understanding of the policy problems and policy opportunities at hand

The themes that emerged from the research findings under this first criterion were:

Multiple perspectives of a policy issue,

Child neglect and the political agenda

Child neglect and the policy drivers

Managing conflict, power and influence

An example of disagreement / a conflict of opinion

Managing power and influence, and the role of the Independent Chair

5.2.1 Multiple perspectives of a policy issue

This section is split into two parts. I firstly examine the views around whether or not child neglect was seen to be on the political agenda, following the arguments of Rose and Barnes, (2008) Daniel *et al.* (2011) and Burgess *et al.* (2013) that child neglect is a serious factor in many child deaths, and is a complex matter that needs to be dealt with. I then move on to examine what influences professionals' views of child neglect (for example, media, serious case reviews, research and so on) in order to gauge what weighting different professionals attach to different policy drivers.

- *Child neglect and the political agenda*

In phases one and two of the research, participants from across Education, Health, and Children's Social Care in both areas did not consider child neglect to be on the political agenda at the time of interview. They claimed that if it was on the agenda, then the priorities for tackling child neglect were "*not particularly clearly articulated*" [Area A,

LSCB member, Children's Social Care]. Tackling child neglect was felt to be submerged in other political agendas such as child poverty (see The Child Poverty Strategy 2014-2017, Child Poverty Act 2020 and the establishment of the Child Poverty Unit) and Early Help (for example, intervening early with relevant support services in a child's or family's life before they reach crisis point) (see the Children Act 2004 and the establishment of the Sure Start programme; the Allen Report, 2011; the Children and Families Act 2014). Such responses suggest that little has changed since research undertaken by Daniel *et al.* (2011) and Rose and Barnes (2008) who noted that the complexity of what constitutes child neglect causes confusion for practitioners.

- *Child neglect and the policy drivers*

I now examine more specific factors which influence the perspectives on child neglect and its policy development at LSCB-level, such as serious case reviews; messages from research; government; views of the policy lead; practitioner voices; the media.

Overall, respondents from phases one and two considered serious case reviews to be the biggest influence on LSCB policy, with all participants from each sector saying that LSCBs would take notice of the findings of these before anything else. Neither participating area has had to deal with many SCRs in their area, but each was influenced by the national perspective on high profile cases. Serious case reviews were closely followed by messages from research (for example, findings from published Government research), then government (for example, Government Directives), and practitioner voices (for example, front-line practitioners being consulted and listened to in the policy making process). In Area B, where they had a policy lead (as some LSCBs do), their views had least weight. In Area A there was no such role on the LSCB.

There were some interesting differences when the results were explored by sector (see Figure xv). Whilst they all said SCRs carried most weight, those in Education placed greater importance than other professionals on the views of the policy lead and practitioner voices. They placed messages from research and the Government as the least important. This could be explained by the fact that safeguarding (and child protection) is not 100% of the job role for those in Education, who also need to keep up to date with other material too. Therefore, having a dedicated policy lead for which the

role is to keep up to date with such policy changes and inform the strategic decisions makers might be a key source of safeguarding and child protection information for those in Education.

Figure xv: Perceived child neglect policy drivers in order of importance from highest to lowest importance.

Most to least important	By Sector				
	Children's Social Care	**ADCS**	**Education**	**Health**	**Independent Chair**
	SCRs Research	SCRs Media	SCRs	SCRs	SCRs
	Government	Research	Practitioner voices Views of Policy lead	Government Research Media	Practitioner voices Government
	Practitioner voices	Practitioner voices	Media		Views of Policy lead Research
	Media	Government	Research	Practitioner voices	
	Views of the policy lead	Views of the policy	Government	Views of the policy	Media

Participants were specifically asked if they felt that the government initiative on neglect and abuse - which culminated in the Davies and Ward (2012) report - was an influence in child neglect policy making. There were mixed reactions. Participants felt that research at a strategic level seems to be quite influential but there were disparaging views on what research filters through the layers and who it influences. The Education representatives and the Independent Chairs placed less importance on research than others. As indicated earlier, both Independent Chairs had professional backgrounds in policing and, as with the Education representatives, safeguarding and child protection is only one part of the job role. In particular, one Assistant Director noted:

> "*the last time I can remember where a lot of effort was put into that, was in the 80s when Messages from Research was, you know, there was quite a strong research-based development, practice development from those Messages from Research … I don't think any Government since then has really taken that approach, they very much – and this Government particularly but the last few – have been very much*

into 'this is what's wrong, this is the political response to this, you know, do it!' and if you don't do it, Ofsted'll come and catch you for not doing it"

[Area A, Assistant Director of Children's Services]

The media (whilst they were deemed to "*shout the loudest*" [Area B, Independent Chair]) were given less priority by most LSCB representatives, with some acknowledging that they do not have a good relationship with the media. There is clearly a tension here, given that participants said they were influenced by the national perspective on high profile cases and SCRs, which are usually deemed high profile because they have generated a media interest. Therefore, it might be argued that unknowingly or unwittingly, participants were influenced by the media as a driver for policy. Whilst most participants attributed less importance to the media as a local policy driver (with the exception of the ADCS), it was deemed to be one that practitioners needed to be cautious of, because it has its own agenda.

The two Assistant Directors of Children's Services placed a heavier emphasis on the media than other members of the LSCB, placing it as joint first, with SCRs. This might be because, given the senior nature of the job role, they need to keep a closer watch on media reporting of such issues, especially in such a culture of blame, 'moral panics' and practitioner witch hunts which the media seems to drive (Klijn, 2016; Peters, 2016; Jacobs and Schillemans, 2016) Take for example, Gunn Wahlstrom and Dianne Dietmann following the death of Jasmine Beckford in 1984 (Franklin and Parton, 1991); Martin Ruddock following the death of Kimberley Carlile in 1986 (Aldridge, 1999); Lisa Arthurworrey following the death of Victoria Climbié in 2000 (Butler and Drakeford, 2005; Davies, 2014), and Sharon Shoesmith following the death of Peter Connolly in 2007 (Jones, 2014; Parton, 2014; Warner, 2015).

What this demonstrates, albeit in a rather simplistic fashion, is the different perspectives which Board members have on what *should* be influencing local policy. There was a problem with my question in that I had structured it in such a way to give a linear response (because that is how I viewed it) (see Figure xi, under section 4.4, p74).

☐ Government
☐ Messages from research
☐ Serious Case Reviews
☐ Views of your policy lead
☐ Frontline practitioner voices
☐ Media
☐ other (please state)

However, this did not allow for participants who do not view such things in such a linear manner. One Independent Chair [Area A] said that laying the options out in the form of a list made it seem as though there was a large gap between "government" and "media", whereas in his mind it was more of a cluster of interacting influences.

The next section considers managing conflict management, power and influence within the LSCB in order to examine how those different professionals work through their multiple perspectives in order to *produce a clear and well-informed understanding of the policy problem.*

5.2.2 Managing conflict, power and influence

- *An example of disagreement / a conflict of opinion*

As part of each case study I explored the implementation of a local policy document on child neglect: the 'Threshold for Services' document (Area A) and the Failure to Thrive policy (Area B) (see Chapter 4).

I also sought to explore how disagreements (if any) around child neglect were resolved among Board members. Participants in Area A alluded to the fact that the Threshold Services document caused some difficulties and controversy when being drawn up, which provided a useful example to examine how conflict and disagreement could be managed at the strategic level, and how multiple views on a given issue or policy can be worked through. Such an example did not occur in Area B.

Discussing the Thresholds for Services policy generated some disagreement between the Board members, with one participant stating *"these Thresholds are agreed by the LSCB, although we've had some to-ing and fro-ing with our one here,*" and going on to say that it "*took over a year to develop*" [Area A, Assistant Director of Children's Social

Services]. Another participant was also aware of its problematic implementation. She said "*from what I understand that was a particularly difficult implementation*" [Area A, non-LSCB Designated Safeguarding Lead, CSC]. Part of the problem in relation to this policy document was the fact that the LSCB had not followed its own governance procedures for implementation and this caused some controversy in terms of the fact that it had not been properly challenged. The following quotation provides a summary:

> *"We had the Threshold for Services document which I think some agencies, some representatives were unhappy about the process it had followed and it ended up being approved, and what hadn't happened, we hadn't followed our own Governance so it hadn't gone through the procedures of the subcommittee so I think people felt that actually some of those areas to challenge hadn't been properly gone through. So, we are now in the stage whereby we're going back to it".* [Area A, LSCB member, Children's Social Care]

It was further noted by the same participant that many of the concerns raised in relation to this document derived from Education, as one participant stated "*I think it's fair to say he wasn't silenced*" [Area A, LSCB member CSC], highlighting the fact that there is a forum for open discussion and debate on matters concerning LSCB members. The Education member himself stated that "*there are plenty of people [who sit on the Board] who are confident and able to say they don't agree*" [Area A, LSCB member, Education]. This was attributed to the role of the Independent Chair who balanced the discussion, as discussed in the next section.

- *Managing power and influence, and the role of the Independent Chair*

What was identified was that the role of the Independent Chair was quite crucial in balancing the views and reducing the power and dominance that certain organisations have traditionally held over the Board. This was evident in this particular discussion around working through the Threshold for Services policy.

> "*I mean, there'll always be dissenters saying that the Threshold Document is wrong, so in a way you don't… but you have to, you've got to go with the majority. We have to take a vote on things like that, and we try and negotiate our way through*" [Area A, Independent Chair].

It was noted by both Independent Chairs that prior to the installation of an Independent Chair (following the Laming Review, 2009) both Boards were heavily weighted in favour of the local authority and children's social services. The one went so far as to call the Board "*a bit of a sham*" [Area B, Independent Chair] whilst the other stated "*so Social Care will often feel they've got the biggest voice, they're routinely the biggest financial contributor"* [Area A, Independent Chair]. As a result, decisions had been seen to be made in favour of the local authority. Since the establishment of Independent Chairs (Laming, 2009), however, the Chairs felt this focus had shifted a little and created a more equal power balance on the Board.

> "*So, we don't have such a pronounced dominant agency effect as we used to have. Still working on it though.*" [Area B, Independent Chair].

The Independent Chairs clearly saw their role as being to "*scrutinise*" and "*challenge*" [Area A, Independent Chair] and "*holding to account*" [Area B, Independent Chair]. In relation to managing conflict or disagreement, managing power and 'haggling' through the multiple perspectives, the Independent Chairs' strategies seemed to revolve around honesty and openness, facilitating discussion and negotiation.

> "*It's a case of having an open and honest environment and working, and just getting the right result*" [Area B Independent Chair]

> "*It's about facilitation and negotiation and compromise, but that compromise mustn't dilute, that's the important thing, we can compromise but not dilute"* [Area A, Independent Chair].

The role of the Independent Chair is neither linked to an organisation sitting on the Board, nor are they connected to Government. Therefore, they are not leaders in the traditional sense of 'power, status and hierarchy' (Williams, 2012, p133), but have a facilitation or mediator role (Koppenjan and Klijn, 2004). They could, therefore, be in a position to challenge and scrutinise the government on their proposed child neglect guidance, or lack thereof. That said, however, the Independent Chairs used to be "*hired and fired*" [Area A, Independent Chair] by the Chief Executive of the local authority, which meant they could choose someone who they thought would be "*malleable*" [Area A, Independent Chair] and not give the local authority a hard time.

In order to add to their independence and autonomy, the Association of Independent LSCB Chairs (AILC) was established in 2012. The Independent Chairs said that prior to the establishment of the AILC, information from government would have been sent to the Director of Children's Services to be cascaded to the Independent Chair. This caused problems because it reduced the independence of the chair (who needs to be seen to be detached from the local authority), created a hierarchy between the Director of Children's Services and the Independent Chair, and erected a potential barrier in the dissemination of information from central government to front-line practice.

> "*You cannot use DCS's as a conduit for information because that then puts us in bed together and we're separate. You'd no more send the information to the Chief Constable*" [Area A, Independent Chair].

The AILC was identified by participants to be a better route for government to communicate with Independent Chairs without embroiling them with the local authority. Both Independent Chairs in this study said that this had improved routes of communication between government and LSCBs.

The Chairs differed about their role in terms of being independent from the Board and the Government. The Chair in Area A seemed quite clear on the independence of his role. In response to the question about the Board's role, the Chair in Area A stated "*to challenge, coordinate and scrutinise*" and went further to emphasise "*that's the Board doing that, that's not me as an individual*" [Area A, Independent Chair]. In response to another question, he stated "*can't speak for the Authority, you'll have to ask the Authority that question*". The chair in Area B seemed to consider himself as part of the Board, rather than as mediator or facilitator. In his responses he used words such as "we" and "us" which suggests a more allied approach to mediation.

> *"…between what the government wants* <u>us</u> *to do* …" [Area B, Independent Chair]

> "<u>We</u> *certainly get held to account, if through the Ofsted process,* <u>we</u> *haven't done it"* [Area B, Independent Chair]

Considering the need to produce a clear and well informed understanding of the policy problem of neglect, the key message here is that an Independent Chair was seen to

result in rebalancing the focus on child neglect (and safeguarding children more generally) as the responsibility of everyone involved with providing services for children, and not just a wicked issue for the local authority and Children's Social Care to deal with.

5.2.3 EC 1 summary

According to Torfing *et al.* (2012, p173) an effective governance network 'produces a clear and well-informed understanding of the policy problems and policy opportunities at hand'. LSCBs, therefore, need to grasp the complexities of the policy problem in order to provide the solutions. But within this criterion, under *child neglect and the political agenda*, I found that participants did not perceive child neglect to be a political issue at the moment and was lost to other issues such as CSE. Guidance from government was felt to be confusing because of the differing responsibilities and perspectives underpinning the range of departments disseminating them (DoH, DfE, Home Office) which was detrimental to being able to produce a clear and well-informed understanding of the policy problem. In terms of identifying the *policy drivers*, however, LSCB members from different professional backgrounds were variously influenced by different sources and placed different weight on certain sources than others (see figure xv above).

In terms of *managing power, conflict and influence*, I found that the shift to an Independent Chair has realigned the balance of the LSCB to some extent, but this might need to go further. The establishment of the AILC might have improved this balance in terms of government communicating with the Chair rather than with the DCS.

5.3 EC 2: Generate innovative, proactive and yet feasible policy options that match the perception of the problems and challenges facing the network actors

The themes that emerged from the findings were:

The government as metagovernor or systems architect,

Monitor and controlling mechanisms stifling responses to innovative, creative policy making

Power and influence of the LSCB in terms of professional sway

5.3.1 The government as metagovernor / systems architect

All of the participants thought that the government placed little priority on child neglect as an issue. They said that it seems to be focusing instead on Child Sexual Exploitation (CSE) as a priority. I assume this to be in light of several high-profile cases which have attracted media attention (for example, cases in Rotherham and Oxford). Yet it was said by all participants that CSE was perhaps not the most significant issue and detracted from the other categories of abuse, such as neglect. But as the government monitors and inspects LSCBs they have to be seen to be responding to the government agenda, even if the members of the LSCB think that the priorities are somewhat misplaced. Therefore, there is a mismatch between central and local priorities which should be a concern.

With the exception of Education and Health, participants stated that the government agenda was more of a hindrance than a help. Education thought it provided "*direction*" [Area B, LSCB member, Education] and one participant from Health stated "*I definitely think all government legislations and procedures actually help us formulate what we need to do locally*" [Area A, LSCB member, Health]. Children's Social Care, however, thought that guidance from government was disorganised, numerous, difficult to follow, had a short shelf-life and was difficult to keep up to date with. This takes me back to the premise of this study in which Children's Social Care seems to have been the focus of several public inquiries (for example, Laming, 2003, 2009; Munro, 2010a, 2010b, 2011) and has received many recommendations for changes to practice which it was difficult to put into practice, or have been changed between governments (for example, Labour's establishment of Contact Point, and Sure Start Children's Centres, and their subsequent closure and demise at the hands of the Coalition government). Such constant, but negative, changes in short time frames lead to disaffected perspectives of the working environment. It might be argued that Health and Education were also part of those inquiries, because of the multi-disciplinary approach to safeguarding children, therefore if this were the case they would not have had the slightly more open view on government legislation, but Children's Social Care and child protection were the focal point of the inquiries, and perhaps bore the brunt of the changes and their consequences. This brings me to the next point on government monitoring and controlling mechanisms.

5.3.2 Monitor and controlling mechanisms stifling innovative / creative policy making.

This section considers how monitoring, evaluation and inspection regimes further stifle *innovative* and *creative* policy making and control the policy agenda of governance networks. As well as inspecting the LSCBs (via Ofsted), the Government also carries out single assessments of some of the bodies that make up the LSCB: schools, social services, and in turn the LSCB audits and monitors the policy implementation of the organisations under its jurisdictions.

Whilst one Education representative said that the Ofsted monitoring of LSCBs was effective because "*it provides rigour and accountability in much the same ways schools do*" [Area B, LSCB member, Education], others were less positive about its impact. One participant described it as "*bizarre*" [Area A, ADCS], and something that undermined professional decision-making; another noted that "*it was clear that inspectors were very variable in their knowledge of Boards*" [Area A, Independent Chair]. Other comments concerned it being "*prescriptive*" [Area A, Designated Safeguarding Lead, Health2]. Such views were echoed by frontline participants, who were sceptical because they felt it drove practice for the sake of ticking a box rather than driving practice to improve quality and performance. Many of the participants noted similar points evident in current practice.

> "*the guidelines, well they're not even guidelines, the requirements and the documents that have come from the DfE are you need to have this in place, and if you don't, when Ofsted come in you'll be in breach of your safeguarding expectations so … there's not much wriggle room, you couldn't opt to have certain paperwork in place, you couldn't*" [Area A, Designated Safeguarding Lead, Education]

> "*If everything is too regulated and you know staff become more concentrated on the procedures and getting things done to timescales and less focused on the children and the families which isn't good*" [Area A, Designated Safeguarding Lead, Health 2]

> "*We're absolutely hide-bound with that kind of, you know, we-have-to-do-it-this-way-because…and we-have-to-be-able-to-justify-it-because ….*" [Area B, Designated Safeguarding Lead, Children's Social Care].

All of this contradicts the findings of Ofsted (2011, noted in Chapter 2) that there had been a shift from a compliance culture to a learning culture. These findings emphasise that the compliance culture still exists, and such compliance limits the ability of governance networks (such as the LSCB) to come up with innovative and creative policy making, in this case for fear of being negatively judged by either the media, or in an Ofsted inspection.

Taking this argument further, it might seem that the answer to these issues is to abolish the inspection mechanisms and prescription, and to give autonomy to the governance network so that they can be innovative and proactive in policy making. Yet this was not what I discovered. It would seem that it is not that simple in practice to abolish targets and data collection; for instance, for LSCBs there would still be "*a requirement to measure*" [Area B, Independent Chair]. Therefore, some of the bureaucratic measures (for example, data collection, targets) that are required for inspection and monitoring purposes, LSCBs would still need to collate in order to measure benchmarks and evaluate the *effectivity* of their own practice in dealing with wicked issues. For some participants, a certain amount of prescription and auditing was deemed necessary in order to ensure the quality of safeguarding practice across the area.

> "*they have an important role to play, you know, at the end of the day we're talking about children's lives aren't we, the stuff that we're dealing with and keeping children safe, so …*" [Area B, Designated Safeguarding Lead, Children's Social Care].

It is not so much the fact that LSCBs are monitored that is the issue, but *how* they are monitored that was felt to create the tensions. One participant in the study noted that under the Labour government "*there was a genuine kind of feeling from external inspection that they were inspecting you, but also trying to be helpful in terms of looking to the future*" [Area B, Assistant Director of Children's Services]. But since 2010, with the change in government, monitoring and inspection has felt more hostile, pressured and

"*punitive*", [Area A, Assistant Director of Children's Services]. This is important to highlight because it is not necessarily that practitioners would want to completely remove monitoring and inspection in child neglect and have complete reign over their own policy agenda. Rather than being a critical friend of current practice and policy making, participants felt that inspections are focused on the negative and were just trying to catch out agencies, and lay blame.

5.3.3 Power and influence of the LSCB in terms of professional sway

Whilst participants in both areas highlighted that the working relationship between the LSCB members was positive, seemingly effective, and everyone had a voice on the Board, they did not perceive that the LSCB itself was effective or influential. Such views were particularly strong in Area A.

In short, within Area A the LCSB was seen as having "*no authority to make things happen*" [Area A, LSCB member, Education] and not being "*challenging enough*" [Area A, non-LSCB Designated Safeguarding Lead, Children's Social Care]. One participant described it as being "*pretty toothless*" [Area A, LSCB member, Education] and another stated "*it hasn't any teeth*" [Area A, LSCB member, Health]. Whilst LSCBs were an initiative of the Government, participants alluded to the fact that the Government had not granted it sufficient authority to actually be able to satisfactorily achieve anything. It was seen as having no power to compel any organisation to adopt its policies and procedures. The only tool it had was "*persuasion*" [Area A, LSCB member, Education], and it was stated by one participant from Education that key senior bodies in partner organisations could easily block any policy or guidance.

Whilst the LSCBs seem to lack any power, they were still viewed by participants from all sectors as being essential, with a major role in preventing the current system from falling into chaos and disarray. As one participant from Area A stated;

> "*I am frustrated by the lack of teeth and authority that the safeguarding board has but I wouldn't want us not to have it ….Because I think things would be worse if we didn't have it*" [Area A, LSCB member, Education].

5.3.4 EC 2 summary

It seems that the government agenda, and monitoring and control mechanisms, prevent LSCBs from 'generating innovative, proactive and yet feasible policy options'. In terms of the *government as metagovernor or systems architect*, the case studies identified that the level of control that central government retains over such a state driven activity as safeguarding children, and child neglect prevents LSCBs from generating innovate and proactive policy.

Furthermore, when considering the power and influence of the LSCB in terms of generating innovative and proactive policy that matched the perceptions of the problems facing the network actors, these two case studies found that whilst on the one hand, the government has seemingly devolved power and authority to governance networks (for example, the LSCB), at the same time it has not given it sufficient authority, or *teeth*, with which to compel any changes. It was seen to be a tokenistic gesture of government to put something in place and give it all of the responsibility but at the same time, it has not given it sufficient power and influence to be able to enforce or compel any changes. Whilst it has responsibility to make and implement policy and to monitor practice, it cannot authorise any sanctions to compel organisations to adhere to a local policy. Wicked issues such as child neglect remain entwined in a mesh of government bureaucracy and inspection regimes, which disengage creativity and innovation in policy-making.

5.4 EC 3: Reach joint policy decisions

The theme that emerged from the findings was:

joined-up, horizontal government.

5.4.1 Joined up government / horizontal government

In relation to local child neglect policy, one Independent Chair identified that their current child neglect policy was "*quite old"* and *"in need of a refresh*" [Area B, Independent Chair]. He said that participating in this study had prompted him to think about the policy and suggested that there could be potential to develop regional child neglect policy rather than just an LSCB-wide one.

"*there is potential for joint working particularly in these austere times around a bigger regional policy group for that and that's where I'd see that in one fell swoop you would get a refreshed and up-to-date policy across a region that covers many millions of people as opposed to 300 thousand*" [Area B, Independent Chair]

This notion followed on from a joint SCR which this LSCB had carried out in partnership with another LSCB in the same region (which ultimately lead to the Failure to Thrive guidance in Area B).

Also in Area B, it was noted that another weakness of the LSCB is the continued *lack of joined up working*. Prior to having LSCBs there was an argument that organisations worked in silos, but even with the multi-agency approach of LSCBs there is a further argument that LSCBs remain siloed and do not share good practice between them.

"*what I do think is that as safeguarding boards we tend to work very much in silos whereas actually there could be more cohesive working, you know that safeguarding boards share good practice, we've all got a limited budget we've all got limited time, so actually taking good practice from other areas … but some areas are quite reluctant to share*" [Area B, LSCB member, Health]

This, however, links back to my argument on issues of policy interpretation and needs of local areas. If there are calls for regional child neglect policy to be made, and there are a number of varying LSCBs within any given region with varying issues such as social and economic factors, how each LSCB interpreted the needs for their own area in order to factor this into a regional policy would need to be considered. There would need to be a network governance of representatives from each LSCB, or strong influence from the government's role as metagovernor (Newman, 2005; Rhodes, 2017). Depending on how the LSCB viewed the issue of child neglect (social care? health? education?) might depend on which representatives were put forward for the regional network. These again would need to be independently chaired (in line with Koppenjan and Klijn's (2004) view of chairs as mediator or facilitator and not director) in order to detract from one LSCB being given the *power* to see itself as the lead organisation. But ultimately, again, the first argument needs to come back to how they define child neglect, which link back to the issues around multiple perspectives and conflict management.

5.4.2 EC 3 summary

This criterion enabled an analysis of the joined-up decision making horizontally across the governance network. It was useful to explore how much weight or authority does the LSCB convey in the policy making and policy implementation arena; is it a strategic force to be reckoned with or is it one that no one really pays any attention to. As part of this examination, this was a useful section under which to explore the value attributed to the joint policy decisions made within the LSCB around child neglect.

5.5 EC 4: Ensure a smooth policy implementation based on continuous coordination and a high degree of legitimacy and program responsibility among the actors involved.

The themes that emerged from the research findings were:

Policy implementation and coordination linked to accountability,

The dual role of network actors and accountability,

5.5.1 Policy implementation and coordination linked to accountability

As highlighted above, government guidance on child neglect can be very disjointed, and it is difficult to know what guidance is coming from which department. There seemed to be a high level of responsibility expected of strategic level practitioners to search out child neglect guidance for themselves. This guidance should be informing local level child neglect policy design and implementation, but if those in strategic-level positions with the power to be making organisational policy decisions are unaware of the most relevant child neglect research and policy guidance, then it cannot be expected or assumed that front-line practitioners are accessing this guidance either. There needs to be improved coordination and *accountability* for dissemination of the child neglect research and policy guidance from the top down in order to ensure continuous coordination.

It can be difficult for professionals to grasp how far, or to whom they might need to disseminate information, both horizontally and vertically. A good example of this complexity and lack of clarity was given by one participant who said: "*what you tend to find is you get information time and time again to be honest, but I would rather have that than not know about it at all*" [Area B, LSCB member, Health]. As one participant in this

study suggested that once the "send" button of an email has been pressed it almost seems that all sense of responsibility has been discharged.

> "*They* [the LSCB] *tend to assume that the person who is receiving it will disseminate it out*" [Area B, LSCB member, Health].

She went further to highlight the difficulty in tracing the dissemination trail. She said:

> "*but again how do you know if it's read, that's the big thing for me and the only way is to go round and ask the staff but when you've got 50 practices and there's one of me, do you know what I mean, it is really hard, and if you send them a survey via electronically are they going to fill it in? so it's a real challenge, it is a real challenge*" [Area B, LSCB member, Health].

This becomes more complicated when the multifaceted nature of job roles is taken into account. This particular participant from Health held a designated safeguarding role for many other members of the LSCB (Education members for example) their responsibilities to the LSCB and disseminating particular guidance (for example, around child neglect), is just one part (in some cases, a minor part) of their full professional role.

5.5.2 The dual role of network actors and accountability

In terms of accountability, representatives on the LSCB were also strategic leaders within their employing organisation, and many also sat on other networks (for example, Health and Well-Being Board, Boards for Head teachers, or Adoption and Fostering Board and so on). Two participants said:

> "*I know safeguarding is hugely important but when you consider that's a tiny amount of the day job"* [Area B, LSCB member, Education]
>
> "*you can have a Board member whose role is purely safeguarding and nothing else … or somebody that has got a million other things to do and you can't expect that Board member to be as conversant and as knowledgeable with safeguarding issues as the counterpart who does it all the time"* [Area A, Independent Chair]
>
> *"The problem is we all work within lots of organisations, and they've all got lots of different priorities*" [Area A, LSCB member, Health]

"*Because this is not my sole job, we are teachers and I've got other leadership responsibilities*" [Area A, Designated Safeguarding Lead, Education]

To give a specific example of such juggling, when discussing the development of a new local child neglect policy in Area A, one participant noted significant delays in the policy's development because of the multi-professional nature of those Board members who were designated to draft it.

"*There's a subgroup supposed to be working on it* [the new child neglect policy] *but these are people with other jobs, and, so, she's* [the Board manager] *not sure it's progressing as it should do*" [Area A, Independent Chair]

There was a difficulty around collaboration across organisations for a collective purpose (that is to say, safeguarding children) whilst at the same time maintaining the integrity of the home organisation (Williams, 2012). This is important for LSCBs to understand when considering how they might best – or more effectively – disseminate child neglect policy guidance beyond the LSCB.

5.5.3 EC 4 summary

A major role of the LCSB is to disseminate information (implementation) with the aim of improving safeguarding. Effective networks are those that have recognised legitimacy and whose members have a sense of shared responsibility. The LCSBs examined in this study appeared to fall short of this criterion in a number of respects. In terms of *policy implementation and coordination linked to accountability*, there seems to be little accountability in order to ensure coordination of the policy guidance. It would seem that filtering guidance through email discharges responsibility for that guidance once the email is sent. Of course, this all needs to be balanced with the fact that often the LSCB is not the only network that people attend. In terms of *dual roles and accountability*, LSCB members have to balance the accountabilities and priorities of the LSCB with their own organisations and any other networks to which they belong. This, therefore, examined not only the complexities, but also the *magnitude* of accountability that governance network actors often have to balance in the face of multifaceted nature of their role. This has been very important in relation to this study to explore why and how certain

child neglect guidance may get through some parts of the governance web, but not necessarily to all parts.

5.6 EC 5: Provide a flexible adjustment of policy solutions and public services in the face of positive and negative policy feedback and changing conditions, demands, and preferences

This section considers how guidance is communicated from top-down, in order to examine whether or not the governance network is able to, firstly, get feedback on policy, and secondly, whether or not it responds to positive or negative feedback to change a policy. The themes that emerged from the research findings were:

Communication

From government to LSCB

Within the LSCB

From LSCB to non-LSCB designated safeguarding leads

To front-line practitioners

Information dissemination.

5.6.1 Communication

- *Communication from government to LSCB*

Findings highlighted that, across all sectors, communication from central government has become less direct in recent years. One participant from Children's Social Care noted that there was less communication from the Coalition-created DfE than its labour-established predecessor, the Department for Children, Schools and Families DCFS). Furthermore, it was also noted that there was no consistency in which department disseminates the guidance on child neglect.

> *"I think one of the really interesting things is the number of different government departments that can be involved in disseminating policy"* [Area B, LSCB member, Children's Social Care]

In addition, a key problem in terms of communication from government to LSCBs was that there was little or no structure in terms of how guidance from central government emerges. One participant noted that there were "*not particular ways*" [Area A, LSCB member, ADCS] in terms of top-down communication, and another said "*there's been no*

structure I think, yeah, that's the summary isn't it, there's been no structure" [Area A, Independent Chair]. Guidance was described as "*disjointed*" [Area B, Independent Chair] with some coming from DfE, others from DoH or even the Home Office, and this created confusion among professionals (see also Criterion 1).

> "*They [government] do get criticisms levelled at them, do they not, for failure to coordinate at national level*" [Area B, LSCB member, Children's Social Care].

> *"The other thing that was very apparent …is that people like DfE and Ofsted don't talk to each other*" [Area A, LSCB member, Education].

> "*I think nationally when these kinds of things happen Government is very disjointed and disorganised in the way it disseminates the messages which isn't helpful to local authorities I don't think*" [Area B, Assistant Director Children's Social Care].

Furthermore, participants from Health and Education noted that key guidance seems quite often to creep out from Government, with "*no lead in, no fanfare*" [Area A, LSCB member, Education]. This means that professionals may not be aware of certain policy, guidance or government-funded research, even though it may be pertinent for their roles.

> *"I think this is what we all struggle with, the fact that sometimes you just, you come across stuff and you go flipping 'eck where's this been, you know, because you have fanfares for the Rotherham enquiry and fanfares for this that and the other inquiry and then actually something as important as that* [Davies and Ward (2012) Safeguarding Children Across Services] *because I mean it is quite a comprehensive piece of work that is isn't it? That's a lot of work gone into that and no I don't think it was well distributed at all"* [Area B, LSCB member, Health].

In short, I would infer that as communication from government to LSCB has reduced in recent years, and is also poorly joined-up, it must be quite difficult for the LSCB to know what to feedback on to be able to make any change to policy at a national level, unless asked explicitly as part of a consultation.

- *Communication within the LSCB*

In spite of the positive working relationship among the LSCB representatives (as perceived by the participants), the LSCB was deemed to be equally poor at communicating guidance either to, or from, their own organisations, or to front-line practitioners generally. There is somewhat of a blind faith, or trust, placed in LSCB representatives to successfully cascade guidance within their home organisations and to report back on the views from within their organisation.

> "*As a Board we're reliant on those same people, so the people we task to do it are then reporting back to us that it's all done, all fine and dandy*" [Area B, Independent Chair].

> *"Then we will ask people to make sure they disseminate it through their organisations. Do I have confidence that that happens all the time? Probably not*" [Area B, ADCS].

In relation to the Threshold for Services document (Area A) participants noted that whilst the document was debated a lot at the Board, the Board relied on its representatives to communicate it within their agencies, yet the Board did not have a "*standard fixed process*" or "*defined implementation strategy*" [Area A, ADCS] for dissemination. This highlights that it is indeed one thing for the Board representative to disseminate the guidance to their list of contacts, and another to ensure that the recipients receive, read and disseminate it further or implement it. Variations in how information is communicated, what information is communicated, and how that is interpreted and translated into practice, will all lead to variations in practice.

- *Communication from LSCB to non-LSCB Designated Safeguarding Leads*

In relation to LSCB members communicating to non-LSCB Designated Safeguarding Leads, responses in phases two and three were mixed in terms of how well this was done. Participants in phase two seemed confident of how the guidance was being disseminated. In relation to the Failure to Thrive guidance (Area B) they felt it was clearly practitioners' responsibility to pass down the line.

"*certainly, with the Faltering Growth policy, and I know this because I've spoken to the staff members, they actually brought it up in their team meetings, to say read it and have a look*" [Area B, LSCB member, Health]

In Area A, for the Thresholds for Services document one participant said "*we put a whole thing in place you know about people's various responsibilities and making sure old ones* [documents] *are withdrawn*" [Area A, Independent Chair]. But then went on to say:

"*do you know I'm not clear that we have got a defined implementation strategy so the new Threshold came out and there was quite a lot of debate at Board and then at subgroup about how the Threshold document would be promulgated so I don't think that this Board has got a standard fixed process for doing that*" [Area A, Independent Chair].

In phase three, schools felt the relationship between themselves and the Board's Education representative was good, insofar as the representative ensured that the schools received what they needed in order to be able to put in place relevant safeguarding guidance in their setting. Views from Health, and Children's Social Care participants were, however, less positive, with participants claiming that both LSCBs were ineffective at communicating their priorities to operational teams and frontline practitioners.

Tracing the through flow of the guidance in each area, one non-LSCB Designated Safeguarding manager said that she had never heard of the local authority's Thresholds for Services document [Area A, non-LSCB Designated Safeguarding Lead, Health 1]. Another participant from Children's Social Care felt that this lack of communication was a reflection of the turmoil that Local Authority A had been in for the previous few years. Another Health participant within Area A felt that communication from the LSCB was "*a little bit ad hoc*" [Area A, non LSCB Designated Safeguarding Lead, Health 2] and went on to explain;

"*Sometimes things will come out and you think well it would have been nice to have had it sooner. We get it eventually, but you know…*" [Area A, non LSCB Designated Safeguarding Lead, Health 2].

In relation to the Thresholds for Services document (Area A) and the Failure to Thrive

policy (Area B), the communication might be deemed to be moderately effective. As already highlighted, the Failure to Thrive policy in Area B was a clinically-led policy aimed at health practitioners and had not been circulated for wider consultation. Therefore, the fact that those in Education and Children's Social Care had not heard of it and do not use it should not necessarily be a note for concern, because it was not aimed at these practitioners. By contrast the non-LSCB Designated Safeguarding Lead confirmed that she knew of the guidance, claiming "*yes. It's a community policy, it's not a hospital policy but yes I'm aware of it*" [Area B, non-LSCB Designated Safeguarding Lead, Health]. In Area A, however, the Thresholds for Services guidance had reached some Designated Safeguarding Leads but not all. One representative from Health (a Designated Safeguarding Nurse within a hospital) and one within Children's Social Care were aware of the Threshold for Services documents but the Designated Safeguarding Lead in Education and the other Designated Safeguarding Lead in Health (a GP) had not heard of it.

France *et al.* (2010) raised the concern that LSCBs were uncertain of whether or not they were informing and affecting practice. Building on this concern, the findings here suggest that it actually depends on the sector, and there are still challenges to be overcome in terms of improving communication.

> "*I would have to say one of the biggest frustrations in [Area B], the Safeguarding Board do recognise this, is still communication between the departments whether it be health, social care, education, they are the challenges to overcome*" [Area B, LSCB member, Education].

In relation to responding to policy feedback and adjusting policy, therefore, in phase three, the operational teams within Education perceived that they received enough information for them to be able to implement appropriate safeguarding policies within their school. On the other hand, Health and Children's Social Care did not feel that information was forthcoming from the government or the LSCB. They claimed that there was no clear strategy for disseminating information to them. This might be a reflection of the multitude of layers within both the Health sector and Children's Social Care sector that need to be permeated (Hogwood and Gunn, 1984), in comparison with schools. The larger and more complex an organisation's structure the less straightforward will be the

lines of communication (Goggin *et al*., 1990; *Bowe et al.,* 1992; Lupton *et al*., 2001; Crozier, 2008). School structures are fairly straightforward, and all will have a Head teacher and Designated Safeguarding Lead. The Health sector nationally is particularly complicated with variations by NHS, Clinical Commissioning Groups, or Primary Care Trusts and so on, not to mention deliverance between public and private (contracted) sector. In addition, the sector has undergone a period of change triggered by the Health and Social Care Act 2012. This is useful to understand in order to acknowledge the impact that organisational (or even network) restructuring can have on sharing policy guidance and dissemination through the network.

- *Communication to front-line practitioners*

LSCB representatives and non-LSCB Designated Safeguarding Managers were asked about the methods of dissemination that they used to communicate policy from themselves to front-line staff. The main methods were through training or workshops, email and staff meetings. Websites and screen savers were other noted routes for disseminating policy guidance, but these were deemed less useful routes. LSCB websites in particular generated negative responses, from designated safeguarding leads and front-line practitioners, with them being described as complex, and "*not very user friendly*" [Area A, non-LSCB Designated Safeguarding Lead, Health 2].

Front-line practitioners in both areas noted that communication to them was predominantly by email. This was problematic because of the sheer volume of emails that they received, which seems to have created a feeling of desensitisation, and apathy, towards messages posted in emails, and any importance the sender placed on it.

> "*I rarely read emails, I have to admit, I don't have time … if it's an issue I quickly look at it and if it says please-look-at-this-link, I just don't have time*" [Area A, frontline practitioner A]

In terms of filtering the emails, front-line practitioners in both areas stated that the ones which will help with their current cases will be the emails that are prioritised.

> "*if I went back to my desk now and I've got ten emails, there was a health visitor who wanted a call, a midwife who wanted a call and a policy document off the LSCB that policy document would be the least of my priorities*" [Area B, front-line practitioner, M]

Practitioners seemed to prefer face to face communication. Front-line practitioners in Area A stated that much of their training (another form of receiving relevant policy and practice guidance in relation to child neglect) had now reverted to online training rather than classroom based training, which was not a popular format, and described it as a "*chore*" [Area A, frontline practitioner D],

> "*and the general attitude by staff is it's boring because you're sat at your desk all day so for staff to actually absorb this information I don't think it's going to be as effective as training within the classroom*" [Area A, frontline practitioner J].

Electronic training, and a reduction in face to face training, or communication, is known to reduce the sharing of information, joined-up learning and 'can severely disrupt the flow of information and ideas' (Goldsmith and Eggers, 2004, p94).

One clear message that came through from participants within all phases of the fieldwork was that communication was not as good or effective as it used to be. In Area A, during phase two of the fieldwork, it was noted that

> "*So I don't think communication is as strong as it used to be and I think it is hard for practitioners to kind of really understand the Board because it is quite a strange concept in some ways*" [Area A, LSCB member, Children's Social Care].

This sentiment was echoed in phase three. One participant stated that she had not been confident for a long time that communication with front-line workers was effective:

> "*I don't think they've been very good at communicating what they're doing to frontline practitioners for a number of years now*" [Area A, non-LSCB Designated Safeguarding Lead, Children's Social Care].

There was recognition from the LSCBs that more work needed to be done to gain the views and input from front-line practitioners.

> "*We recognise the need to engage more with frontline practitioners. I've long held a belief that the more senior you get the less you keep touch with reality and actually very often it's the people at the coalface who know exactly what needs to be done and where the best ideas come from …. but, you're right, it's a two-way thing, we need to deliver a message, but we also need to listen to everyone as well*" [Area B, LSCB Independent Chair].

Both areas seemed to have been in a considerable period of flux and turmoil at the time of interviewing. Within Area A one participant in phase three stated that she had been trying to find previous minutes from an LSCB meeting but noted that she could only find some from over twelve months prior. She felt that this was "*kind of a reflection about the period of turmoil that [Local Authority A] seems to have had in the last couple of years*" [Area A, non-LSCB Designated Safeguarding Lead, Children's Social Care]. Two front-line practitioners also within Area A noted similar points, with one saying;

> *"I don't know if this has got anything to do with it but the hierarchy of [Local Authority A] … has changed quite a lot recently. It used to be stable, we had a continuous Head of Service kind of thing, but that's all changed over the last couple of years, we've got like agency people come on board, which is no criticism but, it's not consistent like it used to be and whether that has any impact on what filters down to us"* [Area A, Social Worker P]

The picture was portrayed as being similar in Area B.

> *"I'm just trying to think when we last had a manager for more than a few months"…"but the restructuring now has been going on for nearly two years and so, you know, we've had two three Service Managers that I can think of and our team's had – one, two, three, four, five – five managers [*In 2 years*]"* [Area B, Social Worker M].

It would be very hard for a governance network to be able to adjust a policy in light of feedback, if the information is not reaching relevant parties for them to then provide feedback. Front-line practitioners working with child neglect on a daily basis have a wealth of experience and insight to offer in the policy making process. Communication is key to adjusting services in the face of policy feedback and changing conditions, therefore, it is crucial to ensure that guidance is reaching such people and that policy making is as much bottom-up as it is top-down.

5.6.2 Information dissemination

As well as exploring communication in order to assess how well the governance network provides flexible adjustment of policy and services in light of feedback, it is

important also to examine information dissemination methods, and whether or not these change in light of conditions and preferences.

In phases one and two, when asked about receiving guidance about Government priorities, one participant laughed *"ooh, we're bombarded with them, usually in the form of instructions from the DfE*" [Area A, ADCS]. She went further to note that government generally "*does it in terms of putting forward guidance*" and also noted "*there are conferences and things like that but they're not particularly well sponsored or set up*". Another participant noted "*regional briefings*" [Area B, ADCS] run by the DfE, and another said "*invitations to conferences*" [Area A, LSCB member, Children's Social Care] which then have to be funded, and had in any case become less frequent.

During the first two phases of the fieldwork, participants also cited networks such as 'Research in Practice' or NHS England as key sources of information on child neglect. Other responses from Board representatives included scanning websites, invitations to participate in policy consultations, DfE, NSPCC or other mailshots (for example, CASPAR) and similar newsletters, the Board manager and internal safeguarding meetings. Very few mentioned Government research publications as a source of learning about child neglect guidance. Only one participant from Children's Social Care made an unprompted reference to the recent research publications on child neglect (Davies and Ward, 2012) that the Government had published in light of the fact neglect and emotional neglect are the single biggest categories for children being placed on a Child Protection Plan (CPP).

When asked about the Davies and Ward (2012) research overview of Government-funded safeguarding initiative much of which covered neglect as a policy driver for child neglect, this was much less well known although many felt that actually they should have been made aware of it because it sounded useful. There is a connection between the receptivity of senior managers to research and the likelihood of research knowledge being put into practice by their organisation (Chagnon *et al*., 2010). However, my findings do not indicate a similar pattern. Figure xv (page 90) shows that LSCB representatives from Children's Social Care placed research second, and ADCS placed in

third. Yet, front-line practitioners seem to be unaware of guidance coming from key research.

As one might expect guidance to be filtered down to front-line and operational practice, the fact that many strategic level people had not heard of the government's research initiative, it is perhaps unsurprising that operational and front-line staff were not familiar with it. When asked about messages from research, one replied "*I don't think we get much from that, no*" [Area A, non-LSCB Designated Safeguarding Lead, Health].

None of the front-line practitioners in Area A had heard of the government's research initiative which culminated in the report by Davies and Ward (2012). In Area B, the picture was fairly similar. Two non-LSCB Designated Safeguarding Leads from Health, and Education were unaware of Davies and Ward's report. Despite not having heard of the government's research initiative many front-line practitioners stated that they had to use research in reports such as case files, assessments and court reports, and made use of Research in Practice resources.

Building on from these findings, I made enquiries to the DfE regarding the dissemination of the Davies and Ward report. A respondent from the DfE noted that:

> "*The Safeguarding Children research initiative was an important element in the government response to the Laming inquiry following the death of Victoria Climbié*". (Miller, 2017)

In response then to enquiring about how such an "*important element*" of the government's response to improve the protection of children in England was disseminated, it was stated that:

> *"As is standard practice for all DfE commissioned research, the report was published on the department's website. Safeguarding is a multi-disciplinary area of practice with multiple audiences and a number of targeted summaries were produced (for health professionals, professionals in Children's Social Care and Adult Services professional working with parents)*." (Miller, 2017)

Furthermore:

> *"The findings were distilled to meet the needs of those professionals in order that they could use the research findings to shape their day-to-day work. These summaries were also published on the department's website."* (Miller, 2017)

The purpose of this overview was to summarise the 15 studies and make it clear how strategic and operational managers and policy makers can apply the findings on child neglect (and other forms of abuse) to shape the safeguarding practice within their service provision. This clearly is not being done if operational and strategic managers have either not heard of it or are vague as to whether or not they have heard of it and cannot remember what the main messages were. The communication method from the DfE of simply publishing it "*on the department's website*", along with summaries for professional groups, is not an effective method of dissemination. Poor communication and poor electronic communication are the primary reason that front-line practice may not deliver as anticipated (Goldsmith and Eggers, 2004).

As policy is continually and rapidly changing, there is a question as to whether or not practitioners are able to keep up to date with the policy guidance. The majority of participants said that they kept up to date, but never in the working day, it was always something that needed to be done out of normal office hours. Sometimes this was to do with simply not having enough time at work, but some also felt they could concentrate more at home. This research evidence was echoed across each of the participating sectors.

As indicated above, for many LSCB representatives, safeguarding children is only one part of their job and keeping up to date with the large number of documents around safeguarding generally – in addition to the rest of their responsibilities – was difficult.

> "*I know safeguarding is hugely important but when you consider that's a tiny amount of the day job, there's too much to actually find out what you need to know and find out what you need to do about it*" [Area B, LSCB member, Education]."

> "*the only problem is we are GPs, and there's so many things we need updating on, you would end up never going to work if you went to everything*" [Area A, non-

Board, Designated Safeguarding Lead, Health]

In short, Government-funded research did not seem to be first and foremost in minds as a resource. Furthermore, given the lack of awareness around the major safeguarding research initiative funded by Government and intended to be a factor in shaping practice, it is fair to say that their dissemination methods need considerable development. Uploading summaries to a website which were intended to "*shape their day-to-day work*" (Miller, 2017) is clearly not effective and is not having much effect on shaping practice if practitioners are not aware of it.

5.6.3 EC 5 summary

From these findings, I would infer that the governance network does not provide a flexible adjustment of policy solutions and services in the face of any feedback or in light of changing conditions and preferences. In short, the communication from government was poor and this was a trend that trickled through the knowledge transfer process, with information seemingly being disjointed at every phase. Education perceived communication routes to be satisfactory, but Health and Children's Social Care suggesting that communication generally was not done well. This in turn means that the bottom up process, and getting views heard on policies and guidance was fairly non-existent. Furthermore, persistent and prolonged organisational restructure was deemed to be a major factor in terms of lack of communication and not seeking front-line practitioner views.

Equally changing conditions and preferences in terms of giving such feedback or learning about new guidance was not considered. Electronic forms of communication were not well received with many participants – particularly front-line participants - preferring face to face forms of communication.

In short, these findings demonstrate a lack of confidence in current policy dissemination and communication processes. Part of the problem comes back to the fact that the LSCB does not have a policy dissemination strategy or any kind of mechanism for both ensuring the guidance is communicated and that it is read, interpreted and implemented appropriately.

5.7 EC 6: Create favourable conditions for future cooperation through cognitive, strategic, and institutional learning that construct common frameworks, spur development interdependency, and build mutual trust.

The theme that emerged from the research findings was the notion of trust as a favourable condition for future cooperation.

5.7.1 Trust

Firstly, there is an element of trust in terms of filtering guidance through to front-line practitioners. The LSCB is reliant on its members to take the guidance back to their organisations and cascade them through their network or email trees. This is not monitored or followed up in any way by the Chair or Board manager. There is a strong element of trust that this will be done. In terms of ensuring that the members could be relied on to do this, one Independent Chair identified that it was about ensuring that you "*get the right people on the Board*" [Area B, Independent Chair] in the first place, and that those people were aware of and fully understood what they were signing up to.

Secondly trust was also touched upon in the notion of conflict management under the first criteria. Such challenge and scrutiny can further foster the element of trust between the network actors. Governance networks which can foster an atmosphere of positive conflict, in terms of open debate and discussion, will build a trusting environment in which actors feel safe and valued enough to openly air their views, concerns and ideas about wicked issues (Koppenjan and Klijn, 2004; Klijn and Edelenbos, 2007). Trust within governance networks is the notion of working together perceiving that the other network actors will respect the views of each other (even in disagreement), will refrain from opportunistic behaviour and will carry out their responsibilities as a member of the network as required. Trust within the network takes time to develop but will also begin to break down when one of the network actors fails to meet the unwritten rules of trust within the network (Koppenjan and Klijn, 2004).

It might be concluded that trust exists within the strategic level of the governance network – the LSCB. As noted in Chapter 1, joined-up working in the field of child protection as a long history, starting with the development of the ARC in 1975, becoming the ACPCs, under the Children Act 1989 and subsequently the LSCBs under

the Children Act 2004. Some of the organisations represented within such multi-agency arrangements, have had a long trajectory in developing trust among the partner organisations. Outside of this strategic level arrangement, however, exploring the findings from this study, it might be concluded that the notion of trust seems to have waned in a bottom up direction; between the front-line practice level and the strategic level LSCB, and then between the strategic level (the LSCB) and the government. Trust, however, can be broken when partners do not deliver as promised or do not communicate effectively. Such incidences of poor delivery or lack of communication – whether deliberate or not – reduces the level of trust (Goldsmith and Eggers, 2004; France *et al.,* 2010) professionals have with the communicating body. This ultimately results in the governance network actors having a sense of mistrust of central government departments or strategic level bodies, and lack of confidence in their leadership. One participant described government actions as "*rhetoric*" [Area B, LSCB member, Health], whilst another expressed it as "*very worn words*" [Area A, non-Board, Designated Safeguarding Lead, Children's Social Care". Another referring to government policies said "*forgive me for being somewhat sceptical*" [Area A, LSCB member, Education]. Such expressions highlight a lack of, or waning, trust in central bodies.

This might be explained by drawing on the poor communication practices highlighted under criterion five, and the lack of a policy dissemination strategy from government to the LSCB, and equally from the LSCB to operational and frontline practices. Furthermore, if network actors are not consulted about policy development, they may feel that policy is simply being *done* to them, which makes them mistrustful of the bodies implementing the policy.

5.7.2 EC 6 summary

This last criterion was almost a secondary theme underlining some of the other core themes that emerged from the data. That said *trust* is an important issue to understand in the context of governance networks, but also in understanding effectiveness of communication through the LSCB in relation to child neglect guidance.

5.8 SUMMARY

In terms of child neglect, participants in both areas perceived that child neglect was not on the government agenda at the moment. Instead it had been superseded by other national priorities such as CSE. This was felt to be to the detriment of local needs and local policy. That said, the study raised awareness of how variously influenced participants in phases one and two were by external factors driving local policy. Such differences in policy drivers lead to multiple perspectives needing to be balanced by the Independent Chair.

The shift to Independent Chair had refocused and rebalanced the Board from being less local authority led. I found, however, that the participating Chairs seemed to view their levels of impartiality quite differently with the chair in Area A keeping an arm's length from the business of the Board, and the chair in Area B working in much closer allegiance with partners on the Board.

Government is viewed as being the metagovernor and very much controlling the local agenda. Such control-led to monitoring of policy implementation practice which met with varied views. Education participants placed more value on Ofsted procedures than participants from Health and Children's Social Care.

In terms of knowledge transfer, it was deemed that the LSCB was not effective as a mechanism for transferring information beyond the Board, and certainly not to front-line practitioners. Participants within Education believed that they received enough information to help them do their job, but those from Health and Children's Social Care were more disparaging about the lack of information being disseminated (or not). In part, some of the difficulties in knowledge transfer were attributed to long periods of organisational restructuring (taking years in the case of Area B). The LSCBs in neither area had a dissemination strategy. There was also a heavy reliance on electronic distribution of messages and a loss of face to face communication, and this was not met favourably with front-line practitioners.

This can all be summed up by looking at the dissemination of the selected national and local policies. I think it is fair to say that the Government's Safeguarding Children

initiative (Davies and Ward, 2012) has not been effectively disseminated. Only one participant made an unprompted reference to the research, no one else had heard of it. In Area A, the Threshold Services document had a problematic implementation as was acknowledged by the research participants in phase two. In turn this was then not acknowledged in phases three or four, so it is questionable as to whether or not this policy document had reached its intended audience. I could argue that Area B has fared better in terms of its policy dissemination. Being a clinically-led guidance document, it would not necessarily be surprising that those in Education and Children's Social Care had not heard of it.

The discussion chapter discusses these findings in relation to the four research questions which have guided this study, in order to give a more conclusive response to the research aim and to identify new messages coming out the research.

Chapter Six: Discussion.

6.0 INTRODUCTION

This study was guided by four research questions:

1. How does the Government interact with LSCBs to disseminate and drive forward its child protection guidance?
2. How does the LSCB identify or learn about the child protection (neglect) guidance from Government?
3. How does the LSCB, communicate child protection (neglect) guidance to operational teams within statutory service?
4. When developing local child neglect policy, what factors help or hinder policy implementation from LSCB strategic level to operational practice?

This chapter revisits these questions, drawing out new findings from the study, contributing to the social work literature on child neglect and LSCBs.

6.1 THE RESEARCH QUESTIONS: DISCUSSION

1. How does the Government interact with LSCBs to disseminate and drive forward its child protection guidance?

As discussed in Chapter 2, France *et al.* (2010) explored communication at Board level to examine whether communication within LSCBs was better than the former Area Child Protection Committees (ACPCs). This study goes further, making an original contribution in examining communication from the Government to the LSCB and beyond, throughout the wider governance network. In answer to this first question, the findings suggest that the government retains ultimate control and influence over the LSCB and the media is a key driver of policy.

- *Interacting with LSCBs: The government as metagovernor*

I found that, as metagovernor and systems' architect, the government still holds the power, despite decentralisation, and controls the agenda of the LSCBs and those organisations working under its jurisdiction to prevent child neglect. My findings suggest that contrary to Torfing *et al.*'s first effectivity criterion, participants did not feel that LSCB or government produced clear and well-informed understanding of neglect or the opportunities to address it, despite the existence of policy guidance. Considering

how the two participating LSCBs interpret and decide on which guidance to take forward, one participant noted finding and acting on "*stuff that's going to come back and bite the Board, if we don't do it*" [Area A, Independent Chair]. Another referred to Ofsted "*catching you for not doing it*" [Area A, Assistant Director] if certain measures were not put in place.

Torfing and Sørensen (2014) argue that, as *metagovernor* of the governance network, government's power and authority has shifted, rather than diminished. The government becomes the *inspector* rather than the *deliverer* of services (Rhodes, 1994; Bell and Hindmoor, 2009). Through being the inspector, it essentially remains as the director too, because it exerts power over the network by controlling the agenda, which LSCBs have to follow (Torfing *et al*., 2012; Rhodes, 2017). This however has negative connotations. Such controlling mechanisms prevent LSCBs from responding in innovative and creative ways which reduces its power to ascertain its own agenda. This was further driven by such mechanisms as Ofsted inspections, whereby LSCBs were evaluated as failing if not implementing the government agenda, rather than failing to fulfil local requirements.

Furthermore, LSCBs were charged with steering child neglect policy, but without the 'teeth' (Horwath, 2010) to significantly impact on practice. Sørensen and Torfing (2007b, p96) note that it is not difficult to find examples of governance networks which are, established by politicians, directed by public administrators, and which have not facilitated public governance. Similarly, Flinders (2005, p86) questioned how a government could be committed to *devolving power* yet still have 'a strong centralising and controlling approach to governing'.

This helps to identify and understand the limitations in place when LSCBs try to respond to wicked issues and, specifically, to implement the innovative and proactive local child neglect policies that Torfing *et al*. argue are one of the criteria of effective governance networks (see EC2). It helps to understand what the LSCBs have to balance in terms of their own professional judgements, in line with the limitations to the autonomy given to the governance network.

- *Driving forward the government's child neglect agenda through fuzzy governance and the media*

Fuzzy governance (Bache *et al.,* 2015) is the idea that government might favour complex governance structures with multiple organisations because the government can push down accountability and blame someone else for unpopular actions or decisions. Within such complex governance architecture lines of accountability might become lost or blurred because of the lack of clarity in leadership and 'fuzzy accountability' in central government. This has created a system that is rife with blame games and blame avoidance. Esmark (2007) suggested that there is a close alignment between accountability and being scapegoated when something goes wrong. In my opinion, nowhere is this more evident than in a high-profile child death when practitioners suddenly find themselves subject to scrutiny by the government *and* the media (for example, the public sacking of Sharon Shoesmith, Head of Haringey Children's Services, in 2008 by the Secretary of State, following the death of Peter Connolly in 2007) (Jacobs and Schillemans, 2016).

Therefore the existence of fuzzy governance is evidenced by participants' views on whether child neglect was on the government's current agenda. Fuzzy governance can explain such confusion and lack of clarity on the part of participants because they were uncertain which department should be leading on the child neglect agenda. Therefore, the responsibility and accountability for a particular problem might be spread across the complex structures of governance.

This might be strengthened by a further argument that the media now also promotes its own agenda by framing issues in such a way to sell newspapers, and drive a political agenda (Jacobs and Schillemans, 2016). Whilst, therefore, the evidence from this study suggests that the LSCB does not want to be guided by the media, and it places less importance on this in comparison with other factors (such as SCRs, and research), the media can control the agenda and will be quick to put the abuse and neglect of children under the public microscope (Schillemans and Pierre, 2016). Fuzzy governance therefore is a useful notion for trying to understand and explain the government's incomprehensible structure or architecture in terms of leadership and strategy in relation to wicked issues such as, child neglect policy.

Drawing together the discussion, the evidence from my two cases studies suggest that the government may not interact positively with LSCBs. It has created a knowledge transfer and policy making mechanism, but it has not given it sufficient authority to make anything happen. Instead it has devolved the workload but not the power. Furthermore, the LSCBs also seem to find themselves unwittingly accountable to the media as well as Ofsted (which will be discussed further under question four) which further exacerbates the negative working relationship between the government and LSCB. This is useful for LSCBS to understand because it gives a clearer idea of the tensions between the LSCB and the government.

2. How does the LSCB identify or learn about child protection (neglect) guidance from Government?

Whilst previous research has explored the role of the LSCB, and the effects of child neglect (see Chapter 2), this study is the first to examine this issue in particular guidance on child neglect. The findings point to: the lack of a clear child neglect agenda, and the disjointed and voluminous information from government.

- *Communication from Government to LSCB*

From the findings it is clear that top-down communication from Government to both participating LSCBs is disjointed, inconsistent and unclear. It is also voluminous and difficult for many child neglect practitioners to keep up with. This runs counter to Torfing *et al*.'s effectivity criteria that effective governance networks provide a flexible adjustment of policy solutions and public services (see EC5). Guidance from central government to LSCBs has reduced with decentralisation, but power and authority are asymmetrical because the power rolled out to the LSCBs is limited by managerialism and bureaucracy, with government retaining ultimate power and authority over child protective services (Newman, 2005; Torfing *et al.*, 2012; Torfing and Sørensen, 2014), as per EC 2.

- *Learning about child neglect guidance*

The findings from this study suggest that contrary to Torfing *et al*.'s first effectivity criterion, the government's agenda on tackling child neglect is not reaching relevant network actors and practitioners. Participants in this research felt that the

government's agenda on tackling child neglect was not clear. They said that it was more often than not tied up as a secondary issue when dealing with issues such as child poverty or Early Help (see Burgess *et al.,* 2013). Therefore the government is failing to ensure that its safeguarding research initiative (Davies and Ward, 2012) was disseminated and transferred appropriately. In addition, it was felt that government policy was currently focused on child sexual exploitation, to the detriment of other core safeguarding guidance because "*the squeaking wheel always gets the grease*" [Area B, Independent Chair].

Participants cited a variety of sources of information, but few acknowledged, unprompted, the use of government funded research (for example, Davies and Ward, 2012) as a source. This links to the issue of poor communication and disjointed guidance from government on key guidance on child neglect (see Chapter 2). Disparities in dissemination practice by government were also raised, with participants stating that there were "*fanfares*" for some guidance, yet others (just as important in their view) just seemed to creep out with little or no notification. Furthermore, all participants said they were unable to keep up to date with policy guidance during the working day, it was, instead, "*always a take-home-bedtime-read, always"* [Area A, LSCB member, Health] because there was too much disjointed guidance which was too voluminous to wade through. Rather, therefore, than research enhancing learning and shared knowledge in such instances, it simply leads to 'information overload' (Klijn and Koppenjan, 2016, p247). This does not resolve the wicked issue, and just adds to complexity and 'superfluous knowledge' (*ibid*) in which new or further knowledge does not help the LSCB to resolve the issue. The solution to issues of complexity, therefore, is not more information which simply increases ambiguity. What is required instead is strategic problem solving informed by the right information at the right time.

What is seemingly missing here too is any link to or use of Dissemination and Implementation (D.I) science and theory, both at a government level, and at the LSCB level. In the Health sector, there has been a realisation that Health professionals were not necessarily always using the most up to date research to inform their treatment of patients (Chagnon *et al*., 2010), because they were unaware of it, or unable to access it. In addition within Health, it takes 17 years for 14% of research to make its way into

practice (Estabrooks *et al.,* 2018). Therefore, within Health, D.I science examines the processes through which Health professionals are made aware of new scientific evidence within their field and how they adopt and implement the findings for the benefit of their patients. In Chapter 3, I stated that I discounted D.I theory because for me, in this study, before devising an implementation strategy, it was important to understand the governance structures through which the strategy will be adopted (Powell *et al*., 2013). I have now completed this so DI science and theory could now be a useful next step to examine more closely the impact of the evidence into practice gap. This, further, connects back to the argument raised by France *et al.,* 2010, that LSCBs do not know how, or even if, their policies are changing practice.

In short, therefore, drawing together the discussion from question two, I deduce from my findings that the government needs a *streamlined* dissemination strategy which can communicate synthesised, consistent and accessible guidance to LSCBs in order to enhance the cognitive learning of the LSCB, rather than throwing further information into the domain in an *ad hoc* fashion. D.I science might be a useful next step to examine how this might be established in a multi-disciplinary environment.

3. How does the LSCB, communicate child protection (neglect) guidance to operational teams within statutory services?

Prior to this study, research had been undertaken on managerialist systems within children's services and the effects of these on practitioners (White *et al*., 2009; Munro, 2010; Preston-Shoot, 2012). As indicated above, France *et al.* (2010) examined communication within the LSCB but I explored how the LSCB decides what to take forward as a priority, how this is communicated to operational teams, and then how (or if) that is monitored in any way, and with what outcome. This both sheds light on the reach of the LSCB beyond its board members, and on how operational teams view the board. The key findings in relation to this question are: the importance of *independence* for the Independent Chair; the variances in views by sector of LSCB communication; the lack of policy monitoring to ensure information is reaching relevant parties; and the preference of face-to-face communication methods.

- *Interpreting the guidance, managing conflict in decision-making and the role of the Independent Chair*

As discussed in Chapter 1, there are many members on any LSCB, each with variable professional backgrounds. Therefore, each has varying perspectives on a particular complex issue, such as child neglect, and how the LSCB should respond. I drew on an example that arose in Area A in which participants acknowledged disagreement and implementation difficulties in relation to agreeing, writing and disseminating its Thresholds for Services guidance (see EC 1). This, however, should not be viewed negatively. Koppenjan (2007) argued that a *lack of* consensus may mean that issues are looked at from more angles, that is to say, an opportunity for debate, disagreement and dialogue is a good thing. Similarly, consensus *can* be viewed as apathy towards a topic. If network actors are dissenting, then it might emphasise a strong position on an issue or being particularly passionate about an issue and refusing to be simply compliant. Once the dissenters stop, it might be time to refresh or renew the actors. On this basis therefore, whilst the development of the Threshold for Services document caused some difficulties for Area A, I think that this should be viewed positively, and front-line practitioners could take this to mean that the policy was developed with a no-stone-left-unturned approach, therefore preventing opportunistic behaviour of individuals and domination of the process by a single agency. But whilst conflict is not necessarily a bad thing it can be resource intensive and lead to implementation problems and delays – striking the right balance is critical.

In previous studies (Laming, 2009; France *et al.,* 2010; HM Government, 2015) the role of the Independent Chair has been viewed from the notion of needing to be *independent* from the Local Authority. Using governance network theory, the evidence in this study suggests that the role of the Independent Chair was crucial in the policy communication/implementation chain. The Chair - and more importantly – an Independent Chair is central to:

- maintaining a horizontal, joined up approach to implementing child neglect policy
- Enabling the network actors to reach joint policy decisions.
- Enabling the government to pass along its child neglect guidance via the AILC, into the network.

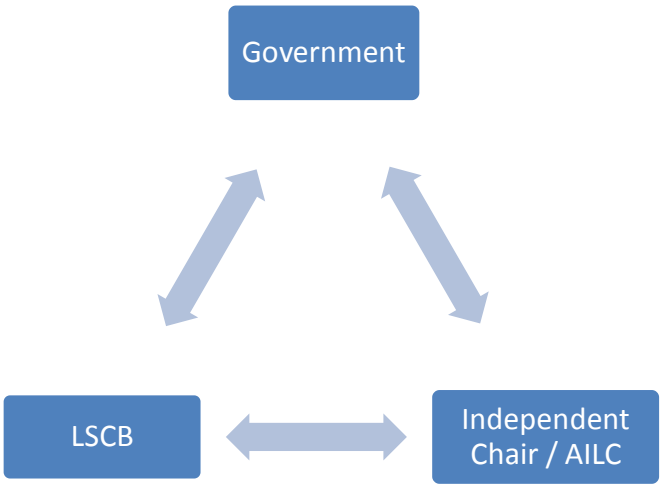
- Assisting, or *facilitating*, the Board in *interpreting* that guidance for translation into local policy.

Of course, as the findings highlight, the role of the Independent Chair within the LSCB is crucial in terms of interpreting guidance and managing conflict that may arise when the Board is making local policy. Koppenjan and Klijn (2004, p11) describe the Chair of such networks as being a 'mediator and stimulator of interaction and not one of central director', someone who is not drawn into the conflicts between the network actors and remains impartial. The Independent Chairs participating in this study clearly saw their role as being in post to "*scrutinise*" and "*challenge*" [Area A, Independent Chair] and "*holding to account*" [Area B, Independent Chair], in an unbiased and impartial manner.

All things considered, the role of the Independent Chair within the LSCB is to maintain a horizontal balance in the joined-up approach to addressing wicked issues and to reduce power games and hierarchies within the governance network. Laming (2009) found that the Chairs were still closely linked to the Local Authority and therefore the Local Authority dominated the LSCB. He recommended that Chairs should be independent of any organisation represented on the Board. When first implementing the Independent Chairs' role however, they found themselves still being linked to the local authority. This had been the view of the Independent Chair in Area A, too. In 2012 the Association of Independent LSCB Chairs (AILC) was established to further separate the Independent Chair from being viewed as connected to the local authority – or any other agency represented at the Board in anyway. It increased the independence of the Chair from the local authority. The chair in Area A was also of this opinion. That said, however, I think that the balance between the government as metagovernor and the AILC / Independent Chair is a difficult one to ascertain within this particular governance network structure. Rather than the Chair being viewed as connected to the Board in a dichotomy (of Government and LSCB/Independent Chair), the power balance should be viewed as a trichotomy (see Figure xvi), in order to view the Independent Chair as unconnected to either party, and truly independent. I thought that the two Chairs within my study were at odds in relation to this. The Chair in Area A clearly saw his role as being independent from any agency connected to the Board and from Government. The

Chair in Area B, however, seemed to closely align himself within, and *a part of*, the Board, more so than being independent from it.

Figure xvi: The trichotomy: the government, the Independent Chair, and the LSCB



It is fair to say that both Independent Chairs were held in regard and trust by Board members, when it came to interpreting information. Klijn and Koppenjan (2016) liken this role of mediator, or in the case of LSCBs, Independent Chair to that of a contractor, jointly commissioned by the network actors, which then forces them 'to interact and coordinate their demands' (*ibid,* p141). Koppenjan and Klijn (2016) highlight that the role of 'process manager' (*ibid*, p173) or Chairperson, is mostly that of being a facilitator, but who is authoritative and trusted by the network actors. They may have 'hidden power' (*ibid*) in terms of their influence, the direction in which they take a discussion, or in including certain network actor's voices but excluding others. But such actions would draw into question their independence and 'impartiality' (*ibid*). Therefore, I think that Klijn and Koppenjan's (2016) views of the chairperson in governance networks helps to explain the difficult situation that LSCB Independent Chairs can find themselves in, and the balancing act they may find themselves in between the government and the LSCB. In my opinion, the role might almost be viewed as that of referee or umpire in a sports match, in which they should not favour one player over the other. That said, however, this would assume that the Independent Chairs, whilst being independent from government or any agency on the LSCB, are also apolitical in order to be completely impartial in facilitating a discussion. Both

Independent Chairs were clearly not apolitical, and one described himself as being "*sceptical*" of government [Area A, Independent Chair]. Given their background in public sector work it is difficult to see how they could be completely apolitical and hold unbiased views when interpreting information from government, particularly in relation to something as highly emotive as safeguarding children.

- *Communicating strategy from LSCB to operational teams within statutory services*

As France *et al*. (2010) found, the working relationship between LSCB members was deemed (by the members) to be positive. My participants said the same, but I also found, however, that they did not consider that the LSCB communicated effectively to statutory services, although this varied by sector (see EC 5). Participants from Health and Children's Social Care were quite disparaging about communication, but participants within Education were satisfied with the information that they received. Insofar as there was no mechanism for communicating any policy or strategy, the conditions were not favourable to cooperation or institutional learning (see EC 6).

The research evidence indicates that preferences of knowledge transfer methods had not been considered. With the growth of electronic medium (for example, email, internets and intranets), it seemed to be assumed that this was the preferential method of communication. In actual fact, whilst this might be the cheapest, quickest and easiest, it was not necessarily the most effective. The data identifies that a face-to-face approach for knowledge transfer was the preferred form of communication, yet this was being replaced with online forums which were deemed to be a chore (see EC 5). Klijn and Koppenjan (2016) provide a useful analysis in relation to email and information overload in front-line practice which can be applied here. They argue that parties within the governance network often use research and its findings as they vie for power. Those disseminating information may cherry pick which information to send or send all of it. But on the front-line sometimes conflicting arguments, or lack of a synthesised argument, causes confusion and leads to apathy towards policy guidance. Practitioners simply keep on doing something the way they have always done, with little regard for the policy guidance, because they have become inundated with (sometimes conflicting) guidance (Crozier, 2008; Morrison, 2010). Whilst face to face knowledge transfer may

be costly and time consuming, actually it might be more worthwhile and beneficial for ensuring that the more important or crucial messages are reaching the relevant practitioners, and this is being understood and taken on board. Equally there may also be more buy-in to a policy if those practitioners are then able to ask questions about it in an open forum.

- *Monitoring child neglect strategy to operational teams within statutory service?*

What also needs to be considered here is policy resistance. The analysis thus far has been based on an understanding of compliance (that is to say, that guidance is received and passed on), but guidance can equally be ignored in an act of resistance; of not wanting to comply, resistance because of information overload, or resistance simply because email is not a personal or effective means of communication. This is important for LSCBs to understand in order to examine their own communication practices. It needs to be understood that in terms of methods of communication, a one-size-fits-all approach may not be appropriate, and perhaps indicates the need for a different dissemination strategy for the different sectors represented within it.

Examining accountability in the policy implementation process (see EC 4), certain Board members said that they were not particularly confident that such guidance was always being passed on. It was evident that there was a strong element of trust placed in LSCB representatives to take back guidance from the Board and filter them through their organisations, and this was not monitored in any way. This can equally explain the idea of passing on guidance and once the "send" button is pressed, all responsibility of the sender is seemingly transmitted to the recipient, with no follow up of what the recipient does with that information. Drawing on Esmark's (2007) and Klijn and Koppenjan's (2016) idea of people being accountable for their actions, it poses the question of what is the responsibility and accountability of the *sender* of the information in terms of following up what happens to the information that they have disseminated (that is to say, has it been read? Understood? Digested? Implemented into practice?). Williams (2012, p39) has argued those who, like LSCB representatives, operate across organisational boundaries, have 'very powerful and often discretionary roles in circulating information'. They can decide what information is disseminated, to whom

and when. Of course, the disadvantage to this is that there is no mechanism for checking how the policy or guidance is affecting practice (if at all).

Whilst it seems that LSCBs are cognisant of this, they need a more robust system through which to monitor the dissemination of child neglect guidance to ensure that it is reaching all relevant parties. The difficulty is that for some Board members, safeguarding and child neglect is not the sole element to their job, and they may be balancing (and being held accountable for) several other, equally important, matters. It was noted that Area B had a policy lead, whilst Area A did not. Perhaps there is an argument for *mandating* a policy lead within safeguarding arrangements, whose responsibility it would be to disseminate the policy, and establish a feedback loop to ensure that child neglect (or other) policy guidance is being disseminated and implemented. In line with proposals suggested here for guidance from government to be streamlined this would further streamline the policy dissemination process between strategic and operational levels.

Drawing together the discussion from question three multiple perspectives on child neglect lead to discussion on guidance and conflicting ideas on how to take this forward. The role of the Independent Chair is important in balancing out the varying professional views and driving forward the local guidance. However, problems seem to arise when it comes to transferring that guidance beyond the LSCB members. There is no dissemination strategy for filtering the guidance through various networks and the onus is simply placed on members to do it. Equally, there is no feedback loop in terms of being able to find out to where the guidance has transcended and whether or not it is being implemented. The research evidence indicates that there is a question over whether the reversion from face to face to email transfer processes is effective (whilst being more cost and time effective). There is also a question over the role of the policy lead on LSCBs and whether or not this role could be strengthened in terms of enabling and monitoring policy and knowledge transfer.

4. When developing local child neglect policy, what factors help or hinder policy implementation from LSCB strategic level to operational practice?

Research has previously identified some resource hindrances to policy implementation in children's protective services for example bureaucracy, duplicate roles, expensive staff, and finances (see, for example, Preston-Shoot, 2012), and financial barriers (Green, 2012). This study though offers an in-depth analysis of the tacit hindrances such as power games, and accountability. The research evidence in relation to this question identifies that board members have to juggle several roles; there may be a potential for regional rather than local policy-making among the LSCBs; organisational restructuring impacts on LSCBs, and there are varied responses to Ofsted.

- *Multiple layers in the communication process.*

The views of participants were that government guidance and research on child neglect is viewed as a hindrance because it is lengthy and emerges through an uncoordinated dissemination approach. The LCSB was therefore not in a position to 'produce a clear and well-informed understanding' of what it expected of agencies' (EC1).

Furthermore, hindrances to the policy implementation process between the LSCB and operational practice can be driven by a fragmentation of service delivery in local areas, which leads to unclear lines of accountability, meaning that LCSBs also fell short of EC3, reaching joint policy decisions. Whilst members of the LSCB are committed to joined-up working and multi-agency solutions to complex problems, it is ultimately ineffective in communicating its intentions to operational practice which therefore hinders policy implementation. Evidence indicates that this creates despondency towards its efforts from operational and front-line practitioners. Wood raised a similar point in his report (Wood, 2016) highlighting that lack of joined up working between national Government departments, did not model effective partnership working and created a lack of commitment to multi-agency working at local level.

In my opinion, consideration needs also to be given to the dual role of LSCB members, juggling Board membership (in some cases, more than one multi-agency network) with their home organisation. This connects to Sørenson and Torfing's (2007a) argument that the ideals of the network often do not sit neatly with those of the 'home' organisation. This suggests that those involved on the LSCB have an equal knowledge or weighting given to the collaborative task (in this case child neglect). But this is not the

case, and this affects levels of responsibility and accountability when dealing with a particular complex issue, as some less knowledgeable members might pass the buck in terms of taking on joint responsibility for a problem. But equally it can explain the blurred lines between LSCB members wearing more than one hat (several in some cases), and the magnitude not only of the accountability and responsibility but of *balancing* the accountability and responsibility among more than one *agency*.

All that said, the idea of regional policy making in relation to child neglect was purported to potentially be a positive policy development. In the face of austerity measures facing many public services (for example, Local Authority, schools, Health and so on.) more than one LSCB (indeed all those in one region) could develop a single, up-to-date child neglect policy affecting thousands of neglected children regionally. This would involve joined up working across the governance networks (the LSCBs), thereby improving their performance against EC3. That is to say that, in the current economic climate, there could be scope for a network of LSCBs tasked with knowledge transfer and policy communication across the wider piece (for example, regionally) which does not currently happen. In light of other findings from this study, however, it would be advisable for LSCBs to carefully consider both how they communicate that policy to operational teams, and how they gain the views of experienced front-line practitioners within such a large-scale policy development on child neglect.

- *Organisational restructuring and power*

The empirical data indicated that participants attributed the lack of information sharing and policy dissemination to the organisational restructuring that both local authorities in Areas A and B had been through in recent times. Lupton *et al.* (2001) argued that communication and information sharing is often not done well when organisations are going through periods of restructuring or turmoil. Understanding the consequences of restructuring on an organisation is nothing new, but having a grasp of the implications on a governance network of which the organisation is part of has not previously been explored in relation to LSCBs. Organisational restructuring causes several problems for governance networks in disseminating policy guidance. Restructuring can cause job insecurities, which can lead to power games (Lupton *et al.,* 2001). This can also lead to changes in the person representing the organisation at the strategic level, as job roles

are restructured. This causes uncertainty for the governance network, and may lead to a lack of accountability, responsibility and continuity in representation (Goldsmith and Eggers, 2004; France *et al.,* 2010). I found that such issues were prevalent in the two participating local authorities, with concerns raised by participants in research phases three (non-LSCB Designated Safeguarding Leads) and four (front-line practitioners). In these cases, the members of management hold the power by virtue of the fact that they are in receipt of knowledge (policy guidance) which others (operational and front-line teams) do not yet have. They then have the power to decide whether or not, and when, to disclose that knowledge (Peters, 2013; Martin and Guarneros-Meza, 2013). Until the knowledge holder decides to impart that knowledge, they render themselves as superior which might be viewed as a survival tactic in the turbulent times of organisational restructuring (Kickert *et al*., 1997; Goldsmith and Eggers, 2004). Such tactics affect how guidance is transferred from the LSCB, through local authorities to front-line practitioners. This also affects front-line practitioners wanting to feed up the policy making chain because they are unclear about to whom they should feedback.

- *Monitoring and accountability*

My study found that, in their current format, Ofsted inspections of LSCBs were not met favourably, being described as undermining professional decision-making and front-line practitioners in particular feeling that it was a tick box exercise which was not for the sake of improving quality. Such practices limit one's ability to think from new and alternative perspectives, to be creative, proactive and innovative (Torfing *et al*., 2012). These arguments echoed those of Munro (2010a; 2010b) who identified how child protection reforms have generated a compliance culture based on a framework of rules and regulation to which social workers must adhere rigorously. She argued that such strict, and impersonal, regulation detracts from being able to understand the needs of a child and family. Similarly, Torfing *et al.* (2012) highlighted how complex, wicked issues, (such as child neglect), do not easily lend themselves to performance targets, prescription and tick boxes because such indicators do not capture the complexities of the problem which is difficult to benchmark for such auditing and inspection systems, like Ofsted.

There was an alternative argument from Education participants, however, in that they felt that such quality control tasks provided rigour and accountability. Even if Ofsted did not exist to inspect LSCBs, they would still need to collate some data and evidence for their own monitoring purposes. Instead, what was resented was the oppressive, "*punitive*" [Area A, ADCS] and "*negative approach*" [Area B, ADCS] by Ofsted. The process needs to be developed into one of a critical friend and enabling the sharing of good practice, rather than prosecutor and persecutor.

Drawing together the discussion from question 4, whilst government guidance on child neglect was seen to provide direction, there seemed to be a number of hindrances in being able to disseminate such guidance and deliver in front-line practice. The vast array of layers through which guidance needs to transcend and permeate is a minefield, not discounting too how this varies by sector, organisation and professional role. It is a huge and intricate web. Organisational restructuring provides a further barrier, especially when job roles are cut or redeveloped. Of course, all of this assumes that policy implementation is carried out in a compliant culture, and it is not. Often there will be front-line resistance to policy implementation which also creates challenges to its operationalization. One response to this is practitioner voice and practitioner buy-in during the development stage of the guidance and ensuring more of a bottom-up approach to child neglect policy-making.

6.2 STRENGTHS AND LIMITATIONS OF GOVERNANCE NETWORK THEORY IN THIS STUDY

- *Reflections on using governance network theory*

On reflection governance theory offered a suitable framework to explore the multi-actor policy arena of the LSCBs. It allowed exploring the issue from a multi actor perspective in an environment of complexity and uncertainty. This was appropriate to task.

- *Reflections on using Torfing et al.'s (2012) effectivity criteria model*

Torfing *et al.*'s (2012) *effectivity* criteria was a useful model for framing the findings because, it could be tailored to the specifics of the research environment in question. The model worked well with the qualitative approach, which was as Torfing *et al.* had intended. It was also helpful in being able to accommodate the multifaceted elements of

understanding how child neglect is currently managed. Nonetheless, I did not think it was possible to apply the ordinal scale of "weak, moderate, and strong" (*ibid,* p180) as suggested by Torfing *et al*. Moreover, I did not think it appropriate to label different criteria as effective or ineffective because that would underplay the nuances and complexities in the research findings, which were more subtle than labelling something as simply effective or ineffective. In addition, whilst this study adopted a multiple case study method, as noted in Chapter 4, the focus of the case studies was the particular *phenomenon* rather than the two cases studies, per se. Applying such an ordinal scale would, therefore, do an injustice to the *complexity* of the particular phenomenon. In line with Greenwood's view (2016, p37) the purpose of the research was more about discovery and drawing together perceptions, knowledge and experience dispersed across the network actors and their varied sectors, job roles (in relation to child neglect) and organisations. For this purpose, Torfing *et al.'s* effectivity criteria model provided a useful lens to use.

What was particularly useful in using Torfing *et al*.'s model was that it enabled an examination of knowledge transfer beyond the LSCB to understand the blockages in the knowledge transfer process, and to offer solutions for how these might be overcome. Furthermore, Torfing *et al.*'s (2012) model could be applied in the future by LSCBs in order to evaluate changes in knowledge transfer processes. The qualitative element of the effectivity criteria means that they could be tailored to specific purposes, and accommodate changes in the policy environment.

Not all criteria need to be fulfilled within a given study because, as Torfing *et al.* (2009) argue, those governance networks whose function is to formulate policy would not deliver on effectivity criteria 4, 5 or 6, and those networks solely focused on service delivery would not need effectivity criteria 1, 2 or 3. Furthermore, within my study, I did not have an equal emphasis on each of the six criteria because my research questions fell under some criteria more clearly than others. For example, EC3 (Reach joint policy decisions that go beyond the least common denominator while avoiding excessive costs and unwarranted cost shifting) was least relevant within this study because I did not set out to examine costs. In a bid to resolve this issue, I decided to abbreviate EC3 to "Reach

joint policy decisions" (see section 5.4 p103) and exclude the references to costs and I this did not result in any conceptual loss within my evaluation of the case studies.

I have been unable to draw on other studies to support my application of Torfing *et al.'*s (2012) Effectivity Criteria model but Torfing *et al.* (2012) and Sørensen and Torfing (2009) acknowledge that governance networks cannot be expected to do well within each of the criteria, and that it depends on the role and function of the governance network whether they fully meet the criterion. This is further clarified by Greenwood (2016) who highlights that there are no studies adopting qualitative approaches to evaluating governance networks, and that the few studies that have been carried out have adopted a quantitative approach focusing solely on 'cost efficiency or cost effectiveness' (ibid p32). Instead he praises Torfing *et al.'*s evaluative approach because they 'leave 'open significant questions about how these criteria might be defined and operationalised' ibid p37).

- *Reflections on using Wicked Issues*

Rittel and Webber's (1973) ten distinguishing features were useful to map the complexities of working with child neglect. There were, however, some similarities between the ten features which made Rittel and Webber's characteristics feel repetitive. Peters (2017) argued that the ten features are ambiguous, therefore further definitions need to be added to these features to make them more measurable. As indicated earlier, further criticisms aimed at Rittel and Webber's definition of wicked issues, include the argument that theirs allows for no variations of wickedness (Alford and Head, 2017; Turnbull and Hoppe, 2018). Such criticisms, however, seem to assume that Rittel and Webber developed their ten features as an objective, or scientific, measurement of *wickedness*. That said, I found it useful to map Rittel and Webber's ten features along with Peters (2017) extra 3 features to assess why, in my view, child neglect is a messy, complex problem and why such a messy, complex problem requires a multi-actor, social and political response. Once this decision has been made, further tools could be applied, if needs be, to assess the variations in wickedness, should that be required. In this study, however, the expansion to degrees of wickedness was not needed.

6.3 STRENGTHS AND LIMITATIONS OF THE RESEARCH METHODS

- *Selecting a qualitative, multiple case study approach*

Given the aim of the study, a qualitative case study approach was an appropriate methodology. Furthermore, a multiple case study approach was more insightful than a single case study. Consideration needs to be given to whether or not two case studies in one region were sufficient. Two case studies have offered an interesting insight into knowledge transfer processes in the LSCB governance network, but further case studies over a wider geographical area might offer more conclusive findings. This brings me to my next point on sampling.

- *Sampling; selecting the LSCBs and research participants*

Using a purposive sampling method to select both the participating LSCBs, and the research participants was an appropriate sampling method to use, because it enabled me to select areas and people who I knew could offer insight into the phenomenon being studied.

Upon reflection, whilst this study focused on the three major funders of the LSCBs and the independent Chairs, it would have been pertinent to have included the LSCB Board Managers. The role of the Board Manager was referred to by some participants as the person who communicated with Board members, and also – in Area A –as the person responsible for coordinating members to devise policy. The Board Manager, therefore, would have offered useful insight into challenges in communicating the array of Government guidance, but also the challenges in forging collaboration and observing decision-making in action at the strategic level.

Furthermore, the LSCB training officers could have offered insight into the receptivity, or resistance of policy guidance at an operational level, and whether or not - in their view – this varied by sector. Therefore, in retrospect, if I were to undertake this study again, I would consider including these actors as an alternative source of knowledge transfer.

If the study were to be continued, I think it would be imperative to include the police. Furthermore, the front-line practitioners within this study were those within Children's

Social Care (that is to say, social workers). Given the differences identified between Health, Education and Children's Social Care in the study (between LSCB members, and the non-LSCB Designated Safeguarding Leads), it would give a more holistic view of the knowledge transfer processes through to front-line practice in each of the sectors if front-line practitioner views were also gained from Health, Education and Police.

- *The semi structured interview*

Semi structured interviews were an appropriate tool to use. They enabled a focused but open discussion of the phenomenon. The interviews allowed me to gain the data that I needed to be able to answer my research questions. Participants could clearly offer in-depth responses in an interview (in comparison with a questionnaire, for example).

Equally the group interviews with front-line practitioners –for all the difficulties which I had in setting them up – were again an appropriate choice. The group interviews allowed me to gain the data that I needed, and also exposed me to insightful data that I may not have come across through other methods. Practitioners appreciated being asked for their views, but not only that, were asked for their views in person. This gave them a sense that their views and experiences were valuable and important to me the researcher, in contrast to a faceless researcher simply circulating a questionnaire to faceless, nameless social workers. I believe that this gave me more thoughtful, in depth data than a questionnaire would have. That said, however, one element for further consideration would be the size of the group interview. Two of the group interviews had three participants, and the third one had eight participants. The smaller group interviews were easier to manage and were possibly more insightful than the larger group because the participants had space in which to express their views better than in the larger group. In future, therefore, it would be better to do more group interviews but with only three or four members in each.

The telephone interviews, I think, were harder to assess for several reasons. Firstly, with the exception of schools that include the names of designated safeguarding leads on their websites, it was more difficult to identify the relevant participants. It was quite time-consuming telephoning various organisations to a) find the relevant person who fitted my criteria and b) would be willing to participate in the study (this was especially

the case with GPs). That said it is difficult to assess whether or not I would have had a better response or not if I had been requesting a face to face interview. From a personal perspective, I preferred the face to face and group interviews, because I think I gained more data by doing the interviews in person, I gained a connection with the participants which I did not get by telephone. Therefore, if I was furthering the study, my preference would be to undertake face to face interviews even if that meant taking slightly longer to carry out the fieldwork.

6.4 SUMMARY

The key messages emerging from this chapter is that the relationship between government, the LSCB, the AILC, to operational and front-line practitioners is marred by inconsistent and disjointed communication which affects the knowledge transfer process. The knowledge transfer process is also affected by the lack of authority bestowed on the LSCB by the government, because the LSCB has no power to act if any organisation is found not to have shared or implemented the guidance. Equally it has no power should any member not communicate and share the information and it very much relies on the sheer good will of its members. Various other factors such as multiple layers in the communication chain, organisational restructuring, and monitoring and accountability hindered guidance reaching and affecting front-line practice.

Contemporary policy making is often characterised by multi-agency approaches in environments of complexity and uncertainty. Within this context, LSCBs need to understand their position in the wider network in order to operate effectively. A governance network approach has been fruitful in exploring the relationships between structure (institutions) and agency (the individual actors) in shaping the work of the LSCBs. Torfing *et al*.'s effectivity criteria has been operationalised to evaluate the efficiency of different elements of the network and might be employed again in the future to assess if issues have improved or worsened.

Future work might consider if more than two case studies would provide more conclusive results. It would also be interesting to incorporate the Police, and expand the study so that front-line practitioners in each of the participating sectors were included

rather than just social workers. This would gain a wider view of the impact of LSCBs to front-line in other sectors, and not just Children's Social Care.

The last chapter considers the political changes that have occurred since the fieldwork for this study was carried out, and it explores how the findings from this study could be of benefit to the new safeguarding arrangements. It also makes recommendations for further research to build on this study.

Chapter Seven: Conclusion.

7.0 INTRODUCTION

This final chapter sets out the pertinent messages from this study and what we can learn from it. Taking this forward, as the fieldwork was carried out between 2015 and 2016, this chapter brings the study up to date with new changes affecting the governance of LSCBs and examines how the findings could be useful to the new safeguarding arrangements.

7.1 WHAT CAN WE LEARN FROM THIS?

In short, the LSCBs in these two case studies were not currently fit for purpose as a *knowledge transfer* mechanism between government and front-line practice in relation to child neglect guidance. In particular Health and Children's Social Care were rather disparaging of the LSCB's communication and dissemination of guidance. Frontline practitioners disliked the move to online training, from face to face methods. Therefore, there needs to be a conscious reversion towards face to face methods of knowledge transfer in order to disseminate policy changes.

What was pertinent in this study was linking the findings from my study to governance network theory to explain the (in)effectiveness of the network in terms of joined-up working and powerlessness of LSCBs to effect change. With the shift from government to governance and the decentralisation of the state, governance networks are seen to be the solution to more joined-up working and joint decision making. That said, however, Sørensen and Torfing (2009, p236) highlight that this 'euphoric celebration' of the upsurge and merits of governance networks ignores inherent weaknesses with governance networks, and why they often fail. They argue that governance networks are often 'unstable, diffuse, and opaque' (*ibid*). In the case of LSCBs, one can argue that they are probably unstable and ineffective because they are a mechanism of government, rather than being autonomous of government. Equally, these arguments once again link back to Bache *et al.*'s (2015) notion of 'fuzzy governance' in that, whilst being a mechanism of government, child neglect guidance coming out from government is diffuse and unclear, which in turn leads to fuzzy policy making at a local level, and undermines the effectiveness of the LSCB.

The application of governance network theory and using Torfing *et al.*'s (2012) Effectivity Criteria model, emphasised that knowledge transfer and policy implementation across children's services is not linear. It is neither top down nor bottom up. It is messy and complicated across all the sectors involved with safeguarding children, at both a strategic level and operational practice. Trying to trace policy communication and implementation is like dropping a bag of marbles and trying to keep an eye on where they all go; how far they go (some will go further than others, others hit barriers in their way); and do they have any effect along the way. In such complex multidisciplinary networks, front line practitioners need to be supported to understand the complex and relational nature of wicked issues and how they manifest themselves in social work practice. For example understanding the relational nature between a physically neglected child, parenting skills and a family on benefits, or the relational nature between a living in deprivation and neglect, or conversely higher socio economic families and emotional neglect. Understanding the relational links can be part of the process of managing the issue as best as one can with the resources available. This requires more than offering training on a new policy. Rather, it points to the need for more transparency in the policy design approaches, in order for practitioners to understand where and how decisions have been made, and why. In addition, it requires practitioners changing the way they conceptualise working together, joined-up working and multi-agency working. Such political mantras do not get to the crux of understanding the relational nature of working in partnership within and across organisations in order to safeguard children. Applying governance network theory offers a deeper approach to understanding the mechanics of relational working. Using the Effectivity Criteria goes a step further in assessing how well (or not) a network might be working effectively and highlights the relational weaknesses.

In order to transfer this knowledge to practitioners, information could be translated into practice papers and published through Research in Practice (a forum to which most local authorities subscribe, and social workers use to find supporting evidence for their cases). Such practice papers might then form the basis on a work-based seminar in order to enable face to face discussion and sharing of ideas. The key points from these seminars could feed up to the LSCB in order to have input from front line practitioners and reflect everyday practice.

In addition, some front-line practitioners within my study highlighted the usefulness of working with university students on placement. This is because, whilst the students gain practice knowledge from experienced practitioners, those experienced practitioners found that university students were more up to date with policy and legislation changes including understanding the rationale behind structural changes such as the LSCB. Such exchange of knowledge could be made formal in the design of learning exchange conversations within the student CPD process.

7.2 FROM LSCB TO MASA, 2018

Since carrying out the fieldwork, it was announced in July 2018 that LSCBs would be replaced with *Multi Agency Safeguarding Arrangements* (MASA). This decision followed the publication of the Wood Review (2016) which has informed changes to the new Working Together to Safeguard Children statutory guidance (HM Government, 2018). This new guidance adheres to the fact that under section 11 of the Children Act 2004 local agencies and organisations have a duty to safeguard the welfare of children in their area. This is no different to the core duty of the former LSCB. What is new, however, is that

> '*The responsibility for this join-up locally rests with the three safeguarding partners who have a shared and equal duty to make arrangements to work together to safeguard and promote the welfare of all children in a local area'*. (HM Government, 2018, p7)

What was previously a statutory duty of the local authority now becomes a joint responsibility between the local authority, the Clinical Commissioning Group (CCG) and the chief officer of police, whose jurisdictions fall within any part of the local authority. In essence this strengthens the argument that governance network theory is both applicable and useful in understanding and evaluating the joined-up local safeguarding arrangements.

It is yet to be seen how these new Multi-Agency Safeguarding Arrangements will operate locally, but the findings from this study are still pertinent to the MASA because they will help to find better ways of designing, communicating and implementing local safeguarding policy on child neglect, or other forms of abuse, within the wider network.

If MASA are to avoid the mistakes or poor practices of its predecessor, the findings from this study suggest they should ensure the following;

- In such austere economic times, MASA may want to consider a regional (rather than local) policy approach to certain wicked issues, such as child neglect because it would be less resource intensive to develop one regional policy than several local ones, and it would have a wider reach affecting several million children rather than a few hundred thousand.
- The Chair needs to remain independent from any of the partner organisations represented on the Board.
- In order to communicate more effectively to statutory services under its authority, MASAs need to develop a streamlined dissemination strategy which communicates synthesised, consistent and accessible information.
- Following on from the previous point, it then needs to develop a feedback loop to ensure that such information is reaching the right people and having the required impact on practice. Further research now needs to be carried out using D.I theory to identify clearly what this might look like, and what might be feasible.
- MASAs needs to move away from the assumption that email is an appropriate form of communication. Front-line practitioners are bombarded with email, and do not like online training. They prefer face to face communication and learning opportunities.
- MASAs need to be more visible to front-line practitioners, and needs to engage them and value their views and experiences.
- Moreover, this is particularly pertinent to the child neglect policy making process, which needs to be more bottom-up. Child neglect policy making needs to draw on the wealth of current practice that front-line practitioners have in relation to working with child neglect on a daily basis. This would avoid policy resistance and increase policy buy-in.

7.3 WHERE NEXT?

What became apparent in undertaking this study was the magnitude of the task. The tangled web of complexities and elements of overlap (for example, between and within sectors, between and within agencies, between the government and the LSCB, between

the government and different practising bodies, between the LSCB and designated safeguarding managers, between the LSCB and front-line staff, between designated safeguarding managers and front-line staff) transpired to be far greater than anticipated for this study.

One implication for policy and practice which emerged from this study is the development of a policy dissemination and implementation strategy. Drawing on dissemination and implementation (D.I) science, rather than governance theory, further research would be useful on this to examine more explicitly what this might look like. For example, would there be views in relation to employing designated, or workplace policy champions? What are the specific administrative or procedural barriers within organisations that might hinder MASA policy dissemination and implementation and could organisations overcome such barriers?

As the LSCBs are replaced with Multi Agency Safeguarding Arrangement it will be interesting to examine the changing dynamic and accountability from safeguarding arrangements being traditionally local authority-led, to being a joint affair between local authority, Health and Police. Clearly, therefore, there are challenges ahead as the LSCBs cease and MASAs come into being with new roles and new governance network structures. This study has offered significant and illuminating insights into how wicked issues are conceptualised by strategic-level policy-makers; how knowledge is transferred (or not) through the network from government to the LSCBs and beyond to front-line practice. These findings could help MASA overcome some of the criticisms and issued levelled at LSCBs.

References

Aldridge, M. (1999) 'State social work and the press in the UK' in Franklin, B. (ed) *Social policy, the media and misrepresentation*. London: Routledge.

Alford, J. and Head, B.W (2017) 'Wicked and less wicked problems: a typology and a contingency framework' *Policy and Society* 36(3) pp397-413.

Andresani, G. and Ferlie, E. (2006) 'Studying governance within the British public sector and without theoretical and methodological issues' *Public Management Review,* 8(3), pp415-431.

Australian Public Service (2007) *Tackling Wicked Problems: A public policy perspective*. Available at http://www.enablingchange.com.au/wickedproblems.pdf

Aveyard, H. (2010) *Doing a literature review in health and social care: a practical guide*. Second edition. Maidenhead: McGraw-Hill.

Babbie, E. (2001) *The Practice of Social Research*. Ninth Edition. London: Wadsworth/ Thomson Learning.

Babbie, E (2017) *The Basics of Social Research*. Seventh Edition. London: Wadsworth Publishing.

Bache I., Bartle, I., Flinders, M. and Marsden, G. (2015) 'Blame Games and Climate Change: Accountability, Multi-Level Governance and Carbon Management', *The British Journal of Politics and International Relations,* 17 pp64-88.

Baginsky, M. and Holmes, D. (2015) *A Reviews of current arrangements for the operation of Local Safeguarding Children Boards*. Local Government Association and Research in Practice. Available at http://www.kcl.ac.uk/sspp/policy-institute/scwru/pubs/2015/reports/baginskyandholmes2015LSCB.pdf [date accessed 29th June 2017].

Batista, J. and Figueiredo Marques, R. P. (2017) 'an overview on information and communication overload' in Batista, J. and Figueiredo Marques, R. P. (eds) *Information and Communication overload in the digital age.* USA: IGI Global.

Bell, S. and Hindmoor, A. (2009) *Rethinking Governance: The Centrality of the State in Modern Society.* New York: Cambridge University Press.

Bernard, C. (2018) 'Recognizing and addressing child neglect in affluent families', *Child and Family Social Work* https://doi.org/10.1111/cfs.12619.

Bevir, M. and Rhodes, R.A.W. (2007) 'Decentred Theory, Change and Network Governance' in Sørensen, E and Torfing, J (eds) (2007) *Theories of Democratic Network Governance*. Basingstoke: Palgrave Macmillan.

Bowe, R., Ball S.J. and Gold, A. (1992) *Reforming Education and Changing Schools: Case Studies in Policy Sociology*. London: Routledge.

Brandon, M., Belderson, P.,Warren, C., Howe, D., Gardner, R., Dodsworth, J., and Black, J, (2008) *Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003–2005*. Research Report DCSF-RR023 available at http://dera.ioe.ac.uk/7190/1/dcsf-rr023.pdf [date accessed 11th February 2018].

Brandon, M., Bailey, S., Belderson, P., Gardner, R., Sidebotham, P., Dodsworth, J., Warren, C, and Black, J, (2009) *Understanding Serious Case Reviews and their Impact A Biennial Analysis of Serious Case Reviews 2005-07*. DCSF-RR129 available at http://dera.ioe.ac.uk/11151/1/DCSF-RR129%28R%29.pdf [date accessed 11th February 2018].

Brandon, M., Bailey, S., Belderson, P. and Larsson, B. (2013) *Neglect and Serious Case Reviews*. University of East Anglia/NSPCC. Available at http://www.nspcc.org.uk/Inform/resourcesforprofessionals/neglect/neglect-scrs-pdf_wdf94689.pdf [date accessed 16th April 2013].

Braun, V. and Clark, V. (2006) 'Using thematic analysis in Psychology', *Qualitative Research in Psychology,* 3(2,) pp77-101.

Bryman, A. (2008) *Social Research Methods*. Third Edition. Oxford: Oxford University press.

Burgess, C., Daniel, B., Scott, J., Mulley, K. and Dobbin, H. (2013) *The State of Child Neglect in the UK: An Annual Review by Action for Children in partnership with the University of Stirling.* Watford: Action for Children.

Butler, I. and Drakeford, M. (2005) *Scandal, Social Policy and Social Welfare*. Second Edition. Bristol: The Policy Press.

Butler, I. and Drakeford, M. (2012) *Social Work on Trial: The Colwell Inquiry and the State of Welfare*. Bristol: The Policy Press.

Bywaters, P., Bunting, L., Davidson, G., Hanratty, J., Mason, W., McCartan, C., and Steils, N. (2016) *Poverty, Child Abuse and Neglect: An Evidence Review*. York: Joseph Rowntree Foundation.

Cairney, P. (2009) 'Implementation and the Governance Problem: A Pressure Participant Perspective', *Public Policy and Administration* 24 pp355-377.

Cairney, P. (2012) *Understanding Public Policy: Theories and Issues*. Hampshire: Palgrave Macmillan.

Chagnon, F., Pouliot, L., Malo, C., Gervais, M.J., and Pigeon, M.E. (2010) 'Comparison of determinants of research knowledge utilization by practitioner and administrators in the field of child and family social services' *Implementation Science*, 5(41).

Clarke, J.R. (2012) 'A study into headteachers' perceptions of the extent to which Ofsted influences how a school is led'. PhD thesis. Institute of Education, University of London. Available at https://ethos.bl.uk/OrderDetails.do;jsessionid=2503A0FB01C3A762C6E75C3120848608?uin=uk.bl.ethos.573006 [date accessed 15th October 2018].

Cohen, L., Manion, L. and Morrison, K. (2011) *Research Methods in Education*. Seventh edition. London: Routledge.

Cooper, J. (2013) 'Quarter of social workers say they never get to read serious case reviews' Tuesday 17th September 2013, available at http://www.communitycare.co.uk/articles/17/09/2013/119499/quarter-of-social-workers-say-they-never-get-to-read-serious-case-reviews.htm [date accessed 23rd September 2013].

Corby, B. and Cox, P. (2000) 'Using child abuse inquiries in child protection education and training' *Social Work Education* 19(3) pp219-230.

Crozier, M. (2008) 'Listening, learning, steering: new governance communication and interactive policy formation' *Policy and Politics*, 36(1) pp3-19.

Daniel, B, Taylor, J. and Scott, J. (2009) 'Noticing and helping the neglected child: literature review'. DCSF-RBX-09-03. Available at http://lx.iriss.org.uk/sites/default/files/resources/Noticing%20and%20helping%20the%20neglected%20child.pdf [date accessed 11th February 2018].

Daniel, B., Taylor, J., Scott, J. *et al.* (2011) *Recognizing and Helping the neglected child: Evidence-based practice for assessment and intervention*. London: Jessica Kingsley Publishers.

Davies, J. (2011) *Challenging Governance Theory: From Networks to Hegemony*. Bristol: The Policy Press.

Davies, L. (2014) 'Working positively with the media to protect children', *Journal of Social Welfare and Family Law* Vol 36(1) pp47-58.

Davies, C and Ward, H (2012) *Safeguarding Children Across Services*. London: Jessica Kingsley Publishers. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/183231/DFE-RR164.pdf.

De Corte, J., Verschuere, B., Roets, G. and De Bie, M. (2017) 'Uncovering the double-edged sword of inter-organisational networks of welfare services: Tackling wicked issues in social work', *British Journal of Social Work* 47 pp524-541.

Denscombe, M. (2017) *The Good Research Guide for Small-Scale Social Research Projects.* Sixth Edition. London: Open University Press.

Denzin, N.K. and Lincoln, Y.S. (2005) 'Introduction: The Discipline and Practice of Qualitative Research' in Denzin, N.K and Lincoln, Y.S (eds) *The Sage Handbook of Qualitative Research.* Third Edition. London: Sage publications Ltd.

Department for Communities and Local Government (2011**)** *The English Indices of Deprivation 2010.* Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/6871/1871208.pdf.

Devaney, J. and Spratt, T. (2009) 'Child abuse as a complex and wicked problem: Reflecting on policy developments in the United Kingdom in working with children and families with multiple problems', *Children and Youth Services Review*, 31 pp635-641.

DfE (2017) *Characteristics of children in need: 2016 to 2017: Children referred to and assessed by children's social services for the year ending 31 March 2017*. Available at https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2016-to-2017 [date accessed 14th April 2018].

DfES (2003) *Every Child Matters*. Norwich: The Stationery Office. http://www.education.gov.uk/consultations/downloadableDocs/EveryChildMatters.pdf.

DHSS (1974) *Non-Accidental Injury to Children* (LASSL (74) (13)).

DHSS (1985) *Social Work decisions in child care: Recent research findings and their implications.* London: HMSO.

DoH (1995) *Child Protection: Messages from Research.* London: TSO.

DoH (2002) *Safeguarding Children: A joint Chief Inspectors' report on arrangements to safeguard children*. Available at https://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2014/04/safeguardingchildrenreport.pdf [date accessed 16th April 2018].

Duerr Berrick, J. (1997) 'Child neglect: definition, incidence, outcomes' in Duerr Berrick, J., Barth, R. and Gilbert, N. (eds) *Child welfare research review: Volume Two*. New York: Columbia University Press.

Esmark, A. (2007) 'Democratic accountability and network governance – problems and potentials' in Sørensen, E. and Torfing, J. (eds) *Theories of Democratic Network Governance*. Basingstoke: Palgrave Macmillan**.**

Estabrooks, P.A., Brownson, R.C., Pronk N.P. (2018) 'Dissemination and implementation science for public health professionals: an overview and call to action' *Preventing Chronic Disease,* 15. Available at https://www.cdc.gov/pcd/issues/2018/18_0525.htm.

Farmer, E. and Lutman, E. (2010) 'Case Management and Outcomes for Neglected Children Returned to their Parents: A Five Year follow-up Study' DCSF-RB214 available at

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/221954/DCSF-RB214.pdf [date accessed 26th July 2013].

Farmer, E. and Lutman, E. (2012) *Effective Working with Neglected Children and their Families: Linking Interventions to Long-Term Outcomes*. London: Jessica Kinglsey Publishers.

Ferlie, E., Fitzgerald, L., McGivern, G., Dopson, S. and Bennett, C. (2010) 'Public policy networks and "wicked problems": A nascent solution?' *Public Administration* 89(2) pp307-324.

Fielding, N and Thomas, H (2008) 'Qualitative Interviewing' in Gilbert, N (ed) *Researching Social Life*. Third Edition. London: Sage Publications.

Finch, H., Lewis, J. and Turley, C (2014) 'Focus Groups' in Ritchie, J., Lewis, J. McNaughton-Nicholls, C. and Ormston, R (eds) *Qualitative Research practice: A Guide for Social Science Students and Researchers.* Second Edition. London: Sage Publications.

Flick, U. (2009) *An Introduction to Qualitative Research*. Fourth Edition. London: Sage Publications.

Flick, U. (2014) *An Introduction to qualitative research*. Fifth edition. London: Sage.

Flinders, M. (2005) 'Majoritarian democracy in Britain: New Labour and the constitution' *Western European Politics* 28(1) pp62-94.

Fontana, A. and Frey, J.H. (2003) 'The Interview: From Structured Questions to Negotiated Text' in Denzin, N. K. and Lincoln, Y. S. (ed) *Collecting and Interpreting Qualitative Materials.* Second Edition. London: Sage publications.

Fontana, A. and Frey, J. H. (2005) 'The Interview; From Neutral Stance to Political Involvement' in Denzin, N.K. and Lincoln, Y.S. (eds) *The Sage Handbook of Qualitative Research.* Third Edition. London: Sage publications Ltd.

France A., Munro E.R., and Waring A. (2010) *The Evaluation of Arrangements for Effective Operation of the new Local Safeguarding Children Boards in England – Final Report*, available at https://www.education.gov.uk/publications/eOrderingDownload/DFE-RR027.pdf [date accessed 19th February 2013].

Franklin, B. and Parton, N. (1991) *Social Work, the Media and Public Relations*. London: Routledge.

Gardner, R. (2008) *Developing an effective response to neglect and emotional harm to children.* London: NSPCC and University of East Anglia.

Gibbs, G. (2002) *Qualitative Data Analysis: Explorations with NVivo*. Buckingham: Open University Press.

Gilbert, N. (2008) 'Research, Theory and Method' in Gilbert, N. (ed) *Researching Social Life*. Third edition. London: Sage.

Glaser, B.G. and Strauss, A.L. (1967) *The discovery of grounded theory*. London: Aldine.

Goggin, M.L., Bowman, A, Lester, J.P., and O'Toole Jnr, L.J. (1990) *Implementation Theory and Practice: Toward a Third Generation*. London: Scott, Foresman and Company.

Goldsmith, S. and Eggers, W.D. (2004) *Governing by network: the new shape of the public sector.* Washington, D.C: Brookings Institution Press.

Gomm, R. (2008) *Social Research Methodology: A Critical Introduction*. Second Edition. Basingstoke: Palgrave Macmillan.

Green, C. (2012) 'Early Intervention' in Blyth, M. And Soloman, E. (eds) *Effective Safeguarding for Children and Young People: What next After Munro?* Bristol: The Policy Press.

Greenwood, D. (2016) 'Governance, coordination and evaluation: the case for an epistemological focus and a return to C.E Lindblom' *Political Research Quarterly*, 69(1) pp30-42.

Hakim, C. (2000) *Research Design: Successful Designs for Social and Economic Research*. Second Edition. London: Routledge.

Hammersley, M. (1992) *What's wrong with ethnography?* London: Routledge.

Hart, C. (2018) *Doing a literature review: Releasing the research imagination*. London: Sage.

HM Government (2004) *Children Act 2004.* UK: The Stationery Office Limited.

HM Government (2006) *Working Together to Safeguard Children. A Guide to inter-agency working to safeguard and promote the welfare of children.* London: The Stationery Office.

HM Government (2013) *Working Together to Safeguard Children; A guide to inter-agency working to safeguard and promote the welfare of children*. Available at http://media.education.gov.uk/assets/files/pdf/w/working%20together.pdf [date accessed 18th July 2013].

HM Government (2015) *Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children.* Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf [date accessed 21st August 2018].

HM Government (2018) *Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children*. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attach

ment data/file/722305/Working Together to Safeguard Children - Guide.pdf [date accessed 30th July 2018].

Hogwood, B.W., and Gunn, L.A. (1984) *Policy Analysis for the Real World*. Oxford: Oxford University Press.

Horwath, J. (2007) *Child Neglect; Identification and Assessment*. Basingstoke: Palgrave Macmillan.

Horwath, J. (2010) 'Rearing a toothless tiger? From area child protection committee to local safeguarding children board', *Journal of Children's Services*, 5(3) pp37-47.

House of Commons (2005) *Every Child Matters: Ninth Report of Session 2004-05. Volume I*. Available at https://dera.ioe.ac.uk/5291/13/9780215023896.pdf

Huggins, R., Hohnston, A and Stride, C (2012) 'Knowledge networks and universities: Locational and organisational aspects of knowledge transfer interactions' *Entrepreneurship and Regional Development* Vol 24(7-8) pp475-502.

Jacobs, S. and Schillemans, T. (2016) 'Media and public accountability: typology and exploration' *Policy & Politics* 44 (1) pp23-40

Jeffrey, B. and Woods, P. (1996) 'Feeling deprofessionalised: The social construction of emotions during an OFSTED inspection', *Cambridge Journal of Education*. 26(3), p325.

Joint Chief Inspectors Report (2005) 'Safeguarding Children: The Second Joint Chief Inspectors' Report on Arrangements to Safeguard Children'. Available at https://www.justiceinspectorates.gov.uk/cjji/wpcontent/uploads/sites/2/2014/04/safeguards_fullprint.pdf.

Jones, R. (2014) *The story of Baby P: Setting the record straight*. Bristol: The Policy Press.

Kapucu, N., Hu, Q., and Khosa, S. (2017) 'The state of network research in public administration' *Administration and Society* 49(8) pp1087-1120.

Kickert, W.J.M., Klijn, E.H. and Koppenjan, J. (1997) *Managing Complex Networks: Strategies for the Public Sector.* London: Sage.

Kitzinger, J. and Barbour, R.S. (1999) 'Introduction: the challenge and promise of focus groups' in Barbour, R.S. and Kitzinger, J. (eds) *Developing Focus Group Research: Politics, Theory and Practice.* London: Sage Publications.

Klijn, E.H. and Edelenbos, J. (2007) 'Meta-governance as Network Management' in Sørensen, E. and Torfing, J. (eds) *Theories of Democratic Network Governance*. Basingstoke: Palgrave Macmillan.

Klijn, E.H. (2016) 'Managing commercialised media attention in complex governance networks: positive and negative effects on network performance' *Policy and Politics*, 44(1) pp115-133.

Klijn, E.H. and Koppenjan, J. (2016) *Governance Networks in the Public Sector*. London: Routledge.

Koppenjan, J. (2007) 'consensus and conflict in policy networks: too much or too little' in Sørensen, E and Torfing, J (eds) *Theories of Democratic Network Governance*. Basingstoke: Palgrave Macmillan.

Koppenjan, J. and Klijn, E.H. (2004) *Managing Uncertainties in Networks*. London: Sage.

Korkki, P. (2013) 'messages galore, but no time to think' available at https://www.nytimes.com/2013/06/16/jobs/messages-galore-but-no-time-to-think.html [date accessed 24th April 2018].

Laming, Lord H. (2003) *The Victoria Climbié Inquiry.* Available at: https://www.education.gov.uk/publications/eOrderingDownload/CM-5730PDF.pdf [date accessed 28th April 2013].

Laming, Lord H. (2009) *The Protection of Children in England: A Progress Report*. London: The Stationery office.

Lewis, J. (2003) 'Design Issues' in Ritchie, J. and Lewis, J. (eds) *Qualitative Research practice: A Guide for Social Science Students and Researchers.* London: Sage Publications.
Lewis, J. and Ritchie, J. (2003) 'Generalising from Qualitative Research' in Lewis, J. and Ritchie, J. (eds) *Qualitative Research in Practice*. London: Sage Publications.

Lewis, J., Ritchie, J., Ormston, R . and Morrell, G (2014) 'Generalising from qualitative research' in Ritchie, J., Lewis, J. McNaughton-Nicholls, C. and Ormston, R (eds) *Qualitative Research practice: A Guide for Social Science Students and Researchers.* Second Edition. London: Sage Publications.

Lewis. J and McNaughton Nicholls, C. (2014) 'Design Issues' in Ritchie, J., Lewis, J. McNaughton-Nicholls, C. and Ormston, R (eds) *Qualitative Research practice: A Guide for Social Science Students and Researchers.* Second Edition. London: Sage Publications.

Lincoln, Y.S. and Guba, E. (1985) *Naturalistic Inquiry*. London: Sage.

Ling, T. (2000) 'Unpacking partnership: Health care' in Clarke, J., Gewirtz, S and McLaughlin, E (eds) *New Managerialism, New Welfare?* London: Sage.

The Local Safeguarding Children Board Regulations (2006) available at http://www.legislation.gov.uk/uksi/2006/90/made [date accessed 11th February 2018.

Lonne, B., Parton, N., Thomson, J. and Harries, M. (2009) *Reforming Child Protection*. Abingdon: Routledge.

Lupton, C., North, N. and Khan, P. (2001) *Working Together or Pulling Apart?: The National Health Service and Child Protection Networks.* Bristol: The Policy Press.

Luthar, S.S., and Becker, B.E. (2002) 'Privileged but pressured: a study of affluent youth'. *Child Development*,73, pp1593–1610.

Lutman, E., and Farmer E. (2013) 'What Contributes to Outcomes for Neglected Children Who Are Reunified with Their Parents? Findings from a Five-Year Follow-Up Study', *The British Journal of Social Work*, 43(3), pp559–578.

Marsh, D. and Rhodes, R.A.W. (eds) (1992) *Policy networks in British Government*. Oxford: Clarendon Press.

Martin, S. and Guarneros-Meza, V. (2013) 'Governing local partnerships: Does external steering help local agencies address wicked problems?' *Policy and Politics*, 411(4) pp585-603.

Miller, J. (2017) Email to Claire Monk, 5th July 2017.

Minshall, T (2009) 'What is knowledge transfer?' *University of Cambridge*, available at https://www.cam.ac.uk/research/news/what-is-knowledge-transfer [date accessed 12th July 2019]

Morrison, T. (2010) 'The strategic leadership of complex practice: opportunities and challenges', *Child Abuse Review*, 19 pp312-329.

Munro, E. (2010a) *The Munro Review of Child Protection Part One: A Systems Analysis*. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175407/TheMunroReview-Part_one.pdf [accessed 25th May2013].

Munro, E. (2010b) *The Munro Review of Child Protection, Interim Report: The Child's Journey.* Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/624946/DFE-00010-2011.pdf [date accessed 25th May 2013].

Munro E. (2011) *The Munro Review of Child protection: Final Report A Child-Centred System.* Norwich: The Stationery Office.

Newman, J. (2005) 'Regendering governance' in Newman, J (ed) *Remaking Governance: Peoples, Politics and the Public Sphere*. Bristol: the Policy Press.

Ofsted (2011) *Good Practice by Local Safeguarding Children Board.* Manchester: Ofsted.

Ofsted (2014) *The new Ofsted framework for the inspection of children's services and for reviews of Local Safeguarding Children Boards: an evaluation* Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/546018/An_evaluation_of_the_new_Ofsted_framework_for_the_inspection_of_children_s_services_and_for_reviews_of_LSCBs.pdf [date accessed 7th July 2017].

Ojo, A. and Mellouli, S. (2016) 'Deploying governance networks for societal changes' *Government Information Quarterly* (article in press).

Ormston, R., Spencer, L., Barnard, M. and Snape, D (2014) 'The Foundations of Qualtiative Research' in Ritchie, J., Lewis, J., McNaughton-Nicholls, C. and Ormston, R (eds) *Qualitative Research practice: A Guide for Social Science Students and Researchers.* Second Edition. London: Sage Publications.

Parton, N. (2014) *The Politics of Child Protection: Contemporary Developments and Future Directions*. Basingstoke: Palgrave Macmillan.

Peters, BG. (2013) 'Toward policy coordination: alternatives to hierarchy' *Policy & Politics,* 41(4) pp569-84.

Peters, BG. (2016) 'Governance and the media: exploring the linkages' *Policy & Politics*, 44(1) pp9-22

Peters, BG. (2017) 'What is so wicked about wicked problems? A conceptual analysis and a research program' *Policy and Society,* 36(3) pp385-396.

Powell, B.J., Proctor E.K., Glisson, C.A., Kohl P.L *et al* (2013) A mixed methods multiple case study of implementation as usual in children's social service organizations: study protocol' *Implementation Science*, 8(92).

Pressman, J.L. and Wildavsky, A. (1984) *Implementation*. Third Edition. London: University of California Press.

Preston-Shoot, M. (2012) 'Local Safeguarding Children Boards: Faith, Hope and Evidence' in Blyth, M. And Soloman, E (eds) *Effective Safeguarding for Children and Young People: What next After Munro?* Bristol: The Policy Press.

Radford, J. (2010) *SERIOUS CASE REVIEW Under Chapter VIII 'Working Together to Safeguard Children' In respect of the Death of a Child Case Number 14* Available at https://northshropshe.files.wordpress.com/2015/07/khyra_ishaq_scr.pdf [date accessed 24th May 2018]

Reder, P., Duncan, S. and Gray, M. (1993) *Beyond Blame: Child Abuse Tragedies Revisited*. London: Routledge.

Rhodes, R.A.W. (1981) *Control and Power in Central-Local Government Relations*. Aldershot: Gower Publishing Company.

Rhodes, R.A.W. (1990) 'Policy Networks: A British Perspective', *Journal of Theoretical Politics* 2(3) pp293-317.

Rhodes, R.A.W. (1994) 'The Hollowing out of the State: The Changing Nature of the Public Service in Britain' *The Political Quarterly* 65.

Rhodes, R.A.W. (1997) *Understanding Governance: Policy Networks, Governance, Reflexivity and Accountability'*. Buckingham: Open University Press.

Rhodes, R.A.W. (2017) *Understanding Governance: 20 years on*. Available at http://www.raw-rhodes.co.uk/wp-content/uploads/2017/07/National-Governance-Review.pdf [date accessed 28th February 2017].

Ritchie, J. and Lewis, J. (2003) 'Generalising from qualitative research' in Ritchie, J. and Lewis J. (eds) *Qualitative Research practice: A Guide for Social Science Students and Researchers.* London: Sage Publications.

Ritchie, J., Spencer, L. and O'Connor (2003) 'Carrying out Qualitative Analysis' in Ritchie, J. and Lewis J. (eds) *Qualitative Research practice: A Guide for Social Science Students and Researchers.* London: Sage Publications.

Rittel, H.W.J., and Webber, M.M. (1973) 'Dilemmas in a General Theory of Planning', *Policy Sciences* 4, pp155-169.

Robson, C. (2011) *Real World Research*. Third Edition. Chichester: John Wiley and Sons Ltd.

Robson, C. and McCartan, K (2016) *Real World Research*. Fourth Edition. Chichester: John Wiley and Sons Ltd.

Rose, W. and Barnes, J. (2008) *Improving Safeguarding Practice: Study of Serious Case Reviews 2001-2003.* Nottingham: DCSF Publications.

Rose, S. and Meezan, W. (1997) 'Defining child neglect: evolution, influences and issues' in Duerr Berrick, J., Barth, R. and Gilbert, N. (eds) *Child welfare research review: Volume Two*. New York: Columbia University Press.

Saldaña, J. (2013) *The coding manual for qualitative researchers*. Second edition. London: Sage.

Schillemans, T. and Pierre, J. (2016) 'Entangling and disentangling governance and the media' *Policy & Politics* 44 (1) pp1-8.

Skelcher, C., Mathur, N., and Smith, M. (2005) 'The public governance of collaborative spaces: discourse, design and democracy', *Public Administration* 83(2) pp573-96.

Social Research Association (SRA) (2003) *Ethical Guidelines*. Available at http://the-sra.org.uk/wp-content/uploads/ethics03.pdf [date accessed 18th March 2014].

Sohi, R.S., and Matthews, A.l (2019) 'Organisational Learning and Interorganisational Knowledge Transfer' in Ingene, C.A., Brown, J. R. and Dant, R.P (eds) *Handbook of Research on Distribution Channels*. Cheltenham: Edward Elgar Publishing.

Sørensen, E. and Torfing, J. (eds) (2007) *Theories of Democratic Network Governance*. Basingstoke: Palgrave Macmillan.

Sørensen, E. and Torfing, J. (2007a) 'Theoretical approaches to metagovernance' in Sørensen, E. and Torfing, J. (eds) *Theories of Democratic Network Governance*. Basingstoke: Palgrave Macmillan. Pp25-42.

Sørensen, E. and Torfing, J. (2007b) 'The second generation of governance network theory and beyond' in Sørensen, E. and Torfing, J. (eds) *Theories of Democratic Network Governance*. Basingstoke: Palgrave Macmillan pp297-315.

Sørensen, E. and Torfing, J. (2009) 'Making governance networks effective and democratic through metagovernance', *Public Administration* 87(2) pp234-258.

Spencer, L., Ritchie, J. and O'Connor, W. (2003) 'Analysis: Practice, principles and Processes' in Ritchie, J. and Lewis J. (eds) *Qualitative Research practice: A Guide for Social Science Students and Researchers.* London: Sage Publications.

Spencer, L., Ritchie, J., O'Connor, W., Morrell, G., and Ormston, R (2014a) 'Analysis in Practice' in Ritchie, J., Lewis, J., McNaughton-Nicholls, C. and Ormston, R (eds) *Qualitative Research practice: A Guide for Social Science Students and Researchers.* Second Edition. London: Sage Publications.

Spencer, L., Ritchie, J., Ormston, R. O'Connor, W. and Barnard, M (2014b) Analysis: Principles and Processes' in Ritchie, J., Lewis, J., McNaughton-Nicholls, C. and Ormston, R (eds) *Qualitative Research practice: A Guide for Social Science Students and Researchers.* Second Edition. London: Sage Publications

Stake, R. E. (2005) 'Qualitative Case Studies' in Denzin, N.K. and Lincoln, Y.S. (eds) *The Sage Handbook of Qualitative Research.* Third Edition. London: Sage publications Ltd.

Stein, M., Rees, G., Hicks, L. and Gorin, S. (2009) Neglected adolescents: literature review DCSF-RBX-09-04 available at http://lx.iriss.org.uk/sites/default/files/resources/Neglected%20adolescents.pdf [date accessed 11th February 2018]

Stevenson, O. (1999) *Neglected Children: Issues and Dilemmas*. Oxford: Blackwell Science Ltd.

Stoker, G. (1998) 'Governance as theory: five propositions', *International Social Science Journal,* 50(155) pp17-28

Thomas, G. (2009) *How to do your Research Project*. London: Sage Publications.

Thomas, G. (2011) *How to do your Case Study: A Guide for Students and Researchers*. London: Sage Publications.

Torfing, J., Guy Peters, B., Pierre, J and Sørensen, E. (2012) *Interactive Governance: Advancing the Paradigm*. Oxford: Oxford University Press.

Torfing, J. and Sørensen, E. (2014) 'The European debate on governance networks: Towards a new and viable paradigm?' in *Policy and Society*, 33, pp329-344.

Turnbull, N. and Hoppe, R. (2018) 'Problematizing 'wickedness': a critique of the wicked problems concept, from philosophy to practice' *Policy and Society*, 38 (2) pp315-337

Warner, J. (2015) *The emotional politics of social work and child protection*. Bristol: The Policy Press.

Webster, S., Lewis, J and Brown, A (2014) 'Ethical Considerations in Qualitative Research' in in Ritchie, J., Lewis, J., McNaughton-Nicholls, C. and Ormston, R (eds) *Qualitative Research practice: A Guide for Social Science Students and Researchers.* Second Edition. London: Sage Publications.

White, S., Broadhurst, K., Wastell, D., Peckover, S., Hall C. and Pithouse, A. (2009) 'Whither practice-near research in the modernization programme? Policy blunders in Children's Services', *Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and Community*, 23(4) pp401-411.

Williams, P. (2012) *Collaboration in Public Policy and practice: Perspectives on Boundary Spanners*. Bristol: The Policy Press.

Wood, A. (2016) *Wood Report; Review of the Role and Functions of Local Safeguarding Children Boards.* Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526329/Alan_Wood_review.pdf [date accessed 25th April 2018]

Yin, R.K. (2009) *Case Study Research: Design and Methods*. Fourth Edition. London: Sage Publications.

Zuravin, S.J. (1999) 'Child neglect: a review of definitions and measurement research' in Dubowitz, H. (ed) *Neglected Children: Research, Practice and Policy*. London: Sage.

Appendix 1: LSCB Regulations 2006: Regulation 5, Functions of LSCBs

5.—(1) The functions of an LSCB in relation to its objective (as defined in section 14(1) of the Act (**1**)) are as follows—

(a) Developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to—

(i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;

(ii) Training of persons who work with children or in services affecting the safety and welfare of children;

(iii) Recruitment and supervision of persons who work with children;

(iv) Investigation of allegations concerning persons who work with children;

(v) Safety and welfare of children who are privately fostered;

(vi) Co-operation with neighbouring children's services authorities and their Board partners;

(b) communicating to persons 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;

(c) Monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children, and advising them on ways to improve;

(d) Participating in the planning of services for children in the area of the authority;

(e) Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1)(e) a serious case is one where—

(a) Abuse or neglect of a child is known or suspected; and

(b) Either—

(i) the child has died; or

(ii) The child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

(3) An LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objective.

(**1**)

Section 14(1) of the Act defines the objective of an LSCB as (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 by which it is established, and (b) to ensure the effectiveness of what is done by each such person or body for those purposes.

Source: http://www.legislation.gov.uk/uksi/2006/90/regulation/5/made

Appendix 2: Literature Search Strategy

Prior to embarking on the literature review, I carried out a systematic search of hard copy and electronic resources (Bryman, 2008; Aveyard, 2010; Hart, 2018) applied to the body of literature of my various key themes. As the research is interdisciplinary I needed to scope the literature (research, professional, policy and grey sources) from social work as well as policy implementation sources (Hart, 2018). The literature search was carried out between January 2013 and June 2014.

Search term generation

Depending on the theme which I was searching, the inclusion and exclusion criteria varied slightly. For example when searching for child neglect, I was only interested in research within the UK, but searching for policy implementation, and also governance theory, some international works were relevant (see figure xvii).

Electronic searching

Initially, I used various electronic search tools such as google (used with caution), google scholar and catalogues and databases (for example Swetswise, Sage Premier Journal Collection, PSYCHinfo, ERIC, Ingenta Connect, JSTOR etc). accessed via the university libraries (Bristol university and Newman university) and Athens (Thomas, 2009; Robson, 2011).

Grey literature and other resource searches

Attendance at conferences (for example, BAPSCAN's international Congress, SPA Annual conference) alerted me to unpublished studies, and interim reports. I also signed up to email alerts (Bryman, 2008) (for example, NSPCC Caspar) and Social media (for example, Twitter to follow the Policy and Politics Journal twitter feed, and BAPSCAN's Twitter feed etc) which alerted me to new material being published during my research so that I could keep the literature review up-to-date (Bryman, 2008).

Reference lists

I used a snowball literature search, through following up references used in other identified studies.

Targeted author searches

Once key researchers were identified, I conducted targeted author searches, using library catalogues and Google Scholar (see Figure xvii).

Managing the literature

Using the ipad, I was able to download the "iAnnotate" app. This was a useful app which allowed me to essential create my own library. I created files using the themes from my research (for example, child neglect, LSCBs, governance theory) and I could keep the electronic documents within relevant files. The iAnnotate app also allows you to make various notes on the documents.

Reviewing the content

Once I had found a particular source, I read the abstract to identify whether or not it was relevant. If the abstract seemed relevant, then I would read some more of the article, and save it if it was relevant.

Reading the article took several phases. Firstly I skim read the item to get a grasp of what it was about. Then I would go back through the article taking more time to highlight relevant passages or to write comments to either follow something up further, or to join arguments/work up with other items that I may have found (Hart, 2018). In some cases I went back to an article several times during the writing of the research. I might be looking for different points each time I go back to an article (Bryman, 2008).

Figure xvii: Summary of literature search strategy

Theme	Inclusion / search criteria	Exclusion criteria	Outcome
Child neglect	Full text only, Academic journals, books, research, government papers, English language, Great Britain only Key authors: Olive Stevenson, Marion Brandon, Elaine Farmer, Jan Howarth, Davies and Ward.	Specific practice issues (e.g. assessment, referrals, toolkits) Countries other than GB.	**Core theme**
Policy communication	Full text only, Academic journals, books, research, government papers, English language. All countries Key authors: Hogwood and Gunn, Barrett and Fudge, Goggin *et al*., Bowe *et al.*	Pre-1980s	Discounted (see Chapter 3)
Policy implementation	Full text only, Academic journals, books, research, government papers, English language All countries Key authors: Wildavsky, Sabatier,	Pre-1980s	Discounted (see Chapter 3)
Local Safeguarding Children Boards	Full text only, Academic journals, books, research, government papers, English language. Great Britain only Key authors: France *et al*., Michael Preston-Shoot		Core theme
Managerialism and Professionalism	Full text only, Academic journals, books, research, government papers, English language All countries Key authors: Janet Newman, Lupton *et al.*	Pre-1980s	Managerialism was adopted as a subsidiary theme but professionalism was discounted to narrow the focus.
Accountability	Full text only, Academic journals, books, research, government papers, English language	Pre-1980s	Adopted as a subsidiary theme

	All countries		
New Public management	Full text only, Academic journals, books, research, government papers, English language All countries Key authors: Rod Rhodes, Chris Hood	Pre-1980s	Discounted (see Chapter 3)
Network governance	Full text only, Academic journals, books, research, government papers, English language All countries Key authors: Jonathan Davies		Search widened to governance theory
Street-level bureaucracy and the everyday maker	Full text only, Academic journals, books, research, government papers, English language All countries Key authors: Michael Lipsky, H. Bang	Pre-1980s	Both discounted to narrow the focus of the research
Boundary Spanners	Full text only, Academic journals, books, research, government papers, English language All countries Key authors: Paul Williams		discounted to narrow the focus of the research
Governance theory and governance network theory	Full text only, Academic journals, Books, research, government papers, English language All countries Key authors: Sorensen, Torfing, Koppenjan, Klijn.	Pre-1990s	Core theme
Wicked issues in social work	Full text only, Academic journals, Books, research, government papers, English language All countries Key authors: Rittel and Webber, Klijn.		Core theme

Appendix 3: Ethics approval