Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Evidence Session on the Safeguarding Board for Northern Ireland with Professor Alan France

25 February 2010

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Mr Thomas Buchanan
Dr Kieran Deeny
Mr Alex Easton
Mr Sam Gardiner
Mrs Dolores Kelly
Mr John McCallister
Mr Conall McDevitt
Mrs Claire McGill
Ms Sue Ramsey

Witnesses:
Professor Alan France) Loughborough University

The Chairperson (Mr Wells):

I welcome Professor Alan France. I believe that this is your first visit to Parliament Buildings. We value the fact that you have taken the time to give us the benefit of your expertise. Please take 10 minutes to make your opening remarks, after which members will have the opportunity to ask questions.

Professor Alan France (Loughborough University):

Thank you for the invitation. I am exceptionally pleased to be here to share some of my work with the Committee.

I am professor of social policy research at the centre for research in social policy at Loughborough University. Over the past two years, I have been undertaking a study of the effectiveness of local safeguarding children boards (LSCBs) in England.

First, I will say something about what I have not been able to provide, because it is important for the Committee to have as much information as possible. Our research has not yet been published. We will publish a briefing paper for the Department of Health around 13 March 2010, and the final report will be published in May 2010. As I am sure you are aware, because of the sensitivity of the research and the fact that the Department of Health and the Department for Children, Schools and Families (DCSF), quite rightly, must manage the way in which the research is put into the public domain, I was asked to restrict what I produce for the Committee. Therefore, I asked the Committee to hold today's session in private. When we have published the report, it is fine for the information to enter the public domain.

I produced two documents for the Committee. The first is a series of overheads, which have been passed by the Department of Health and the Department for Children, Schools and Families, which jointly commissioned the research. I have been using those overheads for the past two months when giving presentations in various places. I could speak about them in detail, but I want to take a slightly different tack. I also produced a table on effectiveness, which I will talk about in a moment.

I will say something about the context and about the research itself, because it is important to understand the boundaries of the research study. The research examines the implementation of the arrangements for working together. Chapter 3 of the study deals with the implementation of LSCBs and their operational effectiveness in improving child welfare and increasing safeguarding for children. It focuses on the types of structures that are to be developed and how effectively those different components should work together to increase the safeguarding of children.

Our study was carried out over a two-year period and had two components. A national survey was undertaken, to which we had a high response rate of around 80%. The responses included details from chairpersons on their experiences of running LSCBs. A further survey identified the contributions of different partners in the process.

We also carried out more detailed and in-depth work on six case studies in different geographical areas of England. We spoke with chairpersons, directors of children's services, business managers responsible for the delivery of safeguarding and board members. We also talked to practitioners about whether the new arrangements had had an impact on their practice.

The aim of the research was to examine whether the new arrangements had overcome the weaknesses of area child protection committees (ACPCs). That was the key question that we were asked to address. While the research was unfolding, Lord Laming's review was published. We contributed to that review by producing some evidence for him on what was happening on the ground. As a result, we were included in one of Lord Laming's recommendations on developing practice guidance based on our research. We are in the middle of producing guidance on practice for the LSCBs in England.

The core question was the effectiveness of local safeguarding children boards. I draw members' attention to the table that I provided. Effectiveness can be researched and assessed in various ways. One such way is to undertake some kind of random control trial. However, as all local authorities must have a local safeguarding children board, no such option was available to us. It would also be extremely difficult to undertake such a task. The research literature identified what the evidence tells us about effectiveness, and we used those measures as a way of assessing the case study areas on which we worked.

The table contains effectiveness factors, all of which are based on evidence from previous research. We know, for example, that for a strategic board, such as a local safeguarding children board, to be effective, clarity of governance arrangements and management are required. Without that clarity, there is a danger that the board's effectiveness may be undermined.

The table also details the indicators of effectiveness. As a research tool, the indicators describe how each factor of effectiveness is measured: for example, for the effectiveness factor of clarity of governance arrangements, the indicator is the extent to which there are clear lines of

accountability for the chairperson and board members. Of the 13 effectiveness factors, 12 are based on research evidence. The final one relates to our research for which we consulted around 150 practitioners. We used the resulting evidence to assess whether the messages about safeguarding had gone out to front-line staff.

We assessed each effectiveness factor in the six case study areas. A score of 1 is the worst, 2 means that progress is OK, and 3 is the best. Each area was assessed and scored on that basis. For LSCBs to have been assessed as 100% effective, they would all have had to score 3 on each of the 13 effectiveness factors, and the final figure would have been 234. The final total of 153, therefore, equates to an effectiveness of approximately 65%.

In a sense, 65% effectiveness is not too worrying, because the LSCBs are on a journey and in the process of improving their effectiveness over time. Ideally, we would like them to be 100% effective. The conclusion is that good progress is being made, but more could be done.

The LSCBs are stronger in some factors than others. We found, for example that on strong leadership, the chairpersons of the LSCBs were highly effective in taking a strong leadership position and had strong authority over local members. However, they scored considerably less well on the factors of stability of board membership and the existence of strong links between LSCBs: a total score of nine means that they are only 50% effective in those two factors. That demonstrates that there are certain areas that the LSCBs should and can target to improve their effectiveness. We hope that they will use the table as a mechanism for self-assessment and thereby improve their effectiveness.

That concludes my introduction, and I now have a series of points to make. I read the Department's detailed policy proposal and found it extremely interesting. I thought about what is trying to be achieved through setting up the Northern Ireland safeguarding board and how our research can contribute to that in some way. You are doing much that the research shows to be correct. In other respects, this research can show how to improve certain elements of the model that is being constructed. I am happy to take questions.

The Chairperson:

Thank you very much, Professor France. We should have said, of course, Loughborough University, which is, as it were, your university. We thank Grahame for giving you the freedom

to come over here for the day.

You deal with 144 boards, and that strikes me as a huge number of bodies to have an oversight role in child protection. What is the level of communication between those boards, and how effective is it? The Department of Health, Social Services and Public Safety proposes one safeguarding board and five panels. There is a debate about whether we need as many as five panels; perhaps one would be enough. Throughout the country, there is a plethora of groups involved in protecting children, but it takes only one dangerous individual to move across a boundary to make the situation difficult to control.

Professor France:

That is a very good question. A great deal of development has taken place in regional areas of England. In the south-west of England, Cornwall, Devon, Somerset and Bristol have combined to create a pan-safeguarding board, which is an overarching regional board, to try to cope with cross-boundary issues of resources and monitoring children's safety. So far, the LSCBs have not been as successful in finding national, formalised ways of talking to one another. If one LSCB felt it necessary to pass on information to another LSCB, it has the relevant contact details. I do not think that any structure is yet in place to ensure that that happens, but that is another part of the journey for the LSCBs. Regional areas are trying to create better lines of communication, and in a sense, part of their development has been inward. It has been quite a task to set up the new boards. Almost four years into the process, they are not quite there yet.

The Chairperson:

During our conversation before the meeting, you mentioned something that I found intriguing: when child protection teams in England meet to review a case, the details are published online.

Professor France:

That applies to serious case reviews (SCRs) in which it has been identified that a certain area needs to review its activities with respect to a child. A serious case review is required when something serious happens, such as the death of a child as the result of seemingly unlawful action. As part of that review, each agency that had any connection to the child must produce a report on its relationship to the case.

Once the report has been finalised, and there is a complex process to arrive at that end product,

a summary of the case must be published, for example, online. That briefing paper is a summary of the full case in which everyone involved, including professionals, remains anonymous. The Parliament in England is debating a request that the full reports be made public. However, if social workers and educationalists who are involved in such cases were identified, the risk is that they would be attacked in the media.

The Chairperson:

Has that happened since the Children Act 2004 led to the formation of the boards?

Professor France:

Yes. In 2004, when serious case reviews were introduced, it was decided that the reports would be made public. As I am sure you are aware, the reputation of social workers is fragile to say the least. When such cases arise, social workers are dragged through the press and blamed for everything.

The danger of the full serious case reviews being made public is that it may create a culture in which the media have direct access to sensitive data that they can use to attack councils and social workers. In one of our case study areas, for example, there were six serious case reviews. Every time that one was published, it became a headline in the local newspaper. The local media used the review as a way of attacking the council and social workers for their work. That can make it difficult to attract people to social work as a profession.

The Chairperson:

The difference, which will become apparent, between here and the situation in England and Wales is that vulnerable children here can be brought back and forward across an international boundary. I know that the 144 boards in England have overseas workers, but we have a particular issue here. From Strabane, for example, which is in the constituency that Mrs McGill represents, it would take someone five minutes to walk across the border into the Irish Republic with a vulnerable child. How does the new system track such individuals? Does anywhere in GB have experience of how to deal with that cross-border issue and protect children in those areas?

Professor France:

Not that I know of, but I am not sure. That is not my area of expertise, so I am cautious about making claims about whether certain systems are in place. In the English policy, great attention

is being paid to monitoring the movement of children, and the setting up of a new national database is one way of trying to address that. If children were to move around the UK, there would, therefore, be ways of being able to track them and find out their histories. If a child had been on an at-risk register in one area and moved to another area, the authority in that area would be able to access the relevant information on the national database. England is also struggling to deal with the issue of international boundaries.

Mr Easton:

You said that the LSCBs are only 65% effective. I understand that the process is ongoing and that there is a learning curve, but that figure concerns me. To what extent is 65% effectiveness an improvement on what went before? Are you considering setting up a simple computer database to enable all 144 boards to share information? That would be a quick and simple method of achieving that, although I accept that it would be costly for each board to have a computer system capable of following somebody right across the country. What are you doing to improve the sharing of information?

Professor France:

An effectiveness rate of 65% is still not good enough; as the Government and the LSCBs would say themselves. It is questionable whether they can ever be 100% effective. There will always be certain areas in which they will struggle to reach the top level of effectiveness. I think that reaching 90% effectiveness would be the best that could ever be achieved. As circumstances change, there will always be areas of weakness.

As we did not carry out the same assessment of previous systems, we do not have exact figures for purposes of comparison. However, our report states, and it is a legitimate point, that the new system is an improvement on the previous one. We are starting to see a broadening recognition among a range of agencies that safeguarding children is not simply the responsibility of social services; it is the responsibility of all those agencies that have contact with children, including adult services, because an adult's serious drug problem is an issue for his or her child. The new arrangement has brought about an acknowledgement that the responsibilities lie with many, not with few, which is an important development. That recognition is still not as broad as it should be, and there remains a long way to go before it is fully embedded, but it is a definite improvement on what was there before.

In a sense, the matter of collating data from 144 boards is not my responsibility; it is more that of the Government. They have a monitoring system and local safeguarding boards must produce reports. I assume that the national Government have a process to audit delivery. However, finding a universal database can be enormously problematic, because people use different systems. Therefore, the attempt to create a single system leads to nothing but tensions. The search for a universal database into which everyone can feed information is a major issue for safeguarding and a range of different areas.

Ms S Ramsey:

Thanks you for your extremely useful presentation and welcome to the Committee. Sometimes it is important to hear from someone with an overview of the subject. What was the time frame for your analysis?

Professor France:

It was started in January 2008 and completed almost two years later in December 2009. We collected national data for Lord Laming in January and February 2009 and reported on that data in our interim report of July 2009.

Ms S Ramsey:

It is important that we learn lessons from other areas. I take it that the third sector to which your submission refers is the community and voluntary sector?

Professor France:

Yes. I could comment more on quite a few issues. I did not go through the submission in detail, but I am more than happy to talk more about some of the items on that list. Having read your policy proposal, some elements of our research could contribute to the development of the plans to roll out safeguarding boards here.

Ms S Ramsey:

Your research found that the boards were 65% effective and 35% ineffective. The table contains a considerable amount of 1s, which is the lowest score, and the boards' combined score exceeds 12 on only three effectiveness factors. It is all right to say that you need a skilled chair. I agree, but every LSCB scores only 2, which means that progress is OK, on the effectiveness of the members' vision of the purpose of the board. On the importance of having the appropriate levels

of seniority, the scores range from 1 to 3. The research was carried out between January 2008 and December 2009, which makes it pretty fresh. Did any serious incidents occur within that time frame?

You state that, without adequate resources, it is not viable for boards effectively to fulfil all their functions. I agree with you. Realistically, however, when cuts are being made, the Cinderella services are always affected. What do you mean by "adequate" resources? I assume that that does not necessarily mean money, because you go on to say that a senior official can make decisions. It does not have to be about money all the time.

Professor France:

I will come back to that point. The Baby Peter case exploded while we were doing our research, and it had a big impact on people's responses. There is evidence to show that more children were taken into care after that event — the increase may have been as high as 30%.

You drew attention to the important issue relating to board membership. The Department's proposals on that issue are impressive and contain some very good ideas about how to develop the boards. Board membership raises several issues: when we looked at the national data across the 144 local safeguarding boards, all the key agencies, save a few, were included. We thought that that was positive, because that is what we wanted to see. However, when we examined the case studies in more detail, particularly the way in which those agencies participated in the boards, we discovered that some of their participation levels were poor. The agencies were on the books as being signed up to the process, but they did not always attend meetings regularly. That had a major impact in several ways on the effectiveness of the boards. If the level of participation is less than it should be, it delays the process and begins to undermine decision-making.

The LSCBs meet every three months. Therefore, if someone does not turn up when a decision that requires his or her involvement needs to be made, that decision is delayed for a further three months. The subgroups that are formed around the local safeguarding boards have a remit to deliver a certain set of outputs, such as the development of policies and procedures in a particular area. If those subgroups are not well attended, it takes them six to nine months to develop a piece of work. Participation, in the real sense of turning up at meetings and being active, is crucial. A low level of participation can impair a board's effectiveness.

In conducting our research, we discovered that levels of seniority varied, but between 30% and 40% of members were what we classified as being at the most senior level of their organisations: for example, a director of public health and a director of children's services. They were, therefore, in a position to make decisions on behalf of their organisations.

That meant that the remaining 70% of LSCB members were not at the top level of their organisation. However, it is important that boards have a balance of senior people and specialist knowledge. It is no good having the Chief Constable on the board if he or she has no detailed knowledge of child protection. A specialist from the police, or whatever organisation, who knows what is required must be a member of the board. If that person is not at a senior level, it is critical that he or she have some direct link into the senior levels of the organisation. The head of the child protection unit of the police, for example, will have a direct link to the Chief Constable. If changes need to take place in the operation of the police, the link to the senior level is in place.

The third membership issue centres on people's understanding of their roles: why, and for what purpose, are members on the board? We discovered that there was quite a strong belief among some members that they were there to represent their agency, but that is not their role. Their role must be to act as a link to their agency, pass information back to it and other connected agencies, to be a board member and undertake the associated board-member functions.

I was pleased to note that your policy proposal defines and sets out the roles and responsibilities of members. That was done in England too, but much depends on the extent to which people take that on board in delivering their responsibilities. Board membership is a critical issue and one that you must get right. Members must understand that have to turn up to meetings, know why they are there, what their role is and how they should connect with their agencies. They are not on the board to represent an agency interest, but as board members.

What was the second question that you asked me?

Ms S Ramsey:

I asked about general ineffectiveness and the issue of resources.

Professor France:

In my written submission, I placed quotation marks around the word adequate, because what

constitutes adequate resources is debatable. We argue that resources are needed, which, in many cases, means people.

In the UK, a post called "business manager" was created. The role of a business manager was not particularly clear. It could involve anything and everything, from servicing the board to strategic operations. That role proved to be critical to success. If that person was not in place, or if, as happened in one case, that person left and was not replaced, the co-operation of the committee was delayed and its ability to deliver was affected. Therefore, someone is required to perform important functions to service the committee. Other staff are also required, such as audit officers to obtain information and, perhaps, policy officers. The infrastructure must also be supported, and investing resources in that is crucial.

One of the difficulties that the English boards have is that there is no formula for funding. The LSCBs have to negotiate with the different agencies, and children's services, the police, health and Cafcass must each contribute a proportion of the required money. That must be negotiated annually, which causes massive difficulties. When the call comes for cuts in services — as it has and will again — those contributions become vulnerable, and, therefore, the resourcing of the board itself becomes vulnerable.

Your proposals sensibly state that resources will be committed. I will not comment on the amount, because I do not know enough about that, but it is sensible to ring-fence a resource to ensure that the board can operate. An independent chairperson cannot operate without some support.

Mr Gardiner:

Professor France, you are very welcome, and I thank you for your presentation. You said that the Department's policy proposals had strengths and weaknesses. We can live with having strengths, and we need encouragement. However, we cannot live with our weaknesses. Will you highlight those weaknesses because we want our standards to reach, if not to better, your standards?

Professor France:

That is a good question. I can talk about strengths and weaknesses, because they are interconnected.

Mr Gardiner:

I mainly want to hear about the weaknesses.

Professor France:

I understand that. The consideration of governance is very good, and it is right to have an independent chairperson. One challenge that was faced in England was the question of to whom an independent chairperson should be accountable. A real debate is going on in the rewriting of 'Working Together to Safeguard Children'. Our research shows that an independent chairperson needs to be separated from some of the agencies that he or she is supposed to scrutinise.

I think that the director of children's services cannot be the chairperson's line manger or be accountable to him or her. An independent chairperson cannot be accountable to the Children's Trust. He or she must be accountable to some sort of independent body. My argument is that a chairperson should be accountable to a chief executive, and I have noticed that is planned for.

I do not know how your system will manage line management and contracts with an independent chairperson. It seems to me that that there must be independence. The contracts cannot be given to an agency on which the chairperson will be commenting. There has to be some way of separating that. How do you see that operating? That is something for you to think about.

I see vulnerability in the size of the board. Our research shows that, if a board is too big, there is a real danger that it could become ineffective. We think that a board should have no more than 20 to 25 members. The board should not be too small, because, if it is, it will not have enough members to take on some of the required tasks. Subgroups will be needed, and people will have to take on roles and responsibilities. If a board is too small, it will be unable to manage all the required tasks. The board will have quite a lot to do.

If a board is too big, its ability to network, to build relationships and for people to feel that they have a voice will be limited. One LSCB was quite large, and some people thought that children's services and health issues dominated and that other interests did not have a say. Thought must be given to the size of the board. If a board were to have an inclusive model, under which anybody and everybody comes onto it, there would be a real danger that it will not be effective. One has to be clear about who is on the board and why, and keeping it to a workable

number of members is a crucial component.

Who should sit on the board? I have not seen the departmental details about the composition of the board. In England, the agencies are set out for which the board has statutory responsibility, and that is quite appropriate. Another list contains the people who should also be on the board. One challenge will be to get the right people on the board. For example, who should be on the board from the health sector? A diverse set of organisations comprise the health sector, and every single organisation that works in health cannot be represented on the board because there would be too many people. The issue is about how to represent, and provide a voice for, a large grouping of people from the health sector, and that same issue applies to the third, or voluntary, sector. Getting some kind of representation on that board is a big issue.

In England, one strategy was the creation of subgroups, such as a third-sector subgroup, in which several parties would be brought together. One person would then represent that group on the safeguarding board. It is important to sort out those membership issues.

How will outcomes be measured? You seem to have an idea of how to do that, and I would be interested to hear more. The boards in England are strategic, so they are not responsible for direct delivery; their role is to scrutinise and oversee. Therefore, it is difficult to link the boards with the improvement of child outcomes, because they are quite removed from delivery. Therefore, the way to measure outcomes is to ask whether the boards are scrutinising appropriately and doing what they are supposed to do. Instead of the big outcome of child welfare, the outcomes that we can measure with the boards are middle of the range, which actually —

The Chairperson:

I interrupt because you are making an essential point. There is no point in reaching a situation in which the boards do everything properly and administrate more effectively if no fewer children are abused or killed. There must be tangible results for the entire process; it is no good having a wonderful bureaucracy and pushing all the right buttons if there are still many high-profile cases of children being abused or killed and no improvement in the numbers and in the protection of children.

Professor France:

Yes, absolutely. However, responsibility for that cannot lie only with the LSCBs; it must lie with

the people who are responsible for delivery. Therefore, the people on the ground who are supposed to deliver services that protect children are accountable for the quality of the delivery. The local safeguarding board's only responsibility is to monitor and scrutinise that practice, so it has a role in the process, but it is not responsible for delivery.

The Chairperson:

If, after 20 years of the process, we do not see the board scrutinising and monitoring and, therefore, do not see much more effective delivery of child protection on the ground, what are we achieving?

Professor France:

Both those factors come together. The improved scrutiny and monitoring of practice should improve the quality of practice and a reduction in the number of child protection cases. That is what one hopes will happen. The two issues are connected, but an LSCB alone cannot be held to account for the end product, because it is not responsible for delivery. However, the end product is a long-term measure for an LSCB, and one would hope that its involvement in the process would reduce the number of child protection cases. As I said, it is not the sole responsibility of the LSCB because, in some cases, it does not deliver the services.

The process in England was weak on engagement with the public. I notice that a communication strategy has been built into the proposed system in Northern Ireland, which is important. That is a positive development. One useful issue that emerged was boards being put under regular political scrutiny. The chairperson of a board needs to be accountable to his or her political paymasters, because, importantly, that is the link back to democracy. The danger is that we create a safeguarding board that is a type of quango that is not accountable to the public. How is a board made accountable?

There is an important role for political scrutiny. That is my personal opinion, and I have had some disagreements with my colleagues in the Department for Children, Schools and Families about the issue. It is important that a safeguarding board is open to public scrutiny, and democracy allows for political scrutiny to be part of that process. That is also worth considering.

I notice that the Department proposes to build a safeguarding board with the involvement of children and young people. That is a sensible approach. In England, children were not really

engaged. Children had no idea what local safeguarding boards were and had little involvement with them. Bringing children into the process is critical, as is finding the right mechanisms and routes to do so. They cannot be members of an LSCB, but having systems whereby they can ask questions in some form of political scrutiny is a good idea.

Mr Gardiner:

They should also be able to make suggestions.

Professor France:

Absolutely.

Dr Deeny:

This is all new territory. As well as being an MLA, I am a GP. I am a little concerned that the LSCBs have only a monitoring and scrutinising purpose. Are there 144 boards in England?

Professor France:

That is correct.

Dr Deeny:

What relationship do the LSCBs have with primary care? I do not know the number of practices in England, but I am curious about that.

I know that this is a closed session, but members have concerns. Some weeks ago, for example, I mentioned a couple of children about whom health professionals — doctors, nurses, social workers — and I were quite concerned because they were at risk.

The Chairperson:

Dr Deeny, please come to a question. We are in closed session, but it is being recorded, so I urge you to —

The Committee Clerk:

We will produce a Hansard report eventually.

The Chairperson:

We need to be careful.

Dr Deeny:

Many people were concerned about the case. What is the relationship between the LSCBs and the courts and the judiciary?

As you know, children are often in and out of primary care in general practice. GPs see families all the time. You said that there was diversity in community care and health. If members of the public suspect that a child is at risk or is being abused, can they contact members of the boards? Do they know them? Do the LSCBs have the power to recommend or advise strongly to change practice as opposed to simply monitoring and scrutinising?

Professor France:

You have asked four questions. The questions about primary care and GPs are interesting because our research found that it was a real struggle to find ways to engage primary care and GPs in the local safeguarding board process. There were issues about their voices being heard and being represented on boards because GP practices are often autonomous. There is not always a community of GPs that speaks with one voice. The question concerned how messages were sent to them and how they actively engaged. GPs are usually the first port of call. They may come across a parent or a child who is struggling. If GPs can put the picture together, they are critical identifiers of problems. There have been real struggles about how to do that. Responses from GPs have not always been positive. Their argument is that, if they have any concerns, they will pass those on to social workers. That is not a lack of concern; it is about culture and practice and the ways in which they operate. I am sure that we could have a longer debate on that issue. However, there are concerns about engaging primary care in the safeguarding process and how GPs can be trained when they are so busy and have many other responsibilities.

The issue of the judiciary is interesting. The LSCBs have tried to involve the Crown Prosecution Service. Interestingly, magistrates and judges, as far as I know, do not have a role on LSCBs; perhaps they should have a role. That is a gap, because the police, youth justice representatives and others who have a service responsibility are involved. Judges are crucial, and perhaps there should be stronger links with the judiciary.

It is clear from our research that communities have little knowledge of LSCBs. If people on the street were asked what they would do if a child in their area were being abused, I would be very surprised if they knew what to do. Someone might phone the police —

Dr Deeny:

They would not have heard of an LSCB.

Professor France:

No, they would not. I like the Department's proposal for a strategy to engage the public. Most English LSCBs did not seem to do that. To be fair to them, there have been resource issues, and they have had to prioritise. What are the priorities and resources? Core business and good child protection procedures should be in place first, because it is only then that it is possible to broaden out and examine ways to develop preventative work, become more proactive than reactive and market the safeguarding board to the public. That should be the model. Four years on, however, the LSCBs have not marketed themselves in the right way so that the public know who they are. That is a big issue, because when there is a crisis and social workers are dragged over the coals, there is no one to speak on their behalf. I think that that is a role that LSCBs could and should take on.

The establishment of a board that has authority and "teeth" is an issue that is raised in our report. It is not clear where and how local safeguarding boards could have powers to make things happen, but there are ways of doing that. I mentioned serious case reviews earlier: one outcome of such reviews is that there are lessons to be taken on board by the relevant agencies. Agencies are required to respond to the recommendations that arise from serious case reviews. For example, if a serious case review of child abuse concludes that a certain agency is not doing what it should be doing, that agency must respond. The issue of monitoring and ensuring that that agency responds is another matter.

There are mechanisms in the system, but the difficulty is that they are not explicit. Another solution is that the independent chair could write to the agency's chief executive to say that it is failing and needs to do something. The independent chair could also write to the Minister of State expressing concerns about safeguarding in certain areas. However, an independent chair does not have much authority.

Another dimension is the independence of the independent chair. At one level, that is important because the chair is not seen to be acting on behalf of a particular agency, but he or she does not have much authority either. A director of children's services has more authority than an independent chair. It is important that the independent chair gets that authority to be able to speak out and to name and shame the agencies that are not doing what they are supposed to do. Lord Laming is taking the LSCBs is that direction, and he is right to do so. We will have to wait and see how effective that will be. As I said, one weakness that we identified in the existing system is that there is no clarity on authority or on "teeth", as we call it.

Mr McDevitt:

I am sorry that I missed the earlier part of your presentation. I am interested in your point about the gap between boards' on-paper representation and the reality of who actually turns up daily and their seniority. What big barriers have caused that gap? Are they political or are they cultural issues in the sponsoring or parent organisations? Did you notice a change in behaviour after the Baby P case?

Professor France:

The causes are mainly cultural. LSCBs are intended to embed a new way of operating and to make people recognise their responsibilities. A shift in operation has been required in a range of agencies and organisations; it takes a lot to make that happen. Therefore, cultural issues are limiting participation. After the Baby P case — it is an interesting observation — the situation began to change. Our research shows that, all of a sudden, people started to approach the issue differently.

England had area child protection committees, and there was a desire and a requirement to broaden their remit to safeguarding and to introduce a preventative framework on early intervention. There was great enthusiasm for that, and a lot of energy was put into it. The Baby P case then shocked people. People, I think, had become complacent, and that case brought people and agencies back to the table to consider the core business. Although that is anecdotal evidence, in reality, people focused on core business issues as a result.

Mr McDevitt:

Can you offer an opinion on which agencies faced the greatest cultural challenge or were culturally less inclined to engage?

Professor France:

I do not want to name and shame too much, but some health agencies had real issues

Mr McDevitt:

Do you mean the Health Departments?

Professor France:

Health has a large multidisciplinary structure. How does a safeguarding board address that diversity? That is a real struggle. Moreover, some aspects of information sharing need more work.

Mr McDevitt:

Are organisations unwilling to share information?

Professor France:

In some cases, they are unwilling. Undoubtedly, there is evidence of improvement. However, in some cases, agencies are reluctant and require an enormous amount of convincing that it is appropriate to share information. That is partly because they work on particular paradigms and use slightly different ways of thinking about data and information. Therefore, the creation of groups such as local safeguarding boards brings such dialogue to the forefront. That is what those boards should be doing. Any disagreements can be played out on the boards, which is why people must take part in those groups, attend meetings, argue their cases and defend their positions. In a sense, LSCBs promote inter-agency working because they bring people together. Those issues need to be thrashed out at those meetings, because we could have all the protocols and directions in the world, but it is the practice that will make a difference.

Mr McDevitt:

You mentioned that the judiciary is not at the table. How important is it for the judiciary to come to the table? Are LSCBs suffering as a result of its absence?

Professor France:

I confess that I have not given that matter a great deal of thought. However, given the importance of family courts, that issue is crucial. Many cases could end up in the family courts. Therefore,

engaging the judiciary is essential. The judiciary must be aware of local developments, what is available and what is happening with the safeguarding boards. Its role is important.

The Chairperson:

We are running close to the end of the allocated time for this evidence session. You will have realised that the Committee is not shy or retiring and that members have many questions to ask. However, that is a good sign.

Mrs Claire McGill wishes to ask a question. Can we try to get this finished quickly?

Mrs McGill:

I will be brief.

I want to ask about three issues: political scrutiny, membership and communication. You mentioned political scrutiny in response to another member, and, in the proposed model for membership here, there will be two district council members who will be employees of the council, rather than elected members. The situation and structures of local authorities in England are different, and you said that the chief executive would be a valuable person on the board. Do you feel that the chief executive will be responsible for providing political scrutiny? You said that you had some discussion with your colleagues on that issue.

Professor France:

In local authorities in England, local members are responsible for the elected members who are there through being elected by the democratic process. They are responsible for scrutinising the way in which services operate in that area and setting out direction and policy. In a sense, they are the critical link back into the community.

In England, we had several examples in which local safeguarding chairs had to appear before scrutiny committees with local members, and they were asked tough questions about the way in which they were operating and how services were dealing with safeguarding. That is a good way to bring local safeguarding boards into a democratic process. Those are personal views and not those of the Department for Children, Schools and Families, but it is important that there is some link back into the democratic process.

Mrs McGill:

Your presentation states:

> "There was limited knowledge about the extent to [which] information reached the appropriate personnel".

That is a big issue, which is absolutely critical to what happens and to how the process improves the structures and the practice for vulnerable children and young people.

Professor France:

It is crucial.

Mrs McGill:

Therefore, it is a little disappointing that your survey found that "limited knowledge" existed.

Professor France:

I will explain quickly because I am aware that we are going to run out of time. There was an assumption that, because people were on boards as representatives, they were taking information back to their organisations, implementing all the measures and ensuring that important changes were made. However, there are two issues. First, that did not always happen, and some members thought that it was the responsibility of the board to deliver those messages to the agencies and not them as individuals. Secondly, members are not always on the board as representatives of their agencies, and if a member represents the health sector and there are large groupings of different health agencies, it is difficult to ensure that those messages go back to those agencies.

More success was achieved when one local safeguarding board set up a subgroup purely for health issues. Healthcare representatives were brought together to be used as a conduit between the safeguarding board and the agencies, both of which were represented on the subgroup. That type of model works well, albeit there being dangers such as the creation of a power base that is external to the board. Therefore, that process must be well managed.

Many LSCBs started to create audit systems. I notice that the Committee has some documentation from Wigan that sets out agencies' responsibilities in a local safeguarding board. The auditing of agencies is a good approach, asking the question: are they doing those things? One must then ensure that there is a way to check that they are doing what they are supposed to do. It is crucial to build that into the system. The weakness is that, because there is an assumption that information will flow, it will not.

Mrs McGill:

Thank you for your interesting and helpful point that board members are responsible for bringing back information to their respective agencies.

The Chairperson:

The word "helpful" sums up Professor France's presentation extremely well. That was a useful introduction to a huge issue for the Committee. The wide range of questions provoked by your evidence indicates the Committee's interest in safeguarding boards. Professor France, I thank you for taking time from your busy schedule to jet over here to meet the Committee.

Professor France:

It has been a pleasure.

The Chairperson:

Members of the Committee are visiting Bolton and Bradford to see child protection issues there at first hand, and your evidence has been extremely helpful in that regard.

Professor France:

I have three final points. First, I thank the Committee for inviting me here. It has been an interesting discussion, and I have fully enjoyed engaging in the debate. Secondly, if the Committee wants any further information, please feel free to come back to me. I will try to be as helpful as I can. That will become easier once the research is published in the next couple of weeks. Finally, my reading of the policy proposals is that the issue is progressing in the right way. The proposals are built on good, solid evidence about what makes for effective work. I was pleased to see the evidence on which the Department based its proposals.

The Chairperson:

Members must treat any material that they received today as confidential for the reasons that have been outlined. I again thank Professor France.