Research Report DCSF-RR126

Effectiveness of the New Local Safeguarding Children Boards in England

Interim Report

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TABLES

EXECUTIVE SUMMARY

Introduction

Local Safeguarding Children Boards (LSCBs) were established under the Children Act 2004 and have the responsibility for co-ordinating and ensuring the effectiveness of the work of partner bodies to safeguard and promote the welfare of children (Children Act 2004, Section 14). The functions of the LSCB are as follows:

(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority…

(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 (The Local Safeguarding Children Board Regulations 2006, Section 5).

Research demonstrates that Area Child Protection Committees (ACPCs) had a number of weaknesses, including lack of statutory power, poor leadership, high variations in membership and insufficient resources (Chief Inspector of Social Services et al., 2002; Ward et al., 2004). In trying to understand how successful LSCBs have been in overcoming some of these weaknesses the Department for Children, Schools and Families (DCSF) and the Department of Health (DoH) have commissioned the Centre for Research in Social Policy (CRSP) and the Centre for Child and Family Research (CCFR) at Loughborough University to undertake a large scale research study that explores the effectiveness of LSCBs in England.

The final report, which will draw on data from six case study areas, including: interviews with Chairs and DCSs, 60 Board members from social care, health, education, early years the police and others and 180 frontline professionals as well as social network analysis (in two areas) to more fully explore the extent to which LSCBs have been able to engender change and their overall effectiveness. In doing so the following will be considered:

- the types of partnership arrangements implemented and their effectiveness in delivering services to improve outcomes for children and their families;
- how LSCBs manage and evaluate their role in safeguarding and promoting the welfare of children and the effectiveness of lines of accountability;
- how partners transfer knowledge and information across the Safeguarding network;
- how LSCBs work alongside other local strategic bodies and partnerships;
- if the new systems and arrangements are ‘fit for purpose’ and whether they safeguard and promote the welfare of children;

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

This report is interim and draws upon research undertaken over the first 12 months (January 2008 - January 2009) of the research study and is based on three core data sources:

- a national mapping exercise of LSCBs, providing data on the size, membership and organisational structures that have been put in place;

- a survey of LSCB Chairs, designed to explore the different approaches that LSCBs have adopted to fulfil their core functions and how arrangements are working in practice; and

- in-depth qualitative interviews with Chairs and Business Managers from six case study areas (12 in total).

The majority of interviews with Chairs and Business Managers were conducted prior to media attention surrounding the 'Baby P' case (September- November 2008). The survey of Chairs was constructed to provide research evidence to contribute to Lord Laming's, *The Protection of Children in England: A Progress Report*. 105 surveys out of a possible 144 were returned, a response rate of 72.9 per cent.

Key Findings

Chapter Two: Chairing Arrangements

This section examines how Local Authorities have adopted different chairing arrangements. It explores the challenges these different approaches have presented for Chairs as they have sought to establish themselves and the Boards. Key findings are:

- 40 per cent of LSCBs appointed an Independent Chair while 41 per cent decided this role should be undertaken by the local Director of Children's Services (DCS). Only 13.3 per cent opted to give the task to a senior employee of one of the LSCB partners.

- the majority (59.2 per cent) of LSCB Chairs are from Children's Social Care. 85.7 per cent of Independent Chairs were from this professional group and it was rare for them to come from an educational background (2.4 per cent).

- 43.1 per cent of all Chairs reported that they spent two days a month on LSCB business. 22.5 per cent indicated that they spent three days a month on LSCB business. There were no significant differences in time spent depending on whether the Chair was Statutory or Independent.

- In interviews with Chairs and Business Managers it was clear that approaches to chairing were still being established.

- Key issues for Chairs and Business Managers in this process were how they:

    - established their authority and commanded respect without dominating;

    - managed relationships between different agencies with varying levels of familiarity with safeguarding children and families;

    - clarified lines of accountability; and

    - adopted strategies to embed the LSCB within wider strategic partnerships, without compromising the separate identity, role and remit of the Board.

Chapter Three: Board Structure and Representation

Safeguarding children is a shared responsibility. Concerns have been raised in the past that this has not been fully recognised and not all relevant agencies have taken an active role in safeguarding and promoting the welfare of children (Morrison, 2000). There is a statutory requirement for a wide range of agencies to sit on the LSCB. It is clear that:

- Analysis of membership data from 124 LSCBs shows that there is a large variation in the size of LSCBs throughout the country, with the smallest Board consisting of 12 members and the largest of 91, with an average (mean) of 26. Larger geographical areas tended to have bigger Boards.

- Overall 68 Boards (55 per cent) have representation from all the statutory agencies outlined under Section 3.58 of Working Together. Of the 56 Boards which have statutory agencies missing, 45 were found to be missing only one statutory partner. Eight Boards were missing two statutory partners, and three Boards were missing three statutory partners.

- In total the 121 Boards that supplied full membership data had 3277 members. Children's Services and NHS Trusts contribute the highest number of staff to sit on the LSCB (17 per cent and 12 per cent respectively). This was followed by the PCT and police (both 7 per cent).

- 69 LSCBs (56 per cent) have representation from adult services; 94 LSCBs (76 per cent) have a designated nurse; 84 LSCBs (68 per cent) have a designated doctor; 73 LSCBs (59 per cent) have both a designated doctor and a designated nurse; and 69 Boards (56 per cent) have representation from the NSPCC.

- Only a small number of Boards have secured representation from independent schools (see also, Singleton, 2009), GPs and Children's Centres, although there is debate about whether it may be more appropriate for staff to be involved in the subgroups.

- Chairs and Business Managers identified difficulties in maintaining continuity of membership and regular attendance once agency representation has been secured.

- Based on an analysis of LSCB membership lists, 39 per cent of *statutory members* on Boards either had overall responsibility for their entire organisation or a large department within it, or they were accountable only to the head of their organisation. Self-completed survey responses indicated that just over half of Chairs (52 per cent: 104) thought that *all* Board members could speak for the organisation they represent with authority; commit their organisation on policy and practice matters and hold their organisation to account.

- However, while seniority is clearly important, Chairs and Business Managers did identify that *specialist* knowledge and expertise in the area of safeguarding children were also necessary considerations.

Chapter Four: Infrastructure to Support the Operation of LSCBs

Lack of a clear and well defined structure that supported the operation of ACPCs was seen as a major weakness of the previous arrangements (Ward et al, 2004). This chapter explores LSCB staffing arrangements, finances, and Executive group and subgroup operation. Key findings:

- Business Managers have been appointed within most LSCB infrastructures. 88.7 per cent (93 out of 105 LSCBs) of LSCBs have created these as new posts. 60 per cent are full time, 25.7 per cent are part-time.

- They have a critical role to play in helping LSCBs function effectively by taking on a wide range of roles such as administration responsibilities, the servicing and managing of Serious Case Reviews (SCRs), supporting Executives, setting up and monitoring training and running subgroups.

- In terms of other staff, of the 102 LSCBs where data were available 86 had just under four full time members of staff. Four had no staff at all.

- When Chairs were asked if they thought their budget was adequate 54.3 per cent said no and 43.8 per cent said yes.

- The biggest impact of an inadequate budget was seen to be that it reduced the number of issues the Board could address.

- From the Chair and Business Manager interviews there is evidence of struggles over getting the funding from the relevant agencies which can lead to workload demands on Chairs and Business Managers and tension between partners.

- The mapping data shows that 81 (65 per cent) of Boards have an Executive. Executive groups tend to meet bi-monthly (32.8 per cent) or quarterly (25.4 per cent).

- The lowest number of subgroups per Board was two and the highest was 20. The average number was six (mean of 6.7; median of 6).

- Training was the most common subgroup (90 per cent) followed by Policies and Procedures (73 per cent) and then Quality Assurance (43 per cent).

- Challenges still exist for Boards in managing subgroups and evidence from interviews suggests that membership and attendance levels can impact on their work.

- Survey responses indicated that reasons for their effectiveness included ‘having committed and engaged members’ (78 LSCBs) ‘having clear terms of reference’ (73 LSCBs) and ‘including representatives with specialist knowledge’ (63 LSCBs).

Chapter Five: Communication, Information Sharing and Relationships

Effective coordination of local work to safeguard and promote the welfare of children is dependent on communication and information sharing between individuals and agencies (Ward et al., 2004). This chapter examines the mechanisms by which LSCBs members communicate policies and procedures and other information to their own agencies, as well as links and networks that have been made to communicate with organisations that are not always represented on the Board. The chapter goes on to explore the relationships that

LSCBs have developed with neighbouring areas and Children's Trusts and considers the contribution that these links make to their work.

- Difficulties have been encountered in establishing effective links with the independent health sector, GPs, faith groups and independent schools.

- 95.2 per cent of LSCBs reported having some form of relationship with other Boards. In all but one case these relationships were seen to be positive and to offer a helpful contribution to the work of the LSCB.

- While links with large children's charities were seen to be strong, Chairs identified that the voice of smaller third sector organisations might not be heard.

- 93.8 per cent said that links with other LSCBs helped them develop their policy and procedures. 89.7 per cent felt that it helped them share learning and information and 87.6 per cent indicated that relationships had been established in relation to child death review processes.

- Relationships with other LSCBs were generally seen as valuable to the operation of LSCBs for a number of reasons, including: sharing learning, providing support and as a cost effective way of developing materials to support them in fulfilling their functions (for example, development of policies and procedures or training).

- Having a clear demarcation of roles and responsibilities is important to facilitate the effective functioning of the LSCB and the Children's Trust. 25 per cent of Chairs said the demarcation between the two structures was very clear, 49 per cent said it was clear and 25 per cent said it was not very clear.

- Regular communication between LSCBs and the Children's Trust is important to ensure clarity about respective roles and how activities dovetail.

- 59 respondents saw a history of good working relationships between Children's Services and other agencies as one factor contributing to the clarity of roles and responsibilities between the Children's Trust and LSCB.

Chapter Six: Serious Case Reviews and Child Death Panels

Two of the LSCBs' functions are undertaking Serious Case Reviews (SCRs) and reviewing child deaths. This chapter examines how LSCBs are fulfilling their responsibilities in respect of these processes, the challenges they have faced and how they have attempted to overcome them. Key findings are:

- The mean average number of SCRs completed per LSCB surveyed over the past twelve months by the LSCBs in our survey was 1.6 (median = 1)[1]. The frequency varied in that 23.2 per cent did not undertake any SCRs, 32.3 per cent undertook one, 23.2 per cent under took two and 21.1 per cent undertook three or more.

- When a SCR is being undertaken it has a significant impact on the resources of LSCBs and partner agencies.

[1] Based on 99 responses.

- Chairs and Business Managers have raised concerns about the quality of some Independent Management Reviews (IMRs) and overview reports and while this is something they are trying to address it remains a challenge to LSCBs.

- Issues have been raised about Ofsted evaluations which were seen to be overly focused upon assessing the process. Interviewees felt that additional clarification of expectations would be helpful and that more attention should be paid to learning lessons from reviews and ensuring that this had an impact upon practice.

- Chairs were clearly committed to the SCR process and were developing mechanisms to monitor implementation of the recommendations and ensure that lessons are learnt.

- While the importance of the child death review process is recognised, they can be demanding on time and resources.

- Engaging health professionals in the rapid response function was found to be problematic in some case study areas.

- Just under two thirds of Boards have seen a value in co-operation with other Boards and established joint panels with neighbouring LSCBs.

- Chairs and Business Managers also felt that greater clarity and guidance on child death review processes and the interrelationship between rapid response and overview panels would be beneficial to them.

The Final Report

The final report will draw on data from six case study areas, including: interviews with Chairs and DCSs (follow-up interviews); interviews with 49 Board members from social care, health, education, the police and others; interviews with180 frontline professionals; and social network analysis (in two areas). It will more fully explore the extent to which LSCBs have been able to engender change as well as improve their overall effectiveness. In doing so the following will be considered:

- the types of partnership arrangements implemented and their effectiveness in delivering services to improve outcomes for children and their families;

- how LSCBs manage and evaluate their role in safeguarding and promoting the welfare of children and the effectiveness of lines of accountability;

- how partners transfer knowledge and information across the Safeguarding network;

- how LSCBs work alongside other local strategic bodies and partnerships;

- if the new systems and arrangements are ‘fit for purpose’ and whether they safeguard and promote the welfare of children; and

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

1 INTRODUCTION

1.1 Background

Local Safeguarding Children Boards (LSCBs) were established under the Children Act 2004 and have responsibility for co-ordinating and ensuring the effectiveness of the work of partner bodies to safeguard and promote the welfare of children. LSCB functions include: the development of policies and procedures for safeguarding children; planning services for children in the authority; reviewing all child deaths; undertaking serious case reviews and monitoring the effectiveness of what is done (Local Safeguarding Children Board Regulations, 2006, Section 5). The establishment of the Boards in April 2006 was a part of wider reforms to Children's Services which aimed to change the way services were provided to children and families. Current statutory guidance, *Working Together to Safeguard Children* (HM Government, 2006) emphasises that safeguarding children is a shared responsibility and that 'effective joint working between agencies and professionals that have different roles and expertise are required' to safeguard children from harm, promote their welfare and to improve outcomes (HM Government, 2006, p.10).

Past research identifies a number of obstacles to inter-agency working, including fragmentation of service responsibilities, differences in values, variable understanding of other professionals' roles and tensions concerning status, autonomy and professional expertise (Easen et al., 2000; Frost and Lloyd, 2006 Hardy et al., 1992; Hudson et al., 1999; Jones et al., 2002; Lupton and Khan, 1998; Ward et al., 2004). Research has also identified variations in levels of representation, structure, practice and effectiveness (Horwath and Glennie, 1999; Narducci, 2003; Ward et al., 2004, Morrison and Lewis, 2005) of Area Child Protection Committees (ACPCs) (which LSCBs have now replaced). The joint Chief Inspectors' Report also indicated that a major obstacle to the effective operation of ACPCs was their lack of statutory power, poor leadership, high variations in membership and insufficient resources (Chief Inspector of Social Services et al., 2002; Ward et al., 2004). The establishment of the new LSCBs presents an opportunity for areas to implement new arrangements that address some of the weaknesses of ACPCs. In trying to understand how successful LSCBs have been in overcoming the weaknesses of previous arrangements, the Department for Children, Schools and Families (DCSF) and the Department of Health (DoH) have commissioned a large scale research study by the Centre for Research in Social Policy (CRSP) and the Centre for Child and Family Research (CCFR) at Loughborough University. This programme of research is exploring the effectiveness of LSCBs in England. The study involves detailed analysis of how LSCBs are operating and explores the successes and challenges that they face in safeguarding and promoting the welfare of children. In order to assess effectiveness the research team will be drawing on the literature about inter-agency working (see Percy-Smith, 2006 and Ward et al., 2004) and on evidence of how collaborations at the strategic level can improve the welfare of children (Horwath and Morrison, 2007). This report is interim and discusses early findings from this research.

1.2 Scope of the Report and Methods

This report presents initial findings from three aspects of the national evaluation:

- A national mapping exercise of LSCBs, providing data on the size, membership and organisational structures that have been put in place;

- A survey of LSCB Chairs, designed to explore the different approaches that LSCBs have adopted to fulfil their core functions and how arrangements are working in practice; and

- In-depth qualitative interviews with Chairs and Business Managers from six case study areas.

Every LSCB in England was asked to supply the research team with an up to date (i.e. December 2008 - January 2009) **LSCB membership** list and an organisational chart of the different subgroups that they had established to support the Board's work. This was **supplied by 86 per cent of LSCBs, that is, 124 out of the 144[2] Boards in England**. Information on job titles was used to examine the seniority of Board representatives (see Annex A). An **electronic survey** was also distributed shortly after the 'Baby P' case came to the attention of the media and public. It was identified that findings from the survey would be used to inform Lord Laming's progress report on Safeguarding Children. This secured a high **response rate of 72.9 per cent, with 105 LSCBs completing the survey**. Although the response rate for the mapping and survey are high, percentages still need to be interpreted cautiously as they are based on a small number of cases. Further details on the LSCBs that completed the survey are provided in Annex C. **87.3 per cent of survey respondents indicated that they were the Chair of an LSCB**. 12.7 per cent of surveys were completed by another representative of the LSCB. As such the findings from the survey need to be viewed as predominately those of LSCB Chairs. They may not accurately reflect the views of Board partners. The survey requested factual information as well as asking respondents for their subjective opinions on the operation of the LSCB. Most questions included a number of pre-defined responses and asked respondents to indicate the 'main' reason for adopting a particular approach. A few open-ended questions were included to clarify issues relating to Serious Case Reviews (SCRs) and Child Death Review Processes (CDRPs). As a part of the larger evaluation qualitative data from in-depth interviews with Chairs and Business Managers has been collected from six (case study) LSCBs. These have been selected on a number of criteria, including geographical location and levels of need. This data is drawn upon to contextualise the predominately descriptive quantitative findings from the mapping exercise and survey and to illustrate some of the challenges and issues that have arisen as Boards have sought to meet their objectives and fulfil their core functions.

The report outlines the structures that areas have put in place to meet their statutory duties by December 2008. Membership decisions require a balance to be struck between involving all organisations with an interest and the need to meet objectives as efficiently as possible (National Audit Office, 2001; see also, Percy-Smith, 2006; Thorlby and Hutchinson, 2002). Percy-Smith (2006) also emphasises the importance of establishing robust accountability systems given that partnerships are unelected, but have responsibility for overseeing services affecting the lives of children and families (see also, Audit Commission, 1998, p.36-38). The findings presented provide an overview of the structures and processes that LSCBs have put in place to meet their aims and objectives. However, it should be recognised that LSCBs are still in a phase of development and that where they started, in terms of Children's Services performance and inter-agency working relationships is likely to influence what they have achieved to date. Frye and Webb (2002) suggest that effective partnerships can take several years to develop. This interim report is a partial picture which will be completed in the final report of the LSCB evaluation. Its contribution at this time is to provide a benchmark on how LSCBs have developed after two and a half years of operation and provides valuable insights into some of the issues that Boards are having to address to ensure they are working effectively. The final report will present further data from a wider range of sources to more fully explore the effectiveness of LSCBs and whether they have overcome identified weaknesses of ACPCs.

[2] Some Local Authorities share an LSCB with one or more neighbouring areas.

2 CHAIRING ARRANGEMENTS

Hallett (1995) identifies that a skilled Chair is essential to the effective functioning of a child protection committee. Technical knowledge of issues concerning safeguarding children, alongside a capacity to manage meetings made up of a disparate group of people are important (Ward et al., 2004). Having a Chair who is able to give leadership and direction is recognised as important for the effective operation of strategic boards such as LSCBs (Horwath and Morrison, 2007). Local authorities across England have adopted different chairing arrangements to meet the requirements of Working Together (see Box 1) and these offer different contributions to the operation of LSCBs. This chapter presents quantitative data on the different chairing arrangements, the professional backgrounds of LSCB Chairs and the time they are able to dedicate to this role. Drawing on the national survey and in-depth interviews with Chairs and Business Managers from six LSCBs, the strengths and weaknesses of appointing either Local Authority (LA) employees or hiring an independent person specifically for the role, are explored.

BOX 1

It is the responsibility of the LA, after consultation with the Board partners, to appoint the Chair. The Chair may be a LA employee, such as the Director of Children's Services (DCS) or the LA Chief Executive, a senior employee of one of the Board partners, or another person contracted with or employed specifically to fulfil this role. Where the Chair is not a senior person from the LA, such as the DCS or Chief Executive, they will be accountable to the LA, via the DCS, for the effectiveness of their work as LSCB Chair. The Chair should not be an Elected Member.

Source: Working Together to Safeguard Children, Section 3.49.

Working Together permitted LAs to make a decision about who to appoint to Chair their LSCB. As outlined in Table 1, 40 per cent of LSCBs appointed an Independent Chair while 41 per cent decided that the local DCS should be the Chair. Only 13.3 per cent opted to give the task to a senior employee of one of the LSCB partners. The balance between these three models is set to change given the Government's decision, in response to Lord Laming's review, that Independent Chairs should be appointed to Chair LSCBs (Lord Laming, 2009; HM Government, 2009). In our case study areas two of the Chairs were DCSs, one was a senior employee in the authority and three were independent being employed specifically for the role of LSCB Chair.

Table 1 What is the Current Chairing Arrangement for this LSCB?

Chairing Arrangement	Frequency	Per Cent
Independent Chair	42	40.0
The Director of Children's Services	43	41.0
Local Authority Chief Executive	3	2.9
Senior Employee of One of the LSCB Partners	14	13.3
Deputy Chief Executive and Director of Children's Services	2	1.9
Interim Chairing Arrangement	1	1.0
Total	**105**	**100.0**

As Table 2 shows, the majority (59.2 per cent) of LSCB Chairs are from Children's Social Care. 85.7 per cent of Independent Chairs were from this professional group and it was rare for them to come from an educational or health background (one person or 2.4 per cent from either background). The split between social work and educational professionals was much more even in respect of Statutory Chairs (41 per cent: Social Care; 41 per cent: Education).

Table 2 What is the Chair's Predominant Professional Background?

Per Cent

Predominant Background	Independent Chair	'Statutory Chair'[3]*	Total
Children's Social Work / Social Care	36 (85.7)	25 (41.0)	61 (59.2)
Education	1 (2.4)	25 (41.0)	26 (25.2)
Health	1 (2.4)	3 (4.9)	4 (3.9)
Other	4 (9.5)	8 (13.1)	12 (11.7)
Total	**42 (100)**	**61 (100)**	**103 (100)**

* There was one missing response from the 'Statutory Chair'; the LSCB Board with the interim chairing arrangement is excluded from this table as their new Chair may have a different background to the current Chair.

2.1 Chairing as a Resource

The amount of time spent by Chairs on LSCB business varies across authorities (Table 3). 43.1 per cent of all Chairs reported that they spent two days on LSCB business per month. 22.5 per cent indicated that they spent three days a month on LSCB business. There were no significant differences according to whether or not the Chair was statutory or independent, although 15 per cent of Statutory Chairs indicated that they spent only one day a month on LSCB business compared to only 7.1 per cent of Independent Chairs.

[3] 'Statutory Chair' is used to describe the boards chaired by the DCSs, LA Chief Executive or employees of one of the LSCB Partners.

Table 3 **How much time does the Chair spend on LSCB business for this Board ?** (excludes time spent on Serious Case Reviews and Child Death Reviews)

Per Cent

Number of days per month spent on LSCB business	Independent Chair	'Statutory Chair'*	Total
1	3 (7.1)	9 (15.0)	12 (11.8)
2	18 (42.9)	26 (43.3)	44 (43.1)
3	9 (21.4)	14 (23.3)	23 (22.5)
4	5 (11.9)	5 (8.3)	10 (9.8)
5	4 (9.5)	5 (8.3)	9 (8.8)
More than 5	3 (7.1)	1 (1.7)	4 (3.9)
Median number of days per month (range)	2.5 (1-8)	2 (1-5)**	2 (1-8)
Total	**42 (100)**	**60 (100)**	**102 (100)**

* There were two missing responses from the 'Statutory Chair'; the LSCB Board with the interim chairing arrangement is excluded from this table.
** The median and ranges were based on 59 responses, as one response from the 'Statutory Chair' was 'more than five days per month' which could not be quantified.

The implementation of arrangements to safeguard and promote the welfare of children are demanding. In our interviews Chairs and Business Managers felt that central government were placing increasing demands on LSCBs and expanding their workload. This expansion served to increase the roles and responsibilities of the Chair and demanded more of their time. Any extra time DCSs committed to the LSCB influenced the time they had available for fulfilling their other service responsibilities. For Independent Chairs the time they had available to spend on LSCB business was limited by the budget available and any expansion of roles and responsibilities required resources to be found to pay for this. This posed a problem for some areas as budgets were set for the year in advance and these did not always reflect the fluctuations that may arise as demand on the Chair's time increased.

Chairs recognised that they had to prioritise core business. However, their involvement in long term planning, strategic development and networking could suffer as a result of time constraints. Business Managers had a core role to play in assisting Chairs in prioritising and identifying future demands, however, there was a risk that this became a filtering process that meant that the Chair no longer had a full picture of what was happening. Growing demands and responsibilities for Chairs could also lead to meetings being rushed and the operation of the LSCB being reactive rather than proactive.

2.2 Strengths and Challenges of Chairing Arrangements

There are strengths and challenges in both independent and statutory chairing arrangements. As outlined in Table 4, Statutory Chairs thought the key strength of this arrangement was that it allowed them to ensure that the work of the LSCB was embedded in local strategic partnerships (49.2 per cent) and that they had influence over key agencies (35.6 per cent). As one Chair said, there are *'advantages of being linked into the system'* (Chair). Those Statutory Chairs interviewed also identified that their position often meant they were able to command respect. However, there was recognition that this could also pose a

problem. Fifty five per cent of Statutory Chairs in the survey identified the possibility of conflicts of interest because of their post, as the main weakness of this chairing arrangement. One Business Manager interviewed, for example, identified that the DCS and children's social care representatives dominated meetings and decisions were made without challenge from other members. This, it was suggested, created tensions as partners were less engaged in meetings and had less influence.

Table 4 What do you think is the MAIN Strength of this Chairing Arrangement?

Per Cent

Main Strength	Independent Chair	'Statutory Chair'*	Total
Allows independence from agencies/gives Chair autonomy	35 (83.3)	3 (5.1)	38 (37.6)
Ensures LSCB work is embedded in local strategic partnerships	1 (2.4)	29 (49.2)	30 (29.7)
Gives Chair influence over key agencies	4 (9.5)	21 (35.6)	25 (24.8)
Brings independent challenge and scrutiny to LSCB work	1 (2.4)	1 (1.7)	2 (2.0)
Visible leadership and ownership within Lead Agency and across LSCB	0 (0)	1 (1.7)	1 (1.0)
Provides greater clarity of accountability	1 (2.4)	1 (1.7)	2 (2.0)
Good understanding of operational implementation of safeguarding arrangements	0 (0)	1 (1.7)	1 (1.0)
Local knowledge of key issues	0 (0)	2 (3.4)	2 (2.0)
Total	**42 (100)**	**59 (100)**	**101 (100)**

* There were three missing or multiple responses from the 'Statutory Chair'; the LSCB Board with the interim chairing arrangement is excluded from this table as it is not clear whether they are referring to their current arrangement or the anticipated strength of the arrangement they intend to adopt.

In terms of Independent Chairs the strength of their role lies in being independent from all agencies. For example, in Table 4, 83.3 per cent of Independent Chairs identified this as a key strength. One Business Manager reflected that:

> '*Our aim as a Board I think is to challenge, and I think if you're independent you can challenge. There's also a bit of a problem if you have a DCS chairing the Board, it's very difficult to challenge your own service*...'
>
> (Business Manager)

However, independent chairing arrangements are not without their own difficulties.

As Table 5 shows, the main challenges of independent chairing are that the 'Chair does not hold sufficient authority to influence change' (33.3 per cent) and Independent Chairs 'have less familiarity with operational arrangements in the area' (26.2 per cent).

Table 5 What do you think is the MAIN challenge of this Chairing Arrangement?

Per Cent

Main Challenge	Independent Chair	'Statutory Chair'*	Total
Chair has less familiarity with strategic arrangements in the area	1 (2.4)	0 (0)	1 (1.0)
Chair has less familiarity with operational arrangements in the area	11 (26.2)	2 (3.3)	13 (12.7)
Creates possible conflicts of interest	0 (0)	33 (55.0)	33(32.4)
Chair does not hold enough authority to influence change	14 (33.3)	1 (1.7)	15 (14.7)
Raises problems of who the Chair is accountable to	9 (21.4)	7 (11.7)	16 (15.7)
Does not have any challenges	4 (9.5)	13 (21.7)	17 (16.7)
Other	3 (7.2)	4 (6.8)	7 (7)
Total	**42 (100)**	**60 (100)**	**102 (100)**

* There were two missing or multiple responses from the 'Statutory Chair'; the LSCB Board with the interim chairing arrangement is excluded from this table as it is not clear whether they are referring to their current arrangement or the anticipated strength of the arrangement they intend to adopt.

These issues were also raised by Chairs and Business Managers during interviews.

> *'It can be difficult to get started if you're coming in absolutely new to an area, because clearly the only people you initially know are the people sitting in the room and by extension all you know is the information that they directly give you.'*
>
> (Chair)

A Business Manager also identified the danger that Independent Chairs could be 'fobbed off' as *'they're not in the middle of it like a DCS is'* (Business Manager). The Chairs themselves sometimes thought they were disadvantaged because they were external and could not always access strategic and operational structures or information. For example, in two cases the Chair was not a member of the Children's Trust which then limited their access to information about wider strategic developments aimed at improving children's lives across the five Every Child Matters (ECM) outcomes. The amount of time Independent Chairs were contracted for could also have an influence on their ability to understand local needs, circumstances and wider developments. If they were only appointed for one or two days a month they had to prioritise core responsibilities, therefore limiting the time they had to develop their knowledge. These problems could be overcome if the Chair had substantial experience in this area of work, had a good understanding of the questions they needed to ask and an understanding of some of the challenges they faced. Knowledge of the broader context could evolve but it could take time and thus impact on the pace of development.

The main challenge for Independent Chairs came through trying to establish authority. Independent Chairs are not part of the LA and had no status (or position) within the infrastructure. As highlighted in Table 5, a third of all Independent Chairs identified this as an issue. It was also raised by our three independent case study Chairs. They could be marginalised from mainstream developments and be seen as not having a strong voice in either operational or strategic developments. They felt that they needed to create their authority and they felt that success in this respect could impact upon their effectiveness. All three Chairs had adopted strategies to try and overcome these problems. Having significant support from senior members of the LA (i.e. the Chief Executive) was important. Being given access to all LA systems (email / internet) and kept informed of wider developments taking place in the authority on a regular basis was also viewed as key.

2.3 Accountability and Line Management

Accountability in strategic partnerships has been recognised as critical for effectiveness (Frost and Lloyd, 2006). Frost and Lloyd, for example, suggest that in traditional working environments vertical forms of accountability can be straightforward and clear but in more complex arrangements these boundaries can become more blurred and problematic (Frost and Lloyd, 2006). In principle, accountability structures for Chairs seemed straightforward. As Table 6 shows, 45 per cent of Chairs were accountable to the DCSs and 37.5 per cent to the Chief Executive in the LA. Over four fifths (83.3 per cent) of Independent Chairs stated that they were accountable to the DCS. In contrast, just under a fifth (19.4 per cent) of Statutory Chairs were accountable to the DCS. The majority (58.1 per cent) of Statutory Chairs were accountable to the LA Chief Executive.

Table 6 To whom is the Chair accountable?

Per Cent

Accountability	Independent Chair	'Statutory Chair'	Total
Director of children's services	35 (83.3)	12 (19.4)	47 (45.2)
Local authority chief executive	3 (7.1)	36 (58.1)	39 (37.5)
Not clear	2 (4.8)	8 (12.9)	10 (9.6)
Other	2 (4.8)	6 (9.7)	8 (7.7)
Total	**42 (100)**	**62 (100)**	**104 (100)**

* The LSCB Board with the interim chairing arrangement is excluded from this table as their new Chair may have different accountability to the current Chair.

However, interview data revealed that how this worked in practice seemed more complex and less clear. Three of the Chairs had *political accountability* through being scrutinised by local members (i.e. Members Scrutiny Committees). One of these committees also included young people. Reporting to these committees tended to be annual. When it came to accountability for the day to day operation of the LSCB and for overseeing its outcomes there remained uncertainty about how this worked in practice. One Statutory Chair explained:

> *'There's a scrutiny committee, I'm accountable to the Chief Executive…but in terms of safeguarding responsibilities I think I'm accountable to the Safeguarding Board, but I think the buck stops with me as far as the authority's concerned, or that's how it feels to me anyway.'*
>
> (Chair)

The two DCS Chairs were mindful that LSCB performance could have an impact on their Annual Performance Assessment (APA) and Joint Area Reviews (JAR). They therefore felt the need to Chair and 'manage' the LSCB as this would impact upon their performance rating. This not only influenced why they had the chairing arrangements they did but also, in some cases, influenced the involvement of others in the decision making process of the LSCBs. One Business Manager noted: *'Children's Services focus about APA, panic, panic you know, knee jerk reaction[s]'* (Business Manager).

For Independent Chairs it was even less clear how accountability operated. Tensions existed if they reported to the DCS (or were line managed by the DCS) because this could potentially undermine their independence and power to be critical of Children's Services. None of the three Independent Chairs had a clear sense of what their relationships were to the LA and in two cases no line management structure existed. Contracts, where they were in place, did not necessarily clarify this. Lack of clarity and transparency concerning lines of accountability has the potential to cause difficulties. One Independent Chair reflected that:

> *'I don't really know what would happen if we had to really test where I was going down a particular road and really needing to take things as far as I could about practice issues and they could…I don't know whether they could then just get rid of me on that basis because I haven't got a written contract.'*
>
> (Chair)

One Chair thought their accountability was derived from being 'elected' by other LSCB members to stand as Chair for another year. In another example reporting to the Children's Trust was seen as an accountability mechanism, but there are potential difficulties with this if the LSCB is commenting on and potentially being critical of the operation of the Children's Trust. Working Together is also clear that the LSCB should not be subordinate to, or subsumed within the Children's Trust arrangements in a way that might compromise its separate identity and independent voice (Section 3.52).

2.4 Conclusion

Having a Chair who is skilled, with good leadership qualities is critical to the effective operation of LSCBs (Hallett, 1995; Ward et al., 2004). Assessing this from the present data is not possible but will be explored further in the final evaluation report on this study. At this stage it is evident that Chairs are in the process of trying to define and develop an effective working model. In doing so the following issues come to the fore: establishing their authority and commanding respect without dominating; managing relationships between different agencies with varying levels of familiarity with safeguarding children and families; clarifying lines of accountability and adopting strategies to embed the LSCB within wider strategic partnerships, without compromising the separate identity, role and remit of the Board. The time that Chairs are able to commit to the operation of the LSCB also has an impact upon what they have been able to achieve.

3 BOARD STRUCTURE AND REPRESENTATION

3.1 Introduction

The joint Chief Inspectors' report, Safeguarding Children (Chief Inspector of Social Services et al., 2002) highlighted that only a few ACPCs were equipped to carry out their responsibilities 'for agreeing and promulgating how different services and professional groups should co-operate to safeguard children in the area, and for making sure that arrangements work effectively' (Department of Health et al., 1999, p.46). LSCBs have since replaced ACPCs. This chapter of the report explores the structures and processes adopted by LSCBs to fulfil their core functions.

3.2 Size of Boards

Some studies identified the size of ACPCs as a problem, with some Boards being unwieldy (Hallett, 1995; James, 1987 in Calder and Barrett, 1997). The optimum size of a group may be influenced by local conditions. Horwath (personal communication, in Ward et al., 2004) suggests that Boards of up to 20 can be manageable if individuals have established relationships and often work together in different groups for different purposes.

It is clear from the mapping data that there is a large variation in the size of LSCBs throughout the country, with the smallest Board consisting of 12 members and the largest of 91, with an average (mean) of 26.

Table 7 Size of Boards

	Minimum	Maximum	Mean	Median
Total	12	91	25.8	24.5
Breakdown by Authority Type				
London	12	48	26.5	24.5
County	15	91	31.9	29
Metropolitan	13	40	23.9	23
Unitary	12	36	22.3	23
Combined[4]	19	49	30.8	27.5
Breakdown by Chairing Arrangement				
Independent Chair	12	91	24.2	23
Statutory Chair	12	49	26.6	25.5

There was a general consensus amongst Chair and Business Managers from case study areas that smaller Boards are easier to manage both in terms of chairing and decision-making. As one Business Manager of a slightly larger than average sized Board commented:

> *'What [the Chair] would be saying is there is too many people and they leave it all to her, because that is what she says to me, she thinks that people don't engage and I would say that…it's very easy to be silent isn't it in a big meeting.'*
>
> (Business Manager)

[4] This includes areas which have combined with one or more other area to form one LSCB. There are four LSCBs of this type for which we have membership data.

Another Board chose to dramatically reduce their membership during the transition from ACPCs to LSCBs, due to the fact that many members were not seen to be contributing during meetings. This is a theme reiterated by interviewees - that in a large Board meeting, certain people and groups may dominate, and that the environment may not bring out the best in others.

> '*If you want people to feel involved and engaged having a group of 30 people in a room is not how to do it.*'
>
> (Chair)

As demonstrated above, dilemmas may arise concerning who to include on a LSCB, as Chairs try to meet the requirements of Working Together, ensure they are inclusive and have a wide representation, whilst also making sure that the size and dynamics of the group do not undermine effectiveness. The wide differentiation in Board sizes, as well as Executives and subgroups (see Chapter 4) across the country indicates that areas have made different judgements about priorities, and adopted different models of delivery, which are likely to raise distinct operational issues and challenges.

3.3 Board Representation

Safeguarding children is a shared responsibility, although it has been suggested that in reality child protection has been treated as the responsibility of Children's Services, with other agencies supporting them in 'their work' (Narducci, 2003). The requirement for responsibilities to be shared is legally underpinned in the Children Act 2004. This section examines agency representation on LSCBs and the extent to which statutory requirements are being met, as well as identifying some of the challenges and issues Boards have faced during the early stages of establishment.

3.3.1 Statutory agencies involved in LSCBs as required under Section 3.58 of Working Together

As outlined in Working Together a number of core agencies are expected to be members of a LSCB (see Box 2). Analysis of **membership data from 124 LSCBs** shows that **overall 68 Boards (55 per cent) have representation from all the statutory agencies** outlined under Section 3.58 of Working Together. Of the 56 Boards which have statutory agencies missing, 45 were found to be missing only one statutory partner. Eight Boards were missing two statutory partners, and three Boards were missing three statutory partners.

BOX 2

The LSCB should include representatives from the Local Authority and its Board partners, the statutory organisations which are required to co-operate with the local authority in the establishment and operation of the board and have shared responsibility for the effective discharge of its functions. These are the Board Partners set put in Section 13(3) of the Children Act (2004)
:

- *District councils in local government areas which have them;*
- *The Chief Officer of Police for a police area any part of which falls within the area of the local authority;*
- *The Local Probation Board for an area any part of which falls within the area of the local authority;*
- *The Youth Offending Team (YOT) for an area any part of which falls within the area of the local authority;*
- *Strategic Health Authorities (SHAs)[5] and Primary Care Trusts (PCTs) for an area any part of which falls within the area of the local authority;*
- *NHS Trusts and NHS Foundation Trusts all or most of whose hospitals or establishments and facilities are situated in the local authority area;*
- *The Connexions[6] Service providing services in any part of the area of the local authority;*
- *CAFCASS (Children and Family Courts Advisory and Support Service);*
- *The governor or director of any Secure Training Centre in the area of the local authority; and*
- *The governor or director of any prison in the local authority area which ordinarily detains children.[7]*

Source: Working Together to Safeguard Children, Section 3.58.

[5] The Priority Review (DfES, 2007) noted that since the change in organisation of the SHAs, it would be more difficult for them to have representation on the Boards. It was suggested that they should co-operate with the Boards rather than be full members. Therefore, for the purposes of our analysis, they are no longer defined as statutory members.
[6] Since the publication of Working Together, Connexions has been subsumed under Local Authorities. Therefore, as all LSCBs have representation from Local Authorities, they are presumed to have representation from Connexions.
[7] Some boards have representatives from prisons which *do not* ordinarily detain children.

The table below provides a detailed breakdown of the representation of the different statutory members across the 124 Boards who provided data.

Table 8 Membership according to statutory representation

Statutory Agency	Total	Per Cent
Children's Services	123[8]	99
Education[9]	82	66
PCT	115	93
NHS Trust	120	97
Police	124	100
Probation	122	98
Connexions[10]	66	53
YOT	99	80
CAFCASS	115	93

* Data on prisons, secure training centres and district councils are presented below.

In total the 121 Boards that supplied full membership data had 3277 members. The table below shows the number of Board members from each of the statutory agencies.

Table 9 Board membership according to statutory agency[11]

Agency	Members	Per Cent
Children's Services	549	17
Police	225	7
NHS Trust	379	12
PCT	224	7
Probation	127	4
CAFCASS	112	3
Connexions	67	2
YOT	99	3
STC or Prison	33	1
District Council	82	2
Total	**1897**	**58**

As Table 9, above, shows Children's Services and NHS Trusts contribute the highest number of staff to sit on the LSCB (17 per cent and 12 per cent respectively). This was followed by the PCT and Police (both seven per cent).

[8] One Board only has representation from Children's Services through the Chair who is the DCS.
[9] Please note that for the purposes of this table only we have separated out members who work specifically under an education department of Children's Services. This does not include head teachers or head teacher representatives.
[10] The figure for Connexions is included for information and is based on the number of Boards which have representatives whose job titles suggest that they specifically represent Connexions.
[11] This does not include Chairs of LSCBs.

Further examination of the membership data reveals that **110 LSCBs (89 per cent) have representation from Children's Services, Police, the PCT and NHS Trusts**. As all of the Boards have representatives from Children's Services and the Police, it was either the PCT or NHS Trust who were unrepresented. That said, no Board was missing both a PCT and NHS Trust representative and this means that **every Board has a representative from Children's Services, the Police and Health**. Other findings include:

- **CAFCASS, probation and YOT have representatives on 93 LSCBs (75 per cent).**
- **83 Boards have representation from Children's Services, Police, PCT, NHS Trusts, CAFCASS, Probation and YOT (67 per cent).**

Box 3

The LSCB should include…district councils in local government areas which have them.

Source: Working Together to Safeguard Children, Section 3.58.

It is a requirement that in counties Local District Councils should be involved in the LSCB (Box 3). Of the 24 areas which are counties, only one area does not have any form of District Council representation.[12]

Box 4

The LSCB should include…the governor or director of any Secure Training Centre in the area of the local authority.

Source: Working Together to Safeguard Children, Section 3.58.

Working Together requires representation from a Secure Training Centre representation if relevant to an area (Box 4). Four local areas who responded to our request for data had Secure Training Centres and all four had at least one representative on the LSCB.

Box 5

The LSCB should include…the governor or director of any prison in the local authority area which ordinarily detains children.

Source: Working Together to Safeguard Children, Section 3.58.

Local Prisons which ordinarily detain children also have to be represented (Box 5). Of the areas which provided data, 23 have representation from prisons. Of these, four areas have representation from the prison service although they do not have a prison which ordinarily detains children in their area. There are a further 11 areas which have Young Offenders Institutions within them, but do not have representatives on the LSCB.

[12] Please note, membership data was provided before some areas changed from counties to unitary authorities.

3.3.2 Other agencies who should be represented under Section 3.59 or there should be access to expertise from under 3.60 of Working Together

In Working Together it is also identified that adult social services (Section 3.59) should be represented on the LSCB, because of the importance of adult social care in safeguarding children and promoting their welfare. LSCBs should also have access to appropriate expertise and advice from all the relevant sectors, including a designated doctor and nurse (Section 3.60). The requirement to involve these groups (i.e. have access to their expertise) does not necessitate membership on the Board. However, findings from the membership data show:

- 69 LSCBs (56 per cent) have representation from adult social care services;
- 94 LSCBs (76 per cent) have a designated nurse;
- 84 LSCBs (68 per cent) have a designated doctor; and
- 73 LSCBs (59 per cent) have both a designated doctor and a designated nurse.

3.3.3 Other members specified under Section 3.62 of Working Together

The LA are also expected to secure the involvement of other relevant local organisations and draw on the knowledge and experience of the NSPCC where a representative is made available (Box 6, Section 3.62). **69 Boards (56 per cent) have representation from the NSPCC**. In addition seven other Boards have representatives from other large national children's charities such as Barnardo's or The Children's Society. There are 17 Boards which have more than one representative from a large national children's charity.

Box 6

At a minimum local organisations should include faith groups, state and independent schools, Further Education Colleges including 6th Form Colleges, children's centres, GPs, independent healthcare organisations, and voluntary and community sector organisations including bodies providing specialist care to children with severe disabilities and complex health needs.

Source: Working Together to Safeguard Children, Section 3.62.

Table 10 Representation from Agencies Specified Under Section 3.62

Agency	Number of Boards	Per Cent
Faith groups	22	18
Secondary school	39	32
Primary school	49	40
Independent school	9	5
Special school	14	12
Children's Centre and Early years	8	7
GP	22	18
Community or voluntary group	75	62
Further education	37	31
Other education[13]	20	16

Box 7

In areas where they have significant local activity, the armed forces…, should also be included [on the LSCB].

Source: Working Together to Safeguard Children, Section 3.62.

Out of the 124 areas, 40 do not have any armed forces in their area. A further 43 have less than 100 armed forces personnel stationed in their area. 15 areas have between 100 and 1000 personnel in their area. 20 areas have between 2000 and 5000, and four areas have between 5000 and 10,000. Only two Boards have over 10,000 armed forces personnel in their area. **In total, 11 Boards have representation from armed forces**. Three of those Boards have up 1000 personnel in their local area; four Boards have between 1000 and 5000; two Boards have between 5000 and 10,000 personnel and both Boards which have over 10,000 armed forces personnel stationed in their area, have representatives from the armed forces on the LSCB.

3.3.4 Chairs and Business Managers' perspectives on statutory representation

Having a broad membership on strategic boards such as LSCBs is seen as critical for effective multi-agency working in Children's Services (Morrison, 2000). For the most part Chairs and Business Managers have been fairly satisfied with the representation on Boards from the statutory partners:

> *'We've got the right membership, so I'm fine about that, everybody you know all the agencies, organisations who should be, are there.'*
>
> (Chair)

[13] This includes Learning and Skills Council representatives, and head teacher representatives of combined primary and secondary schools.

Social care, education, police and health tended to be seen as the 'major players', with YOTs, probation and CAFCASS seen as more peripheral. Differences in levels of representation are also evident from the membership data with 89 per cent of Boards with representation from all the 'major players' but only 55 per cent with representation from all statutory agencies listed in Working Together[14]. Total figures also reveal that, overall, health followed by Children's Services contribute by far the highest percentage of members to Boards. Overall 28 per cent (907) of Board members are from health (PCT, NHS Trust, Designated Doctor, Designated Nurse and 'other' health). 23 per cent (748) of representatives are from Children's Services (children's social care, education and 'other' education). Concerns were expressed by some interviewees about the dominance of these partners on the Boards.

A further problem that interviewees identified was that agencies which cover more than one LSCB area are required to provide representation for more than one Board. Police, probation, CAFCASS and health services have all been presented with this issue.

> *'So, your region, so if you look at this you've got ten Boards to service, if you had probation you've got ten Boards to service. So you know basically that's harder for them but also for us it's a challenge to operate regionally.'*
>
> (Chair)

Continuity of membership and regular attendance at meetings are likely to facilitate the effective operation of LSCBs. Survey data indicated that 84 per cent (87 Boards) felt that LSCB membership had been stable over the preceding 12 months. However, interview data identified a number of difficulties in this respect. In some cases there was simply a lack of attendance at meetings, but in others there was a high turnover of members. Interviewees mentioned this in relation to all the major players, including Children's Services, police and health. Changes were usually due to promotions or internal changes in staff roles and responsibilities and tended not to be perceived by Board members or Chairs as demonstrating a lack of commitment to the LSCB. Lack of continuity does, however, have implications for the operation of the Board:

> *'So that lack of continuity does have a major consequence because new people come into the Board structure…and so you're constantly reverting back to first base in trying to get people onto the Board, plus the knock-on consequence in terms of the interrelationships with other people on the Board.'*
>
> (Chair)

Regular attendance was also identified as an issue. Some Boards had developed mechanisms to try to respond to poor attendance. This could involve the Chair or Business Manager contacting the head of the agency concerned to *'remind them that they do need to ensure that they are represented and that their representation comes'* (Business Manager) or *'if somebody misses two meetings we write a reminder letter to remind them of the importance [of attending]'* (Business Manager). One Business Manager does suggest that:

> *'I think the Board needs to have a little bit more power to enable people to take seriously, both the Board and the agenda of Board and need to be complied with.'*
>
> (Business Manager)

[14] Excluding Connexions, which is now part of Children's Services, and Strategic Health Authorities, which - due to restructuring - are no longer required to have representatives on LSCBs (DfES, 2007).

3.3.5 Involvement of other groups and agencies specified under Section 3.63 of Working Together

Table 11, below, outlines other groups that are represented on LSCBs. Amongst these, housing has the highest representation (43 per cent). It should be noted that, whilst many of these other groups do not appear to be well-represented on the LSCBs, the interviews with Chair and Business Managers suggest that these agencies are often represented on subgroups.

Table 11 Involvement of other agencies and groups

Agency	Number of Boards	Per Cent
Coronial service	2	2
Dental health	3	2
Domestic violence forums	30	24
Drug and alcohol misuse services	16	13
Drug action teams	2	2
Housing[15]	53	43
MAPPA[16]	2	2
Local sports bodies and services	12	10
Other health providers such as pharmacists[17]	7	6
Sexual health services	6	5
Crown Prosecution Service	13	10
Fire and rescue[18]	27	22

The mapping data shows that there are a wide range of non-statutory and third sector agencies represented on the Boards. Chairs and Business Managers had different perspectives on whether these agencies should be represented on the Board itself, or whether they would have more impact if they were to sit on one of the subgroups.

> *'Somebody from the fire brigade wants to be on the Board and my reply is well it's actually likely that the links here are not so much with the Board but with the prevention sub-committee.'*
>
> (Chair)

Although a wider representation on the Board was seen to have benefits it was also acknowledged that a larger Board with wider representation could cause difficulties as the number of attendees at meetings could make active engagement and participation of all partners challenging. At the same time, there was evidence that the Boards were all keen to establish good links with the third sector. This is borne out by the mapping data which shows that over 90 per cent of Boards have some representation from the third sector, with 60 per cent having representation from one of the larger national children's charities[19].

[15] Some housing representatives may be represented by District Council members, and are therefore counted as District Council representatives.
[16] This is also included in the count of boards which have representation from probation.
[17] Includes private health providers.
[18] Fire and Rescue is identified in Working Together, but is included as there are a significant number of boards with representation from this service.
[19] NSPCC, Barnardo's, Action for Children.

3.3.6 Seniority of Board representatives

The joint Chief Inspectors' report indicated that major obstacles to the effective operation of ACPCs was their lack of statutory power, poor leadership, high variations of membership and insufficient resources (Chief Inspector of Social Service et al., 2002). Working Together identifies the importance of a broad representation of agencies on LSCBs and that members should be of sufficient seniority to speak for their organisation with authority; commit their organisation on policy and practice matters and hold their organisation to account (Working Together, Section 3.55).

In order to establish the extent to which the LSCBs are meeting these requirements, the seniority of Board members was examined (see Annex A).

Table 12 Seniority on LSCBs

Seniority Coding	Number of all Statutory Members	Per Cent
1 and 2	706	39
3 and 4	1009	56
5	87	5

Based on analysis of LSCB membership lists 39 per cent of *statutory members* on Boards either had overall responsibility for their entire organisation or a large department within it, or they were accountable only to the head of their organisation. Self-completed survey responses indicated that just over half of Chairs (52 per cent: 104) thought that *all* Board members could speak for the organisation they represent with authority; commit their organisation on policy and practice matters; and hold their organisation to account.

In general, in case study areas, the Chairs and Business Managers were 'comfortable' with the level of seniority of members, although there were some exceptions. One of the questions that was raised was whether it is more important for members to be at the most senior level or whether it is more important for them to have the ability to speak for their agency and make decisions on their behalf:

> *'We've gone for senior people…but not necessarily the most senior people, but we also have a role description which is basically saying that if an issue on the agenda is not in your ownership we expect you to come to the Board with the authority from your agency to say yes or no.'*
>
> (Chair)

This was connected to issues about whether or not senior members always have sufficient *specialist* knowledge and expertise:

> *'A lot of people come onto the Board, they come because they're senior members with other organisations, they're not necessarily that familiar with details of Safeguarding Board or child protection work, and all of that…'*
>
> (Business Manager)

One example of this related to the police. It was generally seen as inappropriate for the Chief Constable to be present at LSCB meetings, especially as police geographical boundaries usually require them to be represented on a number of Boards. Having such a senior figure attend would not always be useful to the LSCB because they held less detailed knowledge of safeguarding issues. What tended to happen was that a senior police officer represented the police. This approach could be a strength if this officer had a detailed understanding of child welfare. However, this could raise questions about their ability to commit their organisation and hold them to account. In one area this was overcome as the Board member was line managed by a senior executive and clear lines of accountability had been established. Dean and colleagues' (1999) identify the importance that representatives have sufficient decision making powers or delegated authority and the need for parity in the perceived seniority of representatives from different organisations.

Lower levels of seniority were seen as a weakness of ACPCs (Narducci, 2003), however, the literature on inter-agency working also identifies how lack of common understanding about safeguarding children can act as a barrier to effective communication (Cooper et al., 2003). This raises wider issues concerning influence on the Board. Neither representation nor attendance automatically secure influence or effectiveness.

3.3.7 Understanding roles and responsibilities and influence

Clarity about roles and responsibilities is essential for effective multi agency working at a strategic level (Horwath and Morrison, 2007). Making sure that members of Boards are clear about their role and central tasks is important. For example, Morrison and Lewis (2005) argue that in joined up working, roles can become blurred and confused. Negotiation is a part of participation and to be effective, partners need to have confidence that they are clear about their responsibilities. Others have suggested this was a weakness of ACPCs (Morrison, 2000). Open discussions or job descriptions may assist in assuring clarity. Different professional cultures can serve as a barrier to effective practice (Frost, 2005). In seeking to establish effective LSCBs, Chairs and Business Managers have faced the challenge of bringing together professionals from different organisational cultures and backgrounds to agree a common set of priorities. 81.4 per cent (83 LSCBs) of survey respondents felt that all LSCB members were clear about their roles and responsibilities. As Table 13 shows, under half of Chairs felt that LSCB members had a well developed shared language.

Table 13 To what extent do you feel that LSCB members have developed a shared language?

	Frequency	Per Cent
Very well developed	44	41.9
To some extent	58	55.2
To a limited extent	1	1.0
Not developed	0	0.0
Number of LSCBs who answered this question	**103**	**100**

Two LSBCs did not respond to this question.

Active engagement may be influenced by different levels of knowledge and experience in relation to safeguarding children. Chairs were mindful of this and recognised the risk of children's social care and health dominating meetings. Chairs are aware of these tensions and have tried, in a number of areas, to address this issue. There was evidence that in some LSCBs progress had been made in that agencies who previously had little understanding of child protection were becoming more knowledgeable about the issues through being actively involved in strategic discussions at LSCB meetings. Although progress was seen as being made in terms of encouraging the engagement of a wider range of agencies and the third sector, it was also recognised that:

> *'Some agencies still think they are helping out social care rather than I think that safeguarding is everybody's responsibility.'*

It was recognised that Children's Services had a vested interest in the effective function of the Board as LSCB activity could affect their Annual Performance Assessment (APA) and Joint Area Review (JAR) ratings, and this made it difficult for them to not be the dominating force on the Boards.

Chairs also identified the importance of Board members recognising that their role on the Board is not simply one of championing the interests of their own agency.

> *'New people come into the Board structure, they think their role is about representing their agency, they struggle with, yes that's one of your roles, but your other is to be an independent member of the Board.'*

Chairs had been aware that this was going to be a major challenge and many had insisted that in the early stages of establishing the Board, discussions about these responsibilities were clearly outlined. In some cases LSCBs had used a written statement as setting this 'on the record' but if personnel changed or practice did not emphasise this as core then Chairs felt that representatives did not always fully grasp this responsibility or act upon it.

Chairs also believed that in order to be effective it was essential that Board members recognise that they *need to disseminate information within their own agencies*. Whilst this was seen as crucial, there was less certainty amongst Chairs and Business Managers about the extent to which this was happening and whether the Board was having an impact at an operational level. Being able to monitor this was difficult and relied on personal perceptions and agency representation at LSCB meetings. The issue of dissemination also becomes complicated for those agencies who may be responsible for feeding back to different divisions of their agencies. Again, it was not always clear how effective this was.

3.4 Conclusion

LSCBs have faced the challenge of trying to balance the need for a broad and inclusive LSCB membership against the need to have a Board that is a manageable size. The decisions taken on who to include on the main Board vary considerably across the country, although the average Board has 26 representatives. Only a small number have secured representation from independent schools, GPs and Children's Centres, although there is debate about whether it may be more appropriate for such groups to be involved in the subgroups. Chairs and Business Managers identified difficulties in maintaining continuity of membership and regular attendance once agency representation has been secured. Under half of Chairs also felt that not all Board members were sufficiently senior and lacked the authority needed to fulfil their responsibilities The mapping data also indicates that the majority of LSCBs do not have the most senior representatives of their agencies on the Board. However, while seniority is clearly important, Chairs and Business Managers did identify that *specialist* knowledge and expertise in the area of safeguarding children were

also necessary considerations. Developing shared language and understanding in this respect is important as is establishing engagement from those who may have traditionally had a less prominent role in work with children and young people. Changing organisational cultures and finding new ways of working always takes substantial time and although there is evidence that this process is underway it remains ‘a work in progress’ for most LSCBs.

4 INFRASTRUCTURE TO SUPPORT THE OPERATION OF THE BOARD

4.1 Introduction

Lack of a clear and well defined structure that supported the operation of ACPCs was seen as a major weakness of the previous arrangements (Ward et al, 2004). In this chapter we explore how LSCBs have been establishing an infrastructure to support their work. In the first section of the chapter the development of the role of the Business Manager and other staff appointed to support the work of the LSCB are examined. Secondly, issues of finance and how Boards have been generating their resources to support activities are explored. It was proposed in Working Together that LSCBs may wish to construct Executive Groups and subgroups to help support their operation. The structures adopted and the role and purpose of these are examined in the final section of this chapter.

4.2 Resources and Staff

Working Together recognised that LSCBs need to be adequately resourced to function effectively (Box 8). In terms of staffing, a number of Boards have created Business Manager posts to help process work effectively.

Box 8

To function effectively LSCBs need to be supported by their member organisations with adequate and reliable resource.

Section 15 of the Children Act 2004 sets out that statutory Board partners (or, in the case of prisons, either the Secretary of State or the contractor) may:

- *make payments towards expenditure incurred by, or for purposes connected with, an LSCB, either directly, or by contributing to a fund out of which payments may be made;*
- *provide staff, goods, services, accommodation or other resources for purposes connected with an LSCB.*

The budget for each LSCB and the contribution made by each member organisation should be agreed locally. The member organisations' shared responsibility for the discharge of the LSCB's functions includes shared responsibility for determining how the necessary resources are to be provided to support it.

Source: Working Together to Safeguard Children, Section 3.74, 3.75 and 3.76.

4.2.1 The development of the Business Manager role

This new but important post has emerged in most LSCB infrastructures. 88.7 per cent (93 out of 105) of LSCBs have created this new post. 60 per cent are full time, 25.7 per cent are part-time with 2.9 per cent not indicating whether they were full or part time. The role of the Business Manager varies across LSCBs. The functions they fulfil may be defined locally based on what is needed for the Board to function effectively:

'Well, I'm actually business support, so it's all about agenda setting, it's about supporting all the subgroups, working very closely with someone else who is my PA to make sure the minutes are sound and correct. Supporting [the Chair] in his role as Independent Chair, and making sure that everybody does their business really.'

(Business Manager)

'It's about managing the work of the safeguarding Board, so it's setting up the subgroups when there's actions that need completing for serious case reviews…also in that job I'm a child protection lead for the local authority.'

(Business Manager)

Business Managers often seem to be responsible for the day-to-day management of the Board, which can be very demanding in terms of time. It is clear, then, that the Business Manager's role can incorporate a wide range of tasks, and they appear to be invaluable to Chairs and are beneficial in various different ways. For example, one Chair said:

'The great advantage of having a full-time Board manager is they're steeped in it, my head at various times is all over the place.'

(Chair)

However, Chairs are also aware that the Business Managers role is broad, and in some ways, impossible:

'[The Business Manager] was managing the whole thing, the job was enormous, absolutely enormous and I used to be concerned in some ways about [this because] I knew the hours he worked and he was really given an impossible job.'

(Chair)

At a basic level the Business Manager is actively involved and responsible for a wide range of significant administrative duties. This can include setting agendas, ensuring minutes are circulated and managing the wider administrative team. The administrative teams can be quite large, and the Business Manager will often be required to line manage at least some of those team members:

'The permanent team….is me, a policy officer, a training officer and originally it was one admin worker, it's now a policy officer, who I line manage, a training officer who is line managed within Children's Service learning development environment and three administrators.'

(Business Manager)

Their role may go beyond this and include responsibility for overseeing or managing training commissioned by the LSCB. As one Business Manager outlined:

'Some of the other big aspects of it is training, because I have two trainers, we have a huge training programme…so we also manage that in terms of the training programme and how it's delivered and I deliver some of it myself.'

(Business Manager)

The administrative tasks can be spread across a wide range of functions of the Board. For example, they can also be responsible for managing the subgroups and will often attend all the subgroup meetings to ensure that agendas and action plans are being pushed forward. In one area, for example, the Business Manager was a member of all LSCB subgroups and had a key role in managing and maintaining them, ensuring they had agendas and were delivering on their responsibilities. Similar responsibilities existed over Serious Case Reviews and Child Death Overview Panels. Business Managers could find themselves having key

roles in ensuring that everyone is aware of their responsibilities, and that management reports are written on time and that any recommendations are put in to place.

> *'The time I give to [serious case reviews] is more about overseeing the processes and helping people to understand what they needed to do, lay that out and sort of advise people around that.'*
>
> (Business Manager)

Other roles that Business Managers take on relate to some of the wider responsibilities of the LSCB. For example one Business Manager explained how they had taken on the role of the Local Authority Designated Officer (LADO) for their LA and therefore were dealing with allegations against staff. Business Managers also became more involved in the effective functioning of Boards, with some indicating that they had a role to 'challenge' the way things were being done and to make sure that the right issues were raised and being addressed by the Boards.

> *'Critical friend kind of support and challenge role of my role…but it's a sort of a supported challenge I am there to say to, you know sort of raise issues and say you know the police really aren't engaging with the training or whatever and raise that.'*
>
> (Business Manager)

One important issue to recognise is that Business Managers are often paid from the contributions which agencies make, and are therefore hired by the LSCB, not by individual agencies.

> *'I'm multi-agency funded, I'm multi-agency accountable you know, so I'm here for you as much as I'm here for you know anybody else really.'*
>
> (Business Manager)

However, in some cases, individual agencies pay for particular roles on top of their contribution to the LSCB:

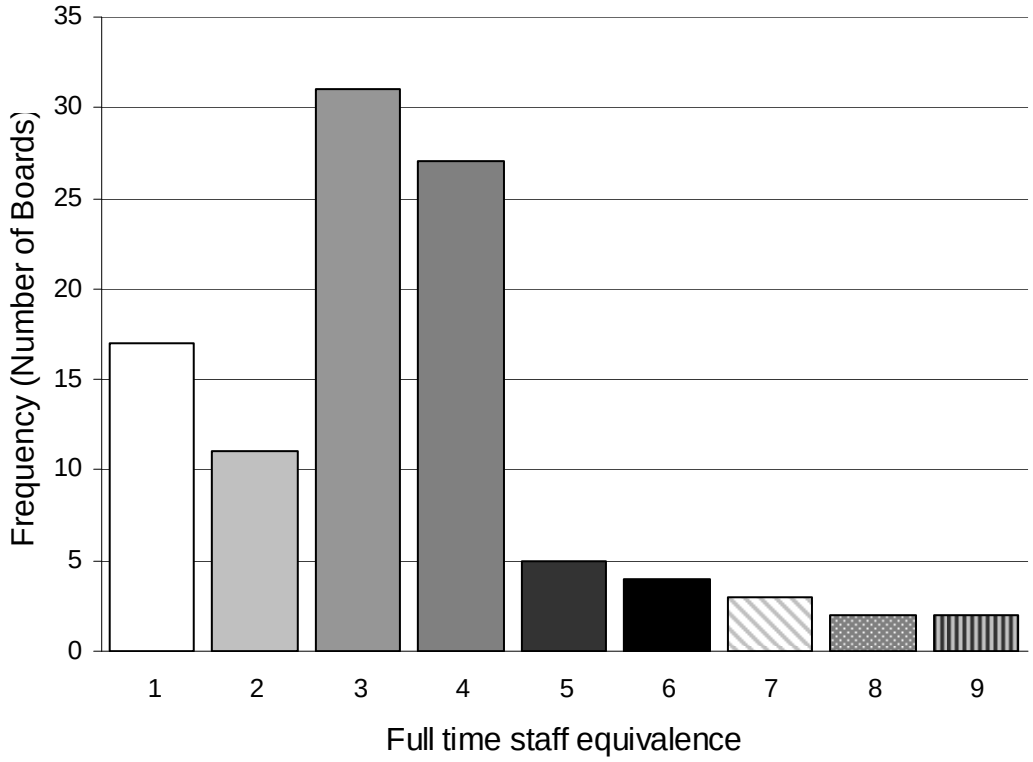
> *'Some of our salaries are paid by the local authority, but not as part of a contribution to the safeguarding Board…everybody else is multi-agency paid.'*
>
> (Business Manager)

4.2.2 Other staff employed in safeguarding

LSCBs have also employed a wide range of other staff. Many of our case study areas had employed Administrators, Safeguarding Managers, Audit Managers or specialist workers responsible for supporting certain aspects of the work (administrator to Serious Case Reviews). Each area employed people as was thought appropriate for their own circumstances and linked to their plans under their own Business Plans. These posts have been funded from a wide range of sources. In some cases they are funded from the main Safeguarding budget, whereas in other cases they can be secondments from other agencies. In our case study areas agencies such as health allocated specialist people to the Safeguarding Board to help it function more effectively. These costs would be covered by the agency themselves and not included in the overall contributions identified in annual budgets. Many of these posts could be temporary or part-time which makes it difficult, at any one time, to gain clarity about exact numbers. In our survey we asked Chairs to indicate the number of posts they had working for the LSCB. To make it easier to understand we have converted part time into full time equivalence to try to get a clearer idea of the spread of resources

across the LSCBs[20] (see Figure 1). Of the 102 LSCBs where data was available, 86 had less than four full time members of staff. Four had no staff at all. Issues of resources were always a key factor in the type of structure they could construct, which will be discussed further in the next section. A point we shall discuss in the next section.

Figure 1 Number of Posts



Key to chart:
1 = equivalent to less than 1 full time member of staff.
2 = equivalent to at least 1 full time member of staff, but less than 2 full time members of staff.
3 = equivalent to at least 2 full time members of staff, but less than 3 full time members of staff.
4 = equivalent to at least 3 full time members of staff, but less than 4 full time members of staff.
5 = equivalent to at least 4 full time members of staff, but less than 5 full time members of staff.
6 = equivalent to at least 5 full time members of staff, but less than 6 full time members of staff.
7 = equivalent to at least 6 full time members of staff, but less than 7 full time members of staff.
8 = equivalent to at least 7 full time members of staff, but less than 8 full time members of staff.
9 = equivalent to at least 8 full time members of staff.

[20] For example, an LSCB with one full time staff member and two part time members each working 50 per cent of a full time post, would have the equivalent of two full time members of staff. There were 102 LSCBs which were included in this analysis. It was not possible to determine the staff full time equivalence for the others.

4.3 Impact of Finance

Hardy and colleagues (1992) identify how differences between organisations in planning, budgetary cycles and process as well as differences in funding mechanisms and resources can hinder inter-agency working. Chairs in the survey were asked if they thought the budget was adequate for their LSCB to function effectively. 54.3 per cent said no and 43.8 per cent said yes[21]. This was investigated further by asking those who thought the budget was inadequate to explain the impact this had on the operation of their LSCB (Table 14). The biggest impact was seen to be that it reduced the number of issues the Board could address. The second biggest impact was on the ability of LSCBs to focus on communication.

[21] Two LSCBs were excluded due to missing or unclear responses.

Table 14 What is the effect of an inadequate budget?

Effect of inadequate budget	Ranking (1 = most important)								Number of LSCBs
	1	2	3	4	5	6 or lower	Not Applicable	Missing*	
Reduced the number of issues the Board could address	20	12	15	2	0	0	3	5	57
Less resources to focus on communicating	14	21	12	4	0	0	1	5	57
Limited capacity to identify training priorities	10	9	10	10	0	1	10	7	57
Created tension among Board members	5	7	6	10	0	3	11	15	57
Other impacts	11	2	3	2	1	1	0	38	57

*The 'missing' column shows how many of the 57 LSCBs did not rank a particular role, or indicate it was not applicable. Columns may sum to more than 65 because multiple responses were required to this question.

Securing the finance needed to run a LSCB effectively was a major challenge to Chairs and Business Managers. In our interviews it was identified that the absence of a funding formula had proved problematic for LSCBs as they have been left to negotiate with partners on contribution levels. There are considerable tensions and variations in agencies' willingness and capacity to contribute to the operation of the LSCB:

> *'Where there are tensions is about saying and doing, and it comes out in the budget…. we've had tense debates about the relative proportions of money that people should pay, and whether they're going to or whether they're not going to, or whether they can.'*

A number of our case study Boards attempted to identify an annual budget through their Business Planning process. This was seen as the most effective way of developing a long term strategy to implement work in an area, as it involved local agencies being partners to future plans. This would then require them to recognise that they had to provide adequate funding to support what had been agreed in the Business Plan. Implementing this model was not without its problems. Some agencies made contributions based on what they could afford rather than what was needed. There are three potential reasons for this. Firstly, agencies with a national responsibility that are required to make a contribution under Working Together, for example CAFCASS have found this difficult. As a result they have tried to set a 'national limit' that is to be shared out across all the LSCBs. This model is in conflict with setting budgets that address local needs. Secondly, some of the agencies with smaller budgets have found it difficult to provide a proportion of the annual budget requirements. Getting money out of these agencies has been difficult for LSCBs and involves Chairs or Business Managers in regular negotiations (usually for small amounts of money). These problems are annual and can be made more difficult if their agency budgets are being cut while the LSCB is asking for increases. Finally, and most importantly, tensions exist with those agencies that have to service more than one LSCB. This is usually a major issue for the police and health service. Arguments over 'local need' versus what agencies can realistically afford has been a significant problem for setting annual budgets. For example, in one area where the police had to service a number of LSCBs they decided to split the money equally across the local areas. The result for our case study area was that the contribution received was below what was needed to implement the Business Plan.

These difficulties created the following problems:

- LSCBs could find themselves having shortfalls in their planned budgets which could mean they may be unable to deliver on all priorities they had identified. One area that seemed to suffer most was training.

- The process of securing the annual budget could be very time consuming. The Chair and / or Business Manager spent a substantial amount of their time on trying to ensure financial contributions are made.

- Planning beyond a twelve month period seemed virtually impossible for most LSCBs. This could also be made more difficult if a number of agencies set budgets at different times of the year. This serves to undermine capacity for strategic planning.

- Gaps in budgets put pressure on Children's Services to make larger contributions than they planned for.

- Conflict and tensions could arise between LSCBs. Some Chairs could be better at negotiating for resources than others. Discrepancies in income from agencies such as health could exist, not because of a funding formula, but because some Chairs had managed to negotiate a better deal for their Board.

One other major impact on budgets was Serious Case Reviews (SCRs). These can be costly to run and manage. It is not possible for an LSCB to predict how many SCRs will need to be undertaken in a given year. This makes accurate budgeting difficult and Boards could have to return to participating agencies to ask for more contributions which could cause further tensions.

Children's Services usually made the major contribution to the LSCB budget. They found themselves taking on most of the additional costs that came with running an LSCB. In a number of areas the 'in-kind' contributions had come from Children's Services. These contributions tended not to be part of the annual budget set by the LSCB but remained important for the LSCB to function effectively. For example, in one area the Business Manager was funded not by the LSCB but by the LA (via Childen's Services). In another area administrative support was provided by members of staff in Children's Services. Other agencies could be more committed and provide extra support over and above what was agreed. For example, in one area Health agreed to pay fifty per cent of the costs to a new post that was needed.

4.4 Executive Groups

Box 9

It is possible to form a 'core group' or 'executive group' of LSCB members to carry out some of the day-to-day business by local agreement.

Source: Working Together to Safeguard Children, Section 3.69.

Working Together states that Boards may establish an Executive or Core group to carry out some of the LSCB's day-to-day business (see Box 9). The role and functions adopted by Executive groups may vary considerably, depending upon the size of the main LSCB and the nature of the tasks that it is agreed locally that they will undertake. The mapping data shows that 81 (65 per cent) of Boards have an Executive group. Executive groups tend to meet bi-monthly (32.8 per cent) or quarterly (25.4 per cent) (Table 15). A slightly higher percentage of LSCBs who met quarterly had an Executive group compared to those who met bi-monthly.

Table 15 How frequently does the Executive group meet?

Main Reason	Frequency	Per Cent
Monthly	12	17.9
Every 6 weeks	12	11.4
Bi-monthly	22	32.8
Quarterly	17	25.4
Other	4	6.0
Total	**67**	**100.0**

The smallest Executive group has four members and the largest has 30. The mean average is 12 and the median is 11. Six areas have Executive groups that are larger than their LSCB and two Boards have Executives which have no members of their LSCB on them. In terms of seniority, there are 44 LSCBs where the average seniority of the Executive group is higher

than that of the LSCB Board. However there is little difference between the Executives and the LSCBs in the 'spread' of seniority on Executives and main Boards. While one might expect an Executive to have more members who are of the highest seniority (1 or 2 in our analysis[22]), this is not in fact the case. There are still more members with responsibility for a smaller sub-section or team within their organisation (3 or 4) than senior professionals with overall responsibility for their entire organisation or a large department (1 or 2). The table below shows the percentage of all members of the Executive board for each level of seniority in comparison to the percentage for LSCBs. It shows quite clearly that there is little difference in the seniority of Executive groups and LSCBs. This suggests that the Executives are tending to reflect the distribution of membership of the LSCBs and are not operating to create a forum for more senior managers.

Table 16 Executive Seniority

Seniority	Number of Statutory Members[23]	Per Cent
1 and 2	181	32 (39 LSCB)
3 and 4	359	65 (56 LSCB)
5	32	5 (5 LSCB)

Survey data indicated that the main reason for forming an Executive group was to separate out operational from strategic issues (47.8 per cent Table 17). As Table 18 shows, in response to a question about the key roles that the Executive fulfils, 17 Chairs rated 'dealing with operational business' as most important. A further 13 per cent ranked this as second most important. Overall, however, identifying LSCB priorities was most commonly chosen as the most important function of the Executive group. 22 Chairs ranked this as most important and a further 13 ranked this as the second most important function of the Executive group. However, variations in perspective are evident and 18 Chairs saw 'making recommendations for the LSCB to consider' as most important.

Table 17 What was the main reason for forming an Executive group?

Main Reason	Frequency	Per Cent
To separate operational from strategic issues	32	47.8
To deal with day to day business	11	16.4
LSCB too big, meetings unmanageable	8	11.9
To monitor subgroups and identify strategic priorities	7	10.4
To take strategic decisions for the Board	5	7.5
Don't know	1	1.5
Other	3	4.5
Total	**67**	**100.0**

[22] Classifications of seniority are outlined in Annex B.
[23] Statutory members include all those identified in Section 3.58 of Working Together.

Table 18 What is the role of the executive group?

Roles	Ranking (1 = most important)								Number of LSCBs
	1	2	3	4	5	6 or lower	Not Applicable	Missing	
Makes recommendations for the LSCB to consider	18	17	19	9	0	0	1	1	65
Identifies LSCB priorities	22	13	11	8	3	1	3	4	65
Deals with operational business	17	13	9	12	7	1	2	4	65
Deals with strategic business	5	10	6	11	17	2	10	4	65
Reduces the workload of the LSCB	3	10	12	14	17	1	7	1	65
Other roles	4	2	5	1	0	0	1	52	65

Two LSCBs with Executive groups did not respond to this question and have been excluded from this table. The 'missing' column shows how many of the 65 LSCBs did not rank a particular role, or indicate it was not applicable. Columns may sum to more than 65 because multiple responses were required to this question.

Three of our six case study areas established an Executive group. Once in place they were identified as helpful to facilitating day-to-day decisions and enabling background work to be undertaken so that Board meetings could really focus on the main issues.

> *'I think we realised quite quickly that it would be far too cumbersome to manage it any other way…we had to have an Executive that was going to do a lot of business in-between meetings.'*
>
> (Chair)

> *'I think the Business group does a lot of the nitty gritty work and makes sure it's done and then things are reported to the Board.'*
>
> (Chair)

The mapping data shows that there are wide variations in how LSCB executives are structured and on the membership of these groups. As one Business Manager put it:

> *'No two of us are the same probably, the Executive board at [another LSCB] looks like our Children's Board.'*
>
> (Business Manager)

Major challenges existed for LSCBs in having Executive groups. As Table 19 shows, 27.7 per cent of those with Executive groups felt the main challenge was being able to separate out what tasks should be undertaken by the Executive group and what should be done by the main LSCB. 23.1 per cent suggested that being a member of the Executive created a heavier workload for those involved and 23.1 per cent thought that a major challenge was keeping other LSCB members involved in the decision making process. One of the case study Chairs indicated that the latter point had influenced their decision not to establish an Executive group. It was suggested that introducing an Executive and delegating certain decisions to this smaller group could mean that the wider Board would potentially feel excluded and like 'second level citizens'. The case study areas that had not introduced an Executive structure tended to view the main LSCB as the 'Executive' with the subgroups acting as more operational forums.

Table 19 What are the main challenges of having an Executive group?

Challenges	Frequency	Per Cent
Separating out LSCB tasks and Executive group tasks	18	27.7
Keeping other LSCB members involved in decision-making process	15	23.1
Creates a heavy workload for the Executive	15	23.1
Having clear lines of accountability	7	10.8
Other	6	9.2
No challenges encountered	4	6.2
Total	**65**	**100.0**

Two LSCBs with an Executive group did not respond to this question.

4.5 Subgroups

Having subgroups as a part of the LSCB infrastructure is recognised in Working Together as a mechanism to help Boards manage the workload, obtain specialist advice and involve a wider body of partners.

Box 10

It may be appropriate for the LSCB to set up working groups or subgroups, on a short-term or a standing basis, to:

- *carry out specific tasks, for example: maintaining and updating procedures and protocols; reviewing serious cases; and identifying inter-agency training needs;*
- *provide specialist advice, for example: in respect of working with specific ethnic and cultural groups, or with disabled children and/or parents;*
- *bring together representatives of a sector to discuss relevant issues and to provide a contribution from that sector to LSCB work, for example: schools, the voluntary and community sector, faith groups; and*
- *focus on defined geographical areas within the LSCB's boundaries.*

Source: Working Together to Safeguard Children, Section 3.68.

While all LSCBs in the mapping survey had subgroups, data on specific subgroup types was only available for 122 Boards. The lowest number of subgroups per Board was two and the highest was 20. The average number was six (mean of 6.7; median of 6). Table 20 outlines the main type of subgroups that LSCBs have constructed to assist them in meeting their core responsibilities. Training was the most common subgroup (90 per cent) followed by Policies and Procedures (73 per cent) and then Quality Assurance (43 per cent).

Table 20 Specific task subgroups

Type of Subgroup	Number of Boards	Per Cent
Policies and Procedures	89	73
Training	110	90
Monitoring and Evaluation	26	21
Audit	10	8
Performance Management	28	23
Chairs of Subgroups	9	7
Quality Assurance	52	43
Staying Safe	14	11
Media and Communications	43	38

LSCBs have also established 'specialist advice' subgroups. The most common were e-safety (38 per cent) and employment/recruitment and Managing Allegations (31 per cent).

Table 21 Specialist Advice Subgroups

Type of Subgroup	Number of Boards	Per Cent
Domestic violence	21	17
Missing / runaway children	14	11
Anti-bullying	18	15
Hidden harm	10	8
E-safety	46	38
Sexual exploitation and trafficking	27	22
Prevention	19	15
Employment / Safer recruitment / Managing allegations	38	31
Ethnic or cultural groups	4	3
Disabled children	5	4
Private fostering or looked after children	9	7
Other specialist advice groups	5	4

A smaller number of LSCBs had sector focused subgroups (see Table 22).

Table 22 Sector Focused Subgroups

Type of Subgroup	Number of Boards	Per Cent
Faith	7	6
Professional single sector	33	27
Voluntary and community	3	2

As the mapping data demonstrates there are wide variations in both the number and the type of subgroups that LSCBs have established. A Board may establish subgroups which are time limited and focus on a specific piece of work; they may establish more practitioner focused groups and/or they may establish very issue-focused groups to address specific local needs. One Business Manager indicated that:

> *'We have working groups that just do the piece of work and then fold, we have four sub audit groups which meet quarterly which reports to the main audit group, so that's five, we have four multi-agency practitioner groups that meeting quarterly, then we have the mapping hub group, so that's another five, we have two protocol groups at the moment, we have a training subgroup….that's about 12/13 isn't it, so quite a lot of them.'*
>
> (Business Manager)

Working groups facilitate focused work on a specific topic or priority issue that an LSCB has identified as important to safeguard and promote the welfare of children in the local area.

As Table 20 shows, the *specific type* subgroups are the most common, with Training, Policies and Procedures and some type of Audit or Performance Management group being established by the majority of Boards. In some areas, Policy and Procedure documents are shared between areas and are therefore written by an overarching group:

> *'The safeguarding Board doesn't do policies and procedures, there's a subgroup called [regional area of England] policies and procedures subgroup…that group looks at the procedures across the [regional area of England] and decides which procedures from different authorities are going to be part of it, or going to be adapted to be cross regional.'*
>
> (Business Manager)

Other areas, however, have chosen to keep the task of writing policy and procedures with the main Board:

> *'If we're talking about wanting a new policy or new procedure on something it will inevitably start here [on the LSCB].'*
>
> (Chair)

It is seen as vital that people with relevant expertise are members of subgroups, but also that there are a range of agencies represented on the subgroups. It is one mechanism to increase the number of agencies that are actively engaged. LSCBs may be seen as central but subgroups may be where 'the real work goes on'.

> *'Well everybody wants to be on the Board for some reason, and the message I give people is that's the dull place, where you actually probably want to be is one of the sub-committees.'*
>
> (Chair)

Establishing and maintaining subgroups is not without challenges and there is evidence from our interviews that attendance levels at some subgroup meetings can be low, and this may have an impact on their effectiveness. As one Chair stated:

> *'Some of the other sub-committees were struggling in terms of continuity and attendance.'*
>
> (Chair)

That being said there was a general feeling across the case study areas that subgroups have a critical role to play and that they help Boards tackle operational issues. The general consensus among our interviewees appeared to be that the subgroups were where most of the work of implementing LSCB decisions takes place.

LSCBs are trying to find effective ways of making subgroups more accountable. As one of our Business Managers stated:

> *'We've kind of brought them in more and made them a bit more accountable and linking it with the Board.'*
>
> (Business Manager)

Subgroups tend to share information or communicate with LSCBs by using minutes and regular written reports (65.7 per cent). Only 22.9 per cent said verbal feedback from the subgroup Chairs was the main means of communication. Subgroups are seen as accountable to the main LSCB and also feedback to the LSCB. In some cases there is an update from the subgroups at every meeting (depending on the frequency of Board meetings) while in others this is less frequent:

'There is now reporting arrangements on every quarter they report back on their action plans to the Board to say we've done this, we haven't done that.'

(Business Manager)

Setting priorities for the subgroups was usually undertaken through consultation with the group (41.3 per cent) although many of the LSCBs took responsibility for defining the priorities (39.4 per cent). Interestingly no Board allowed subgroups to set their own priorities. The Training subgroups were seen to be most effective, (34 per cent) with Monitoring and Evaluation (17 per cent) and Policies and Procedures (16 per cent) also identified by a number of LSCBs as the most effective groups. In our interviews the subgroups were generally seen to be fairly effective overall:

'I would say that they appear to work very well because they get given a lot of work and they appear to generate it back in the right form.'

(Chair)

There were very few complaints about their operation. Survey responses indicated that reasons for their effectiveness (see Table 23) included 'having committed and engaged members' (78 LSCBs) 'having clear terms of reference' (73 LSCBs) and 'including representatives with specialist knowledge' (63 LSCBs).

Table 23 What makes a subgroup particularly effective?

Reasons for Efficiency	Frequency
Committed and engaged members	78
Clear terms of reference and shared understanding of priorities	73
Includes representatives with specialist knowledge	63
Includes representatives involved in frontline practice	42
Has an explicit communication strategy	28
Other reasons	11
Number of LSCBs who answered this question	**100**

The responses sum to more than 100 because multiple responses were permitted for this question

4.6 Conclusion

LSCBs have created various structures to support their operation. Four-fifths have established Executive groups. Although the roles fulfilled by these groups vary, an important reason for their formation is the separation of operational issues from strategic business. A key function for many appears to be the identification of LSCB priorities. Boards also have a wide range of subgroups to support their work, both in terms of development of policies and procedures and focused work to address safeguarding issues affecting children and young people in the local area. The effectiveness of these is influenced by levels of commitment, clear priorities and terms of reference. To assist with the effective operation of the LSCB the majority of areas have appointed Business Managers and additional support staff. 43.8 per cent of Chairs feel that the budget available to support their work is inadequate and this can create tensions between Board members as well as influencing the breadth of work they can realistically take on.

5 COMMUNICATION, INFORMATION SHARING AND RELATIONSHIPS WITH OTHERS

5.1 Introduction

Effective coordination of local work to safeguard and promote the welfare of children is reliant on good communication and information sharing between individuals and agencies (Ward et al., 2004). This chapter examines the means by which LSCB members communicate policies and procedures and more general information to their own agencies, as well as the networks and links that have been made to communicate with those organisations that are not represented on the Board. It then goes on to explore the relationships that LSCBs have developed with neighbouring areas and Children's Trusts and considers the contribution that these links make to their work.

5.2 Communication and Information Sharing

Mechanisms to ensure that information is communicated from the LSCB to agencies are important. Survey data suggest that nearly 50 per cent of Boards (47.5 per cent) see Board members as having responsibility for communicating policies and procedures to their own agency. Interviews with Chairs and Business Managers indicated that individual Board members were responsible for this, however, they were less certain about how far this was happening and whether information was reaching the appropriate staff:

> *'It's difficult to know if it's happening in terms of the information sharing until you get a specific issue that you do a random audit…Obviously people say they're doing it, but it's only when you try and implement policies or procedures in your random sample that you find out if people have actually got the information.'*
>
> (Business Manager)

> *'There is a big issue with agencies, bigger agencies letting people know about their serious case reviews…often it doesn't filter down, it doesn't filter down, you know and then there is a big why didn't anybody know? Oh that is terrible you know and it's shocking and I think well you're accountable in my view, the person sitting around the table.'*
>
> (Business Manager)

> *'Communication to other agencies and externally to the Board, but across the workforce and you know it is a really wide and varied work force so I think that, between agencies and Board members I think it is reasonable…but I think it could be improved if there was a wider strategy.'*
>
> (Business Manager)

Other mechanisms are also used to communicate policy and procedures (Table 24). For example, the use of web pages (18.2 per cent), training (17.2 per cent) and regular newsletters (6.1 per cent) are seen as alternative routes to circulate information.

Table 24 What is the main way the LSCB communicates policy and procedures?

	Frequency	Per Cent
LSCB members ensure their agencies are aware of, and use, available material	47	47.5
Expect all professional groups to access material from webpage	18	18.2
Deliver or monitor training on policies and procedures	17	17.2
Circulate regular newsletter and other briefing material	6	6.1
All of the above	5	5.1
Other	6	6.1
Number of LSCBs who answered this question	**99***	**100**

*Six LSCBs did not respond to this question.

Interviews with Chairs and Business Managers revealed that disseminating information to frontline practitioners was still seen as a challenge, although one LSCB had created multi agency forums where information could be distributed and discussed in more detail. These forums also provided an opportunity to get feedback from staff about what information they need:

> *'Every quarter of accounting we see groups of practitioners, and there are people who run those groups for us and we say to them, right ask this question, see what response we're getting for this sort of issue.'*
>
> (Business Manager)

Working Together recognises that the LSCB should also make contact with a range of organisations and develop networks and forums to facilitate communication (Working Together, 3.62). LSCBs have been very active in trying to build and maintain networks. As outlined in Table 25 the degree of communication varies across agencies and sectors. Difficulties have been encountered in establishing effective communication with the independent health sector; of the 49 who identified links 39 felt the degree of communication was either limited (10 respondents) or not developed (29 respondents). Communication with GPs was also seen as weak, with 40 out of 85 LSCBs viewing links as either limited (33 respondents) or not developed (seven respondents). Half of those who identified network links with faith groups felt communication was limited (31) or not developed (14). In education, communication with state schools was seen as strong (with 54 seeing it as well developed and 30 to some extent). Links with independent schools were weaker, with 39 out of 73 LSCBs stating communication was limited (21) or not developed (18). Similar distribution figures were evident for non-maintained or special schools.

Table 25 Degree of communication with local organisations if communication is via a network or forum

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

While the information in Table 25 suggests strong communications with the third sector, interviews with Chairs and Business Managers highlighted that there remained a challenge understanding and accessing the views of smaller organisations.

> *'I mean there is the NSPCC are involved and NCH are involved…but I think there may well be some of the smaller organisations that it would be helpful if we could target particular work with them and I think…it's a bit I would like to see improve and I think about making safeguarding more real because I think there must be all sorts of things going on in the individual organisations that the safeguarding Board ought to know about, but I'm not sure those links are there sufficiently.'*
>
> (Chair)

Boards appear to have been trying hard to find ways of actively engaging the third sector and sharing information with them. It was clear that it is often the voluntary sector who have face-to-face contact with vulnerable children and therefore need to be aware of policies and procedures. However, it was often a challenge for the LSCB to disseminate information effectively to this group:

> *'The voluntary sector it's an entirely different challenge isn't it, you know, to disseminate information.'*
>
> (Chair)

One area for example had run a large conference and found massive interest, recognising that the challenge is how to get access and how to resource the work:

> *'There's just been a massive voluntary sector conference on safeguarding, it was meant to be for one day, but we've now had it for two days because we had so many people wanted to come….it's not a lack of want for the voluntary sector, it's a lack of access and resource.'*
>
> (Business Manager)

5.3 Relationships between neighbouring LSCBs

In our survey 95.2 per cent of LSCBs reported having some kind of formal or informal relationship with other Boards. In all but one case these relationships were seen to be positive and to offer a helpful contribution to the work of the LSCB. For example, 93.8 per cent (Table 26) of survey respondents said that links with other LSCBs helped them develop their policy and procedures. 89.7 per cent felt that it helped them share learning and information and 87.6 per cent indicated that relationships had been established in relation to the Child Death Review Processes.

Table 26 How relationships between neighbouring LSCBs help

	Frequency	Per Cent
Helps in the development of policy and procedures	91	93.8
Helps LSCB share learning and information	87	89.7
Helps undertake Child Death Review processes	85	87.6
Helps the LSCB in its strategic development	59	60.8
Is not very helpful	1	1.0
Other	5	5.2
Number of LSCBs who answered this question	**97***	**100**

*Five LSCBs did not have established links with their neighbours and two LSCBs which did have links did not respond to this question.
This table sums to more than 100 per cent because multiple responses were allowed.

The survey data suggests that most LSCBs are forming some sort of relationship with other Boards. There can be different reasons for developing relationships, including establishing Child Death Overview Panels (CDOP) (addressed in Chapter 6), sharing policy and procedures (discussed in Chapter 4) and regular meetings between Chairs and / or Business Managers. These meetings can be more formal, such as with the Pan-London Safeguarding Board, or more informal where the Chairs of a number of Boards have decided to meet up to share information. There can also be very informal links whereby personnel from one Board may know personnel from other Boards and be able to contact them because of previous informal relationships.

There are many benefits of linking with other LSCBs. For example, it allows Board members, Chairs and Business Managers to learn from one another. This was seen as particularly important for Business Managers. As one suggested, the Business Manager of an LSCB is a unique role within a LA and being able to discuss issues and challenges with others helps Business Managers to get different perspectives:

> *'So it's quite a useful way of getting a bit of peer contact, a bit of networking as well, because Safeguarding Board Manager is quite an isolated position in a way because there's nobody else in the authority that does it…so it is quite useful to get a perspective of Safeguarding Board Managers.'*
>
> (Business Manager)

Chairs also recognised the important contribution it could make to the development of LSCBs:

> *'I guess that's one of the advantages of regional networks isn't it, is that you can have a support network, a learning network and find kind of good practice out there.'*
>
> (Chair)

5.4 Formal relationships with other Boards

There is a wide variation in how formal working relationships and communication networks between Boards are. LSCBs can and do collaborate over a wide range of activities such as producing policy and procedures for the region, sharing information and learning, developing training and webpage development. This is usually seen as very productive. One approach has been to develop formal collaborations. One example of this is the Pan-London Safeguarding Board. This is a regular meeting forum of the Chairs of London LSCBs. This is seen as having positive benefits and helps Boards maintain a consistent approach across geographical boundaries:

> *'The great benefit is that we use the one set of procedures across the whole of London, and that matters tremendously because…you can take a bus journey of ten minutes and can cross four different boroughs.'*
>
> (Chair)

Other regions have similar pan-regional Boards and they have clearly been an important source of help to local LSCBs in developing coherent material to help with operations. This has brought important savings in terms of time and resources yet there can be some confusion about what the role of these Boards should be:

> *'Well I don't think they should be called the London Safeguarding Children's (sic) Board for a start, because it isn't, and I think that's what part of the problem is, because people therefore want to treat it as a Board, particularly the police'*
>
> (Chair)

As outlined in the above quote the tension is in how such activities are profiled across London and the risk is that it confuses and blurs the distinctive responsibilities of individual LSCBs. It also raises concerns about resourcing the activity, as there is a danger that if it is seen as a Board, expectations about how much resource a local LSCB should contribute may be raised. Given the pressure on the limited resources LSCBs have there is a fine line to be drawn about participation in the regional activity. For example, in the quote below the Chair highlights the potential benefits of this activity yet also suggests this will require four meetings a year:

> *'There's a meeting this week actually of the [regional] network for Safeguarding Boards, and it's been going I'd say for about a year, I think we've probably had four meetings, we meet every quarter and it's basically Chairs and Safeguarding Board Managers and sometimes people from Safeguarding Boards, members of Safeguarding Boards, and really it's a forum to say look this is the issue, this is what we're doing, we're worried about this, or for the government of the [region] to say this is what the government, the latest government directive is.'*
>
> (Business Manager)

Other areas indicate that meetings are more regular with all Business Managers in a region meeting every month and Chairs also having their separate meetings. It would therefore seem that there is considerable variation in how often these regional networks meet, and who is a part of them.

5.5 Relationship between the LSCB and Children's Trust

As outlined in Working Together (see Box 11) the working relationship between the Children's Trust and LSCBs needs to be clearly defined.

Box 11

The LSCB and its activities are part of the wider context of children's trust arrangements. The work of LSCBs contributes to the wider goals of improving the wellbeing of all children. Within the wider governance arrangements its role is to ensure the effectiveness of the arrangements made by individual agencies and the wider partnership to safeguard and promote the welfare of children.

The LSCB should not be subordinate to or subsumed within, the children's trust arrangements in a way that might compromise its separate identity and independent voice. The LSCB should expect to be consulted by the partnership on issues that affect how children are safeguarded and their welfare promoted. The LSCB is a formal consultee during the development of the Children and Young People's Plan.

The LSCB and the wider children's trust arrangements need to establish and maintain an ongoing and direct relationship, communicating regularly. They need to ensure that action taken by one body does not duplicate that taken by another, and work together to ensure there are no unhelpful strategic or operational gaps in policies, protocols, services or practice.

Source: Working Together to Safeguard Children, Section 3.51, 3.52 and 3.53.

Communication is a critical component of this process. Survey responses indicated that having the Chair of the LSCB as a member of the Children's Trust was seen as the most important mechanism of communicating information between the Children's Trust and LSCB. This was followed by production of written reports and the sharing of a common membership (Table 27).

Table 27 How is information communicated between the LSCB and the Children's Trust?

Method of Communication	Ranking (1 = most important) 1	2	3	4	5 or lower	Not Applicable	Missing	Number of LSCBs
Chair is a member of both Boards	68	9	2	3	0	13	8	103
Written reports provided between Boards	8	35	19	12	4	11	14	103
Chair of Children's Trust is a member of LSCB	13	10	3	0	1	46	30	103
Shares common members	9	24	31	17	11	5	6	103
Regular formal meetings with Chair of Trust	9	14	11	11	4	29	25	103
Exchange of minutes	2	7	17	21	11	26	19	103
Other methods of communication	3	5	3	2	3	0	87	103

Two LSCBs did not respond to this question. They have been excluded from this analysis.
The 'missing' column in the table shows the number of LSCBs which did not rank a particular method, or declare it to be not applicable.
If more than one 'other' method of communication is used by an LSCB, the highest ranking is shown in this table.

Having a clear demarcation of roles and responsibilities is important to facilitate the effective functioning of the LSCB and the Children's Trust. As Table 28 shows, 25 per cent said the demarcation was very clear, 49 per cent said it was clear and 25 per cent said it was not very clear with only one per cent seeing it as unclear.

Table 28 How clear is the demarcation of roles and responsibilities between the Children's Trusts and the LSCB?

	Frequency	Per Cent
Very clear	26	25.0
Clear	51	49.0
Not very clear	26	25.0
Unclear	1	1.0
Number of LSCBs who answered this question	**104***	**100**

*One LSCB did not respond to this question.

Table 29 Reasons why the demarcation of responsibilities between the LSCB and Children's Trust are clear or unclear

	Demarcation of Roles	
	Very Clear/ Clear	Not Very Clear/ Unclear
	Frequency	Frequency
Good working relations have always underpinned delivery of Children's Services	59	2
Clarity of roles and responsibilities has been embedded in all our professional practice	33	0
Agreement has been made between the two Boards which is continually evaluated	44	2
Confusing messages about roles and responsibilities are being given by central government	21	19
No formal arrangement has been put in place	3	17
The Children's Trust is still being constructed and clarity of roles and responsibilities has not yet been agreed	3	9
Although a formal arrangement is in place it does not work very well	1	4
There is disagreement between the LSCB and Children's Trust over roles and responsibilities	1	0
Other reasons	4	0
Number of LSCBs who answered this question	**75**	**27**

Three LSCBs did not respond to this question.

The most common reason why the demarcation between Children's Trusts and LSCBs was seen to be clear or very clear by survey respondents was based on a history of working together, that is, 'good working relations have always underpinned delivery of Children's Services'. 59 respondents saw this as one factor contributing to the clarity of roles and responsibilities between the Children's Trust and LSCB. Other important factors were agreement between the two Boards (with ongoing evaluation) (44 respondents) and clarity of roles and responsibilities being embedded in professional practice (33 respondents). In total 40 survey respondents felt that confusing messages were being delivered by central government concerning the appropriate demarcation of roles and responsibilities between the LSCB and Children's Trust. However, 21 of these respondents appeared to feel that they had still managed to establish 'clear' or 'very clear' arrangements at a local level.

Interview data revealed variations in the extent to which Chairs felt they had developed and clarified relationships between the LSCB and the Trust. Regular communication between the two is very important to ensure clarity about respective roles and how activities dovetail. The functioning of the Children's Trust can influence the demarcation of responsibilities. For example, in one area the Chair reflected that:

> *'The stay safe group of the Children's Trust have become much more advanced, very strategic…so that is now giving the Board the opportunity to say to the stay safe group, we think you need to do that, these are the standards you need to apply to and we would want to see the outcomes from that. Whereas in the past because there's nobody else to do it the Safeguarding Board would have done it.'*

Having the Chair as a member of this group was seen as critical in helping develop a shared understanding and minimise any confusion. The stage of development of the Children's Trust can also influence the roles that each adopted. For example, in one case study area the Children's Trust was still in the early stages of development. This meant that the LSCB were taking on some functions that may ordinarily be undertaken by the Children's Trust. It was felt these could be re-designated at a later stage, when the Children's Trust was more established.

5.6 Conclusion

The transfer of information from the LSCB to agencies is critical to their effectiveness. Primarily this is seen to be the responsibility of individual Board members. In practice, Chair and Business Managers were uncertain about the extent to which Board members were conveying information to their own agencies and whether this was filtered down to the appropriate staff. It was also evident from the survey data that communication and links with some organisations and groups could be better developed and are currently weak. This includes relationships with the independent health sector, GPs, faith groups and independent and non-maintained schools. While links with large children's charities were seen to be strong, Chairs identified that the voice of smaller third sector organisations might not be heard.

Relationships with other LSCBs were generally seen as valuable to the operation of LSCBs for a number of reasons, including: sharing learning, providing support and as a cost effective way of developing materials to support them in fulfilling their functions (for example, development of policies and procedures or training). That said, networking and joint working with other LSCBs is not without its own problems. Areas may have different needs and priorities.

Clearly the relationship between LSCBs and the Children's Trust is critical. The survey suggests that the demarcation of roles and responsibilities between these two is relatively clear. The Chair sitting on the Children's Trust was seen to facilitate the relationship between the LSCB and the Trust. Previous history of good inter-agency working relationships was also seen to assist with the establishment of clear boundaries and clarity of roles.

6 SERIOUS CASE REVIEWS AND CHILD DEATH REVIEW PROCESSES

6.1 Introduction

A core set of functions and responsibilities for LSCBs are Serious Case Reviews (SCRs) and Child Death Review Processes (CDRP). Rose and Barnes (2008) identify that:

> *Serious case reviews make an important contribution to understanding what happens in circumstances of significant harm. Their effectiveness can be improved and there are examples of promising approaches using the findings of serious case reviews to bring about improvements in safeguarding practice However, achieving such improvements require Local Safeguarding Children Boards to develop a much stronger learning culture within which serious case reviews are but one important source of knowledge for improving safeguarding practice* (p.3).

This chapter focuses on the decisions that LSCBs make about instigating reviews, the challenges that LSCBs have faced in managing the SCR process and how they have sought to overcome these. The second section of the chapter explores the processes and practices that have emerged to collect and analyse information about child death and the ways that LSCBs are handling these new responsibilities.

6.2 Serious Case Reviews

Box 12

When a child dies, and abuse or neglect are known or suspected to be a factor in the death, local organisations should consider immediately whether there are other children at risk of harm who require safeguarding (For example: siblings, other children in an institution where abuse is alleged). Thereafter, organisations should consider whether there are any lessons to be learned about the ways in which they work together to safeguard and promote the welfare of children. Consequently, when a child dies in such circumstances, the LSCB should always conduct a serious case review into the involvement with the child and family of organisations and professionals… Additionally, LSCBs should always consider whether a serious case review should be conducted:

- *where a child sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect, or*
- *has been subjected to particularly serious sexual abuse; or*
- *their parent has been murdered and a homicide review is being initiated; or*
- *the child has been killed by a parent with a mental illness;*
- *the case gives rise to concerns about inter-agency working to protect children from harm.*

Source: Working Together to Safeguard Children, Section 8.2.

Working Together sets out the circumstances in which LSCBs *should* undertake a SCR and when they should *consider* doing so (see Box 12). The mean average number of SCR completed over the past twelve months by LSCBs in our survey was 1.6 (median = 1)[24]. The frequency varied in that 23.2 per cent did not undertake any SCRs, 32.3 per cent undertook one, 23.2 per cent undertook two and 21.1 per cent undertook three or more. The most recorded was six (two per cent). The time LSCBs are spending on SCRs is likely to influence their capacity to fulfil their wider remit. Qualitative interviews with Chairs and Business Managers in case study areas revealed that they had different perspectives on the value of conducting SCRs when they were not required to do so. One Business Manager explained that:

> Business Manager: *Anecdotally there are other LSCBs that would not choose to have one [a SCR] where we would say the criteria was met.*
>
> Interviewer: *Thresholds vary?*
>
> Business Manager: *Yes…I think [this local area] seems to agonise rather a lot…look at what we've done wrong…they're quite reflective*.
>
> (Business Manager)

Elsewhere, a Chair indicated that they had taken a decision that SCRs would only be undertaken when it was absolutely necessary.

6.2.1 Resourcing SCRs

In our interviews with Chairs and Business Managers concerns were raised about the resource impact of doing a SCR. One Chair suggested that a SCR could cost over £12,000 and if this had not been budgeted for in the annual Business Plan, then the LSCB was in danger of being in deficit. In another case the Chair had to ask for extra resources from contributing agencies to avoid deficit. The major cost was related to staff time or the payment of independent authors. SCRs could create a huge demand on LSCB staff time, not only on the Chair and Business Managers but also on other LSCB members and participating agencies.

The mean average time a Chair spent on a SCR was 3.7[25] days, the median was 3. 23.8 per cent estimated spending three days of their time on a SCR and 20.6 per cent estimated spending four days. The maximum number of days a Chair indicated spending on a SCR was 10. This could be a problem for Independent Chairs when the time needed for this additional work was over and above what the LSCB was paying them. Additional payment had to be negotiated. Statutory Chairs had to find time to undertake this work as well as manage their existing workload, which for DCSs could be difficult.

In many cases Business Managers found themselves having to take a major role in driving the process and this was also very demanding on their time:

[24] Based on 99 responses.
[25] These figures are based on 63 LSCBs. The 13 other LSCBs did not say how many days the Chair spent on SCRs because it varied too much (8 LSCBs), or they did not know because the process was being updated (two LSCBs) or the Chair was a recent appointment who had not carried out an SCR (two LSCBs) or they did not respond to this question (one LSCB).

'Serious case review [take] a huge amount of time because we've had three in the last 12 months, and as you say it takes a lot of time coordinating that, and giving the feedback and analysis…And the work that comes out of those, so having to create subgroups for devising particular protocols or amended protocols or looking at particular pieces of work.'

(Business Manager)

This issue was clearly supported by data from the survey. The average (mean) number of days Business Managers were reported to spend on SCR was 15.2[26], the median was 12 and the maximum was 60 days. Table 30 provides a breakdown of the number of days, on average, that Business Managers were thought to spend on SCRs.

Table 30 On average, how many days does the Business Manager spend on SCRs?

	Frequency	Per Cent
1-5	10	18.2
6-10	16	29.1
11-15	11	20.0
16-20	9	16.4
20+	9	16.4
Number of LSCBs who answered this question	**55**	**100.0**

Having to negotiate with agencies, meet with those involved, read drafts of Independent Management Reports (IMR) and oversee submissions required a considerable amount of the Business Manager's time. Interview data from Chairs and Business Managers in case study areas also suggest that IMRs were demanding a substantial amount of time from a wide range of agencies. For example, in one LSCB the Designated Nurse was having to contribute to four SCRs at the same time. This work usually had to be done in addition to other responsibilities.

While Chairs and Business Managers clearly recognised the importance of SCRs and lesson learning, it was also clear that resource commitments and demand on staff time were a concern. This may influence LSCB decisions as to whether or not to undertake a SCR. It was also noted that the demands of SCRs have an impact upon a LSCB's capacity to fulfil their broader remit. As one Chair reflected:

'*Because the expectations are so great now in terms of Serious Case Reviews you know I've got managers just saying well I don't have time to do anything else now. And we're losing the wider safeguarding agenda because we're so busy concentrating on Serious Case Reviews.*'

[26] These figures are based on 55 LSCBs. The 21 other LSCBs did not say how many days the Business Manager spent on SCRs because it varied too much (six LSCBs), or they did not know because the Business Manager was a recent appointment who had not carried out a SCR (three LSCBs) or they did not have a Business Manager (two LSCBs) or it was not part of the Business Managers role to work on SCRs (five LSCBs). The other five LSCBs gave answers that could not be processed.

6.2.2 Concerns over quality

In the first year of Ofsted evaluations 20 out of 50 SCRs were judged to be inadequate (Ofsted, 2008). Survey data indicates that LSCB Chairs have major concerns about the quality of SCRs. For example, when asked if they had any concerns over the quality of IMRs 84.2 per cent of survey respondents said yes[27]. Similar concerns were expressed about overview reports, with 53.9 per cent saying they had concerns regarding the quality of these. All six case study areas were committed to the SCR process, lesson learning and improvement, however they were struggling with producing high quality SCRs. Reflecting the data above, the Chairs and Business Managers had major concerns about the quality of the IMRs produced by some of the agencies involved and the Overview Reports. They were conscious that getting this wrong could have major implications for how the LSCB was seen, how they were perceived as effective Chairs, and most importantly, how lessons learned could inform practice. A number of key issues were raised:

- Major concerns were raised about agencies having the *skills and knowledge* to conduct an IMR. A number of areas had returned submissions, asked for re-writes and/or insisted on further analysis.

- *Guidance and / or templates* were provided for IMRs in the majority of cases but agencies still struggled to follow these and produce quality reports. In some cases agencies ignore the template or just did not know how to construct analysis of their practice.

- For some agencies, especially in the third sector, IMRs could be very demanding. The *limited experience* of being involved in such a process was a major issue.

- Some agencies, especially those in the third sector, were still *not keeping good records of their work with children and families* and therefore gathering information for IMRs retrospectively could be problematic.

- *Recommendations of IMRs were poor and usually too general*. Examples existed of agencies making recommendations on practice that had radically changed (i.e. failures of early years service in the late 1990s leading to recommendations in 2008). Other recommendations could be impossible to achieve.

- In a small number of cases senior professionals would produce what they thought was adequate for the review and then refuse to change it. Challenging this and making them change their presentation was difficult.

- In terms of Overview reports, some LSCBs had *difficulties finding relevant independent authors* with the necessary skills for doing this task. This tended to be a problem for smaller local authorities although independence was always an issue.

- Problems existed when Overview reports did not reflect the complexity of issues or highlight the key messages. One example related to regulation of fostering - because the overview author did not have a social care background and little knowledge of fostering they were unable to link recommendations to the regulations.

[27] This data is based on 76 responses. Twenty three did not complete this section because they had not completed any SCRs in the previous 12 months and six did not say how many SCRs they had completed in the last 12 months.

6.2.3 The experience of Ofsted evaluations

In our interviews with Chairs and Business Managers, questions were raised about the effectiveness of the Ofsted evaluation process. While having such a process was generally seen as positive, how it was being used and implemented was not. In their evaluations Ofsted, it was claimed, seem to be more concerned with process than outcomes. A consensus existed across the six case study LSCBs that this was detrimental.

> *'I think the government are evaluating the reviews but one of the challenges is…are you evaluating the process of the review, or whether the lessons are learnt, they're not the same thing.*'

It was also felt that many of the early judgements about the quality of SCRs were made before appropriate guidance to LSCBs was available. Continued uncertainty existed among Chairs about what was required to ensure the evaluation was positive for the LSCB. Chairs and Business Managers thought there was also a discrepancy between the Ofsted grade descriptors used, the evaluation report and judgements. Judgements about the quality of SCRs varied, yet in many cases LSCBs could not see significant differences between such evaluations. This created a situation where Chairs remained unclear about what was needed to meet Ofsted's requirements. One of the major impacts of this is that Chairs do not always have confidence in the effectiveness of this mechanism for helping them to evaluate their practice.

6.2.4 Learning lessons

Chairs see SCRs as quite powerful tools for bringing about changes in practice. LSCBs had devised a number of ways of ensuring lessons were learnt from SCRs.

> '*We would have an action plan, we would be establishing who is going to oversee the action plan, and so there's some that are going to be training issues, some that are going to be policy, some that are going to be basic messages…other Boards have actually [held] conferences…*'

In one case study area they had set up a system of colour coding recommendations (Red for not been implemented, Amber for in progress and Green for implemented) to assist in identification of whether action plans are being implemented. Other areas thought most recommendations had significant training implications for agencies, therefore programmes were devised by LSCBs to roll out multi-agency training that ensured learning was passed on to practitioners. Similarly, recommendations could change policy and procedures and these were sent to the relevant subgroups for development.

All LSCBs were keen to ensure lessons were learnt and to promote best practice in their area. Interviews with Chairs and Business Managers revealed that they felt a major issue remained over how learning was being disseminated to frontline staff within large agencies. One area was concerned that recommendations made regarding schools were not reaching teachers and other staff. Effective dissemination of information within and between agencies remains a challenge for LSCBs.

6.3 Child Death Review Processes

Box 13

One of the LSCB functions, set out in Regulation 6, in relation to the deaths of any children normally resident in their area is as follows:

(a) collecting and analysing information about each death with a view to identifying

(i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);

(ii) any matters of concern affecting the safety and welfare of children in the area of the authority; and

(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area;

(b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

Source: Working Together to Safeguard Children, Section 7.4.

By April 2008, all LSCBs were expected to have put systems in place to enable them to fulfil statutory child death review functions (Box 13). There are two interrelated processes for reviewing child deaths:

- A rapid response by a group of key professionals who come together for the purposes of enquiring into and evaluating each unexpected death of a child.
- An overview of all child deaths (under 18 years) in the LSCB area(s) undertaken by a panel (Working Together, 7.1).

6.3.1 Rapid response to unexpected deaths

Box 14

It is intended that those professionals involved (before or after the death) with a child who dies unexpectedly should come together to enquire into and evaluate the child's death. This means that some roles may require an on call rota for responding to unexpected child deaths in their area. The work of the team convened in response to each child's death should be co-ordinated, usually, by a local designated paediatrician responsible for unexpected deaths in childhood. LSCBs may choose to designate particular professionals to be standing members of a team because of their role and particular expertise. The professionals who come together as a team will carry out their normal functions, i.e. as a paediatrician, GP, nurse, health visitor, mid-wife, mental health professional, social worker, probation or police officer in response to the unexpected death of a child in accordance with this guidance. They should also be working according to a protocol agreed with the local coronial service.

Source: Working Together to Safeguard Children, Section 7.18.

Working Together sets out the procedures (outlined in Box 14) which should be followed in the case of an unexpected death of a child. A multi-professional approach is required, however, some Boards have found it difficult to engage with health professionals in this area:

> '*It's very difficult to get all the paediatricians on Board with the rapid response process, we're doing better than some other areas, but it is tough because we're asking them to produce quite a lot of work, GP's are saying go whistle really, they're saying we really don't want to do this, and it's hard work, it's very hard work, an uphill struggle*.'
>
> (Business Manager)

There was a general feeling among Chairs and Business Managers that the rapid response function has been difficult to implement and has, in some cases been very time-consuming:

> '*The thing we've spent most time on is the local rapid response, the local response to unexpected child deaths*.'
>
> (Business Manager)

6.3.2 Establishing and administrating the Child Death Overview Panel (CDOP)

Working Together states that a CDOP should have a fixed core membership and should meet regularly in order to review the appropriateness of the professionals' responses to each unexpected death of a child and also to identify any patterns or trends in the local data and report these to the LSCB (Working Together, Paragraph 7.50).

Boards may opt to join with neighbouring areas to create a CDOP. Findings from the survey indicate that 64.8 per cent of LSCBs have decided to work with others in their region. The decision to do this may be based on a range of factors, including the total population of the area. Areas with relatively small populations may benefit from sharing a CDOP with others as this is less resource intensive.

> '*Four of us sat down, the four Chairs of the LSCBs, sat down at one of our meetings and we said, right, we've got to form a Child Death Review Panel (CDRP), why don't we have just a single panel, having a CDRP for [our area] we'd be twiddling our thumbs for some of the time I think.*'
>
> (Chair)

Equally, if areas are close together geographically, there may also be a benefit in having a joint CDOP as areas may share local service providers such as health or police. However, setting up a CDOP with another Board is not without its challenges, as one Chair explained:

> '*We were always very clear that our potential linkage was going to be with…another local authority, and what we're hearing from the police force is that they were actually very keen to join up with us …[but] a key person there… was dead set against [us] joining with them'*
>
> (Chair)

Just over a third of Boards have established their own panels (34.3 per cent). The challenges of establishing a joint CDOP may be have influenced decisions about this. The size and population of areas is also likely to have been influential. Working Together suggests that the total population to be covered should be greater than 500,000 (Working Together, Paragraph 7.8). As the Chair below suggests, establishing a separate Board does not preclude cooperation between neighbouring areas:

'*Child death reviews, that has taken a lot of time and energy to set that up, yes [our region] went down the road of four individual panels but that doesn't mean to say there hasn't been meeting across the authorities in terms of trying to get that right.*'

(Chair)

Meetings may involve discussing the process or looking at trends across the region. It is clear that substantial work has gone into setting up child death processes, and that they often require a full-time administrator or manager to cope with the workload:

'*We're about to appoint a CDRP manager because it's rather like the Board, we are required to review every death, once you start dealing with the range of agencies, even just grappling with health, never mind anything else, is a huge task*.'

(Chair)

However, as the CDOP panel has a fixed membership (although others can be co-opted where appropriate) it does mean that not everyone needs to know or understand the process in detail.

'*We don't need to sort of go to town on training everybody on child death review process because they're not going to come across it that often*.'

(Business Manager)

6.3.3 Implementation issues and challenges

Chairs and Business Managers were interviewed approximately six months after child death review functions became mandatory. As such, reflections were provided in the early stages of process implementation. However, some interviewees raised issues concerning the clarity of the guidance and about the interrelationship between the rapid response function and the overview process:

'On that there is...the differentiation between the child death review panel and the rapid response. Working Together put those two issues into the one chapter and in fact there's bits in the same paragraph and they're absolutely separate roles, one is operational and response to the death of a child, and when there's a need to move in, and the other is the review..it has been a struggle to get people to separate off the two things.'

(Chair)

Securing agency engagement and ensuring that the process was understood and implemented was not always straightforward:

'*It's not always easy to get the medics or other agencies for that matter to fill in the notifications.'*

(Chair)

'*I think that's been another one of the learning points for our kind of social care colleagues, it's partly trying to make the distinction between this and child protection, because it's not another bit of child protection*.'

(Business Manager)

Notwithstanding these issues, it was clear that areas were developing their approaches to reviewing cases, considering how child deaths might be prevented in the future and identifying patterns and trends from local data.

'*So we review all deaths, but we'll review a limited number of deaths in much more detail, we tend to look for clusters.'*

(Chair)

'*A lot of them are expected, and when that happens what one is looking at is the way in which the expected death was handled. Was bereavement support in for the family, how well did the agencies work together…*'

(Chair)

In one area an issue was raised about how data were going to be processed and analysed in their region. A decision had been made amongst local neighbouring LSCBs that a local organisation would receive all data, analyse it and then feed this information back to each area. This was a concern to one Chair in that they wanted access to their own local data:

'*He [organisation asked to do this] said I'll do all the child death reviews for all the different authorities and you can pay me to do it....and we said no, we'll do it on our own, thank you, because we want the local data...and if you do it regionally actually we won't be able to extrapolate what it means for us.'*

(Business Manager)

Finally, some Chairs and Business Managers raised concerns about the time and resources necessary for areas to meet their statutory duties.

'*Of course once that has been sorted out there's this huge DCSF piece of paperwork that needs to go off for each child, each death, and then there's also feedback that's required both to agencies where they're found wanting, there might be a serious case review that we can go back to the LSCB and say, look we've looked at this, you passed it up, we've looked at it in considerable detail and we think you should be running a serious case on this.'*

(Chair)

'*We would feel that most of the significant work is going to be done at local level, prior to submitting what is like your final draft to the overview panel. So in some ways it's kind of two tier process going on, and that has implications in terms of resources as well.'*

(Business Manager)

Despite these challenges and the problems of getting CDOPs established there was recognition that the process can be instrumental in providing data for LSCBs to inform developments to safeguard children from harm:

'*I think for example in terms of key performance indicators looking at issues like bullying and how we drive that forward, looking at issues around domestic abuse, driving that forward, looking at safety in the home and making changes, the child death review team clearly is going to make massive differences.'*

(Chair)

6.4 Conclusion

Taken together, child death and serious case reviews yield important information to inform local policy and practice and ensure that children's welfare is safeguarded and promoted. These processes involve a considerable investment of time and resources which can influence Boards' capacity to fulfil their wider remit.

Concerns have been raised by Chairs and Business Managers about the quality of IMRs and overview reports for SCRs, although they were committed to trying to address weaknesses. Issues were also raised about Ofsted evaluations which were seen to be overly focused upon assessing the process. Interviewees felt that additional clarification of expectations would be helpful and that more attention should be paid to learning lessons from reviews and ensuring that this had an impact upon practice. Chairs were clearly committed to this and saw it as an important function.

The role and value of collecting and analysing information on child deaths was also recognised in case study areas. Just under two-thirds of Boards have seen the value of regional co-operation and established joint panels with neighbouring LSCBs. Engaging health professionals in the rapid response function was found to be problematic in some case study areas. Chairs and Business Mangers also felt that greater clarity and guidance on child death review processes and interrelationship between rapid response and overview panels would be beneficial to them. Multi-agency training materials have recently been issued by DCSF and may address this issue (see:http://www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/childdeathreviewprocedures/trainingmaterials/trainingmaterials/).

7 CONCLUSION

Local Safeguarding Children Boards (LSCBs) have been in place since April 2006. The research findings reported here were collected between September and December 2008, approximately two and half years after implementation.

This is an interim report and while the data is robust it remains a partial picture. Response rates are high, however, the picture presented from the survey and interviews is based upon the perspectives of LSCB Chairs and Business Managers. In the next phase of research the views of Board members and Frontline Practitioners will be brought together to allow us to undertake further analysis. It is also the case that some of the data were collected prior to the Baby P case becoming public (interviews with Chairs/Business Managers) and some after the case hit the news headlines (survey and mapping data). While this does not directly effect the quality of our data it may have influenced responses.

As suggested in the previous report in the context of strategic partnership working LSCBs are still in the early stages of development and embedding practice and operation. As Frye and Webb suggest:

> *'An effective partnership can take several years to develop; new partnerships are inappropriate vehicles for outcomes expected in the short to medium terms.'*
>
> (Frye and Webb, 2002, p.11)

Involvement from education, early years, health and police is needed to ensure that all partners are working together in discharging their statutory duty to co-operate on child safeguarding (Lord Laming, 2008, p.39). Historically there has been a perception that safeguarding children is the responsibility of children's social care, rather than everybody's responsibility. The challenge lies in breaking down organisational barriers to ensure effective cooperation to improve outcomes.

Findings from the research so far, identify a number of issues that LSCBs have faced as they have sought to establish structures and systems to assist them in fulfilling their statutory functions and supporting effective operation. Boards have had to balance competing demands and prioritise certain aspects of their work with reference to the local context, needs and circumstances. They have had to develop structures and practices of accountability, identify resources and oversee the delivery of services. LSCBs also have a core role in bringing about change. These issues are explored further below with reference to Lord Laming's recommendations in *The Protection of Children in England: A Progress Report* (Lord Laming, 2009) and the Government's subsequent response and action plan (HM Government, 2009).

The research in this report suggests substantial progress has been made and that implementation of the LSCBs in England seems to be progressing in a positive way. All local authorities have set up a Board with an infrastructure to support their operation. Chairing arrangements are in place and a broad representation of agencies has been achieved by the majority of Boards. Most Boards have 'travelled far' in this respect and are focusing attention on ensuring that safeguarding partners attend regularly. The importance of this, and that Board members are fully involved as *equal* partners, has been reiterated by Lord Laming and will be reflected in revised regulations and guidance (Lord Laming, 2009; HM Government, 2009).

7.1 Charing Arrangements

In response to Lord Laming's review, the Government has signalled that in light of concerns about the conflicts of interest that *may* arise when LSCBs are chaired by Directors of Children's Services, that Independent Chairs should be appointed. The National Safeguarding Delivery Unit will have a role in supporting the transition to such arrangements for the 41 per cent of LSCBs that currently are chaired by DCSs. Securing enough Chairs with the broad range of skills and knowledge needed may be a challenge. As Lord Laming recognised having Independent Chairs who are 'sufficiently experienced in statutory safeguarding and child protection services' (Lord Laming, 2009, p.74) is critical. From our research it would seem many areas are making this core to their decision making (with 85.7 per cent of current Independent Chairs having a background in Children's Social Care). Other evidence from the report suggests that Independent Chairs also need to be skilled in managing large multiagency groups, managing conflict and they need to be able to operate at a senior level and have the confidence of Lead Members, Directors of Children's Services and health agencies. From our research so far it is clear that in appointing and using Independent Chairs a number of issues need to be resolved to ensure they can work effectively at the local level. These are:

- They must be seen as independent and 'beyond reach' of influence by any agency.

- Local Authorities need to ensure that lines of accountability of the Chair are clear and well defined so that they understand how this operates for them in everyday practice. Chairs need to have a clear understanding of this when they are appointed.

- Line management systems need to be clear and should not conflict or threaten to undermine the Chair's capacity to 'challenge' agencies. For example, it may not be appropriate for Chairs to be line managed by a DCS.

- Independent Chairs need to have access to, and opportunities to gain a clear understanding of:

    - strategic developments in the local area;

    - existing networks and partnerships; and

    - a full understanding of the infrastructure that is in place to support service delivery and meet local needs.

- Local Authorities need to ensure that the Chair has sufficient paid time allocated to fulfil their role. Our research suggests on average Chairs are allocated two days a month (not including time for SCRs), although this is usually determined by availability of funding rather than workload. Local Authorities need to undertake assessments of what might be needed and to review this on a regular basis.

While Lord Laming and DCSF have recognised training for Chairs as an area for development there remains little detail of the nature and extent of this. The wide range of tasks and responsibilities LSCB Chairs have to fulfil requires significant skills and knowledge about safeguarding, child protection and managing large multi agency groups. While regional learning networks are emerging it might be valuable if Independent Chairs had opportunities to be involved in support networks such as Learning Sets (see http://www.actionlearningsets.com/). These can be valuable support infrastructures and also offer real opportunities for learning to be shared.

7.2 Board Structure and Representation

7.2.1 Membership and the size of Boards

While it is clear that LSCBs have made substantial progress on ensuring the level of representation required, gaps seem to remain in some areas. For example, the local YOT is still not always represented (20 per cent do not have YOT members) and CAFCASS and PCTs are missing from 7 per cent of LSCBs. While these figures are not a significant worry (and may be explainable) the expectation (and requirement) is that 100 per cent of Boards have a representative from these partners. It is important that partners take shared ownership and responsibility for shaping the agenda and setting the strategic focus of their LSCB.

Findings reveal that only a small percentage of Boards include representatives from schools. Although schools are not statutory members of LSCBs, there is an expectation that both state and independent schools are involved. The *Review of Safeguarding Arrangements in Independent Schools, Non-Maintained Special Schools and Boarding Schools in England* (Singleton, 2009) recommended that 'LSCBs' existing responsibilities to reach out to schools in their area' needs to be reinforced (p.61). Challenges also exist in terms of fully engaging with the Third Sector. Large organisations such as the NSPCC are relatively well represented (62 per cent), but it would seem that there is also a need to understand and ensure effective communication with smaller agencies and organisations.

Evidence from this report raises questions about what the appropriate size of a LSCBs is or should be. While there is no national guidance and each area is developing a model of work that reflects local need and interest, there are concerns amongst Chairs and Business Managers that the large size of Boards can pose difficulties. The Government has signalled, in response to Lord Laming's report, that adult mental health and adult drug and alcohol services should be statutory members of the LSCB. Two lay representatives are also going to be required to sit on the Board. The impact of Board size will be explored further in the final report. However, it is clear that further consideration needs to be given to how to try and ensure wide representation and a breadth of knowledge and experience, whilst also ensuring that the size of meetings in manageable and facilitates rather than inhibits effective work.

7.2.2 Board membership, seniority and bringing about change

LSCBs are catalysts for bringing about a sea change in professional practice. The importance of safeguarding children as a shared responsibility was re-emphasised by Lord Laming (2009) and supported by Government's response. As was recognised, the key challenges are to '…translate policy, legislation and guidance into day-to-day practice on the frontline of every service' (Lord Laming, 2009, p.4). The power and influence of senior representatives, who are in the position to bring about change in their own organisation and act as 'brokers' is important, as research evidence demonstrates (Frye and Webb, 2002; Dean et al., 1999). Lord Laming (2009) also emphasises that membership and regular attendance and active involvement are required from senior decision makers. At the same time, the balance between seniority and/or specialist knowledge requires further consideration. This feeds in to discussions about Board size (as outlined above), but also impacts on whether members have sufficient power to bring about changes in organisational culture and practice.

At this stage, a wider question also remains about members understanding of the Boards' role and their willingness to act. In our research, questions were raised by Chairs and Business Managers about how representatives perceive their role. Some felt that Board members saw their role as championing the interests of their own agency rather than being an independent member of the Board. Information sharing was also seen as critical to

effectiveness, but there appeared to be less clarity from those interviewed about the extent to which Board members were disseminating information to their own agencies and from strategic to operational levels. That said, it is clear that Boards have been trying to develop ways of holding agencies to account.

Perspectives of Chairs and Business Managers varied as to whether or not Boards have sufficient 'teeth', or whether non-compliance with recommendations should have greater repercussions on the agencies concerned:

> *'In terms of teeth, I mean it's quite clear that we do have recourse to government departments if we're clear things are going awry.'*
>
> (Chair)

> *'I think agenices ought to be called more robustly to account for not complying at all, and where they haven't been compliant that should be taken into account when their performance is assessed.'*
>
> (Chair)

Boards were looking to develop and expand internal mechanisms that could help them put agencies under the microscope:

> *'So in a way it's those functions, like LADO, like the Serious Case Review, like the Health Community Audit, all of these functions actually that give the Board it's power…because at the beginning we were all thinking what are the things we're going to be able to make a difference…'*

Lord Laming's recommendations outline that the 'formal purpose of Serious Case Reviews is to learn lessons for improving individual agencies, as well as for improving multi-agency working' (HM Government, 2009, p.48). Revisions to Chapter 8 of Working Together are planned to ensure that there is a focus upon effective learning and timely implementation of recommendations from SCRs. This should address some of the concerns raised by Chairs and Business Managers that SCRs had become too focused upon process and reporting at the expense of lesson learning. The contribution that SCR reports might make to inspections is also potentially strengthened as 'Ofsted will share full SCR reports with HMI Constabulary, the Care Quality Commission and HMI Probation (as appropriate) to enable all four inspectorates to assess the implementation of action plans when conducting frontline inspections' (HM Government, 2009, p.48).

The introduction of a requirement for LSCBs to produce an annual report to the Children's Trust Board on the effectiveness of safeguarding in the local area (subject to parliamentary approval) also demonstrates that the LSCB has a crucial role to play in providing 'robust challenge' to the work of Children's Trusts and partners. Once again, this formalises systems designed to ensure that LSCBs have mechanisms at their disposal that could strengthen their capacity to influence and encourage improvements in practice. Having Lead Members may also be important in this process of scrutiny (DCSF, 2007; Lord Laming, 2009).

7.2.3 Accountability

As outlined above accountability is a major requirement for strategic partnerships such as LSCBs. As Percy-Smith suggests:

> *'Partnerships are typically unelected and yet responsible for planning and overseeing services affecting lives of countless people. Accountability mechanisms should, therefore, be sufficiently robust to reflect the responsibilities with which partnerships have been charged.'*
>
> (Percy-Smith; 2006, p.219)

It would seem that if these processes and practices of accountability are not clearly defined this can create confusion or possible conflict and also has the potential to delay the LSCB's progress and development. For example, Independent Chairs' capacity and willingness to effectively challenge agencies *may be* limited if they are concerned about raising issues about children's services' performance with the DCS who may have appointed them or they may be accountable to. Strengthening national and local leadership and accountability is central to Lord Laming's recommendations and the Government's response acknowledges the importance of this (Lord Laming, 2009; HM Government, 2009). Under revised regulations and Working Together guidance the Children's Trust and LSCB will be chaired by different people and the LSCB Chair will be selected with the agreement of a group of multi-agency partners.

Evidence from our research suggests Chairs are still concerned about how to bring people 'to the table' and be accountable for their actions. Issues such as Serious Case Reviews can, and do, create such opportunities (see discussion above) but it would be valuable for the re-working of 'Working Together' to clarify what accountability means across the system at individual, agency and LSCB level.

7.3 Resources and Delivery

An adequate budget and resources are important to facilitate the effective operation of the LSCB. The Children Act 2004 sets out details concerning the funding of Boards (Section 15). However, the budget and contribution made by each member organisation is agreed locally (Working Together, 3.76). A large proportion of Chairs clearly feel that the budget for LSCBs remains inadequate and has the potential to impact on the delivery of activities and responsibilities necessary to meet their statutory duties. This is perhaps unsurprising, but it is important to recognise that the demands on LSCBs to deliver on a wide range of responsibilities and to try to ensure they are widening their focus beyond child protection is challenging. Resources are not infinite and Boards may feel that certain activities have to be prioritised. Undertaking SCRs, which is recognised as an important and core activity, also requires significant resources which may then impact on delivery of other areas of work. Making sure an appropriate infrastructure is in place, that is funded appropriately is critical if LSCBs are to be effective. Getting this right is made more difficult if finances are hard to come by or limited.

A major player in the support network for LSCBs is the Business Manager (88.7 per cent of LSCBs have a Business Manager). This is a 'new' post that has grown as a result of the new arrangements being put into place. From our research it is clear that the role is central to the successful operation of LSCBs. Not only do Chairs rely upon their guidance and active involvement in the administration of the process but they also have a critical role in taking a lead on certain tasks (e.g. LADO) and for networking. Lord Laming and the Government's action plan both acknowledge the importance of training and development across the social care workforce. It would be valuable to ensure that training opportunities for Business Managers are included in plans. Access to locally established Action Sets might also be helpful.

Most LSCBs have developed models of working that include either (or both) Executive groups and subgroups. There are a variety of reasons beyond those set out in Working Together (…to carry out some of the day-to-day business, Section 3.39) cited by Boards for establishing Executive groups. Membership and size vary considerably between LSCBs. It is also the case that membership does not necessarily reflect seniority. The models adopted and their strengths and weaknesses will be explored further in the final report.

A similar pattern emerges with LSCB subgroups, with the number, size and membership varying between Boards. Challenges exist over maintaining an engaged membership and making them more accountable. As was suggested in the research an effective subgroup has committed and engaged members, clear terms of reference, and a shared understanding of priorities and members with specialist knowledge. LSCBs need to consistently review their subgroups against these criteria.

One final issue relating to the operation and structures of LSCBs is the question of communication. Presently LSCBs tend to assume that information on policy and procedures is communicated to statutory agencies via the Board Members (47.5 per cent). Interview data from our research suggests that Chairs and Business Managers are uncertain about the mechanisms in place to ensure this happens or whether information is disseminated effectively to agencies or the general public. At the moment little is known about what works best and how best to ensure that information is shared effectively. Given the importance of effective communication and publicity it would be desirable for LSCBs to focus attention more attention on this.

7.4 The Final Report

The final report will draw on data from six case study areas, including: interviews with Chairs and DCSs (follow-up interviews); interviews with 49 Board members from social care, health, education, the police and others; interviews with 180 frontline professionals; and social network analysis (in two areas). It will more fully explore the extent to which LSCBs have been able to engender change as well as their overall effectiveness. In doing so the following will be considered:

- the types of partnership arrangements implemented and their effectiveness in delivering services to improve outcomes for children and their families;
- how LSCBs manage and evaluate their role in safeguarding and promoting the welfare of children and the effectiveness of lines of accountability;
- how partners transfer knowledge and information across the Safeguarding network;
- how LSCBs work alongside other local strategic bodies and partnerships;
- if the new systems and arrangements are ‘fit for purpose’ and whether they safeguard and promote the welfare of children; and
- how far the new arrangements are influencing and improving frontline practice.

As one Chair reflected:

> *‘It’s a journey and we’re still on the bus…I think we’ve got…structures are only part of anything aren’t they, I think we always have had the commitment and people’s passion about children and safeguarding and that ideology.But I think what we’ve got now is we’ve got more performance management coming into it, and we’ve got more mutual challenge.’*
>
> (Chair)

REFERENCES

Audit Commission (1998) *A fruitful partnership*. London: Audit Commission.

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*. London: Department for Education and Skills.

Calder, M. C. and Barratt, M. (1997) 'Inter-agency perspectives on core group practice', *Children & Society*, 11(4), pp. 209-221.

Chief Inspector of Social Services, Director for Health Improvement, Commission for Health Improvement, HM Chief Inspector of Constabulary (2002) *Safeguarding children: a joint Chief Inspectors' report on arrangements to safeguard children.* London: Department of Health.

Children Act (2004) *Children Act*. Norwich: HMSO

Cooper, A., Hetherington, R. and Katz, I. (2003) *The risk factor: Making the child protection system work for children*. London: Demos.

Dean, J., Hastings, A. and Young, R. (1999) *Fitting together? A study of partnership processes in Scotland*. Edinburgh: Scottish Homes.

Department for Education and Skills (2007) *Local safeguarding children boards: A review of progress*. London: DfES.

Department of Health, Home Office, Department for Education and Employment and The National Assembly for Wales (1999) *Working together to safeguard children: A guide to inter-agency working to safeguarding and promote the welfare of children*. London: Department of Health.

Easen, P., Atkins, M. and Dyson, A. (2000) 'Inter-professional collaboration and conceptualisations of practice', *Children and Society*, 124, (5), pp. 355-367.

Frost, N. (2005) Professionalism, partnership and joined-up thinking: A research review of front-line working with children and families. Research in Practice.

Frost, N. and Lloyd, A. (2006) Implementing Multi- Disciplinary Teamwork in the New Child Welfare Policy Environment, *Journal of Integrated Care*, Vol. 14, Issue 12, pp. 11-17.

Frye, M. and Webb, A. (2002) *Effective partnership working.* London: Public Inquiry Unit.

Hallett, C. (1995) *Interagency Coordination in Child Protection.* London: HMSO.

Hardy, B., Turrell, A. and Wistow, G. (1992) *Innovations in Community Care Management.* Aldershot: Avebury.

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

HM Government (2009) *The protection of children in England: action plan. The government's response to Lord Laming* London: TSO

Horwath, J. and Glennie, S. (1999) ‘Inter-agency child protection training: gathering impressions ‘, *Child Abuse Review*, 8, (3), pp. 200-206.

Horwath, J. and Morrison, T. (2007) Collaboration, integration and change in children’s services: Critical issues and key ingredients, *Child Abuse & Neglect*, 31, pp.55-69.

Horwath, J. and Morrison, T. (2000) ‘Identifying and implementing pathways for organisational change - using the framework for the assessment of children in need and their families as a case example’, *Child and Family Social Work,* 5, pp. 245-254.

Hudson, B., Hardy, B., Henwood, M. and Wistow, G. (1999) ‘In pursuit of inter-agency collaboration in the public sector: What is the contribution of theory and research?’ *Public Management: an International Journal of Research and Theory,* 1, (2), pp. 235-260.

Jones, L., Nahrstedt, K. and Packard, T. (2002) ‘Evaluation of a training curriculum for inter-agency collaboration’, *Journal of Community Practice,* 10, (3), pp. 23-40.

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

Lupton, C. and Khan, P. (1998) ‘The role of health professionals in the UK child protection system: a literature review’, *Journal of Interprofessional Care*, 12, (2), pp. 209-221.

Morrison, T. (2000) Working together to safeguard children: challenges and changes for inter-agency co-ordination in child protection, *Journal of Interprofessional Care*, Vol. 14, No. 4, pp. 364-373.

Morrison, T. and Lewis, D. (2005) Toolkit for Assessing the Readiness of Local Safeguarding Children Boards: Origins, Ingredients and Applications, *Child Abuse Review*, Vol. 14, pp. 297-316.

Narducci, T. (2003) *Increasing the effectiveness of the ACPC.* London: NSPCC.

National Audit Office (2001) *Joining up to improve public services.* London: National Audit Office.

Ofsted (2008) *Learning lessons, taking action: Ofsted’s evaluations of serious case reviews 1 April 2007 to 31 March 2008.* London: Ofsted.

Percy-Smith, J. (2006) ‘What works in strategic partnerships for children: a research review’ *Children & Society,* 20, (4) pp. 313-323.

Rose, W. and Barnes, J.(2008) Improving safeguarding practice: study of serious case reviews 2001-2003 Nottingham: Department for Children, Schools and Families (DCSF).

Singleton, R. (2009) Keeping Our School Safe: Review of Safeguarding Arrangements in Independent Schools, Non-maintained Special Schools and Boarding Schools in England. Available: http://www.teachernet.gov.uk/_doc/13447/8156-DCSF-Safeguarding%20Arrangements(WEB).pdf

Thorlby, T. and Hutchinson, J. (2002) *Working in partnership: a sourcebook.* London: New Opportunities Fund.

The Local Safeguarding Children Board Regulations (2006) Statutory Instrument no. 200Statutory Instrument no. 2006/90

Ward, H., Holmes, L., Moyers, S., Munro, E. R. and Poursanidou, D. (2004) *Safeguarding Children: a scoping study of research in three areas. Final report to the Department for Education and Skills.* Loughborough: Centre for Children and Family Research.

ANNEX A

Aims and Objectives of the Study

Overall, the study aims to examine and assess:

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

Methodology

The research is designed to examine effectiveness by assessing practice against an evidence base that already exists in the social sciences about strategic partnership working (Percy-Smith, 2006). A mixed method approach is being adopted and includes:

- National electronic mapping of LSCBs (to identify models of working).
- The use of a case study method that will include interviews with: six LSCB Chairs (twice); 60 strategic partners from health, social work, education, youth justice, police, early years and the third sector; and 180 frontline professionals.
- Social Network Analysis will be piloted in two of the case study areas. It will provide detailed micro information on relationships and partnerships between Board members.
- User involvement will be explored through interviews with user representatives on LSCBs and representatives of organisations responsible for the protection of users.
- Data on the costs of Board activity will be collected, including budget and spending information and details on the level and type of financial contributions made by member organisations to the running of the Board. Time use data from LSCB members will also be sought to capture activity involved in the running of an LSCB.

ANNEX B

Classifications of Seniority

In order to establish the extent to which the LSCBs are meeting these requirements, the seniority of Board members was examined. The task was challenging as job titles are not universally consistent across areas. Job titles also differ according to agency and so members were classified based on identification of key titles such as Chief Executive and Assistant Director and based on their level of responsibility.

- Members were coded **1** if they had overall responsibility for their entire organisation.
- Members were coded **2** if they had overall responsibility for a large department within their organisation, or if they were accountable only to the head of their organisation.
- Members were coded **3** if they had responsibility for a smaller sub-section of their organisation.
- Members were coded **4** if they were a manager or had responsibility for a small team within their sub-section.
- Members were coded **5** if they were below team manager level.
- Members were coded **6** if they were not from one of the statutory organisations as defined in section 3.58 of Working Together to Safeguarding Children.
- Members were coded **7** if we were unable to ascertain their seniority from their job title, or if no job title was given.

ANNEX C

Table C 1 Type of Authority

	Respondents to the Survey		All LSCBs	
Type of Authority	**Frequency**	**Per Cent**	**Frequency**	**Per Cent**
Unitary	32	30.5	40	27.8
County	23	21.9	33	22.9
Metropolitan	28	26.7	35	24.3
London	18	17.1	31	21.5
Joint LSCBs	4	3.8	5	3.5
Total	**105**	**100.0**	**144**	**100.0**

Information about all LSCBs from national mapping exercise. Joint LSCBs have been formed when two or more local authorities have formed one LSCB to cover their combined areas.

Table C 2 LSCB Region

	Respondents to the Survey		All LSCBs	
Region	**Frequency**	**Per Cent**	**Frequency**	**Per Cent**
North East	8	7.6	11	7.6
North West	14	13.3	21	14.6
Yorkshire and the Humber	15	14.3	15	10.4
East Midlands	5	4.8	7	4.9
West Midlands	11	10.5	14	9.7
East England	8	7.6	10	6.9
Inner London	9	8.6	13	9.0
Outer London	10	9.5	19	13.1
South East	13	12.4	20	13.9
South West	12	11.4	14	9.7
Total	**105**	**100.0**	**144**	**100.0**

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