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Sefton Council

MEETING: OVERVIEW AND SCRUTINY COMMITTEE (CHILDREN'S SERVICES AND SAFEGUARDING)

DATE: Tuesday, 25th September 2018

TIME: 6.30 pm

VENUE: Committee Room, Town Hall Bootle

| Member | Substitute |
|---|---|
| Councillor | Councillor |
| Cllr. Paula Murphy (Chair) | Cllr. Michael O'Brien |
| Cllr. Clare Carragher (Vice-Chair) | Cllr. Carla Thomas |
| Cllr. Richard Hands | Cllr. Iain Brodie - Browne |
| Cllr. Pat Keith | Cllr. Mike Booth |
| Cllr. Daniel Terence Lewis | Cllr. Catie Page |
| Cllr. Brenda O'Brien | Cllr. Anthony Carr |
| Cllr. Michael Pitt | Cllr. Terry Jones |
| Cllr. Yvonne Sayers | Cllr. Liz Dowd |
| Cllr. Paula Spencer | Cllr. John Kelly |
| Cllr. Veronica Webster | Cllr. Robert Brennan |
| Mrs Sandra Cain | |
| Stuart Harrison | |
| Father Des Seddon | |
| Karen Christie | |


COMMITTEE OFFICER: Debbie Campbell, Senior Democratic Services Officer

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# A G E N D A

**1. Apologies for Absence**

**2. Declarations of Interest**

Members are requested at a meeting where a disclosable pecuniary interest or personal interest arises, which is not already included in their Register of Members' Interests, to declare any interests that relate to an item on the agenda.

Where a Member discloses a Disclosable Pecuniary Interest, he/she must withdraw from the meeting room, including from the public gallery, during the whole consideration of any item of business in which he/she has an interest, except where he/she is permitted to remain as a result of a grant of a dispensation.

Where a Member discloses a personal interest he/she must seek advice from the Monitoring Officer or staff member representing the Monitoring Officer to determine whether the Member should withdraw from the meeting room, including from the public gallery, during the whole consideration of any item of business in which he/she has an interest or whether the Member can remain in the meeting or remain in the meeting and vote on the relevant decision.

**3. Minutes of the Previous Meeting** (Pages 5 - 20)

Minutes of the meeting held on 10 July 2018

**4. Children's Social Care Continuous Improvement Plan** (Pages 21 - 60)

Report of the Director of Social Care and Health

**5. Fostering Service Annual Report** (Pages 61 - 78)

Report of the Director of Social Care and Health

**6. Local Government Association Care Practice Diagnostic (Peer Review)** (Pages 79 - 100)

Report of the Director of Social Care and Health

**7. Enhancing Elected Member Involvement** (Pages 101 - 106)

Report of the Director of Social Care and Health

**8. Serious Case Review** (Pages 107 - 154)

Report of the Director of Social Care and Health

**9.** **Effectiveness of Local Authority Overview and Scrutiny Committees – Government Response to DCLG Select Committee Report** (Pages 155 - 232)

Report of the Chief Legal and Democratic Officer

**10.** **Cabinet Member Report** (Pages 233 - 238)

Report of the Chief Legal and Democratic Officer

**11.** **Work Programme Key Decision Forward Plan** (Pages 239 - 256)

Report of the Chief Legal and Democratic Officer

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**THIS SET OF MINUTES IS NOT SUBJECT TO "CALL IN".**

OVERVIEW AND SCRUTINY COMMITTEE
(CHILDREN'S SERVICES AND SAFEGUARDING)

MEETING HELD AT THE TOWN HALL, SOUTHPORT
ON TUESDAY 10TH JULY, 2018

PRESENT: Councillor Murphy (in the Chair)
Councillor Carragher (Vice-Chair)
Councillors Brenda O'Brien, Yvonne Sayers, Spencer and Webster

ALSO PRESENT: Mrs. S. Cain, Advisory Member
Ms. L. Kitt, Healthwatch Representative
Councillor J. J. Kelly, Cabinet Member – Children, Schools and Safeguarding

## 1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Hands and his Substitute Councillor Brodie-Browne; Councillor Pitt and his Substitute Councillor Jones; and Councillor Dan T. Lewis.

## 2. DECLARATIONS OF INTEREST

No declarations of personal or pecuniary interest were received.

## 3. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

That the Minutes of the meeting held on 20 March 2018, be confirmed as a correct record.

## 4. SEFTON PUBLIC HEALTH ANNUAL REPORT 2017

Further to Minute No. 5 of the meeting of the Overview and Scrutiny Committee (Adult Social Care and Health) of 26 June 2018, the Committee considered the report of the Head of Health and Wellbeing on the Annual Report of the Director of Health and Wellbeing 2017/18 that was a statutory requirement and identified key issues affecting health in the Sefton population. This year's annual report had been produced as a short film that explored the emotional wellbeing and mental health of

children and young people, together with the services and resources available to support them.

Prior to consideration of the report, a short video presenting the latest Public Health Annual Report (PHAR) was shown to the Committee, which was entitled “Growing Up Healthy and Happy”. The film explored the emotional wellbeing and mental health of children and young people and the services and resources which were available to support them. The film recognised the importance of building resilience, promoting good mental health and wellbeing and enabling children and young people to grow up happy and healthy. The PHAR also covered key facts and figures and highlighted a number of recommendations for implementation during 2018/19.

Following the meeting of the Council on 19 July 2018, the video would be available for viewing via the Council’s web-site and would be widely disseminated.

Steve Gowland, Public Health Lead, was in attendance at the meeting to present the PHAR and respond to questions put by Members of the Committee.

Hard copies of the PHAR were circulated at the meeting.

Members of the Committee asked questions/raised matters on the following issues:-

- The PHAR was very well received by Members.

- Which groups had been involved with the video?
  There were so many established groups it had been difficult to determine who to involve. A number of schools had been involved including Greenbank High School and Merefield School.

- How would the PHAR be promoted within schools so that young people would be aware of services?
  Some activity was just commencing and a charity, Young Minds, would be getting involved with schools. The link to the video would go live once full Council had received the PHAR and the link would be shared with schools. Liverpool John Moores University would be evaluating a number of pilot projects that had been commissioned to develop resilience amongst school age children.

- How widespread was mindfulness practiced in schools?
  Some schools were using forms of mindfulness practice. However, the Public Health team had not identified a cost effective intervention that could be rolled out across all schools.

RESOLVED:

That the Public Health Annual Report be received and its contents be noted.

## 5. DEVELOPMENT OF FAMILY WELLBEING SERVICE – PROGRESS REPORT

Further to Minute No. 27 of 5 December 2017, the Committee considered the report of the Director of Social Care and Health providing the Committee the opportunity to comment on the proposals to align Family Wellbeing Centres into Locality working and note the outcomes of Sefton Community First.

The report set out the background to the matter; the context of Family Wellbeing; the all-encompassing operating model developed, namely Sefton Community First offer that provided a holistic approach and joined up work with public health, NHS and wider council work, together with the ASPIRE outcome framework; engagement sessions held with the community, partners, parent/carers, schools and Head Teachers; the implementation of a new funding methodology; the delivery programme currently being developed, timetabled and shared with families; and conclusions.

The following appendices were attached to the report:-

- Appendix 1 - Sefton Community First;
- Appendix 2 - Delivery model;
- Appendix 3 - Staffing structure; and
- Appendix 4 - Staffing allocation.

Members of the Committee asked questions/raised matters on the following issues:-

- What control did the Local Authority have over the delivery of services commissioned directly through schools?
  When Children's Centres were first delivered through schools, the specification/model was probably not robust enough. There was much more clarity on the model now and services would be commissioned through schools with the Local authority having control through the Locality model. An annual review would also take place.

- Reference was made to Appendix 1 – the "Sefton Community First 2018-2020" document which was marked as a draft.
  The Locality model had been agreed by the full Council and consultation had taken place during 2017. There were still a small number of board meetings yet to receive the document.

- Concerns were raised regarding issues with the speech and language service.
  The service was commissioned and discussions might be required with the Clinical Commissioning Groups. An update could be provided to the Committee in the future. The Director of Social Care and Health would contact the Member concerned for details.

- There were anecdotal reports of parents/carers not receiving services for children with autism unless they were classed as targeted families. This was considered to be contrary to early intervention and prevention approach.
  The Director of Social Care and Health would contact the Member concerned for details.

- Reference was made to Appendix 4 – "Proposed Staffing". Which Council Department(s) would these posts come under?
  The services referred to would become part of the Locality model which would be one generic service and would be more seamless, rather than officers working in silos.

RESOLVED: That the following aspects of the development of the Family Wellbeing Service be noted:-

(1) the principles of Sefton Community First;

(2) the ASPIRE outcomes;

(3) the role of Family Wellbeing Centres within Sefton Community First; and

(4) the new posts currently being consulted on within the structure.

**6. CHILDREN'S SOCIAL CARE ANNUAL REPORT**

Further to Minute No. 5 of 21 June 2017, the Committee considered the report of the Director of Social Care and Health providing a summary of the progress in relation to the Children's Social Care Improvement Plan 2017 /18, to be considered alongside the performance scorecard data.

The Plan identified three key objectives, namely:-

1. Ensure frontline practice is consistently good, effective and focussed on timely, measurable outcomes for children.
2. To improve management oversight at all levels to ensure effective services for children and young people receive good quality supervision
3. Ensure that frontline services are sufficiently resourced and the workforce appropriately skilled to enable high quality work to be undertaken with children and young people.

The following appendices were attached to the report:-

- Children's Social Care Annual Report
- Annual performance score card

Members of the Committee asked questions/raised matters on the following issues:-

- What sort of accommodation was available for care leavers?
  An increasing number of care leavers were continuing to live with carers. A range of accommodation was available and close work took place with Housing associations to identify types of supported living schemes. Care leavers were not placed in Bed and Breakfast type accommodation.

- Reference was made to front-line services being sufficiently resourced and the workforce being appropriately skilled. When would this support be "bedded-in"?
  Although the re-structure had gone smoothly, some issues had arisen since and it was considered that support was required for newly qualified social workers. The Local Government Association (LGA) had undertaken a peer review and a new improvement plan would be developed to ensure that improvement continued.

- Could information on Serious Case Reviews be reported to this Committee for information?
  Serious Case Reviews were reported to the Local Safeguarding Children's Board (LSCB) and could also be reported to the Committee.

- Timeliness of reports to Child Protection conferences was a concern as only 28.5% of reports were available 3 days prior to conference. What could be done to support this process?
  This action was monitored via monthly monitoring reports and it was anticipated that performance would improve.

- Were newly qualified social workers being retained by the Council?
  The Council was generally good at retention and not over-dependent on agency workers, although this area was always a challenge. National research indicated that social workers tended to stay for around three years in a front-line role.

- When would the next update to the Committee be reported?
  The refreshed Improvement Plan, together with the outcome of the peer review was likely to be submitted to the Committee in September 2018.

RESOLVED: That

(1) the Committee continues to receive bi-annual reports and updated performance scorecards;

(2) the Committee receives the reviewed and refreshed version of the Children's Social Care Improvement Plan at the September meeting; and

(3) the receipt of information on Serious Case Reviews be added to the Committee's Work Programme for 2018/19 and the Head of Children's Social Care be requested to submit information to the Committee as and when cases arise.

## 7. CAHMS WORKING GROUP - INTERIM REPORT.

Further to Minute No. 102 of the Cabinet meeting of 11 January 2018, the Committee considered the report of the Head of Schools and Families highlighting the work done on implementing each of the agreed recommendations contained within the Children and Adolescent Mental Health Service (CAMHS) Final Report.

This Committee had established a Working Group in July 2016, to review the CAMHS Service across Sefton. At its meeting on 5 December 2017, the Committee had considered the Working Group Final Report and commended it, together with the recommendations, to the Cabinet for approval. Following Cabinet approval in January 2018, the Committee had asked for an interim report on the recommendations of the Working Group.

The report set out the background to the matter, together with an update against each of the recommendations made by the Working Group and agreed by Cabinet.

Fiona Taylor, Chief Officer for NHS South Sefton Clinical Commissioning Group and NHS Southport and Formby Clinical Commissioning Group (CCG), was in attendance from the CCGs to update the Committee.

Members of the Committee asked questions/raised matters on the following issues:-

- Concerns had been expressed at the last meeting regarding the waiting times to access services.
  The average waiting time from referral into the service was now 23 weeks. The first assessment waiting time was 7-10 weeks.

- Were the CCGs satisfied with the current waiting times?
  The CCGs were not content with the waiting times but were contributing additional funding to the Provider and working with the current Provider to improve performance. Investment was also being made with the Voluntary, Community and Faith (VCF) sector, as some organisations provided certain services.

- Could Mersey Care NHS Foundation Trust be considered as an alternative Provider?
  Mersey Care was registered to provide services to adults, not children and young people.

- What was an acceptable waiting time to access services?
  Ideally, waiting times should be zero. The NHS Constitution provided for 18 weeks waiting time and the CCGs would like to see 18 weeks waiting time to be achieved, as a minimum.

- At what point would the CCGs consider withdrawal from the contract with the current Provider?
  Consideration would be given at the end of the current financial year. The CCGs would at least expect the waiting times to be reduced by then.

- A number of initiatives were being provided for children and young people and these would be evaluated by Liverpool John Moores University.
  The Committee would be interested to see the results, once available.

- Mindfulness was used in adult services and Members expressed surprise that it was not adopted by schools.
  Mindfulness tended to be an expensive intervention and whatever interventions were implemented needed to be sustained. Interventions adopted tended to be evidence based as they were able to be evaluated.

- A Task and Finish Group had been established to develop an on-line resource for schools to access information for pupils' emotional health and wellbeing needs. Was there any update on this?
  An update could be obtained prior to a further report providing an annual position.

- The CCGs had undertaken a piece of mapping work on "Every Child Matters" and this could be provided to Committee Members.

- Would the THRIVE model affect the service and the way it was provided?
  The model was used to locate the child in its environment, with a view to understanding a child's challenging or troubling behaviour or communication.

- Further information on performance and patient experience could be provided to Committee Members.

- A further update on CAMHS would be made available to the Committee in January 2019.

RESOLVED: That

(1) the report be noted; and

(2) the Head of Schools and Families be requested to submit a further update on CAMHS to the Committee in January 2019 and this be included in the Committee's Work Programme for 2018/19.

## 8. NEETS WORKING GROUP REPORT

Further to Minute No. 5 of the meeting of the Overview and Scrutiny Committee (Regeneration and Skills), the Committee considered the report of the Executive Director setting out the progress made against each recommendation of the Not in Education, Employment or Training (NEET) Working Group Final Report, published in 2013.

The report detailed the evolving context for NEET support relating to the Liverpool City Region (LCR) Careers Hub; the Liverpool City Region (LCR) Apprenticeship Hub; the LCR Apprenticeship Growth Plan; the National Careers Strategy; provision for special educational needs and disability and Youth Employment Initiatives through Sefton@work; and the local impacts for Sefton.

The report concluded by detailing updates against each of the recommendations in the Final Report; and recommended that future reporting on this issue form part of the reporting framework to be devised once the Council had adopted the forthcoming Sefton Economic Strategy, as this would supersede and update the recommendations of the NEET Working Group dating back to 2013.

Claire Maguire, Service Manager (Employment and Learning) referred to Career Connect key performance measures, "unlocking potential" statistics and 4 case studies which highlighted the work being undertaken by Career Connect.

Information was provided on Career Connect.

Members of the Committee asked questions/raised matters on the following issues:-

- Could information regarding monitoring of young people leaving care and young people with SEND and their participation in education, training or employment be provided to the Committee?

RESOLVED: That

(1) the report setting out the progress made against each recommendation of the Not in Education, Employment or Training Working Group Final Report be noted;

(2) future reporting on this issue form part of the reporting framework to be devised once the Council adopts the forthcoming Sefton Economic Strategy, as this will supersede and update the recommendations of the NEET Working Group dating back to 2013;

(3) the information relating to Career Connect Ltd. key performance measures, "unlocking potential" statistics and 4 case studies which highlighted the work being undertaken by Career Connect be circulated to all Committee Members; and

(4) the Executive Director be requested to submit information regarding the destinations of young people with SEND in terms of education, training and employment to the Committee at its meeting to be held in January 2019.

## 9. LICENSING/CHILD SEXUAL EXPLOITATION WORKING GROUP FINAL REPORT – JUNE 2018

Further to Minute No. 6 of the meeting of the Overview and Scrutiny Committee (Regulatory, Compliance and Corporate Services) of 12 June 2018, the Committee considered the report of the Head of Regulation and Compliance setting out progress made against each of the recommendations formulated by the Licensing/Child Sexual Exploitation Working Group and approved by Cabinet.

One recommendation requested that contact be made with the borough's three Members of parliament seeking the views of Government on strengthening the existing Regulations regarding personal licences and to ensure that Care Providers who offer residential placements for 16 – 18 year old children and young people were inspected by a regulatory body. Peter Dowd M.P. had contacted Nadhim Zahawi M.P. Parliamentary Under-Secretary of State for Children and Families and Mr. Zahawi's response was attached to the report.

A Further recommendation requested the Head of Schools and Families to promote the Child Sexual Exploitation e-learning tool with all schools and governing bodies and with a request that school e-newsletters contain a hyperlink to the e-learning tool. The report provided information on how 23 schools across the borough had actioned the request.

Members of the Committee asked questions/raised matters on the following issues:-

- The Child Sexual Exploitation e-learning tool was being promoted with all schools and governing bodies, with a request that school

newsletters should contain a hyperlink to the e-learning tool. What was the Council doing to encourage the issue of on-line safety with schools?
The Director of Social Care and Health chaired a group on child exploitation. He would ensure that the e-learning tool was promoted at the next meeting.

RESOLVED:

That the report setting out progress made against each of the recommendations formulated by the Licensing/Child Sexual Exploitation Working Group and approved by Cabinet be noted.

## 10. SPECIAL EDUCATIONAL NEEDS AND DISABILITY PROCESS OF ASSESSMENT WORKING GROUP - FINAL REPORT

The Committee considered the report of the Head of Regulation and Compliance formally presenting the final report of the Special Educational Needs and Disability Process of Assessment Working Group. The Committee had established the Working Group at its meeting on 26 September 2018 and the Final Report of the Working Group was attached to the report.

The Terms of Reference for the Working Group had been as follows:-

> "To review the Special Educational Needs and Disability Process of Assessment, in terms of "what it will look like in the future", to include the following aspects:-
>
> - Confidence in mainstream education to support Special Educational Needs; with particular reference to:-
>
>  - Referrals and Assessments;
>  - Information provided to parents/carers, particularly on assessment and during the transition to secondary school;
>  - SEN provision in schools;
>  - Sharing of "good/best practice".

Councillor Spencer, Lead Member of the Working Group, presented the Working Group's Final Report to the Committee.

The Chair commented that she had only been able to attend a couple of Working Group meetings. She requested recommendation 1. (h) to be re-worded, in order to make it more directive in nature.

Members of the Committee asked questions/raised matters on the following issues:-

- The role of the School Nurse.

- Dedicated non-teaching Special Educational Needs Co-ordinators (SENCOs), as opposed to those SENCOs with a combined teaching role; and
- The use of the term “unit” within schools.

The Director of Social Care and Health indicated that recommendation 1. (a) was likely to require a report back on the matter.

The Chair raised concerns regarding the revenue costs that were potentially associated with the recommendations and requested the recommendations to be subject to any budget implications.

The Chair thanked Members of the Working Group for their time and input into the review.

RESOLVED:

That provided the recommendations are subject to any budget implications and the inclusion of the revised recommendation 1 (h), the report and the following recommendations be supported and commended to the Cabinet for approval:-

(1) That the Head of Schools and Families be requested to:-

(a) Review the current provision of Special Educational Needs (SEN) units within schools, in order to ensure that appropriate provision is available within the relevant schools, as evidence provided suggests that the current system is not meeting the needs of children and their families appropriately;

(b) Encourage relevant schools to consider an alternative term for “SEN unit”, possibly describing themselves as a “SEN-friendly school”, in order to reduce stigma and improve compliance with the Equality Act;

(c) Liaise with the Sefton Clinical Commissioning Groups and Alder Hey Children’s NHS Foundation Trust in order to explore the possibility of requesting assessment appointments by professional experts to be carried out in schools wherever possible, particularly specialised schools and those schools with a unit, in order to provide a “safe” environment for children, with less preparation required for those children who experience anxiety when their routine is disrupted;

(d) Encourage those schools that have a SEN unit to have a dedicated Special Educational Needs Co-ordinator (SENCO), particularly where there are a high proportion of children with SEND, as evidence provided indicates that

access to appropriate resources is greater in settings where there is a dedicated SENCO;

(e) Encourage schools to include SENCOs on the management team for the school, in order to enhance the profile of SEND;

(f) Encourage schools to support SENCOs to undertake referrals of children with SEND for professional input and assessment appointments, in order to minimise delays in obtaining Education, Health and Care Plans (EHCPs);

(g) Explore the possibility, in conjunction with the Council's Senior Educational Psychologist, of encouraging schools to undertake joint training on SEND for parents/carers' groups within schools, with teachers and governors, in order to ensure that the information and approach provided are consistent, appropriate embedded;

(h) Include Frequently Asked Questions (FAQs) for parents/carers of children with SEND within the information available on school admissions, as part of the "school readiness" approach, in order to create an efficient and effective home-school partnership from the outset, in conjunction with the Assessment, Resource and Provision Planning Team;

(i) Explore the possibility of increasing communication with parents/carers on SEND through the Borough's Family Wellbeing Centres, particularly from an early years' perspective and possibly through the development of leaflets, in order to enhance "school readiness" for the children and their parents/carers;

(j) Liaise with the Sefton Clinical Commissioning Groups to explore the possibility of requesting that information on SEND for parents/carers is included with/within the Personal Child Health Record (red book) and through the Healthy Child Programme, in order to assist in early intervention;

(k) Encourage schools to include potentially useful contacts and useful events on SEND within school newsletters, in order to ensure that all parents/carers have access to them;

(l) Encourage primary schools to share good practice and to consider undertaking inclusivity education with all children, particularly relating to SEND and neuro-diversity, in order to raise standards and ensure equitable and universal access to provision within schools;

(m) Revise Sefton's Local Offer in order to make it more user-friendly and accessible to parents/carers, which could

include ensuring that it is easier to find on the Council's web-site, using less formal language and the inclusion of a glossary of terms and abbreviations;

(n) Liaise with the Council's Head of Health and Wellbeing in order to:

(i) Encourage schools to advertise and promote the School Nurse drop-in sessions within their newsletters, so that parents/carers have a greater opportunity to access them;

(ii) Request the School Nursing Service to approach the SENCO Forum, with a view to discussing the Healthy Schools Programme and to clarify the role of the School Nurse, particularly in relation to assessing children with SEND and in order to minimise delays in obtaining EHC Plans, as this would help to manage the expectations of parents/carers;

(o) Submit a report to a future meeting of the Overview and Scrutiny Committee (Children's Services and Safeguarding), following an audit, providing information on the following:-

(i) Any high schools which are restricting the number of enhanced transitions for SEND, together with explanations for the reasons behind the decisions;

(ii) The number of children with SEND accessing Sefton schools who come from outside the Borough and the reasons for this;

(iii) Consideration of how parents who have children with SEND and who are not engaging with schools could be engaged, or re-engaged;

(iv) Whether funding has been withdrawn for children with SEND in Year 6 and the reasons for withdrawal;

(2) That the Head of Health and Wellbeing be requested to ensure that the School Nurse carries out their role prior to any collaboration with the school SENCO, in relation to assessing and referring children with SEND, in order to minimise delays in obtaining EHC Plans;

(3) That the Overview and Scrutiny Committee (Children's Services and Safeguarding) be requested to consider the establishment of a Working Group in the future to examine post-19 provision for SENDs, in order to improve conditions for this vulnerable group of young people. This could be a Joint Working Group with the Overview and Scrutiny Committee (Regeneration and Skills); and

(4) That the Senior Democratic Services Officer be requested to liaise with relevant officers in order to ensure that the Overview and Scrutiny Committee (Children's Services and Safeguarding) receives a six-monthly monitoring report, setting out progress made against each of the recommendations outlined above and as a means of ensuring SMART objectives.

## 11. CABINET MEMBER REPORT

The Committee considered the report of the Head of Regulation and Compliance in relation to the most recent report of the Cabinet Member – Children, Schools and Safeguarding for the period June 2018. The report outlined information on the following:-

- Schools Funding;
- Academy Conversions;
- Sefton School led School Improvement System;
- Free School Meal Eligibility Changes;
- SEND Inspection Letter;
- School Attendance and Absence;
- Family Care Associates; and
- Enhancing Elected Members Involvement with Children's Social Care.

RESOLVED:

That the Cabinet Member update report be noted.

## 12. WORK PROGRAMME KEY DECISION FORWARD PLAN

The Committee considered the report of the Head of Regulation and Compliance seeking the views of the Committee on the draft Work Programme for 2018/19; requesting the identification of potential topics for scrutiny reviews to be undertaken by any Working Group(s) appointed by the Committee; and identification of any items for pre-scrutiny scrutiny by the Committee from the Key Decision Forward Plan.

A Work Programme for 2018/19 was set out in Appendix A to the report, to be considered, along with any additional items to be included and agreed.

Further to Minutes nod. 6 (3), 7(2) and 8 (4) above, the Committee had requested certain additional items for meetings during 2018/19.

The Committee was invited to consider a topic for review during 2018/19. Further to Minute no. 10 (3) above, a proposal had been made by the Special Educational Needs and Disability Process of Assessment Working

Group to establish a working group to consider post 19 provision. This could be a joint working group with the Overview and Scrutiny Committee (Regeneration and Skills).

There were two Decisions within the latest Key Decision Forward Plan, attached to the report at Appendix D that fell under this Committee's remit, and the Committee was invited to consider items for pre-scrutiny.

Further to Minute No. 102 (7) of the Cabinet meeting of 11 January 2018, the possibility of a site visit to the Dewi Jones Unit in Waterloo was currently being investigated and Members would be advised of arrangements in due course. The Senior Democratic Services Officer would liaise with the Chair of the Committee regarding potential dates for the visits.

RESOLVED: That

(1) the Work Programme for 2018/19, as set out in Appendix A to the report, be agreed;

(2) the following additional item(s) be added to the Committee's Work Programme for 2018/19:-

- The Head of Children's Social Care be requested to submit information on Serious Case Reviews to the Committee, as and when cases arise;

- the Head of Schools and Families be requested to submit a further update on the implementation of the recommendations of the Children and Adolescent Mental Health Services Working Group (CAMHS) to the Committee on 29 January 2019; and

- the Executive Director be requested to submit information regarding young people with SEND in paid/voluntary employment to the Committee at its meeting to be held on 29 January 2019;

(3) the Overview and Scrutiny Committee (Regeneration and Skills) be requested to consider the establishment of a joint working group to consider post-19 provision for Special Educational Needs and Disability, with Members of this Committee;

(4) the contents of the Key Decision Forward Plan for the period July to 31 October 2018 be noted, and

(5) following the outcome of the Children and Adolescent Mental Health Services (CAMHS) review, the Committee is requested to note the possibility of a future site visit to the Dewi Jones Unit, Waterloo.

**13. LIBBY KITT, CO-OPTED MEMBER**

The Chair reported that this was Libby Kitt's last meeting of the Committee, as she was stepping down from her role as Healthwatch Sefton Adviser.

RESOLVED:

That best wishes be accorded to Libby for the future and thanks be extended for her input into the work of this Committee.

| | | | |
|---|---|---|---|
| **Report to:** | Overview and Scrutiny Committee (Children's Services and Safeguarding) | **Date of Meeting:** | Tuesday 25 September 2018 |
| **Subject:** | Children's Social Care Continuous Improvement Plan | | |
| **Report of:** | Director of Social Care and Health | **Wards Affected:** | (All Wards); |
| **Portfolio:** | Children's, Schools and Safeguarding | | |
| **Is this a Key Decision:** | No | **Included in Forward Plan:** | No |
| **Exempt / Confidential Report:** | No | | |

**Summary:**

Children's Social Care was inspected by Ofsted under the Single Inspection Framework in April 2016 and were judged as requires improvement. An improvement plan was developed which addressed the 11 recommendations made by Ofsted. Bi – annual reports have been provided to the committee in relation to progress against these recommendations supported by a performance dash – board. The Annual report was presented to the last committee on 10th July 2018

This plan is the third refresh of our Improvement plan and incorporates learning from the Local Government Care Practice Diagnostic which took place in April 2018, the recently published Serious Case Review as well as learning from audits.

The Plan identifies three key objectives:

1. Ensure frontline practice is consistently good, effective and focussed on timely, measurable outcomes for children.
2. To improve management oversight at all levels to ensure effective services for children and young people receive good quality supervision
3. Ensure that frontline services are sufficiently resourced and the workforce appropriately skilled to enable high quality work to be undertaken with children and young people.

**Recommendation(s):**

(1) Bi – annual reports and performance scorecards continue to be received by the committee for scrutiny and challenge.

**Reasons for the Recommendation(s):**

Overview and scrutiny committee have an important role in receiving and scrutinising performance data to assure themselves of the effectiveness of Children's Social Care

**Alternative Options Considered and Rejected:** (including any Risk Implications)

**What will it cost and how will it be financed?**

**(A) Revenue Costs**

The Children's Social Care budget is under significant pressure, with the placement costs for Looked After Children is currently forecast to overspend by £4m in 2018/19. Any costs associated with the outcomes from the attached Social Care Continuous Improvement Plan must be contained within existing resources.

**(B) Capital Costs**

**Implications of the Proposals:**

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| **Resource Implications (Financial, IT, Staffing and Assets):** |
| **Legal Implications:** |
| **Equality Implications:**<br><br>There are no equality implications |

**Contribution to the Council's Core Purpose:**

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| Protect the most vulnerable: Children's Social Care have a statutory duty to protect the most vulnerable. |
| Facilitate confident and resilient communities: Children's social care work with children and their families to improve outcomes for children |
| Commission, broker and provide core services: Children's social care work in partnership with a range of organisations to ensure vulnerable children are safeguarded |

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| Place – leadership and influencer: |
| Drivers of change and reform: |
| Facilitate sustainable economic prosperity: |
| Greater income for social investment: |
| Cleaner Greener |

**What consultations have taken place on the proposals and when?**

**(A) Internal Consultations**

The Head of Corporate Resources (FD.5298/18) and the Chief Legal and Democratic Officer (LD4523/18) have been consulted and any comments have been incorporated into the report.

**(B) External Consultations**

N/A

**Implementation Date for the Decision**

Immediately following the committee meeting.

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| **Contact Officer:** | Vicky Buchanan |
| Telephone Number: | Tel: 0151 934 3128 |
| Email Address: | vicky.buchanan@sefton.gov.uk |

**Appendices:**

The following appendices are attached to this report:

Children's Social Care Continuous Improvement Plan

**Background Papers:**

There are no background papers available for inspection.

# Sefton MBC
# Children's Services
# Improvement Action Plan
# 2018-19
## (V.1)

Sefton Council

# Foreword

Welcome to our Children and Young People's Improvement Plan 2018 – 2019. This plan sets out how we will ensure that outcomes for children and young people in Sefton continue to improve, and we achieve our aspiration that all our services for children and young people are good or better.

We want all children and young people in Sefton to have a positive start in life and to be safe. In order to achieve this we need to continue to find ways to put children and young people at the heart of all our activity and focus on listening to them.

## Key areas of focus for 2018-19

**The Senior Management Team have met regularly throughout 2017 and 2018 to review last year's Improvement Plan and ensure all staff are aware of the priorities and actions through Practice and Performance Workshops and our Practice Champions. We have reviewed progress made against the previous plan, alongside performance management information, quality audit findings. We have also considered Sefton LSCB quality audit findings, performance data analysis and Serious / Local Case Review findings. The following areas remain a focus of the 2018-19 plan:**

**1. *Ensure frontline practice is consistently good, effective and focussed on timely, measurable outcomes for children.***

- **1.1 Assessment and Planning**
- **1.2 Voice of child and understanding the daily live experience**
- **1.3 Looked After Children and Care Leavers**

**2. *To improve management oversight at all levels to ensure effective services for children and young people and that frontline staff receive good quality supervision.***

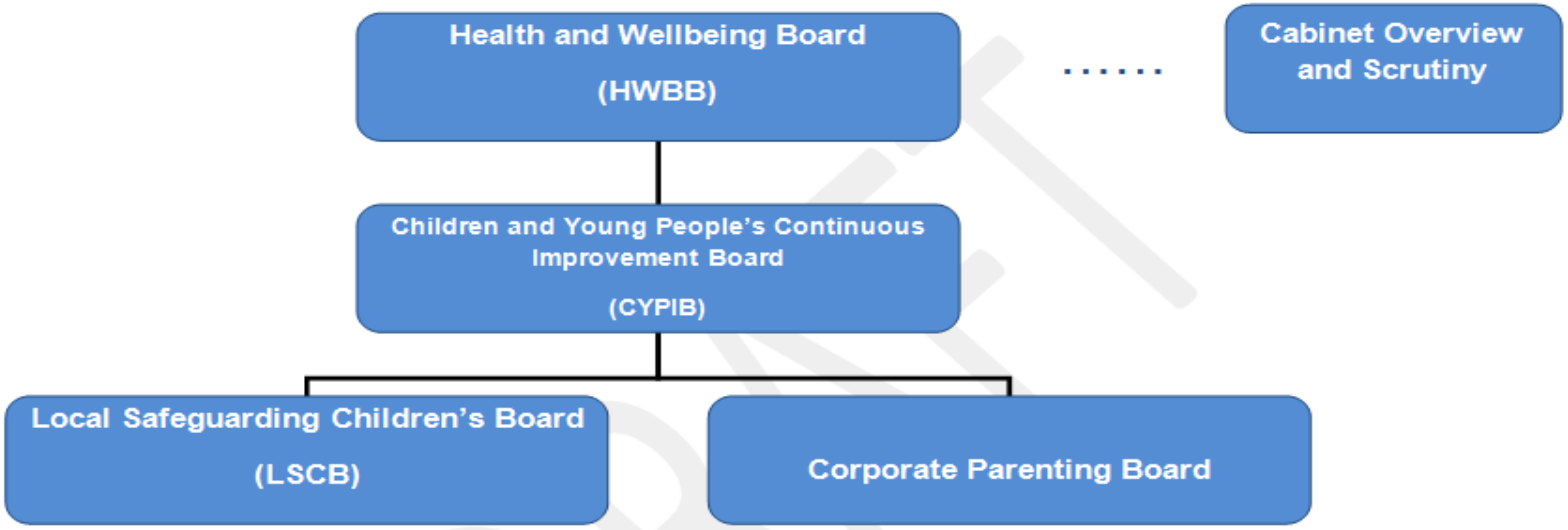
**3. *Ensure that frontline services are sufficiently resourced and the workforce appropriately skilled to enable high quality work to be undertaken with children and young people.***

*We are committed to embedding a culture of continuous learning, support and challenge. Our staff are passionate and committed and they are key to driving this improvement.*

*The plan addresses our areas for improvement, building on the work we undertook last year to address recommendations from the Ofsted inspection in April 2016 and the action plan that was developed. The wider plans for Children's services are contained within the Children and Young People's Plan 2015 – 2020, The LSCB Business Plan, the Health and Wellbeing Strategy and the Corporate Parenting Strategy. In addition, the plan aligns with Sefton Borough Councils 2030 vision and Framework for change.*

*The council has been through a significant transformation and children's social care have restructured to assure that we fully align with new models of locality delivery, strengthening our links with early help and improving our response at all levels of need.*

*The plan is focussed on activity to continually improve services. The plan will evolve over time in response to feedback from children, young people, partners, staff and external review and challenge. Our plan will be regularly reviewed and scrutinised, with the help of our children and young people, to ensure we are achieving the desired impact we need for children and young people to reach their full potential, through the following Governance Arrangement.*



| Recommendation | 1.1 Front Line Practice – Assessment and Planning |
|---|---|
| **Our ambition (what 'good' looks like)** | • For children who need help and protection, assessments (including common or early help assessments) are timely, proportionate to risk, and informed by research and by the historical context and significant events for each case<br>• Assessments[1] (including children in need assessments) result in a direct offer of help to address any identified needs<br>• Assessments and plans are dynamic and change in the light of emerging issues and risks<br>• Viability assessments of members of the family are carried out promptly to a good standard and sequential assessments are avoided<br>• Children who are looked after benefit from assessments that are routinely updated in response to a change in circumstances or changing need<br>• Information from specialist workers, such as substance misuse workers and mental health professionals, is used to inform assessments where relevant factors are present<br>• Assessment and subsequent planning for children and young people is sensitive and responsive to age, disability, ethnicity, faith or belief, gender, gender identity, language, race and sexual orientation<br>• All plans are SMART – specific, measurable, attainable, realistic and time limited, and outcome focused<br>• Plans are based on individual needs of children and young people and their family<br>• Contingency plans are in place to mitigate risk and protect children and young people<br>• There is a clear process for assessing whether the outcomes in the plan have been achieved, which is understood by all parties: children, young people, parents, carers, and all agencies<br>• Progress against the plan is robustly monitored and the action taken is timely and results in improved outcomes<br>• The sustainability of changes is fully considered and appropriate support and contingency plans are in place to support families to maintain changes<br>• Pathway planning is effective and plans address all young people's needs in particular education, employment and training and are updated as circumstances change<br>• Plans, Social Work Reports and Case Records are kept up to date and are clear and concise<br>• All children benefit from good robust plans regardless of where they are placed<br>• Children and young people who are privately fostered are identified by the local authority, in conjunction with partners<br>• Once they are identified, Sefton discharges in full its statutory responsibility to ensure that they are safe and that their health and well-being are properly promoted<br>• Workforce and partnership all have a clear understanding of what Private Fostering is and our statutory duty<br>• All young people aged 16 or 2017 who present as homeless to be assessed in accordance with statutory guidelines within 10 working days<br>• All such assessments explore the wishes of the young person in relation to becoming a looked after child and the need for this measure<br>• Appropriate risk assessment and management to be put in place for all young people who present as homeless and |

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| | require emergency accommodation<br>• Continue to provide a range of good quality accommodation<br>• Care plans are regularly reviewed to ensure that the child or young person's current and developing needs continue to be met<br>• Care plans for Looked After Children are updated within 10 days of the review |

## WHAT WE WILL DO TO DEVELOP CONSISTENTLY GOOD PRACTICE

| Ref | Action | *Progress / Review Date* | Lead | Update Commentary |
|---|---|---|---|---|
| 1.1.1 | CSC & IRO Service workforce to be provided with the Aug LSCB newsletter stating need to read the SCR Report re: Martha, Mary & Ben (MMB). | Aug 2018 COMPLETE | Vicky Buchanan, Head of Service | **Completed**, LSCB newsletter sent out to workforce 01.08.18. |
| 1.1.2 | Review Performance and Quality assurance framework to reflect new approach to focussed audits and include audit plan for the year. | Oct 18 | Kara Haskayne, Service Manager Independent Safeguarding & Quality Assurance Unit | Briefing paper due to be discussed at August CSC Performance Meeting to include dates of Audits. |
| 1.1.3 | Practice & Performance Meeting to be undertaken with workforce focused on learning from SCR (MMB) - discuss SCR report and CSC Individual Management Review recommendations and agree actions workforce to undertake. | Sept 2018 | Trish Galloway, Service Manager | Practice & Performance Meeting being prepared for Sept 2018 |
| 1.1.4 | Undertake quality audit re: completed S47 enquiries which have been no further actioned, to ensure:<br>• If key agency unable to attend strategy meeting, changes have been made to accommodate attendance or agency has provided a written report<br>• All strategy meeting/discussion actions have been undertaken<br>• Professional agency views have been taken | Oct 2018 | Trish Galloway, Service Manager | |

| Ref | Action | *Progress / Review Date* | Lead | Update Commentary |
|---|---|---|---|---|
| | in account.<br>*(SCR MMB - recommendation 1 & CSC IMR recommendation)* | | | |
| 1.1.5 | Undertake quality audit of children subject of a CiN or CP Plan re: neglect concerns, to ensure Graded Care Assessment has been undertaken *(SCR MMB - recommendation 3)* | Nov 2018 | CSC QA Manager, Helen Splaine | |
| 1.1.6 | Review to be undertaken of CSC CiN Practice Standards, to ensure they include:<br>i) if evaluation of risk of harm is obscured by parental non-engagement, the CiN meeting must be chaired by a Team Manager<br>ii) ii) this meeting must address impact of non-engagement by parents<br>iii) iii) Rationale for decisions and actions must be clearly recorded in all the child's record. *(SCR MMB - recommendation 4)*<br>*iv)* Ensuring the right team is around the family and that CIN and Multi agency working is just as robust as CP or LAC *(LSCB Child Criminal Exploitation Audit – CSC recommendation 9)* | Sept 2018 | Trish Galloway, Service Manager | |
| 1.1.7 | Communicate learning from Q1 (2018-19) CiN Audit & updated CiN Practice Standards to CSC workforce at Practice & Performance Meeting *(SCR MMB - recommendation 4)* | Sept 2018 | Trish Galloway, Service Manager | |
| 1.1.8 | Undertake re-audit re: children subject of a CiN Plan, to ensure i) meetings chaired by Team Manager when agencies have not been able to engage parents, ii) meetings have address impact of non-engagement and iii) rational for decisions are recorded on the child's record & iv) the right team is around the child and their | By end of Q3 | CSC QA Manager, | |

| Ref | Action | *Progress / Review Date* | Lead | Update Commentary |
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| | family.<br>*(SCR MMB - recommendation 4)* | | | |
| 1.1.9 | Undertake quality audit of children subject of a CP Plan to ascertain:<br>• If Core Groups are being timely undertaking<br>• CP Plans are being updated by Core Groups<br>• If the CP Plan is focused on improving children's outcomes & family outcomes re: 'Turnaround Families outcomes'<br>• If the child's life daily experience has been understood and the child's voice has been heard<br>• If Safety Plans have replaced Working Agreements | Nov '18 | Kara Haskayne Service Manager & Nicky Horn IRO Manager | |
| 1.1.10 | Information Sharing Protocol between CSC and Substance Misuse Provider be reviewed, via Public Health Commissioner, to ensure learning from SCR MMB is addressed; and includes all potential points of communication from general enquiries, to advice working together under child protection plans.<br>*(SCR MMB, recommendation 6)* | Oct 2018 | Trish Galloway, Service Manager & Kara Haskayne, Service Manager | |
| 1.1.11 | Provide updated CSC and Substance Misuse Protocol to LSCB Workforce Development Lead so can be referred to within all elements of the LSCB Training programme, and CSC Workforce Development Lead so can be referenced in all CSC Training.<br>*(SCR MMB, recommendation 6)* | Oct 2018 | Trish Galloway, Service Manager | |
| 1.1.12 | Review training offered to Social Workers re: drug misusing parents and the impact pf parenting on children. | Oct 2018 | Joy Hughes, Service Manager (Principal Social Worker) | |

| Ref | Action | *Progress / Review Date* | Lead | Update Commentary |
|---|---|---|---|---|
| | *(SCR MMB - CSC Individual Management Review recommendation)* | | | |
| 1.1.13 | Review of Signs of Safety methodological approach to be undertaken and agreed actions to be reported to the LSCB 2nd or subsequent Plan Task & Finish Group<br>*(LSCB 2nd or subsequent Plan Review)*<br>*(LGA Review – recommendation k)* | Sept 2018 | Vicky Buchanan, Head of Service | Visit to Lincolnshire, Partners in Practice, undertaken to review their implementation of Signs of Safety |
| 1.1.14 | Develop Practice Guidance re: when a family has previously been subject to a CP Plan and further child protection concerns are referred to CSC, as part of the S47 enquiry, a multi-agency meeting, including wider family members should be held, to ensure the child's case is safely managed and maximise opportunity for a wider safety net.<br>*(LSCB 2nd or subsequent period CP Plan Review – recommendation 6)* | Sept 2018 | Joy Hughes, Service Manager | |
| 1.1.15 | Practice & Performance Workshop re: SCR MMB have focus session re: Assessments, to ensure assessments include:<br>• critical thinking<br>• detailed assessment of all adults either living in the household or providing significant care to children, regardless of their relationship with them<br>• analysis of accumulative risk of harm<br>• evaluation<br>• and are undertaken timely<br>*(LSCB 2nd or subsequent period CP Plan Review – recommendation 7)*<br>*(LSCB Child Criminal Exploitation Audit –* | Sept 2018 | Trish Galloway, Service Manager | |

| Ref | Action | *Progress / Review Date* | Lead | Update Commentary |
|---|---|---|---|---|
| | *recommendation 1)*<br>*(SCR MMR CSC Individual Management Review recommendation)* | | | |
| 1.1.16 | Deliver a briefing to Team Managers regarding the CSC Guidance to assess parent's capacity to change and agree that this will be considered in every child and family assessment that the managers authorise.<br>*(LSCB 2nd or subsequent period CP Plan Review – recommendation 8)* | Sept 2018 | Trish Galloway, Service Manager | |
| 1.1.17 | Deliver a briefing to Team Managers regarding the need to:<br>Upload EHC Plans to children's records<br>• Ensure a child's disability is recorded in their records<br>• Update the child's chronology<br>• Ensure SDQ (Strengths and Difficulties Assessment) is shared with Health to inform the annual Health Assessment and is recorded on a child's record and informs their Plan<br>*(LSCB Disabled Children Audit – CSC recommendation 1)* | Sept 2018 | Trish Galloway, Service Manager | |
| 1.1.18 | Undertake an audit of assessment quality to ensure all actions stated in 1.1.14 & 1.1.15 & 1.1.17 are consistently undertaken | By end of Q3 | CSC QA Manager, Helen Splaine | |
| 1.1.19 | Convene a joint Team Manager Forum meeting, with CSC and YOT and Early Help Team Managers, to discuss effective information sharing between services so that all services risk assessment informs the Plan being | Sept 2018 | Nicola Driscoll, MASH Team Manager | |

| Ref | Action | *Progress / Review Date* | Lead | Update Commentary |
|---|---|---|---|---|
| | undertaken with the child.<br>*(LSCB Child Criminal Exploitation Audit – CSC recommendation 1)* | | | |
| 1.1.20 | Undertake a joint audit (CSC & YOT) to ensure effective risk assessment sharing has improved the quality of 1 Plan for the child / young person. | By end of Q4 | Nicola Driscoll, MASH Team Manager | |
| 1.1.21 | Undertake a dip sample audit to monitor MASH providing feedback to agencies re: contacts they have made which have progressed to a S47 enquiry.<br><br>Undertake a dip sample audit to monitor Locality Team Managers providing feedback to agencies re: contacts they have made which have progressed to a S17 assessment.<br><br>(LSCB Domestic Abuse Audit – CSC recommendation 1)<br>*(CQC Health Review recommendation – reported awaited)* | By end of Q3 | Trish Galloway, Service Manager<br><br>Joy Hughes, Service Manager | |
| 1.1.22 | Ensure families are provided with Child Protection Conference Report 3 days before the Conference is taking place.<br>To support this the Safeguarding and Quality Assurance Unit will provide a monthly report re: timeliness to SMT and CSC Performance Meetings. | By end of Q3 | Vicky Buchanan, Head of Service | Monthly reports are being provided to CSC SMT and Performance Meetings. |
| 1.2.23 | Monthly report re: IRO Formal Practice Alerts re: themes to be provided to CSC Performance Meetings. | Sept 2018 | Nicky Horn, IRO Manager | |
| 1.2.24 | MASH Administrator to commence undertaking review of the professional involvements | Sept 2018 | Trish Galloway, Service Manager | |

| Ref | Action | *Progress / Review Date* | Lead | Update Commentary |
|---|---|---|---|---|
| | recorded on children's records, to ensure reflect the team around the child and their family. | | | |
| 1.2.25 | IROs to implement a compliance monitoring methodology for Child Protection Reviews | Oct 2018 | Nicky Horn, IRO Manager | |

## HOW WE WILL KNOW OUR PRACTICE IS GOOD?

| Performance Measure | What does it show? | Thresholds | | | |
|---|---|---|---|---|---|
| | | Inadequate | Requires Improvement | Good | Outstanding |
| Percentage of children and young people seen within 10 days of the referral. | That children are being visited regularly at a minimum in line with statutory timescales and are thus effectively being safeguarded and that their views are being used to inform assessment | <65 | 65-75 | 75-84 | 85+ |
| Percentage of children and young people seen within **5 days** of the referral | That children are being visited regularly at a minimum in line with statutory timescales and are thus effectively being safeguarded and that their views are being used to inform assessment | <50 | 50-60 | 60-75 | 75+ |
| Percentage of assessments completed within 15 days | The amount of assessments that are completed in a timely way, within Sefton's standard for good practice to drive improvement to timeliness for assessments. | <30 | 30-39 | 40-49 | 50-100 |
| Percentage of assessments completed within 35 days | The amount of assessments that are completed in a timely way. | <65 | 65-74 | 75-80 | 85+ |
| Percentage of assessments completed within 45 days | The amount of assessments that are completed within the national standard for timeliness. | <75 | 75-80 | 81-89 | 90+ |
| Percentage of assessments that are completed as NFA | That assessments are thorough and that children and families are not subject to multiple assessments in a short period of time, that support is afforded at the earliest opportunity. | >50 | 40-50 | 49-25 | >24 |
| Percentage of assessments audited that meet or exceed good (audit measure) | That the quality of assessments is of a good standard | <50 | 50-60 | 61-80 | 81+ |

| Performance Measure | What does it show? | Thresholds | | | |
|---|---|---|---|---|---|
| | | Inadequate | Requires Improvement | Good | Outstanding |
| The proportion of Children Looked After (CLA) who have been looked after for over 12 months who have had an assessment completed within the latest 12-month period | That Children Looked After are having their changing needs and circumstances assessed regularly. | <50 | 50-60 | 61-80 | 81+ |
| The proportion of Children with Disabilities subject to CiN for over 12 months who have had an assessment completed within the latest 12-month period | That Children with Disabilities receiving a service from Aiming High have a plan that is based on a current assessment of need. | <50 | 50-60 | 61-80 | 81+ |
| The proportion of CP plans ending that are accompanied by a C & F assessment that has been completed within 3 months of plan ceasing. | That social workers are making informed decision to end the plan using a C&F to assess whether the risk as suitably reduced risk and the child's daily lived experience has improved | <50 | 50-60 | 61-80 | 81+ |
| Percentage of plans meet or exceed good across all service areas (audit measure) | The amount of cases that have SMART plans – so these are clear and measurable, and this indicates they are a good quality, and it should be easy for professionals and families to know what is required, and to measure progress. | <65 | 65-79 | 80-89 | 90-100 |
| Percentage of children and young people with an up to date plan in line with practice standards CIN and CP | The amount of cases that have an up to date plan. This should increase as practice improves. | <65 | 65-79 | 80-89 | 90-100 |
| Percentage of children and young people subject to a child protection plan for a second or subsequent time | The number of children which have had support from children's social care were there was a high level of concerns, but then need this again at a later date. Demonstrates how well families are able to maintain the changes | >25 | 25-20 | 19-15 | <14 |

| Performance Measure | What does it show? | Thresholds | | | |
|---|---|---|---|---|---|
| | | Inadequate | Requires Improvement | Good | Outstanding |
| | they have made – a low percentage is an indicator of good performance. | | | | |
| Number of 16/17 year olds who present as homeless who are progressed to referral | That the Sefton Joint Homeless Protocol is embedded in practice | | Increase | | |
| Percentage of cases judged as meet or exceed good for assessment and risk (audit measure) | That practice is compliant and to a good standard and that risk is mitigated effectively. | <65 | 65-79 | 80-89 | 90-100 |
| Proportion of care plans completed within 10 days of the LAC review | That Sefton is compliant with practice standards and statutory guidelines and children have up to date high quality care plans | | 65-79 | 80-89 | 90-100 |
| Timeliness of cases stepped down or across to early help from date stepped over to date allocated a Lead Practitioner and first TAF meeting | That children are being effectively safeguarded and risk is mitigated by tight partnership arrangements and working | | Increase | | |
| The percentage of cases closed in Early Help in a 12-month period because we have not engaged the family | That families understand and engage with Early Help offer and that parents feel supported and helped. | >25 | 25-21 | 20-17 | <17 |

| Qualitative Information | Feedback from Children and Young People, Parents and Carers | | Feedback from Staff |
|---|---|---|---|
| **Audits** – show that the quality of front line practice is improving across all areas and can be clearly evidenced in records | **Survey of families and young people in conjunction with voluntary sector and through Focus on Practice week as well as feedback from MAD group** – demonstrate children, young people and parents feel they have received a good service that has helped them. Children, young people and parents report that they are clear on why the plan was in place and how this met their needs. | | **Practice and Performance Workshops and Supervision –** Staff reflect on what support they need to strengthen practice, and that their knowledge or relevant research, policies and procedure is evident |



| Recommendation | 1.2 Front Line Practice – Voice of the child |
|---|---|
| **Our ambition (what 'good' looks like)** | • The influence of age, disability, ethnicity, faith or belief, gender, gender identity, language, race and sexual orientation on the identity of the child / young person are considered during assessment and clearly recorded upon the child's record<br>• Children, young people and families benefit from improved multi-agency interventions and the impact of their feedback is well evidenced through improved performance, quality of practice and increased positive feedback<br>• Prompt action is taken to address areas identified for improvement through analysis of feedback<br>• Frontline staff know what the common themes are from feedback from children, young people and families, what they want services to look like, and how frontline staff can influence and affect this vision<br>• There is evidence of practice and service design that is informed, modified and sustainably improved by feedback about the quality of services and the experiences of children, young people and families who use them across the system<br>• The child's lived experience is understood and well evidenced in assessments and planning processes and informs decision making<br>• Views of children and young people are routinely used to inform planning<br>• Children and young people are encouraged to and are appropriately involved in meetings and reviews<br>• Children and young people are seen by their social worker alone and understand what is happening to them, their |

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| | views, wishes and feelings are listened to on visits, captured in written records and used to update planning<br>• Visits to children and young people are a viewed as a priority and valued by all staff |

## WHAT WE WILL DO TO DEVELOP CONSISTENTLY GOOD PRACTICE

| Ref | Action | *Progress Review Date* | Lead | Update Commentary |
|---|---|---|---|---|
| 1.2.1 | Implement Children Social Care & IRO Service CiN / CP Young Advisors Report recommendations | Nov 2018 | Trish Galloway / Joy Hughes Service Managers & Nicky Horn, IRO Manager | |
| 1.2.2 | Engage young people in undertaking a review Missing Children Independent Return Interviews | Nov 2018 | Kara Haskayne, Service Manager & Janette Maxwell, Team Manager Early Help | |
| 1.2.3 | Develop a directory of Direct Work Tools for staff to utilise to ascertain a child's daily lived experience. | Nov 2018 | Joy Hughes, Service Manager & Practice Champions Group | |
| 1.2.4 | IROs to develop minutes re: LAC Reviews to focus on communicating decisions and their Care Plans to the children and young people, to support that they understand decisions made about their life, and understand their 'life story'. | Oct 2018 | Nicky Horn, IRO Manager | IRO Development Meeting undertaken and IROs to prioritise changing the methodology of recording LAC meeting minutes, to focus on communicating to the child / young person during Q3. |
| 1.2.5 | Undertake audit of LAC Review IRO minutes, to ascertain if all IROs have changed the methodology of recording to focus on communicate to the child / young person. | Nov 2018 | Nicky Horn, IRO Manager | |

## HOW WE WILL KNOW OUR PRACTICE IS GOOD?

| Performance Measure | What does it show? | Thresholds | | | |
|---|---|---|---|---|---|
| | | Inadequate | Requires Improvement | Good | Outstanding |
| Percentage of statutory visits and CiN and CP visits completed within timescale increases | That children are being visited regularly at a minimum in line with statutory timescales. | <70 | 70-84 | 85-94 | 95-100 |
| Percentage of audits that meet or exceed good for children and young people and their families are appropriately involved (audit measure) | That children are being listened to and their voice is informing their plan and outcomes | <65 | 65-79 | 80-89 | 90-100 |
| The proportion of all CLA 5 and over who participate in the annual pledge survey | That children, young people are engaged and that they value the help, support, and interventions that they received. | <25 | 25-33 | 34-66 | 67-100 |

| Qualitative Information | Feedback from Children and Young People, Parents and Carers | | Feedback from Staff |
|---|---|---|---|
| **Audits** – show that the quality of front line practice with respect to capturing the child's voice is improving across all areas and can be clearly evidenced in records | **Survey of families and young people in conjunction with voluntary sector and through Focus on Practice week as well as feedback from MAD group** – demonstrate children, young people and parents feel they have received a good service that has helped them. Children, young people and parents report that they are clear on why the plan was in place and how this met their needs. | | **Practice and Performance Workshops and Supervision –** Staff reflect on what support they need to strengthen practice, and that their knowledge or relevant research, policies and procedure is evident |

| Recommendation | 1.3 Front Line Practice – LAC and Care Leavers |
|---|---|
| **Our ambition (what 'good' looks like)** | • Decisions to look after children and young people are timely and made only when it is in their best interests. Those decisions are based on clear, effective, comprehensive and risk-based assessments involving other professionals working with the family where appropriate.<br>• There is evidence of the effective use of the Public Law Outline, including letters before proceedings, family group conferences and parallel planning. Care is used only if this is in the child's best interests. Children and young people are safely and successfully returned home; where this is not possible for them, permanent plans are made for them to live away from the family home. Families are made aware of, and encouraged to access, legal advice and advocacy.<br>• Where the plan for a child or young person is to return home, there is evidence of purposeful work to help the family to change so it is safe for the child to return. Further episodes of being looked after are avoided unless they are provided as a part of a plan of support.<br>• Applications and assessments for care or other orders are accepted by the courts, minimise the appointment of experts and avoid unnecessary delay. The wishes and feelings of children and young people, and those of their parents, are clearly set out and contemporary. Viability assessments of members of the family are carried out promptly to a good standard and sequential assessments are avoided.<br>• Children and young people are protected or helped to keep themselves safe from bullying, homophobic behaviour and other forms of discrimination.<br>• Any risks associated with children and young people offending, misusing drugs or alcohol, going missing or being sexually exploited are known by the local authority and by adults who care for them. There are plans and help in place that are reducing the risk of harm or actual harm and these are kept under regular review by senior managers.<br>• Children and young people are in good health or are being helped to improve their health and their health needs are identified. Child and adolescent mental health provision, therapeutic help and services for learning or physically disabled children and young people are available when needed and for as long as they are required.<br>• Children and young people attend school or other educational provision and they learn. Accurate and timely assessments of their needs, as well as specialist support where it is needed, help them to make good progress in their learning and development wherever they live. They receive the same support from their carers as they would from a good parent. The attainment gap between them and their peers is narrowing. The local authority maintains accurate and up-to-date information about how looked after children are progressing at school and takes urgent and individual action when they are not achieving well. All looked after children and young people attend a good school.<br>• Children and young people who do not attend school have access to 25 hours per week of good-quality registered alternative provision. They are encouraged and supported to attend the provision and there is regular review of their progress. Urgent action to protect children is taken where they are missing from school or their attendance noticeably reduces.<br>• The local authority holds clear records in respect of the numbers of children receiving alternative education and for those missing from education. |

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| | • Social workers, residential staff and carers support children and young people to enjoy what they do and to access a range of social, educational and recreational opportunities. Those adults have delegated authority to make decisions about children's access to recreation and leisure activities.<br>• Children and young people live in safe, stable and appropriate homes or families with their brothers and sisters when this is in their best interests. They move only in accordance with care plans, when they are at risk of harm or are being harmed. They do not live in homes that fail to meet their needs and they do not move frequently.<br>• Care plans comprehensively address the needs and experiences of children and young people. They are regularly and independently reviewed, involving as appropriate the child or young person's parents, kinship carers (connected persons), foster carers, residential staff and other adults who know them. This helps ensure that the placement and plans for their future continue to be appropriate as well as ambitious.<br>• Children and young people have appropriate, carefully assessed and supported contact with family and friends and other people who are important to them *(applies to adoption judgement*).<br>• Children and young people who live away from their 'home' authority have immediate access to education and health services that meet their needs as soon as they begin to live outside of their 'home' area. Placing authorities adhere to the requirements of the placement regulations including notifying the 'receiving' authority that a child is moving to the area and assessing the adequacy of resources to meet the child's need before the placement is made *(applies to adoption judgement*).<br>• The placement of children and young people into homes and families that meet their needs is effective because there is a comprehensive range and choice available *(applies to adoption judgement*).<br>• Family-finding strategies are informed by the assessed needs of children and young people. There is decisive action to find families and the avoidance of drift and delay is a priority. Respite care is only used when this is in the best interests of children and young people *(applies to adoption judgement*).<br>• The recruitment, assessment, training, support, supervision, review and retention of foster carers including kinship carers (connected persons) and, as appropriate, special guardians, ensures that families approved are safe and sufficient in number to care for children and young people with a wide range of needs. This enables children to be placed with their brothers and sisters and have contact with their birth family and friends when this is in their best interests.[2]<br>• Children and young people whose care and support is provided by a third party provider to which statutory functions have been delegated will receive the same high quality services that they could expect from the social work service provided directly by a local authority<br>• Early planning and case management results in appropriate permanent placements, including Special Guardianship or Child Arrangements Orders, that meet the needs of children and young people without delay or unnecessary moves *(applies to adoption judgement*).<br>• Well-trained and supported social workers engage effectively with the Children and Family Court Advisory Support Service (Cafcass), courts and other partners, including health professionals, to reduce any unnecessary delay in proceedings or in achieving permanence and to support arrangements once they are made *(applies to adoption judgement*). |

[2] Services should be delivered in accordance with the national minimum standards and regulations.

| | |
|---|---|
| | • Children and young people are effectively prepared for, and carefully matched with, a permanent placement. Their wishes and feelings are understood and influence the decisions about where they live *(applies to adoption judgement*).<br>• Children and young people are helped to develop secure primary attachments with the adults caring for them. Social workers help them to understand their lives and their identities through life history work that is effective and provided when they need it. Therapeutic materials are made available to the child and their family when and wherever the child is placed *(applies to adoption judgement*).<br>• Case records reflect the work that is undertaken with children and clearly relate to the plans for their futures. The style and clarity of records enhances the understanding that children and young people have about their histories and experiences.<br>• Children and young people are represented by a Children in Care Council or similar body which is regularly consulted on how to improve the support they receive.<br>• Children and young people receive care that is sensitive and responsive to age, disability, ethnicity, faith or belief, gender, gender identity, language, race and sexual orientation (applies to adoption judgement).<br>• Care leavers are safe and feel safe, particularly where they are living, and are helped to understand how their life choices will affect their safety and well-being<br>• The health needs of care leavers are clearly assessed, prioritised and met including regular dental appointments for care leavers<br>• Child and adolescent mental health services, adult mental health provision, therapeutic help and services for learning or physically disabled young people and adults are available when they are needed<br>• Care leavers are helped to find housing solutions that best meet their needs. Risks of tenancy breakdown are identified and alternative plans are in place<br>• Accommodation and support for care leavers is appropriate and of good enough quality for each young person to safely develop their independence skills<br>• Ensure risk assessment is completed when placing care leavers are placed in emergency accommodation. |

## WHAT WE WILL DO TO DEVELOP CONSISTENTLY GOOD PRACTICE

| Ref | Action | *Progress Review Date* | Lead | Update Commentary |
|---|---|---|---|---|
| 1.3.1 | Develop and integrate a joint pathway with Health to integrate SDQ into the Review Health Assessment process.<br><br>Utilise the 'Thrive model' framework to identify appropriate service for children and young people and meet assessed need at the earliest opportunity<br><br>*(LGA Review – recommendation g)* | Start of Nov '18 | Peter Yates, Service Manager | *CCG have reviewed capacity with the provider and additional resource has been secured.* Meeting undertaken with CCGs, looking to improving quality if breadth of assessment to include emotional as well as physical health and link it to the SDQ |
| 1.3.2 | Establish a regular pattern of meetings with the CCG and Community Health Provider to ensure sufficient capacity to effectively and effectively oversee the performance monitoring of the Health Assessment process<br>*(LGA Review – recommendation f)* | Start of Nov '18 | Peter Yates, Service Manager | |
| 1.3.3 | Inform Public Health review of the Emotional Health offer for children and young people, to ensure the needs of Looked After Children are met at the earliest opportunity to support permanency being achieved.<br>*(LGA recommendation i)* | Nov 2018 | Peter Yates, Service Manager | Survey undertaken of what services looked after children were receiving from CAMHS and other providers to identify unmet need. Additional capacity has since been achieved in the Therapeutic Service to help meet nonacute emotional health needs of looked after children.<br><br>Application made to bid to become a trail blazer.<br><br>Tri – partite funding being |

| Ref | Action | *Progress Review Date* | Lead | Update Commentary |
|---|---|---|---|---|
| | | | | secured to look at delivery of online counselling support. |
| 1.3.4 | With the CCG, consider the potential benefits of commissioning dedicated health services for children and young people looked after by informing the Providers review of their service offer.<br>*(LGA Review – recommendation h)* | Oct 2018 | Peter Yates, Service Manager | |
| 1.3.5 | Undertake an audit of children subject of a CP Plan / Looked After, under the age of 2, to ensure decision making is achieving early permanence, including earlier decision making around placement options.<br>*(LGA Review – recommendation l)* | End of Oct 2018 | Peter Yates, Service Manage & Nicky Horn, IRO Manager | |
| 1.3.6 | Review all Foster Placements with a high risk of breakdown to identify additional support needs and ensure these are met. Review<br>• Young people with multiple placements<br>• Young people with a high SDQ score<br>To strengthen the quality of support and interaction with Sefton foster carers, preventing placement breakdown.<br>*(LGA Review – recommendation m)* | End of Nov 2018 | Peter Yates, Service Manager & Nicky Horn, IRO Manager | |
| 1.3.7 | Undertake an audit of foster carers who have more than 3 children in placement. | Dec 2018 | Peter Yates, Service Manager & Maria Spatuzzi, Fostering Manager | |
| 1.3.8 | Establish a regular forum to listen to foster carers views and the Fostering Social Work team to identify any unmet need of children they are caring for. | Nov 2018 | Maria Spatuzzi, Fostering Team Manager | Head of Service has met with Fostering Forum and attended the Annual Fostering Conference |
| 1.3.9 | Commence a dip sample cycle of audit of placement breakdowns / unplanned moves, to ascertain trigger factors and communicate this ongoing learning to the CSC Performance Meetings / Team Meetings | Oct 2018 | Nicky Horn, IRO Manager | |

| Ref | Action | *Progress Review Date* | Lead | Update Commentary |
|---|---|---|---|---|
| | | | | |
| 1.3.10 | IRO Manager and IRO representatives to support the Corporate Parenting Team to make changes to how Care Plans and LAC Review minutes are recorded by attending a joint Service Meeting, children are written to and plans are focussed on improving their outcomes | Oct 2018 | Nicky Horn, IRO Manager | |
| 1.3.11 | Monitor via the CSC Performance Data that all looked after children have had a C&F assessment undertaken on at least an annual basis. | Oct 2018 | Peter Yates, Service Manager | |
| 1.3.12 | Monitor through CSC Performance Data all children approaching their 16th birthday and whether they have had a Pathway Plan undertaken to support their transition to become a Care Leaver. | Oct 2018 | Peter Yates, Service Manager | |
| 1.3.13 | Undertake a quality audit to review the quality of young people's Pathway Plans. | End of Q3 | Joe Hulse, Leaving Care Team Manager | |
| 1.3.14 | Identify practice exemplars and share these across the service via Practice Champions. | End of Q3 | Joe Hulse, Leaving Care Team Manager | |
| 1.3.15 | Implement a revised training offer re: Care Planning with focus in permanence and adoption planning. | | Nicky Horn, IRO Manager and Peter Yates, Service Manager | |
| 1.3.16 | Improve the % of children with more than 85% educational attendance by regularly monitoring the cohort of children falling below this standard to ensure:<br>• Education is a key discussion point in their LAC review<br>• Their attendance rate is monitored as part of their LAC Review<br>• The Virtual School is fully engaged with the School | Oct 2018 | Peter Yates, Service Manager | |

| Ref | Action | *Progress Review Date* | Lead | Update Commentary |
|---|---|---|---|---|
| | to identify improved attendance<br>• Improved attendance is part of their PEP. | | | |
| 13.1.17 | Implement a Fostering Teen Scheme, to provide an enhanced fostering offer for complex and hard to place looked after children. | End of Q3 | Peter Yates, Service Manager | |
| 13.1.18 | Maintain focus on placement planning and relaunch placement panel and Terms of Reference to reduce emergency admissions into care. | Aug 2018 | Vicky Buchanan, Head of CSC | Placement panel discussed with team managers at Performance meeting and Terms of reference recirculated. |

## HOW WE WILL KNOW OUR PRACTICE IS GOOD?

| Performance Measure | What does it show? | Thresholds | | | |
|---|---|---|---|---|---|
| | | Inadequate | Requires Improvement | Good | Outstanding |
| Percentage of cases judged to meet good or exceed good for quality of placement (audit measure) | That placements are of a high quality and meet the assessed needs of children and young people. | <65 | 65-79 | 80-89 | 90-100 |
| Proportion of children and young people looked after with 3 or more placements in a 12 month period | That placements are of a high quality and meet the assessed needs of children and young people. | >15 | 8-15 | 7-5 | <5 |
| Proportion of children placed on a full care order at home with parents | That there is careful scrutiny by managers and legal to ensure placement at home is the correct decision. | >25 | 16-25 | 6-15 | 0-5 |
| Proportion of children placed on a care order at home with parents interim or full | That there is scrutiny by managers and legal to ensure placement at home is the correct decision. | >25 | 16-25 | 6-15 | 0-5 |
| Percentage of statutory visits for children placed at | That children placed at home | <60 | 60-79 | 80-94 | 95-100 |

| Performance Measure | What does it show? | Thresholds | | | |
|---|---|---|---|---|---|
| | | Inadequate | Requires Improvement | Good | Outstanding |
| home with parents completed in timescales | with parents are safeguarded and the order is being robustly managed. | | | | |
| Percentage of LAC that are classed as persistently absent from education | That educational outcomes for LAC are improved as a result of being in care | >33 | 20-32 | 10-19 | <10 |
| Percentage of Initial Health Assessment's completed | That notification is effective and that children and young people do not experience undue delay in receiving an Initial Health Assessment. | <65 | 65-79 | 80-89 | 90-100 |
| Percentage of Children Looked After with a health check completed within 12 months Under 5 | That there is no delay for children and young people in relation to their Annual Health Assessment and health issues are being addressed for children in our care | <65 | 65-79 | 80-89 | 90-100 |
| Percentage of Children Looked After with a health check completed within 12 months Over 5 | That there is no delay for children and young people in relation to their Annual Health Assessment and Health issues are being addressed for children in our care | <65 | 65-79 | 80-89 | 90-100 |
| Percentage of care leavers living in suitable accommodation | That care leavers are living in accommodation that is viewed as suitable for their needs and their accommodation needs are being prioritised across the partnership. | <80 | 80-89 | 90-94 | 95-100 |

| Qualitative Information | Feedback from Children and Young People, Parents and Carers | | Feedback from Staff |
|---|---|---|---|
| **Audits** – show that the quality of front line practice is improving across all areas and can be clearly evidenced in records<br><br>**Audits** – demonstrate that timely interventions for emotional health and wellbeing have had a positive impact on the outcomes for children and young people and that care leavers are appropriately engaged, prepared for independence and transitions to adult services | **Survey of families and young people in conjunction with voluntary sector and through Focus on Practice week as well as feedback from MAD group** – demonstrate children, young people and parents feel they have received a good service that has helped them. Children, young people and parents report that they are clear on why the plan was in place and how this met their needs. | | **Practice and Performance Workshops and Supervision –** Staff reflect on what support they need to strengthen practice, and that their knowledge or relevant research, policies and procedure is evident |



| Recommendation | 2.0 Management Oversight |
|---|---|
| **Our goal (what 'good' looks like)** | • The child's record gives a clear account of the story and experience of the child or young person, their individual needs, their place and relationships within the family, the work undertaken with them and activity in relation to them and what matters to them.<br>• Supervision is frequent, reflective, challenging and is well recorded in the practitioner's file and on the child's record<br>• Practitioners value the support and challenge they receive through supervision, and know how this has improved their practice<br>• Team managers clearly evidence direction, challenge and support in supervision notes as a clear evidence record for all parties to demonstrate learning<br>• Annual Personal Development Plans (PDPs) are tailored to the individual learning and development needs of practitioners, which is related to improvements to services. Progress against PDPs is evaluated in supervision to ensure these outcomes are attained and there is a continual focus on learning and development opportunities<br>• There is no drift or delay for children and young people, action is timely, plans are effective, and this leads to improved outcomes for children, young people and families |

| | |
|---|---|
| | • Plans to make permanent arrangements for children and young people are effectively and regularly reviewed by independent reviewing officers (IROs). IROs bring rigour and challenge to the care planning and monitor the performance of the local authority as a corporate parent, escalating issues as appropriate. They enable timely plans to be agreed to meet the needs of children and to ensure that their best interests remain paramount. IROs engage with children's guardians and there is evidence that this is focused on what children need and how the plans for them can be properly progressed *(applies to adoption judgement*).<br>• Management oversight of practice, including practice scrutiny by senior managers, is established, systematic and demonstrably used to improve the quality of decisions and the provision of help to children and young people<br>• Authoritative action is taken where change is not secured and the risk to children intensifies or remains<br>• Team managers can clearly evidence direction given with clear rational on the child's record |

## WHAT WE WILL DO TO DEVELOP CONSISTENTLY GOOD PRACTICE

| Ref | Action | Review Date | Lead | Commentary Update |
|---|---|---|---|---|
| 2.1.1 | Undertake a Supervision Audit, to review its regularity and its impact, to ensure improving quality for casework *(LSCB 2nd or subsequent period CP Plan Review – recommendation 10)* | August 2018 | Vicky Buchanan, Head of Service | Supervision Audit has been undertaken and is due to be reported to the Children & Young People's Improvement Board 20th August 2018 |
| 2.1.2 | Review Supervision Policy and Supervision Record template. | Oct 2018 | Joy Hughes, Service Manager | |
| 2.1.3 | Review Training re: reflective supervision, to ensure team managers are able to provide support and challenge to social workers. | Oct 2018 | Joy Hughes, Service Manager | |
| 2.1.4 | Communicate a Briefing note to CSC & IRO Service workforce re: use of Written Agreements. *(LSCB 2nd or subsequent period CP Plan Review – recommendation 11)* | August 2018 COMPLETE | Vicky Buchanan, Head of Service | **Complete** – Briefing note e mailed to workforce |
| 2.1.5 | Undertake Annual Staff Supervision Survey | Oct 2018 | Helen Splaine, CSC QA Manager | |
| 2.1.6 | Identify mentoring / coaching opportunities to improve the quality of supervision. | Sept 2018 | Vicky Buchanan, Head of Service | |
| 2.1.7 | Undertake monthly supervision audits and report findings to CSC monthly performance meeting and individual managers supervisions. | Sept 2018 | Helen Splaine, CSC QA Manager | |
| 2.1.8 | Develop a culture of whole service focus on bi-annual thematic service priorities. 1st focus being to improve the quality of assessment and supervision. | Sept 2018 | Vicky Buchanan, Head of Service | |
| 2.1.9 | Provide opportunities for a wider range of members to engage with children's social | By end of Q3 | Vicky Buchanan, Head of Service | Head of Service has undertaken a briefing with Full Council & the |

| Ref | Action | Review Date | Lead | Commentary Update |
|---|---|---|---|---|
| | care, to enhance understanding of front line delivery, and take advantage of the intake of new councillors following the elections to further raise the profile of the corporate parenting role.<br>*(LGA Review – recommendation e)* | | | Corporate Parenting Board. Safeguarding Training is being provided to Elected Members and a briefing session is planned to take place before 20th Sept '18 Full Council Meeting.<br>A series of Members Front Line Visits has been arranged. And a presentation is being provided to Overview & Scrutiny in Sept '18. |

## HOW WE WILL KNOW OUR PRACTICE IS GOOD

| Performance Measure | What does it show? | Thresholds | | | |
|---|---|---|---|---|---|
| | | Inadequate | Requires Improvement | Good | Outstanding |
| Percentage of supervisions that met the practice standard for frequency (audit measure) | Supervisions are taking place as regularly as they need to. | <70 | 60-74 | 75-89 | 90-100 |
| Percentage of supervisions that met the practice were of a good quality and reflective (audit measure) | Supervisions are good quality. | <70 | 60-74 | 75-89 | 90-100 |
| Percentage of staff report that supervision is beneficial to them with supervision from the annual survey | That staff value the support and challenge they receive through Supervision. | <65 | 60-74 | 75-89 | 90-100 |
| Percentage of cases that meet good for Management Oversight and Effective Decision Making (audit measure) | That decision-making is well informed and evidenced based, timely, proportionate to risk and that there has been appropriate management direction at key points. | <65 | 65-79 | 80-89 | 90-100 |
| Percentage of re-referrals within 12 months | That decision-making is well informed and evidenced based, timely, proportionate to risk and that there has been appropriate management direction at key points. | <20 | 20-24 | 19-16 | <16 |
| **Qualitative Information** | **Feedback from Children and Young People,** | | **Feedback from Staff** | | |

| | Parents and Carers | | |
|---|---|---|---|
| **Supervision Audits –** show improved quality of supervision and that supervision is increasingly reflective and evidence based research is used to inform decision making<br><br>**Quality Practice Audits and Case Review** – demonstrate good quality decision making based on clear management oversight and good quality supervision, that management direction is clearly recorded and impacts on the direction of the case and that procedures are adhered to<br><br>**Complaints Report** – shows specific themes are not recurring, we have good performance on the number of complaints being resolved at the first stage, compliments are received from children, young people and families. | **Complaints Report** – shows specific themes are not recurring, we have good performance on the number of complaints being resolved at the first stage, compliments are received from children, young people and families<br><br>**Survey of families and young people in conjunction with voluntary sector and through Focus on Practice week as well as feedback from MAD group** – demonstrate children, young people and parents feel they have received a good service that has helped them. Children, young people and parents report that they are clear on why the plan was in place and how this met their needs. | | **Practice and Performance Workshops and Supervision –** Staff reflect on what support they need to strengthen practice, and that their knowledge of relevant research, policies and procedure is evident<br><br>**Staff Supervision Survey –** Staff report that supervision is regular, valued, prioritised. Staff feel supported and that supervision is reflective and effective |

| Recommendation | 3. Resources |
|---|---|
| **Our ambition (what 'good' looks like)** | • Social Care Teams are well designed and caseloads and capacity is evenly managed across the system and allows innovative work to flourish and be undertaken with children and families<br>• Children and families receive the right intervention at the right time<br>• The Principle Social Worker function is a valued and highly visible role and is able to provide challenge to Head of Service and Leadership, which results in demonstrable change<br>• Change of worker is minimised particularly at key transition points so that children foster and enjoy strong relationships with adults who care for them<br>• Care plans comprehensively address the needs and experiences of children and young people. They are regularly and independently reviewed, involving as appropriate the child or young person's parents, kinship carers (connected persons), foster carers, residential staff and other adults who know them. This helps ensure that the placement and plans for their future continue to be appropriate as well as ambitious<br>• Plans to make permanent arrangements for children and young people are effectively and regularly reviewed by independent reviewing officers (IROs)<br>• IROs bring rigour and challenge to care planning and monitor the performance of the local authority as a corporate parent, escalating issues consistently and appropriately in line with procedure. IRO's enable timely plans to be agreed to meet the needs of children and to ensure that their best interests remain paramount<br>• Practice alerts result in clear and timely action by Service and Team managers<br>• IROs engage with children's guardians and there is evidence that this is focused on what children need and how the plans for them can be properly progressed. |

## WHAT WE WILL DO TO DEVELOP CONSISTENTLY GOOD PRACTICE

| Ref | Action | Progress Review Date | Lead | Commentary update |
|---|---|---|---|---|
| 3.1 | Review, '1 year on' the operational implementation of CSC restructure and report this to CSC SMT. *(LGA Review – recommendations c & d)* | Sept 2018 | Joy Hughes, Service Manager | |
| 3.2 | Devise a revised SEF, ensuring the data is consistent, robust and supported by appropriate narrative which is shared with, and agreed by, partnership agencies. *(LGA Review – recommendation a)* | Sept '18 | Helen Splaine, CSC QA Manager | |
| 3.3 | Update CSC Learning Improvement Framework, to include additional element to complete the self-improvement cycle, by checking that corrective Kara Haskayne, Service Manager actions are always taken as a result of audit findings. *(LGA Review – recommendation j)* | Sept 2018 | Kara Haskayne, Service Manager | CCG have reviewed structure with Provider and agreed extra resource to enhance support to looked after children, presented to CPB August 2018.<br><br>CSC has agreed an extra post to Therapeutic Team and are working with GGC and Public Health to commission an online Counselling website.<br><br>Children's Integrated commissioning group working with CCG on bid to become a trailblazer. |
| 3.4 | Undertake an Audit of previous Quality Audit actions to ensure all tasks have been undertaken. | Sept 2018 COMPLETE | Kara Haskayne, Service Manager | Complete - Re-audit undertaken re: Nov 2017 Case File Audit actions. Re-audit finding report to be discussed at August CSC Performance Group |
| 3.5 | Review CSC Workforce Strategy. | Sept 2018 | Vicky Buchanan, Head of Service | Review undertaken and currently in draft format. |

| Ref | Action | Progress Review Date | Lead | Commentary update |
|---|---|---|---|---|
| | | | | |
| 3.6 | Monitor CSC caseloads to ensure safe and appropriate and outcomes for children are improved. | Nov 18 | Vicky Buchanan Head of Service | |
| 3.7 | Implement the revised AYSE and AYSE Manager Support Programme, to ensure all ASYEs are provided with support and challenge to achieve their Approved Year. | Oct 2018 | Joy Hughes, Service Manager | |

## HOW WE WILL KNOW OUR PRACTICE IS GOOD

| Performance Measure | What does it show? | Thresholds | | | |
|---|---|---|---|---|---|
| | | inadequate | Requires Improvement | Good | Outstanding |
| reduction in practice alerts | That practice alerts undertaken by IRO's are impacting and informing practice and that practice is beginning to improve more consistently. | | Decrease | | |
| Percentage in the number of cases that meet good for review in audit (audit measure) | That IRO's have the capacity to effectively chart reviews to ensure the plan is being progressed. | <65 | 65-79 | 80-89 | 90-100 |
| Reduction in average team caseloads | That the design of Children's Social Care allows good quality and innovative work to be undertaken. | >35 | 35-26 | 25-20 | 19-10 |
| Percentage of workforce who are enabled for mobile working | That Children's Social Care staff are adequately resourced to allow good quality, timely and innovative work to be undertaken | | 50-60 | 61-75 | 75+ |

| | | | |
|---|---|---|---|
| Timeliness of recording of assessments, plans and visits improves following roll out | That Children's Social Care staff are adequately resourced to allow good quality, timely and innovative work to be undertaken | | Increase |

| Qualitative Information | | Feedback from Children and Young People, Parents and Carers | Feedback from Staff |
|---|---|---|---|
| **Audits -** show that the quality practice is improved with increased resources and that undue drift and delay is minimised, there is case progression and improved outcomes and impact for children, young people and their families | | **Survey of families and young people in conjunction with voluntary sector and through Focus on Practice week as well as feedback from MAD group** – demonstrate children, young people and parents feel they have received a good service that has helped them. Children, young people and parents report that they are clear on why the plan was in place and how this met their needs. | **Practice and Performance Workshops and Supervision –** Staff reflect on what resource they need to strengthen their practice and are able to identify and articulate gaps in service / resource that would enable them to do their job more efficiently |

| | | | |
|---|---|---|---|
| **Report to:** | Overview and Scrutiny Committee (Children's Services and Safeguarding) | **Date of Meeting:** | Tuesday 25 September 2018 |
| **Subject:** | Fostering Service Annual Report | | |
| **Report of:** | Director of Social Care and Health | **Wards Affected:** | (All Wards); |
| **Portfolio:** | | | |
| **Is this a Key Decision:** | N | **Included in Forward Plan:** | No |
| **Exempt / Confidential Report:** | N, | | |

**Summary:**

This report provides information about the Fostering Service and outcomes for children and young people looked after by Sefton M.B.C, from 1st April 2017- 31st March 2018. The purpose of the annual report is to inform the Public, Elected Member's, Partners and Staff of the progress and developments in the Service during this period

**Recommendation(s):**

(1) To note the activity that has taken place in relation to fostering in the year 2017 -18.

**Reasons for the Recommendation(s):**

To provide assurance that Sefton's fostering service meets fostering national guidance and standards

**Alternative Options Considered and Rejected:** (including any Risk Implications)

N/A

**What will it cost and how will it be financed?**

**(A) Revenue Costs**

**(B) Capital Costs**

**Implications of the Proposals:**

| |
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| **Resource Implications (Financial, IT, Staffing and Assets):** |
| **Legal Implications:**<br><br>The Children and Young Persons Act 2008 and the Fostering Services (England) Regulations 2011, Care Planning, Placement and Case Review (England) Regulations 2010 and the Care Leavers (England) Regulation 2010 |
| **Equality Implications:**<br><br>There are no equality implications. |

**Contribution to the Council's Core Purpose:**

| |
|---|
| Protect the most vulnerable: Looked After Children who cannot live with members of their own family should be afforded good quality care in family arrangements within their local community. |
| Facilitate confident and resilient communities: Foster carer recruitment remains a focus to ensure that looked after children are afforded the highest quality of care. |
| Commission, broker and provide core services: Fostering services meet national guidance and standards. |
| Place – leadership and influencer: N/A |
| Drivers of change and reform: N/A |
| Facilitate sustainable economic prosperity: N/A |
| Greater income for social investment: N/A |
| Cleaner Greener; N/A |

**What consultations have taken place on the proposals and when?**

**(A) Internal Consultations**

The Head of Corporate Resources (FD. 5302/18) and the Chief Legal and Democratic Officer (LD 4527/18) have been consulted and any comments have been incorporated into the report.

**(B) External Consultations**

N/A

**Implementation Date for the Decision**

Immediately following the Committee meeting.

**(Please delete as appropriate and remove this text)**

| | |
|---|---|
| **Contact Officer:** | Vicky Buchanan |
| Telephone Number: | Tel: 0151 934 3128 |
| Email Address: | vicky.buchanan@sefton.gov.uk |

**Appendices:**

The following appendices are attached to this report:

Fostering Annual Report 2017 /18
**(Please delete as appropriate and remove this text)**

**Background Papers:**

There are no background papers available for inspection.

**1. Introduction/Background**

1.1 In 2017/18 the Fostering Service has continued to develop and improve practice to meet the needs of children/young people looked after by Sefton and address the requirements of national guidance and fostering standards.

The remit of the Fostering Service is highly circumscribed by legislation and regulations. The Children and Young Persons Act 2008 and the Fostering Services (England) Regulations 2011 are the primary sources of legislation that guide fostering practice, but the service also takes account of other child care legislation such as the Care Planning, Placement and Case Review (England) Regulations 2010 and the Care Leavers (England) Regulation 2010.

When a child/young person becomes looked after, it is one of the most important and significant changes in their life and it is critical that the families who look after these most vulnerable children/young people through foster care are the best they can be. Sefton Council wants to create a fairer future for our most vulnerable children/young people and their families; we want every child/young person to grow up in a safe, stable and loving home. For those young children who cannot remain or return home safely to their birth families, good quality foster care offers them the best opportunity to experience a warm and loving family environment while appropriate plans are made for their future.

The aim of the Fostering Service is to provide high quality care for children and young people in safe, secure and nurturing families by means of recruiting and developing highly skilled foster carers.

Sefton currently has 89 mainstream fostering households, comprising of 73 couples and 16 single carers, with a total capacity of 236 children placed in short-term and long-term placements as of March 2018. There are 66 Connected persons**/** kinship households, 108 carers, 42 couples, 24 single carers. Our foster carers do a good job in supporting children and young people who do not move placements frequently and as a rule they stay with their carer(s) until either the outcome of care proceedings or if the care plan is for them to return to the care of birth parents or alternative family members. There has been an increase in the number of children becoming looked after,170 the previous year compared to 236 this year.

Recruiting sufficient foster carers to meet current demand remains a significant challenge, economic necessity may mean all adults in a family need to work; adult children remain at home longer; families may have less physical space and these, and other issues, together, all have an impact on the capacity of families to foster.

The Annual report details the activities in 2017 – 2018.

Sefton Council

# Sefton Fostering Service Annual report 2017–2018

April 2017 – March 2018

# Sefton Fostering Service Annual report 2017–2018

## Contents

## Introduction

This report provides information about the Fostering Service and outcomes for children and young people looked after by Sefton M.B.C, from 1st April 2017/ 31st March 2018. The purpose of the annual report is to inform the public, elected member's, partners and staff of the progress and developments in the Service during this period.

The government has published Statutory Guidance for local authorities in February 2018. The guidance sets out the role of local authorities and the application of corporate parenting principles, which is set out in section 1 of the Children and Social Work Act 2017.

It states that local authorities must have regard to the seven needs identified in the Children and Social Work Act 2017 when exercising their functions in relation to looked-after children and care leavers and also former relevant children.

The seven principles for corporate parenting:

- To act in the best interests, and promote the physical and mental health and well-being, of those children and young people.
- To encourage children and young people to express their views, wishes and feelings.
- To consider the views, wishes and feelings of children and young people.
- To help children and young people gain access to and make the best use, of services provided by the local authority.
- To promote high aspirations, and seek to secure the best outcomes, for children and young people.
- For children and young people to be safe, and for stability in their home lives, relationships and education or work, and
- To prepare children and young people for adulthood and independent living.

The detail of what Sefton must do to effectively care for looked after children and young people and our care leavers is addressed through existing legislation, regulations and accompanying statutory guidance.

The principles are intended to encourage local authorities to be ambitious and aspirational for our looked after children and care leavers. Sefton Council wholeheartedly endorse these principles and the Fostering Service is a key element in this work.

## Recruitment of Foster Carers

In what are challenging times nationally in respect of fostering recruitment our recruitment team have continued to work together to produce marketing material and recruitment activity which is fresh, modern, and continually updated. Our challenges remain placement sufficiency and placement stability. Placement stability is impacted by availability and choice of placements and the skills of available foster carers. We strive to continue with an active and energetic recruitment campaign to attract prospective foster carers to Sefton, and we will continue to work in collaboration with Knowsley Council to maximise our recruitment efforts.

Telephone enquiries were previously routed through a Regional Fostering Front Door system, that employed two social workers taking enquiries for eight local authorities including Sefton who were available to respond to callers who wanted more information. A review of this system showed a poor return in terms of enquiries and outcomes, and during the year Sefton reverted to having the enquiries within our own provision which allows us to have more control along with a cost saving. Targeted Facebook advertising is ongoing throughout the year and is refreshed for each campaign.

We continue to run information events throughout the year. The number of events has been increased and attendance has been steady. The information events are held alternatively in the North and South of the borough involving foster carers in the recruitment process.

Economic necessity may mean all adults in a family need to work; adult children remain at home longer; families may have less physical space and these, and other issues, together, all have an impact on the capacity of families to foster.

We will endeavour to approve at least 15 households in 2018/19 and to have specific targeted recruitment to meet the particular needs of complex older children, siblings and parent and child placements.

## Fostering Enquiries 2017 – 2018 Progressions

| Stages | Month | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Pre Stage | Enquiries | 33 | 51 | 30 | 19 | 28 | 26 | 33 | 13 | 9 | 40 | 13 | 7 | 302 |
| Stage 1 | ROI | 5 | 8 | 8 | 6 | 6 | 4 | 6 | 2 | 2 | 5 | 1 | | 53 |
| | IV | 4 | 5 | 5 | 4 | 3 | 3 | 4 | 2 | 1 | 3 | | | 34 |
| Stage 2 | Assessments | 4 | 0 | 3 | 1 | 0 | 0 | 0 | 1 | 0 | 2 | | | 11 |
| | Approvals | 2 | 0 | 2 | In progress | | | | | | | | | |

**Total enquiries 302**

**Total Approvals - 10**

**Pre-Enquiry –202 Enquiries closed**

**Closure Reasons * See below**

**Withdrew (184 Total)**

105 No Further Contact
55 Information Only / May Return
4 Financial Reasons
5 Applying to Adopt
4 Remaining / Proceeding with another agency
1 Personal Reasons * *(see below for detail)*

*Currently going through a divorce*
*Currently pregnant*
*Unable to commit to travelling as single carer*
*Needs permission from Landlord to foster*
*Decided to wait until children are older*
*Husband does not want to proceed*
*Change in family circumstances*
*Enquiring about SGO*
*Family Illness*
*Hours of work not compatible with fostering*
*Recent Bereavement*

**Unsuitable / Terminated (18 Total)**

2 Child protection concerns
5 No spare room
5 Undergoing building works / moving
6 Other * (see below for detail)

*Recent separation from partner*
*Currently undergoing IVF*
*Want to foster 0-5 but smoke E – Cigarette*
*Currently serving Community Service*
*Currently undergoing counselling*
*Recently moved in with partner*

**53 progressed to Registrations of Interest (ROI)**

**34 Completed Initial Visits (IV)**

**(19 ROI closed before Initial Visit) *See below for closure reasons**

13 Unable to contact
1 Financial Reasons
3 Need more time to consider
2 Other* (see below for detail)

*Current working hours not compatible with fostering*
*Concerns about son*

**Status of Enquiries that progressed to Stage 1 – (34 Initial Visit)**

21 Closed *see reasons below
11 Progressed to Stage 2
2 Open / Ongoing

*Closure Reasons – Stage 1 (21)

**Withdrew (12)**

1 Needs More Time to Consider
6 No Further contact
1 Financial Reasons
3 Ill health
1 Proceeding with another agency

**Unsuitable / Terminated (9)**

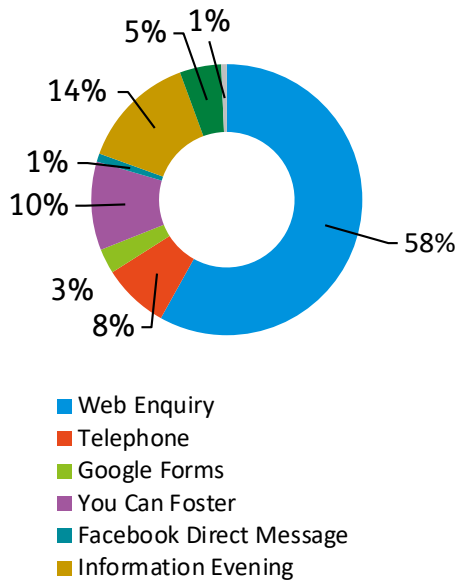
*Concerns with family*
*Going through disciplinary action in work*
*Undergoing counselling*
*Spare room unsuitable for fostering*
*Only moved 6 weeks ago*
*Family too young advised to come back in 6 months*
*2 x Current hours of work unsuitable for fostering*
*Pet hygiene issues*

**Status of Enquiries that progressed to Stage 2**

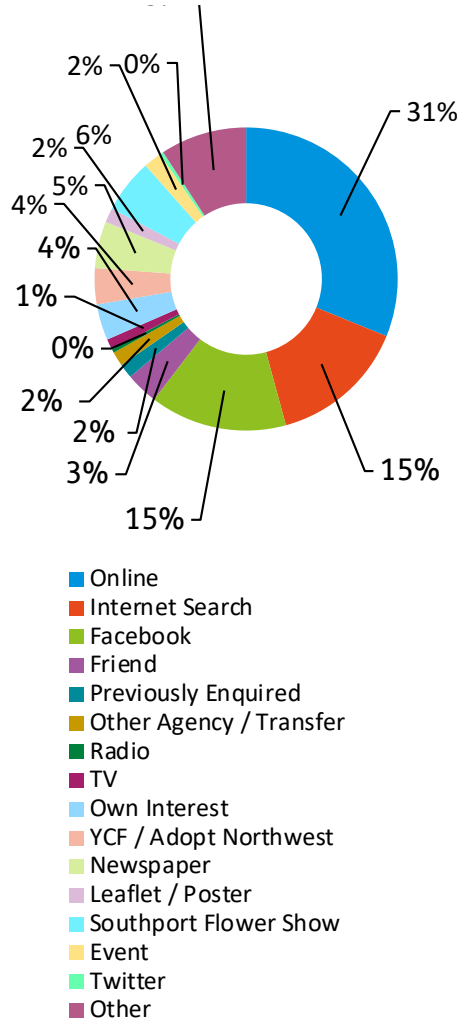
11 Progressed to assessment
4 Approvals

**2017 - 2018**

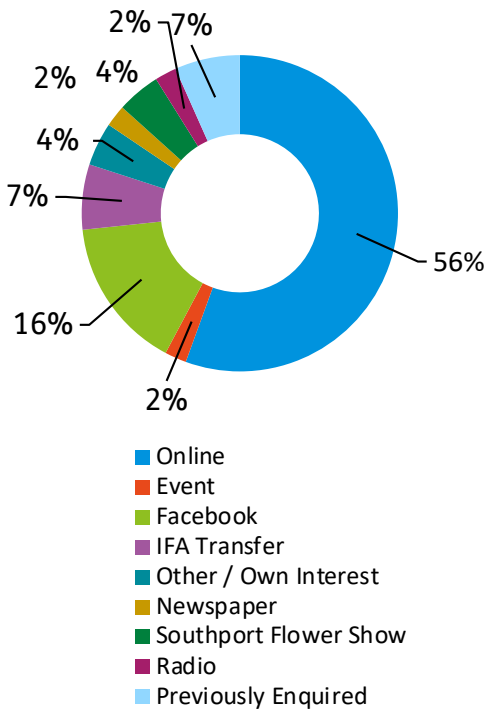
**Method of Enquiry**




**Source of Enquiry**




**Source for Enquiries that progress to ROI**




In April 2017, the Government launched a call for evidence to seek views on the current state of foster care in England and how it could be improved to achieve ambitious outcomes for children and young people. This consultation received over 300 responses. Submissions received were from a range of individuals. Approximately half of all responses were from individual foster carers, whilst other individual respondents included social workers, health practitioners, academics and consultants. A small number of submissions were directly from care-experienced young people and care leavers, as well as organisations bringing together the views of groups of children. Around 20 local authorities and 20 independent fostering agencies contributed to the call for evidence whilst approximately one sixth of all submissions were from organisations, ranging from small charities providing specialist services to large national organisations.

## The Fostering stocktake questions

1. The types of fostering that are currently provided, to understand the full range of provision which is available and when and for which young people it is best used

2. What works best within fostering settings to improve outcomes for the children and young people placed

3. What improvements could be made to the way that fostering provision is commissioned, delivered, regulated and inspected to improve outcomes and value for money
4. The status, role and function of foster carers in relation to other professionals as part of the team working with a child in care
5. How the experiences of young people can be improved when entering foster care, transitioning between placements (between carers or into other settings), and leaving foster care
6. Any other issues which might contribute to better outcomes for children.

## Sefton's Response

- Robust systems remain in place to ensure that children only become accommodated by the local authority when it is their best interest and no safe alternatives exist. The types of fostering placements currently provided in Sefton are mainstream foster care/kinship care, emergency/ respite. The placements are best used for children/ young people coming into care and also during care proceedings /long term fostering/plan for permanence /SGO, CAO
- Fostering settings have proven to work best for children/young people placed when carers have been provided with all the information about the child/young person prior to the placement. Children/young people's engagement in education enhances the chance of placement stability which is also key for looked after children. Structure, routine and continuity and a loving and stable environment for children/young people in care are key component of the fostering experience. Foster carers need to continue in their development by attending training to best support them with looking after children/young people. Support through visits by the child's social worker and supervising social worker ensures that the child/ young person is happy settled and keeps the social worker informed of changes and developments. To maintain placements, it is important that children receive timely assessments and their plans are regularly reviewed.
- The cost of providing placements is a significant budgetary pressure and is the subject of ongoing work to develop effective but cost-efficient provision; this is particularly important in relation to externally commissioned arrangements. Participation in regional collaboration arrangements is intended to improve the procurement of children's care placements and in externally commissioned arrangements. Capacity issues in the Fostering Service inevitably increases the number of children placed with Independent Fostering Agencies (IFA) but they are also struggling to meet the needs of more complex young people leading to children and young people being placed in all children in out of area residential placements.
- There are higher expectations of foster carers to be treated as professionals in the care planning process -to be kept up to date on the progress of any court proceedings and any changes to the child/young person's care plan.
- It is important to ensure that the child/young person has a voice and is included in their care plan especially prior to any move, that they have the opportunity to say goodbye to the current foster carer, have a more planned ending, and in some case may keep in touch with the foster carers when the placement has ended.
- In order to safeguard children/young people, partnership working and good communication is key, and improved outcomes for children/young people can only be delivered and sustained when key people and agency's work together.
- In keeping with good practice and regulatory requirement, the authority continues to place as many children as possible close to their home locality.

As young people move towards adulthood they will be allocated a Personal Advisor and foster carers are involved in the formulation of a pathway plan.

The Fostering Network report that the increased demand for children and young people in care services coupled with the drastic cuts to local authority budgets due to austerity measures has placed a growing pressure on the care system in England. The number of looked after children/young people is now at its highest point since 1985 and the demand for placements varies significantly across **the country.**

## Staffing and accommodation

The Fostering Service has continued to be based at Merton House Bootle; however, along with other Social Care Teams including the Corporate Parenting Teams and the Leaving Care Team will be moving the short distance to Magdalen House in Bootle in mid-June. This is a move from a rented building to one that Sefton owns and is part of a wider strategy to create a more agile and responsive workforce. The team is staffed with experienced staff and management. The proximity to the looked after children's teams continues to be helpful in promoting good planning for children/young people in care.

Agile working is being introduced across the service. Agile working has been described as a way of working in which it empowers its staff to work where, when and how they choose – with maximum flexibility and minimum constraints – in order to optimise our performance and deliver "best in class" value and customer service. It uses communications and information technology to enable staff to work in ways, which best suit, their needs without the traditional limitations of where and when tasks must be performed. It is based on the concept that work is an activity we do, rather than a place we go. With the technology available, there are numerous tools to help us work in new and different ways. The aim of agile working is simply to create a more responsive, efficient and effective organisation, which ultimately improves business performance and increases customer satisfaction.

During the past year the Fostering Team has reduced its staffing complement by two full-time equivalent social workers as part of the Councils wider proposals for financial restraint. This has been managed so as not to impact on the support provided to foster carers and looked after children/young people.

In April 2018, the Adoption Service became part of Adoption in Merseyside (AIM), a regional adoption agency made up of four local authorities and voluntary partners. Their main base is now at the Hutt in the Halewood area of South Liverpool, although through agile working they retain a presence in Sefton and remain in close contact with the Fostering Team to ensure smooth transitions when children are moving on to their adoptive placements.

## Team Managers Action Plan

At the beginning of October 2017 Sefton's Children's Social Care implemented a Service redesign. The design is aimed at reducing caseloads in some areas and to create caseload equilibrium across the service, increase management oversight and decrease transition points for children resulting in less change of social worker and improve capacity for relationship-based social work. Team managers attended a Team Manager Development Day to review progress and learn from single agency and multiagency audit since January 2017 and agreed how to respond in the new arrangement. In response, Team Managers developed a Team Manager Action Plan, which aimed to address key issues and improve performance and quality. This action plan is reviewed regularly against future data and audit findings to assess progress and impact.

## Specific Fostering Targets - Retention of foster carers

The importance of retention of foster carers in Sefton is critical. The fostering network reported that in 2017 on average a service will lose 10% of carers annually through retirement, adopting, changing career, and deregistration. While our data does not show this level of carers formally ceasing to foster, there is an increasing trend for foster carers to step-down from fostering to staying put placements without formally ceasing their registration as foster carers. It should be emphasised that this is still a very important contribution to supporting a young person on their journey to adulthood.

The Fostering Service responds promptly and efficiently to issues and concerns raised by foster carers. Communication includes newsletters throughout the year, emails, phone calls about events and opportunity's. Supervising social workers visit carers to support them in their role, assessing the support needed prior to each new placement which contributes to increasing carers confidence and capabilities in taking children with high needs. Despite its rewards, foster care can be a very demanding vocation. Sefton Fostering Service recognises this and understands good outcomes for children/young people can only be achieved when foster carers feel valued, supported and equipped to provide the stability, love and care that children/young people need when they may have experienced neglect, harm, or abuse.

The Fostering Service has continued to make and embed improvements in the quality of report writing, supervision and foster carer reviews to evidence

carer's ability and skills to meet children/young people's needs. Foster carers who have not met required standards following support and training have been referred to Sefton's Fostering Panel and on occasions have been deregistered.

Improvements in practice have continued and over the past year placement stability meetings are now embedded in the culture of the service and have become a "to do task"

Performance data is now reliably available and teams have continued to embed good performance monitoring and management to create a sustained positive trajectory of improving performance.

## Placement Stability

Placement stability continues to be a critical factor in offering an effective Fostering Service and is crucial to ensuring that we deliver good outcomes for every child/young person in our care. As a service, an improved understanding of the reasons why placements end will be used to help us improve our practice in relation to robust assessment and supervision of foster carers, identification of future vulnerabilities, and pro-active pre-emptive support for children/young people and their foster carers in the future.

The Fostering Service continues to work jointly with other professionals and foster carers to support placements and to progress children/young people's care plans.

## Staying Put

Staying put is the term used to describe a situation in which the Local Authority support young people to remain living with their foster family after they are 18, until they are fully able to live independently. This is a great benefit to young people leaving care and enables them to transition to adulthood normally with the safety net other young people enjoy. Both locally and nationally there is an inevitable impact upon available foster placements as young people remain living within families. The arrangements can also bring different complexities to foster families who effectively have an adult living with them but are still required to meet fostering standards for children/young people. There is a limited statutory guidance in relation to staying put arrangements and as a service we continue to review how we provide a supportive but proportionate service. Sefton continues to support young people who have Staying Put arrangements, and during the year additional training was provided to foster carers to help them better understand the complexity that these arrangements can bring, as well as the financial and practical support available to facilitate the transition.

## Allegations

The total number of allegations made by children/young people in foster care this year was eight. Two of the allegations took over 21 working days to respond to. Analysis of these established that this was due to delay in a Police decision regarding their involvement and awaiting the outcome of a Police investigation.

Being subject to an allegation and subsequent investigation is enormously stressful and distressing for foster carers. For some foster carers, it may threaten or impact upon their family and career in addition to their role as a foster carer. The supervising social worker supports the carers through supervision and provides them with information about the process and progress of the investigation. Sefton also provides independent support for foster carers, spot purchased through Foster Talk.

The team are more aware of the need to hold a review following an allegation. There is awareness that good practice dictates that foster carer reviews include the supervising social worker. On the whole foster carers feel there is stability in the Fostering Service and also recognise that the department are trying to make improvements to the service and recognise the role foster carers play. There are regular meetings of foster carers to which managers including senior managers are invited to speak about different aspects of fostering support and the development of the Service.

## Foster Talk

Sefton purchases individual membership of Foster Talk for our foster carers and their families, including free social work, financial and legal advice. Additionally, it importantly provided carers with access to free legal

support and legal representation should they be in a position of being criminally investigated or charged for an issue resulting from their fostering, such as an allegation by a child/young person.

The service regularly receives positive feedback from foster carers about this service.

A goal of the service this year is to work with managers and the Local Area Designated Officer (LADO) to work to reduce the elements of delay which is within our control and influence.

## Resource Maximisation

Due to the continued rise in the number of children/ young people coming into care, independent providers continue to provide a key resource. In addition, the needs of some children/young people dictate the need to access solo or specialist placements. Wherever possible placements are sought within or nearby to Sefton, along with links with school, leisure activities and contact with family and friends. A fortnightly resource panel oversees and considers all requests for a placement. The Fostering Service intends to contribute to this process through the development of a specialist recruitment programme, known currently as the 'Teen Scheme' and aimed at creating a small pool of salaried carers who will receive additional training and support to provide placements for young people who would otherwise be placed out of borough often in residential care.

## Fostering Panel

Fostering Panel meetings continue to take place monthly, with an independent chair, and a panel advisor (Fostering Team Manager). The panel chair is annually appraised by the agency decision maker (ADM). Panel members are also appraised by the panel chair together with the panel advisor. A newly appointed Independent chair was appointed following the retirement of the last panel chair.

The Fostering Panels continue to be held monthly, discussions are lively, thorough and well balanced. The ADM undertakes a thorough analysis of all panel recommendations and the supporting documents prior to making a recommendation. There was one example of the ADM changing the recommendation of panel during this year.

## Panel Administration

The panel has received a high standard of administrative support, which has been instrumental in developing processes to ensure that the panel papers, minutes and time keeping are adhered to.

Connected persons applications to panel provoke much thought and debate because the issues they throw up alongside the significant needs of the children/young people that they will be caring for. Panel has the task of balancing the needs of specific children/young people, the complexities of the family and wider family relationships as well as any risk factors that there may be inherent in the situation.

Panel give consideration to whether the placement is for short-term/long term panel also frequently need to be mindful of any legal proceedings running alongside applications to panel and on occasions panels work is superseded by legal decisions.

26 First Annual Reviews were presented to panel during the year representing a slight increase in first annual reviews from the previous year when 23 were presented. Panel have continued to encourage carers to attend their first review and moving forward will be tracking data on attendance.

## Observers.

Student social workers, members of staff on induction, members of senior management and prospective panel members have all joined panel to observe. Panel welcomes observing at meetings. It is an excellent way to see how panel works and helps to demystify the process, particularly for those who will present cases to panel for the first time.

## Independent Review Mechanism

If carers or prospective carers are unhappy about recommendations made by the fostering panel and decisions made by the Agency Decision Maker (ADM) they can appeal the decision through two mechanisms. One is a request for another Fostering Panel to hear issues again and another is for the case to be referred to the IRM. In this financial year Sefton had no cases taken to the IRM.

## Training

Sefton continues to have a comprehensive carer training programme that we add to and update ensuring ongoing opportunities for our carers to develop knowledge, skills and keep up to date with developments in practice, research and legislation.

We have delivered regular training courses in the last year. Our training calendar is tailored to meet the needs of foster carers. Our foster carers overwhelming feel that the training delivered is relevant, useful and helps and supports them in their role as foster carers.

## Training attendances

There have been 566 training attendances over 55 courses this year. This compares with 450 attendances in 2016-2017 over 49 courses, with an increase in attendance and more courses being introduced for 2017/18. As a service, we continue to be responsive to carers needs by developing our training and listening to carers views on which courses are crucial in assisting them in their fostering task. We continue to use foster carers as co-facilitators on the Transitions and Endings course which helps make the training responsive to carers needs, reflect their lived experience and respond to the messages from research. A high percentage of foster carers have completed their TSDS workbook.

Last year saw the first foster carers conference which was a huge success, the conference involved guest speakers which the foster carers found extremely beneficial and workshops set up with different topics that the carers could attend two out of the four provided. Due to the success of the conference, this is programmed again for the next year. Below some of the comments from foster carers who attended the conference and training.

## Foster carer's comments

**Fostering Conference April 17 Key Speaker Tania Bright**

*"Tania Bright was absolutely amazing. I liked all the talks, good insight into the service. Nice food. I liked everyone being in the same room so I could talk to whoever I needed easily"*

*"Thought the care leavers sessions were Brilliant"*

**Parenting a child who has been sexually abused June 17**

*"I thought the course was excellent and I feel more equiped to deal with a child who may have been sexually abused"*

The table below indicates the numbers of reports that have been dealt with by Sefton's Fostering Panel compared to the previous four years.

| Assessments of foster carers | 2014-15 | 2015-16 | 2016-17 | 2017-18 |
|---|---|---|---|---|
| Assessment of foster carers | 44 | 57 | 61 | 22 |
| Number of Connected person assessment | 30 | 45 | 47 | 21 |
| Number of mainstream assessments | 14 | 12 | 14 | 10 |
| Annual review of foster carers | 23 | 23 | 23 | 26 |
| De-registration of mainstream foster carers | 25 | 28 | 12 | 9 |
| Other reports, i.e approval changes, termination of assessments | 21 | 34 | 25 | 12 |
| Extension for the time limited Regulation 24 a[illegible]orts. | | | | |

This financial year it has been a busy period for the fostering panel, with a steady flow of assessments being presented to panel with most of the activity being Kinship assessments.

124 viability assessments were completed within this year a slight increase compared to 115 the previous financial year. We again recognise this is a high rate compared to those approved to care for children/young people and less approved under a Special Guardianship Order. There were 19 Special Guardianship Orders granted in 2017/18 a positive outcome for children/young people living with relative friend carers.

There were 35 Regulation 24 placements assessed compared to 24 last year an increase to the number of children placed with relative/friends.

## Exemptions

Due to the number of children/young people coming into care, Sefton has placed children with experienced foster carers who are already within their approval status and require an exemption to allow them to take above their usual fostering limit. This requires a report to panel and oversight by the ADM

Registration as a foster carer usually limits the number of unrelated children who can be cared for at any one time to three.

An 'exemption' refers to the powers given to local authorities to exempt a foster carer in England from the requirement to register as a children's home to care for more than three unrelated children.

Regardless of the foster carer's terms of approval, if more than three children are placed with a foster carer and the children are not all siblings of each other, this requires an exemption to the usual fostering limit (Sch. 7 CA1989) as above. Sefton have used this service to place children coming into care in an emergency were there has not been time to consider a match. If a fostering service provider decide to approve a foster carer, they must give the carer notice in writing of any terms on which the approval is given [Reg 27(5)(a)]. However, there is no legal requirement for any terms to be agreed. If no terms are made, the foster carer will be approved to foster any children, taking account of the constraints of the usual fostering limit.

## Placement Breakdowns from 01/04/2017/ 31/03/2018

- The total number of children/young people moved as a result of placement breakdown was 23.
- Four breakdowns were the result of foster carers wishing to retire and wanting to return to work.
- A sibling group of four was placed with a carer who subsequently felt unable to continue with the placement.
- A sibling group of three were placed elsewhere at the carers request due to an historical allegation against their partner who was asked to leave the placement.
- One young person was moved following an allegation against a grandparent which although unfounded then refused his return.
- A sibling group of two were moved due to their behaviours and the impact on the other children in placement.
- Seven teenager placements broke down due to behaviour which included aggressive behaviour, missing from care, criminal activities, and alcohol/ drug issues.

It is recognised that these behaviours are often a symptom of their pre-care experiences and we work hard to avoid acting in a way that disrupts young people's positive behaviour and support networks.

The Service recognises that due to pressure on placements young people are sometimes placed with foster carers who are outside of their 'comfort zone' and more importantly their skills and abilities, in caring for the older child.

The 'Teen Scheme' will further address this issue by making sure that children with additional needs can be matched with carers who have the level of skill and enhanced support to sustain their placements.

## Disruption Meetings

During 2017/18 the Fostering Service continue to hold disruption meetings so that all professionals involved can review what has occurred in such situations and assist the fostering service in learning any lessons from placement breakdowns alongside supporting foster carers and looked after children/young people in placement.

As corporate parents, we recognise the impact of unnecessary placement moves. Research shows the importance of stable and nurturing placements that can directly influence the child/young person's ability to recover from the abusive and neglectful experiences they have previously had.

## The Fostering Service Looking ahead 2018/19

- Our challenges remain placement sufficiency and placement stability. Placement stability is impacted by availability and choice of placements and the skills of available foster carers, and by the quality of assessment and care planning and the quality and consistency of support offered to carers. These are challenges which require a whole service approach and require Fostering Service to support and influence colleagues as well as develop and improve the service directly provided.
- To continue to provide a comprehensive good quality foster carer service to all children/young people looked after by Sefton.
- To provide looked after children/young people with a positive experience of family life, which promotes their physical, emotional, developmental well-being, and happiness in an environment in or close to their community.
- To continue to work in partnership with partners across children's services as well as with health, education, and other allied professionals to achieve the best outcomes for children/young people in foster placements.
- Continuation in working in partnership with foster carers to enable them to provide warm, safe and caring family environments, so that children/young people's emotional health and development is promoted.
- To guide and work in partnership with foster carers so that they understand the importance of working and co-operating with schools, to ensure access to available opportunities to promote children and young people's attendance and their academic achievements.
- Maintaining positive relationships with foster carers to ensure participation in practice and Service Improvement.
- Refreshing, revising and driving forward an energetic recruitment campaign to attract prospective foster carers to Sefton Councils Fostering Service.
- To continue the positive collaboration work with Knowsley Council in the recruitment of foster carers for both Councils.
- Reviewing and developing foster carer support groups to include specific groups for connected carers.
- Reviewing the foster carers annual review process.
- The Teen scheme was not fully achieved during 2017/18 although progress was made to set the foundations for this which should begin in operation 2018. The teen scheme will endeavour to fully utilise a pool of recruitment foster carers specifically for young people with very complex needs.
- To continue to review targeted recruitment for specific areas.
- Continue to provide advice, information and guidance to those wishing to foster for Sefton.
- Sefton's fostering service continues in its commitment to increase the numbers of foster carers for all ages of children/young people especially for teenagers and sibling groups.
- For our foster carers and young care leavers to continue to be actively involved in foster care recruitment.

**Maria Spatuzzi**
Fostering Team Manager

# Sefton Fostering Service
# Annual report
# 2017–2018

Sefton Council

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| | | | |
|---|---|---|---|
| **Report to:** | Overview and Scrutiny Committee (Children's Services and Safeguarding) | **Date of Meeting:** | Tuesday 25 September 2018 |
| **Subject:** | Local Government Association Care Practice Diagnostic (Peer Review) | | |
| **Report of:** | Director of Social Care and Health | **Wards Affected:** | (All Wards); |
| **Portfolio:** | Children, Schools and Safeguarding | | |
| **Is this a Key Decision:** | No | **Included in Forward Plan:** | No |
| **Exempt / Confidential Report:** | No | | |

**Summary:**

The Local Government Association were invited to undertake a Care Practice Diagnostic of Children's Social care to provide external scrutiny and assurance that services have continued to improve and identify areas for further improvement. The onsite element of the review took place in April 2018 (two years on from the Ofsted Inspection of 2016). The final report was received in June, recommendations from the report have been included in the updated and refreshed Children's Social Care Improvement Plan which has also been tabled for today's committee.

**Recommendation(s):**

(1) Committee receives the report and findings of the Local Government Association.

(2) That Overview and Scrutiny Committee continues to receive the bi-annual report and performance score card which incorporates the recommendations of the LGA to ensure progress is being made against the recommendations.

**Reasons for the Recommendation(s):**

Overview and scrutiny committee have an important role in receiving and scrutinising the LGA report to assure themselves of the effectiveness of Children's Social Care.

**Alternative Options Considered and Rejected:**

None

**What will it cost and how will it be financed?**

**(A) Revenue Costs**

Any improvement outcomes from the attached LGA report must be supported from within existing resources. The number of children coming into care has increased by 45+ children since April 2018 and the budget is forecast to overspend by £4m in 2018/19. More effective collaboration and commissioning arrangements with the CCG may help to improve the health of LAC and potentially reduce costs to the Council going forward

**(B) Capital Costs**

**Implications of the Proposals:**

| |
|---|
| **Resource Implications (Financial, IT, Staffing and Assets):** |
| **Legal Implications:** |
| **Equality Implications:**<br><br>There are no equality implications. |

**Contribution to the Council's Core Purpose:**

| |
|---|
| Protect the most vulnerable:<br>Children's Social Care have a statutory duty to protect the most vulnerable. |
| Facilitate confident and resilient communities:<br>Children's social care work with children and their families to improve outcomes for children |
| Commission, broker and provide core services:<br>Children's social care work in partnership with a range of organisations to ensure vulnerable children are safeguarded. |
| Place – leadership and influencer:<br>The scrutiny of Children's social care performance supports the aspiration for all services to children to be good or better. |
| Drivers of change and reform:<br>There has been significant focus on driving up standards of practice and linking and aligning resources with the framework for change |

| |
|---|
| Facilitate sustainable economic prosperity:<br>Improving outcomes for our most vulnerable children will support them to have aspirations and obtain economic independence. |
| Greater income for social investment:<br><br>N/A |
| Cleaner Greener<br><br>N/A |

**What consultations have taken place on the proposals and when?**

**(A) Internal Consultations**

The Head of Corporate Resources (FD 5299/18) and the Chief Legal and Democratic Officer (LD.4524/18) have been consulted and any comments have been incorporated into the report.

**(B) External Consultations**

N/A

**Implementation Date for the Decision**

Immediately following the Committee meeting.

| | |
|---|---|
| **Contact Officer:** | Vicky Buchanan |
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**Appendices:**

The following appendices are attached to this report:

Local Government Care Practice Diagnostic

**Background Papers:**

# Sefton Metropolitan Borough Council
# Care Practice Diagnostic

24th to 27th April 2018

## Feedback Report

Local Government House, Smith Square, London SW1P 3HZ **T** 020 7664 3000 **F** 020 7664 3030 **E** info@local.gov.uk
www.local.gov.uk
Chief Executive: Mark Lloyd

## 1. Executive Summary

Sefton Council and its partners have clear ambitions to drive their children's services improvement journey within the context of wider reform of the council's developing approach to locality delivery of neighbourhood public services. Children's Social Care benefits from good leadership - managerial and political - both corporately and within the service. Children's Services faces some real challenges – Sefton has some very deprived communities (several of the most deprived super output areas in the country are found in Sefton), while some northern parts of the Borough are relatively affluent. There are a high number of private children's residential homes, drawing in children looked after by other authorities. The council has developed good relationships with these privately managed homes. These 'outlier' issues provide challenges for the council which it manages well within the resources available.

The last Ofsted inspection of Children's Services in 2016 found that they 'Require improvement'. Both the Director of Children's Services (who is also Director of Adult Services) and the Head of Children's Social Care were only recently appointed at that time. They have led the service's response following that inspection. Key elements of this have been a new structure and ways of working for social work teams; an increased focus on practice; improved quality assurance arrangements and the development of a stronger learning culture. Managers and staff are equally aware that they are part way through a significant cultural change. The Chief Executive has championed that improvement through her chairing the council's Improvement Board and Children's Social Care has benefited from appropriate challenge and support from the lead member and Overview & Scrutiny.

A key strength is that social workers and foster carers like working for Sefton. Social workers feel supported and secure with their managers. Supervision is regular, reliance on agency workers is minimal, managers are visible and morale is good. The new structures have been received positively by staff and there is a willingness to embrace change. This is not to say that this change is not presenting difficulties – for example the need to develop a new and wider range of skills for social workers in the Locality Teams, and balancing assessment and longer term work within teams. There has been a significant impact on caseloads in some teams. However, staff and managers are supporting each other through this process. The new structures are leading to fewer handovers between social workers and give the opportunity to develop longer term relationships with children and families.

The MASH (Multi Agency Safeguarding Hub), the 'front door' into early help or social care, appears to be robust. There is a consistent and appropriate application of thresholds, based on the revised Level of Need Guidance which is well regarded across partners. From the sample of cases reviewed, decisions appear to be generally sound and timely.

From our in-depth review of a small sample of cases of children looked after or at the edge of care, care planning and risk management is generally effective, although recording could be more consistent and comprehensive and permanency planning

needs to continue to be strengthened. There is rightly now a stronger focus on neglect than was previously the case in Sefton, which is leading to older children with more complex needs now coming into care. There is evidence of the use of the Signs of Safety approach, both in the MASH and to a lesser extent in care planning. Signs of Safety is regarded as a useful tool by social workers, but is less favoured by managers. In particular it is thought to be less helpful for longer term planning for looked after children and consideration of permanence. It may be giving rise to instances of 'professional optimism' to persist with a plan or placement that may not be child focused or timely, and / or result in placement instability. Signs of Safety should be seen as one tool within a wider approach.

Adoption performance is on a positive trajectory, with an increase in children placed for adoption albeit the numbers remain relatively small. There are good tracking, monitoring and decision making arrangements for children with a plan for adoption. Sefton has a commitment to placing older children for adoption and for placing sibling groups together, notwithstanding that these children may be harder to place.

Sefton thus has a good platform on which to build. However, leaders and practitioners recognise that there is more to do to improve support and outcomes for looked after children and young people in Sefton and are keen to pursue that journey. The peer team consider that the following are among the key issues which Sefton needs to address with its partners.

The current re-structuring of health commissioning arrangements across Sefton and the wider Liverpool City area provides the opportunity to develop stronger relationships with key health partners. Commissioning arrangements can be improved – those for services for looked after children are currently fragmented and find it challenging to demonstrate improvements in health outcomes. There are opportunities to build upon a number of good health-related projects and initiatives which already exist, such as developments around lower level support to promote emotional wellbeing. There are early signs of improvement in key areas, such as the timeliness of health assessments. The council should develop closer working relationship with health, to nurture a shared commitment to statutory duties and improving performance further.

Data is not always robust and sometimes contradictory – particularly cross agency data. Sefton needs to improve the quality and consistency of the data it produces, to improve the management and delivery of services and more effectively tell the story of the improvements it has achieved, to future external scrutiny or inspection.

Leaders and managers need to keep a close eye on caseloads and frontline work in localities. Although overall social work caseloads have decreased, those in the Locality Teams remain relatively high. Sefton needs to address the current dip in performance which has been associated with the change to new working arrangements and structures to ensure that this does not become a trend. It should complete the self-improvement cycle to check corrective actions are taken as part of the wider quality assurance framework.

Sefton should implement Signs of Safety as part of a wider framework that draws on other approaches, particularly around risk assessment and capacity to change. The peer team have provided examples of such approaches adopted by other councils. There is a need to improve the quality and timeliness of child focused decision making to achieve early permanence, particularly for young children, and earlier decision making around whether siblings should be placed for adoption together or apart. Sefton should build on the commitment of foster carers by greater engagement with them at a senior level, listening and responding to their views to enhance its intelligence of the impact of practice on children and young people.

## 2. Recommendations

a) Ensure that data used for service management and self-evaluation is consistent, robust and supported by appropriate narrative as necessary

b) Develop a more concise and focused self-assessment format to better tell Sefton's story

c) Closely monitor social work caseloads, in particular in Locality Teams, and take action to address if these rise to a level which impacts on the quality of casework

d) Address the current dip in aspects of performance, associated with the re-structure and introduction of new ways of working. Ensure that these do not become a longer term trend, so that the benefits of the changes are realised

e) Provide opportunities for a wider range of members to engage with children's social care, to enhance understanding of front line delivery, and take advantage of the intake of new councillors following the elections to further raise the profile of the corporate parenting role

f) Continue to strengthen working relationships with heath partners, in particular around key performance challenges such as the timeliness of initial and review health assessments. Establish clear and shared ownership for the care pathway and performance improvement

g) Consider opportunities for the wider and more effective use of the information gathered from the SDQs (Strengths and Difficulties Questionnaires) to improve support and outcomes for children looked after, including work with health partners

h) With the CCG, consider the potential benefits of commissioning dedicated health services for children and young people looked after

i) Further enhance the offer of low level support to promote emotional wellbeing, ensuring that this is linked to the wider CAHMS strategy and well communicated

j) Complete the self-improvement cycle by checking that corrective actions are always taken as a result of audit findings

k) Implement Signs of Safety as part of framework that draws on other approaches, particularly around risk assessment and capacity to change

l) Improve child focused decision making to achieve early permanence, including earlier decision making around placement options

m) Strengthen the quality of support and interaction with Sefton foster carers, including building a carer engagement programme that considers all factors that may lead to instability in placements.

## 3. Summary of the peer diagnostic approach

The fundamental aim of each diagnostic is to help councils and their partners reflect on and improve the impact of looked after services for children and young people. It is important to remember that a peer review is not an inspection; it provides a critical friend to challenge the council and their partners in assessing their strengths and identifying their own areas for improvement.

The Care Practice Diagnostic (CPD) is designed to follow the child's journey from the edge of care through care and permanency planning, adoption and leaving care. The main elements of the CPD were:

- A review of data and key documentation
- A review of case records (we looked in depth at a small sample of eight cases in advance of the main CPD visit plus a further four cases while we were on-site. We also sampled 26 recent contacts / referrals to the MASH as part of our review of the 'front door' to social care and early help in Sefton)
- On-site work over four days (from 24th to 27th April 2018) including individual interviews, focus groups and a practice observation of a LAC review.

The documentary evidence provided to the team was used to guide its focus in assisting you with your on-going improvement and enabled the team to provide some feedback concerning the effectiveness of the council's self-assessment. In particular, the case records review helped to inform the peer team's findings in relation to frontline practice. However, it should be recognised that the team were only able to consider a relatively small number of cases and but the diagnostic is not a substitute for the council's own quality assurance processes.

**The peer team**

Peer diagnostics are delivered by experienced officer peers. The make-up of the peer team reflected your requirements and the focus of the diagnostic. Peers were selected on the basis of their relevant experience and expertise and their participation was agreed with you. The peers who delivered the CPD at Sefton were:

- Stuart Smith, Director of Children's Services, Calderdale Metropolitan Borough Council (lead peer)
- Beate Wagner, Director of Children's Services, Wakefield Council
- Parmjit Chahal, Head of Service for Children's Access, London Borough of Harrow
- Sue Lowndes, Head of Adoption and Fostering, Hertfordshire County Council
- Nancy Sayer, Designated Nurse for Looked After Children, Kent CCGs
- Andy Gill, associate peer (document analysis)
- Paige Gore, LGA Children & Community Safety Team (shadowing the diagnostic)
- David Armin, LGA diagnostic manager

## 4. Scope and Focus

In general, a CPD looks at care practice under four broad themes:

- Effective practice and service delivery
- Outcomes for children, birth parents and adopters
- Vision, leadership and strategy
- Managing resources and workforce.

In undertaking the CPD in Sefton, we paid particular attention to the following areas of focus agreed with the council and present our findings under these headings:

- **The council's self-assessment** - does it accurately reflect the current position and identify what needs to be addressed?
- **The effectiveness of the 'Front Door'** - taking account of the refreshed Level of Need guidance and the focus on early help
- **The restructure of children's social care** - is this having an impact, in particular in relation to more effective decision making and care planning?
- **Improving the health of children looked after** - in particular the interface between health and social care and the contribution of all partners
- **The implementation of signs of safety across the partnership** - is this well embedded and used effectively?
- **Adoption performance** – is this continuing to improve and is there scope to further enhance Sefton's approach?

In addition to the above, the team also provide their reflections on the leadership of children's social care and the council's approach to its key role as a corporate parent.

## 5. Main Findings

### 5.1 The council's self-assessment

We begin by providing some reflections on the impressions formed by the council's self-assessment and supporting documentation, before the on-site evidence gathering phase of the diagnostic which provides the basis of the team's main findings and conclusions.

The documents provided clear evidence of progress since the Ofsted SIF inspection in 2016. There is a clear key focus on outcomes for children in care, practice improvement and learning together, rather than an over focus on compliance monitoring. The vision and supporting road map is clear, particularly the focus on early intervention and Edge of Care provision, though not yet having a significant impact on overall numbers.

From the self-assessment, there is an evident commitment towards developing a learning and reflective culture and quality assurance systems appear well developed. Corporate parenting and member engagement appears strong and there is an explicit financial commitment towards the growing numbers of children in care and meeting their needs. It appears that Sefton engages, listens to and responds well to the views and wishes of children in care and there is a commitment to improving life chances and placement quality. Most of these areas of strength were confirmed through the on-site diagnostic work.

However, the self-assessment could be further strengthened to tell Sefton's story more convincingly and with greater coherence. There was some inconsistent data, including that provided from different partners and, until the data was refreshed shortly before the diagnostic, some key performance information was not up to date. The data used should be current and triangulate with the main messages the self-assessment is intended to convey. For example, we found data around placement stability in the documentation confusing and similarly the data and narrative around the rising number of children in care in the self-assessment. Where data is necessarily different across partners (for example due to central government reporting requirements) there should be a narrative to explain this.

The format of the self-assessment is that adopted across the North West to support regional peer challenge work. It may well be effective for this purpose, but the peer team are not convinced that it is appropriate to best tell Sefton's story and improvement journey for a peer diagnostic or more particularly in advance of an inspection. Sefton should consider an alternative format for this purpose, clearly based around the area's challenges, the progress Sefton has made and the key Ofsted questions to provide a compelling narrative. This should be clearly linked to the relevant and succinct evidence, provided in supporting documentation as necessary avoiding information overload. We provide some further analysis of the background documentation at **Appendix A**, including some suggestions as to the format for the self-assessment. Members of the peer team have offered to share examples of self-evaluations prior to an inspection which they believe to be effective.

### 5.2 Leadership and corporate parenting

Children's Services issues are understood and prioritised appropriately by the Leader of the Council, and the Chief Executive. The Chief Executive personally chairs the Service Improvement Board for Children's Social Care and is able to both

reassure herself and hold the Director of Children Services (DCS) to account appropriately.

The Chief Executive ensures that the corporate agenda considers the implications of council decisions upon looked after children. This can involve meeting young people directly, including the Young Advisers drawn from the council's Children in Care Council (known as 'MAD' – Making a Difference). MAD is an active Children in Care Council, with separate groups for those for up to 14 and over 14 years old who benefit from the opportunity to have their voices heard corporately. They have helped to develop specific initiatives, such as the offer to care leavers. However, there could be more tailored opportunities for the younger MAD group to have a higher profile and have their voices heard.

As part of Sefton's arrangements to strengthen quality assurance and promote a learning and reflective culture, it has introduced Focus on Practice weeks during which senior managers observe practice and are involved in case auditing. The Chief Executive, Lead member, the DCS and Head of Children's Social Care are all involved in these practice weeks. The Head of Children's Social Care in particular has a high profile with social workers and is clearly committed to working with staff to enhance practice including by modelling sound case decision making through the ADM (Agency Decision Maker for adoption) process. Social workers feel supported by both senior and team managers, in addition to their colleagues, and value this in helping to feel safe in their practice.

The Cabinet Member for Children, Schools and Safeguarding is both qualified and experienced in children's services activities and maintains a high level of interest and challenge in all aspects of the service, while retaining an appropriate strategic overview. The Children's Services and Safeguarding Scrutiny Committee is regarded as effective and appropriately challenging. Several members of this committee also serve on the council's Corporate Parenting Board (CPB), which is chaired by the Cabinet Member.

The CPB is committed to improving the welfare of children looked after and care leavers in Sefton and is able to report directly to scrutiny, which in the experience of the team is relatively unusual. However, the team feel that there could be greater challenge to poor performance to prompt action to address this in the interests of children and young people looked after. The voice of the child is present at the Board, through some young people from MAD being members of the CPB.

There are opportunities for the wider council to receive reports and updates in relation to the progress of the Borough's looked after children. This includes two briefings per year before Full Council meetings which are reported to be well attended by councillors. However, councillors do not routinely undertake visits to children's homes and front line teams and there are no other formalised opportunities for elected members to meet and talk with children in care, foster carers or social workers (other than through membership of the CPB and engagement with MAD). This is an area for development, to enhance member's understanding of front line issues and strengthening transparency of service delivery which should further underpin the safety of children and young people. As part of this Sefton's political and managerial leadership should increase their engagement with foster carers.

Following the local elections in May 2018 there will be an intake of new members onto Sefton Council. Sefton should take advantage of the opportunity presented by induction programmes etc. to engage them with the children's service agenda and in particular their responsibilities as corporate parents. The team were able to share some materials which Calderdale MBC intends to use to raise the profile of corporate parenting with new members – and in particular that of corporate grandparent. With the extension of council's responsibility for care leavers up to age 25 it is likely that a number of care leavers will be parents themselves. Calderdale is also asking its children looked after to provide some 'top tips' for councillors as corporate parents.

**5.3 The 'front door' – the Multi Agency Safeguarding Hub (MASH)**

As part of the peer diagnostic, members of the peer team visited the Sefton MASH and interviewed managers and staff. The team also sampled case records for 26 recent contacts / referrals (received in the week preceding the CPD). This quick review focused on the application of thresholds; the quality and timeliness of decision making and the provision of return to home interviews for children who had been missing.

The journey of the contact is evident both in the physical layout of the MASH as it proceeds through the team from receipt, information gathering to decision and how the processes were described by team members. The MASH benefits from a highly motivated, stable and child focused team who are passionate about the work they do. There is high morale and a focus in the MASH on 'getting it right for children'. There is a reflective learning culture in the MASH with strong management oversight evident from two experienced managers. The co-location of partners has further strengthened decision making with MASH enquiries being used appropriately.

The contacts reviewed provided evidence of thresholds being well embedded and consistently applied in the majority of cases (in line with the Level of Need Guidance), leading to proportionate action to protect children. Management decision making and oversight is strong and was evident on all contacts seen. The quality of screening was of a very good standard with evidence of historical concerns being considered to inform risk assessment and decision and the consistent use of Signs of Safety.

The quality of referrals has improved following work with partner agencies. The refreshed Level of Need Guidance is well regarded by both council staff and a wide range of partners. Its use of both narrative descriptors and the 'windscreen wiper' diagram to describe the type of service required and agencies responsible at different levels of need (i.e. thresholds) is regarded as clear and helpful. While a number of partners, including from the voluntary sector, thought that they were being expected to hold relatively complex cases at the early help stage rather than social care, they felt the criteria where clear and enabled an informed discussion around thresholds when required. In this respect, the social work consultation phone line is an added strength which provides agencies with an opportunity to discuss concerns at an early point. Partner agencies are feeling increasingly confident to challenge MASH decisions, and both managers and staff are open to this. Again this is being helped by the refreshed Level of Need Guidance.

The early support offer is embedded and well used. During the diagnostic we heard of number of examples of good work to avoid the need for more intensive social care and risk reduction. For example, the Community Adolescent Service (CAS) in its

support to families, diversion from gang activities and provision of short break accommodation. Return Interviews for missing children remain a strength, including being offered to children placed in Sefton by other local authorities.

On the basis of the relatively small sample of recent contacts reviewed and the peer team's limited discussions with MASH staff and partners, it appears that the 'front door' in Sefton is robust. However, there are some opportunities to enhance arrangements further. Evidence of whether consent to share information has been sought and obtained is absent from the contacts viewed. Sefton should ensure that such consent is recorded on the case record. Thought should be given to reviewing the process for seeking consent for MASH enquiries at the contact stage, to simplify the process and enable a quicker response. Contacts would benefit from evidence of consent being clearly documented for MASH checks. Where the decision based on risk is to override consent, the rationale for overriding consent should also be clearly recorded.

While the screening of contacts appears strong, there were gaps in analysis on some contacts seen to underpin the rationale for decision making. The aim is for all contacts to leave the MASH within 24 hours and Sefton believes this is the case in the overwhelming number of cases. From the sample taken by the peer team, there was evidence of a few contacts going over this timescale (however those observed were lower risk contacts resulting in NFA). Managers should actively monitor this aspect of performance to ensure that the target timescales continue to be met.

### 5.4 Case records review

The review of case records informed our findings across a number of areas of practice in respect of children in care, in particular care planning, the use of Signs of Safety, consideration of early permanency and adoption performance. A summary report detailing the approach and main findings from our case records review work is provided at **Appendix B**, with findings related to the individual cases reviewed at **Appendix C**.

A member of the peer team reviewed eight cases in Sefton in depth in advance of the main CPD visit. The peer reviewed case records and then interviewed the social worker and team manager in respect of each case. The sample drew on cases from a number of different social work teams and were for children in care, at the edge of care or with a plan for permanency. We reviewed a further four cases during the on-site CPD, mainly with a view to considering the timeliness of adoption and permanency planning and the findings of this lighter touch review are reported in section 5.7 below. During the diagnostic good practice was observed in the arrangement for a large sibling group (now care leavers) to remain at home on Care Orders, whilst effective monitoring and support were in place to safeguard the arrangement and ensure stability. The authority may wish to consider using this case as an example of good practice.

The key messages from the case record review can be summarised as follows:

- In most cases effective care planning and risk management is taking place
- Social workers and managers know their cases well (but this is not always evident from the case records alone but became apparent in discussion)

- Children are being seen and their views and wishes known by social workers
- Signs of Safety is identified as a useful tool by social workers, but less favoured by managers
- There is some evidence of 'professional optimism,' that is leading to perhaps excessive confidence that a placement will 'work out', when a more objective overview would identify clear risks to the likelihood of stability being achieved from the existing care plan. This may in part be attributed to the use being made of Signs of Safety in longer term care planning.
- Better use is needed of chronologies and case summary to record reflection and analysis
- Recording of management oversight in case notes needs to be more consistent
- Sefton's supervision policy requirement that supervision is recorded as a supervision case note on the child record needs to be clarified and implemented.

**5.5 Service structure, decision making and care planning**

Sefton introduced a new structure for Children's Social Care during the course of 2017. This entailed moving from a structure of more specialised teams to one based on nine Locality Teams responsible for a wide range of children's social care work (children in need, child protection and the early stages of care for looked after children). Three Corporate Parenting Teams are responsible for the longer term care of looked after children (including children with a plan for adoption once the placement order is made) and a fourth team supports Sefton's Care Leavers. The 'front door' to social care is provided by the MASH, up to the initial child protection conference where relevant. The intention behind this re-structure was to reduce handovers between different teams experienced by children and families; increase ownership of problem solving and achieving better outcomes to avoid a tendency to move on to more intensive social care; and to provide more equitable caseloads between different teams.

The move to the new structure has been aided by strong high level leadership that is child and practice focused. There has been a positive reception by staff and willingness to embrace the new structure. Social workers recognise that the new structure presents challenges through the need to develop a wider range of skills and knowledge in the Locality Teams, but feel supported in doing so by both their managers and colleagues with complimentary skills.

Managers and social workers believe that the new structure is leading to fewer handover points and the potential to build relationships with families that can effect long term change. It would be helpful to develop a performance indicator to evidence whether the re-structure is achieving its aims to reduce the number of changes in social workers for children. The Permanency tracker, and the associated Permanency Planning Meeting, is providing a system of understanding workflow for some children in care, but could be further developed.

Neglect now appears to be receiving a stronger focus and the service is proactively addressing historically weaker practice in this area. This has contributed to the

increase in the number of children coming into care, whose needs are extremely complex. Where neglect has not previously received such focus, this has led to older children suffering significant neglect over a period of time which means that they are presenting greater challenges as children looked after. This increased focus on neglect may also be contributing towards the recent increase in children becoming looked after.

Following the recent re-structure there has been a dip in performance across some indicators, which has been acknowledged by senior managers (e.g. an increase in the small number of assessments taking over 60 days to complete). It is not unexpected that such a dip in performance should have occurred at a time of significant change. The new Locality Team structures mean that staff are still learning the wider range of tasks and duties expected of them and this has the potential to hamper an effective workflow. This is contributing to increased caseloads as it is currently taking longer to complete tasks. This dip needs to be closely monitored and actively addressed to ensure that it does not become a trend. Caseloads in the Locality Teams should continue to receive attention. While average caseload across all social care teams have reduced (Sefton report these as just under 20 in March 2018), caseloads in Locality Teams are higher than this average. Sefton's figures give these as typically in the range of 25 to 30 and our discussions with social workers indicate that these can be higher, when there is a vacancy or sickness or when a team is on the one week in four duty rota for intake of new cases.

The authority has not yet gained the full confidence of the courts in its decision making - more robust and timely care planning would contribute to addressing this. Further focus is required to improve sound and timely decision making at the front line and first line management levels, to increase the confidence of staff in taking difficult decisions. This will impact positively on earlier realistic permanence planning.

The authority has undertaken a focused piece of work with children placed with their parents – this should be further strengthened in recognition of the particular and significant vulnerabilities of this group of children. A significant number of children are placed with parents across the North West region, attributed to the preferences of the courts in the region. However, Sefton appear to be impacted by this more than some other local authorities and this significantly inflates the number of children looked after in the authority and has an impact on associated indicators such as placement stability. Sefton may wish to consider disaggregating the data for internal reporting and management purposes to test this hypothesis and gain a clearer understanding of the difference in outcomes for children in care placed at home as compared to placed elsewhere.

As a result of this recent focus on children placed with parents, some 30 such care orders have been discharged, which has reduced unnecessary statutory intervention in the lives of these children and families. Sefton should continue to work with the courts and colleagues in the region to address this issue where possible.

The audit approach is providing good multi-agency engagement and increasing partnership understanding of quality. However, not all social workers within the council were clear about the lessons from audit, but were more familiar with learning from other quality assurance work through the practice weeks and staff engagement and learning events. In addition, there is a lack of assurance and checking that audit

has an impact on practice both in individual cases and more generally and that the required corrective actions have been taken in response to audit findings.

### 5.6 The implementation of Signs of Safety

From our review of a small number of case records and other discussions with managers and social workers, Signs of Safety is identified by social workers as a useful tool, but less favoured by managers. It is seen as useful for bringing out the voice of the child. The Signs of Safety approach is providing a helpful multi-agency framework for joint agency working in the MASH (we found evidence of the consistent use of the tool in our review of recent referrals). However, a number of managers thought it to be less helpful for longer term planning for looked after children and consideration of permanence.

The strength based approach encouraged by Signs of Safely has been helpful in engaging some children and families more proactively in the child protection and particularly the conference process. Some families really get the approach, but others struggle with it and we heard of some cases, where social workers had persisted with the approach, even though it had proved unsuccessful in previous episodes of engagement with families. Signs of Safety should be seen as part of the toolbox, not the only approach.

If fully implemented, the Signs of Safety approach encourages the use of genograms to understand the whole family network, encourages the family to develop solutions and promotes the voice of the child at the centre of practice. However, the approach places an emphasis upon direct work which children and families which the peer team believe may not be compatible with the current relatively high caseloads across the Locality Teams.

The Signs of Safety approach has not supported a permanency culture in the organisation and may be contributing to an undue focus on the needs of parents, unrealistic plans for rehabilitation and/or placements with connected persons and delays in making difficult decisions about sibling placements. The emphasis on strengths and the focus on parents' views may be contributing to this 'professional optimism' which is leading to some plans failing. Signs of Safety may be better suited to child protection rather than work with children who are looked after.

The approach is not fully implemented and, if taken forward, would benefit from being considered as part of a model incorporating wider evidence based approaches that take more account of risk management and capacity to change. Examples of Signs of Safety being incorporated within a wider approach include the:

- Rotherham Family Model (Signs of Safety combined with Restorative Practice and Social Pedagogy); or
- North East Lincolnshire "Creating Strong Communities" practice model.

### 5.7 Improving the health of children looked after

It is important to acknowledge the wider context of the commissioning and provision of healthcare services in Sefton, which has implications for the services to children looked after and relationships across the partnership. Sefton suffers from a legacy of weak commissioning arrangements and poor community service delivery, leading to the dissolution of Liverpool Community Health Trust in April 2017 and consequent

re-organisation. Across the local health sector, attention is inevitably focused on the recovery plan to address the financial deficit and on the high spending areas of adult health and social care. However, a quick sample of agendas for the Sefton Health and Wellbeing Board over the past year indicates about 30% of items where for matters concerning children and young people, which suggest that leaders across the partnership are still able to give attention to the children's agenda.

There is a commitment from the leadership of NHS South Sefton and NHS Southport and Formby Clinical Commissioning Groups (referred to as Sefton CCGs) to work to improve the health of children looked after. Sefton CCGs Chief Officer has expressed the goodwill to support further improvement and build on the strengths and good practice which already exists across the partnership. The CCGs demonstrate understanding of the risks associated with current commissioning arrangements, as evidenced by the inclusion on its risk register of related issues such as the timeliness of health assessments for children looked after.

The Transition pathway from CAMHS Tier 3 to adult mental health services is embedded in practice and working well, leading to continuation of appropriate service at age 18. Communication from Children's Social Care with health when a young child is removed from birth family is working well – for example Health Visitors are advised of this to avoid the risk of making an unnecessary home visit which could be difficult for all concerned.

The GLAM project (Girls Leading, Achieving and Motivating), offered by Addaction to raise self-esteem has positive outcomes with no drop outs. Based on this success, consideration is being given to develop a similar project for teenage boys. Another area of good practice is the Star Centre which provides support to young people with low level mental health issues. Sefton should take advantage of any opportunities to expand this offer and further communicate the impact it is having.

The newly appointed Designated Nurse for children in care has a background in working with children with multiple disabilities which will support the SEND agenda – around services for children with special educational needs and disabilities. A previous Ofsted SEND inspection required a statement of action from Sefton to address the issues identified.

It is recognised that performance in terms of compliance with timescales for health assessments for children looked after is unsatisfactory (e.g. the council's data reports that 40% of initial health assessments (IHAs) were completed within 20 days in the year to end of February 2018). A recent joint IHA audit by health and the council identified timescale issues within the overall pathway. A further pathway mapping exercise was completed resulting in recommendations for the partnership. This should provide the basis for action and improvement, if allied with clear ownership of the issues identified. There was significant improvement in compliance with timescales for review health assessments in the last quarter of 2017-18, although the statutory requirement that all looked after children should have an up to date health assessment is not yet being met. North West Boroughs Healthcare NHS Foundation Trust are working with the council's fostering service to improve understanding of health assessments, which should increase attendance at statutory health assessment appointments

A number of wider initiatives which are relevant to looked after children appear impressive. The multi-agency criminal exploitation pathway is well understood and

believed to be working well. LTP (Local Transformation Plan) funded initiatives to address low level emotional wellbeing concerns are innovative and show promise, such as the provision of a drop-in centre with the ability to refer directly to Tier 3 CAMHS services.

However, a number of significant challenges remain which are making it difficult to improve the health of looked after children to the extent that all in Sefton desire. Current commissioning arrangements to meet the health needs of children looked after are fragmented and find it challenging to demonstrate improvements in health outcomes. Consideration should be given to the potential benefits of commissioning a dedicated service for children in care. In the meantime, the Children's Integrated Commissioning Group (chaired by the council's Head of Children's Social Care) should work to ensure a more coherent approach.

The SDQs (the Strengths & Difficulties questionnaire – a measure of children and young people's emotional health and wellbeing) completed by carers for the council is returned to the DfE to develop understanding of national trends. However, it appears that little use is being made of this information beyond this minimum requirement, including sharing with health. For example, they are not being used to inform the emotional health element of the review health assessment.

Difficulties in the joint health assessment pathways are impacting significantly on the timeliness of statutory health assessments, in particular that for initial health assessments. There needs to be clear ownership of performance improvement across the whole pathway, and action taken to drive improvement. One aspect is that a significant proportion of children placed at home on an order are failing to attend statutory health assessments. Working with families to understand the importance of such attendance should help (along with wider efforts to reduce the incidence of such placements).

There is insufficient regular dialogue between partners around addressing issues or concerns that impact the health outcomes of children in care, for example concerning the timeliness of health assessments. There is a need to develop relationships and strengthen such dialogue around problem solving, getting the right people involved who can take action. The peer team are not convinced that this is happening on a regular basis.

Confusion exists across the partnership in relation to roles and responsibilities for improving health outcomes, including responsibilities within the respective agencies. Moreover, there is a lack of clarity across the local authority and key partners (including Public Health, Children's Social Care and the CCG) about the extent of the health needs of looked after children. These need to be fully understood in order to be addressed, underpinned by the JSNA (Joint Strategic Needs Assessment) which should include the needs of looked after children as a particularly vulnerable group.

**5.8 Adoption performance**

The trajectory of timeliness and numbers is positive. Sefton has seen an increase in children adopted, albeit that the numbers remain relatively small and appear low compared to statistical neighbours (15 were placed for adoption by Sefton during 2016-17). The time taken for adoption has improved, although this remains above the DfE threshold. Sefton has a commitment to placing older children and sibling groups for adoption. From our case review work it is evident that this is translated

into practice, although it may lead to a longer period of time being required to complete a placement.

There are good tracking and monitoring arrangements for children who have a plan for adoption. The ADM (the council's agency decision maker) process is robust and used as a window to practice and modelling good practice to front line staff, who are involved in the process.

The RAA (Regional Adoption Agency) has the potential to support Sefton in modelling good permanency planning practice and increasing placement choice. The council should ensure that it takes advantage of these opportunities. The quality assurance function of the Adoption Panel needs to become more robust as part of the RAA development

As noted previously, the historical lack of focus on neglect in Sefton is leading to children having more complex needs and this affects timeliness of matching and adoption orders being made. The quality of permanence planning for very young children requires improvement, including earlier decision making around placing children together or apart – there is a risk that Sefton's commitment to placing sibling groups together means that such decisions are being delayed which will increase the time taken to complete adoption. Similarly, a lack of experience and understanding of permanence planning and professional optimism about the potential to effect change is having an impact on early decision making. The adoption process itself also needs to be better understood to help reduce delays. The move to generalist Locality Teams with responsibility for some children being considered for adoption up to the grant of a Placement Order may well be exacerbating the need to develop this experience and understanding.

The peer team noted that Sefton has granted exemption to the normal fostering limit of three foster children to a relatively high number of foster carers. Such exemption is at the discretion of the council, and the foster carers met by the team felt they were well supported and appeared capable of fostering effectively. However, a continued high level of such exemptions, particularly over an extended period of time, may represent a vulnerability for the council. Foster carers also noted that they would welcome more contact with those in leadership roles in Sefton.

## 6. Next Steps

The Local Government Association would be happy to discuss how we could help you further through the LGA's Principal Advisers for the North West, Claire Hogan (claire.hogan@local.gov.uk or tel. 07766 250347) and Gill Taylor (gill.taylor@local.gov.uk or tel. 07789 512173).

Members of the peer team have indicated their willingness to provide further advice to Sefton and share examples of good practice if this would be helpful to you.

The peer team would like to extend their thanks to everyone involved for their participation and for engaging so constructively with the diagnostic. In particular, please pass on thanks from the peer team to Helen Splaine, Gill Cowley and their colleagues for their help prior to the diagnostic and during the on-site phase.

**Appendices:**

Appendix A – Summary feedback on the council's self-evaluation
Appendix B – Summary of findings of case records review
Appendix C – Observations on individual case records reviewed

| | | | |
|---|---|---|---|
| **Report to:** | Overview and Scrutiny Committee (Children's Services and Safeguarding) | **Date of Meeting:** | Tuesday 25 September 2018 |
| **Subject:** | Enhancing Elected Member Involvement | | |
| **Report of:** | Director of Social Care and Health | **Wards Affected:** | (All Wards); |
| **Portfolio:** | Children, Schools and Safeguarding | | |
| **Is this a Key Decision:** | No | **Included in Forward Plan:** | No |
| **Exempt / Confidential Report:** | No | | |

**Summary:**

1.1 During April 2018, the Local Government Association undertook a Care Practice Diagnostic into Children's social Care. The team made the following recommendation,

Provide opportunities for a wider range of members to engage with children's social care, to enhance understanding of front-line delivery, and take advantage of the intake of new councilors following the elections to further raise the profile of the corporate parenting role.

**Recommendation(s):**

(1) That the Over view and scrutiny committee support the suggested approach to introduce a rota of front – line visits by elected members to Children's Social Care teams.

**Reasons for the Recommendation(s):**

To enhance the elected members understanding of front – line delivery and further enhance the profile of the corporate parenting role.

**Alternative Options Considered and Rejected:** (including any Risk Implications)

N /A

**What will it cost and how will it be financed?**

**(A) Revenue Costs**
There are no additional revenue costs to the Council within this report

**(B) Capital Costs**

**Implications of the Proposals:**

| |
|---|
| **Resource Implications (Financial, IT, Staffing and Assets):** |
| **Legal Implications:** |
| **Equality Implications:**<br><br>There are no equality implications |

**Contribution to the Council's Core Purpose:**

| |
|---|
| Protect the most vulnerable:<br>Children's Social Care have a statutory duty to protect the most vulnerable. |
| Facilitate confident and resilient communities:<br>Children's social care work with children and their families to improve outcomes for children |
| Commission, broker and provide core services:<br>Children's social care work in partnership with a range of organisations to ensure vulnerable children are safeguarded. |
| Place – leadership and influencer:<br>The scrutiny of Children's social care performance supports the aspiration for all services to children to be good or better. |
| Drivers of change and reform:<br>There has been significant focus on driving up standards of practice and linking and aligning resources with the framework for change |
| Facilitate sustainable economic prosperity:<br>Improving outcomes for our most vulnerable children will support them to have aspirations and obtain economic independence. |
| Greater income for social investment:<br><br>N/A |
| Cleaner Greener |

| |
|---|
| N/A |

**What consultations have taken place on the proposals and when?**

**(A) Internal Consultations**

The Head of Corporate Resources (FD 5300/18) and the Chief Legal and Democratic Officer (LD4525/18) have been consulted and any comments have been incorporated into the report.

**(B) External Consultations**

N/A

Immediately following the Committee meeting.

| | |
|---|---|
| **Contact Officer:** | Vicky Buchanan |
| Telephone Number: | Tel: 0151 934 3128 |
| Email Address: | vicky.buchanan@sefton.gov.uk |

**Appendices:**

There are no appendices to this report

**Background Papers:**

There are no background papers available for inspection.

**1. Introduction/Background**

1.1 During April 2018, the Local Government Association undertook a Care Practice Diagnostic into Children's social Care. The Team made the following recommendation,

Provide opportunities for a wider range of members to engage with children's social care, to enhance understanding of front-line delivery, and take advantage of the intake of new councilors following the elections to further raise the profile of the corporate parenting

1.2 Lord Laming's Inquiry into the death of Victoria Climbie found a number of failings across all agencies. He found that elected councilors and senior officers didn't know there was a crisis in the frontline teams. He therefore recommended:

*Arrangements must be made for senior managers and councillors to regularly visit intake teams in the children's services department and to report their findings to the Chief Executive and Social Services Committee"*

1.3 In addition in the current Ofsted Framework evaluates the effectiveness of leadership as follows;

**Strategic leadership**

- The leadership of the council, including the chief executive, lead member (and other members) and the Director of Children's Services (DCS) recognise and prioritise the needs of children and this is reflected in corporate decision-making, action and active attendance at key committees and boards.

- The chief executive and lead member are well informed and hold the DCS and their leadership team to account for the quality of practice and the challenges in the local area. This is exemplified through accurate assessments of practice that drive improvement.

- Strategic leaders ensure that relationships with key partners including the health community, the police, schools, Cafcass and the family courts provide a helpful and effective context for social workers and practitioners to work effectively with children and families.

- The local authority is an active, strong and committed corporate parent – in line with the corporate parenting principles.37 There is a corporate sense of responsibility for children in care and care leavers and the chief executive leads a local authority that recognises and prioritises the needs of children in all aspects e.g. housing, career opportunities, education and learning.

1.4 A briefing was given to pre – council on 19th July in relation to elected members role in corporate parenting and a briefing to pre- council on 20th September in relation to elected members role in safeguarding children .

## 2 Proposal for frontline visits

2.1 For the purpose of frontline visits It is proposed that the MASH team, and Social Work Locality Teams will be deemed 'intake teams' for these purposes as they are the teams dealing with new referrals.

2.2 At least one Visit will be undertaken annually to each locality, with the Service Manager of the appropriate team.

2.3 Visits will last approximately 1 hour and consist of: -

i) Discussion with Service Manager(s) / Team Managers
ii) Discussion with team members (as available)

Within the above discussions the following issues will be considered:-

iii) Staffing situation (vacancies/experience/skills/attendance levels)

iv) Workloads and performance monitoring (Outcomes for children)

v) Referral monitoring and management systems

vi) Staff support systems, eg IT, office accommodation, communication

2.4 In addition there will be bi – annual visits to the corporate parenting service which will focus on the services offered to looked after children and care leavers as well as the fostering service.

Visits will last approximately 1 hour and include

i) Discussion with Service Manager(s) / Team Managers
ii) Discussion with team members (as available)

Within the above discussions the following issues will be considered:-

iii) Staffing situation (vacancies/experience/skills/attendance levels)

iii) Workloads and performance monitoring (Outcomes for children)

iv) Staff support systems, eg IT, office accommodation, communication

v) Recruitment, retention and support to foster carers.

2.5 Elected members will record the key issues from the visit on an agreed electronic proforma and send to the Head of Service who will provide a response to issues raised.

2.6 The Head of Service will collate the information from these reports and present them to the Overview and Scrutiny Committee (Children's Services and Safeguarding) Committee on an annual basis (copy to Chief Executive).

| | | | |
|---|---|---|---|
| **Report to:** | Overview and Scrutiny Committee (Children's Services and Safeguarding) | **Date of Meeting:** | Tuesday 25 September 2018 |
| **Subject:** | Serious Case Review | | |
| **Report of:** | Director of Social Care and Health | **Wards Affected:** | (All Wards); |
| **Portfolio:** | Children, Schools and Safeguarding | | |
| **Is this a Key Decision:** | No | **Included in Forward Plan:** | No |
| **Exempt / Confidential Report:** | No | | |

**Summary:**

Sefton Local Safeguarding Children's Board undertook a Serious Case Review which was published on the LSCB's website on 31st July 2018 in line with procedures in Working Together 2015.

Progress on recommendations from the Serious Case Review will be monitored through the Local Safeguarding Children's Board and have been incorporated into the CSC Continuous Improvement Plan which has also been tabled for this committee meeting.

**Recommendation(s):**

(1) Overview and Scrutiny committee receive the findings of the Serious Case Review.

(2) Over view and Scrutiny committee continues to receive 6 monthly progress reports on the improvement plan which includes recommendations from this review.

**Reasons for the Recommendation(s):**

To ensure that the Overview and Scrutiny Committee has a good understanding of the Serious Case Review Process and how learning is embedded within Children's Services and the wider partnerships.

**Alternative Options Considered and Rejected:** (including any Risk Implications)
N/A

**What will it cost and how will it be financed?**

**(A) Revenue Costs**
There are no financial implications arising for the Council as a direct result of this report.

**(B) Capital Costs**

**Implications of the Proposals:**

| |
|---|
| **Resource Implications (Financial, IT, Staffing and Assets):** |
| **Legal Implications:**<br><br>Statutory Guidance: Working Together to Safeguard Children 2015 |
| **Equality Implications:**<br><br>There are no equality implications. |

**Contribution to the Council's Core Purpose:**

| |
|---|
| Protect the most vulnerable:<br>This is a core function of the service who provide statutory social work services to children and young people including those in need of help and protection, looked after and care leavers. |
| Facilitate confident and resilient communities:<br>Ensuring children are safeguarded improves their life chances and supports them to become successful adults. |
| Commission, broker and provide core services:<br>The service provides statutory social work services to vulnerable children. |
| Place – leadership and influencer: N/A |
| Drivers of change and reform: N/A |
| Facilitate sustainable economic prosperity:<br>Protecting vulnerable children supports them to achieve and attain and increase their chances of becoming successful adults. |
| Greater income for social investment: N/A |
| Cleaner Greener N/A |

**What consultations have taken place on the proposals and when?**

**(A) Internal Consultations**

The Head of Corporate Resources (FD 5301/18) and the Chief Legal and Democratic Officer (LD 4526/18.....) have been consulted and any comments have been incorporated into the report.

**(B) External Consultations**

N/A

**Implementation Date for the Decision**

Immediately following the Committee meeting.

**(Please delete as appropriate and remove this text)**

| | |
|---|---|
| **Contact Officer:** | Vicky Buchanan |
| Telephone Number: | Tel: 0151 934 3128 |
| Email Address: | vicky.buchanan@sefton.gov.uk |

**Appendices:**

The following appendices are attached to this report:

Serious Case Review Report
7 Minute briefing – learning form Serious Case Review

**Background Papers:**

There are no background papers available for inspection.

## 1. Introduction/Background

1.1 A Serious Case Review (SCR) is undertaken when abuse or neglect of a child is known or suspected; and either the child has died; or the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

1.2 The prime purpose of an SCR is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children. After the completion of a review the LSCB will publish an anonymised Executive Summary which will include information on the review process, key issues arising from the case, the recommendations and the action plans. For all SCRs initiated on and after 10th June 2010, the government has instructed all local safeguarding children boards to also publish anonymised Overview Reports.

1.3 Sefton LSCB has a sub group (Practice Review Panel) which oversees and quality assures SCRs undertaken by the Board, and provides advice on whether the criteria for conducting a review have been met. The sub group has developed local procedures for Serious Case Reviews in conjunction with Working Together to Safeguard Children (HM Government 2015). Any professional or agency may refer a case to the LSCB if the criteria is met for a SCR. The independent chair makes the decision of whether to instigate a SCR.

1.4 Local Safeguarding Children's Boards are transitioning to new Multi -agency Safeguarding Arrangements in line with Working Together 2018. This will eventually change the way Serious Case Reviews are conducted and the LSCB is responding to this and is developing these arrangements. This review was conducted under the 2015 Working Together Guidance

1.5 Children's Social Care held a Practice and Performance Workshop on 15th September 2018 which is a quarterly meeting of frontline practitioners, the focus of the meeting and main agenda item was the learning from this review and how we can support frontline practitioners to improve and embed the learning form this review.

# Serious Case Review

*Martha, Mary and Ben*

*July 2018*

This report will be published in line with statutory guidance. In order to preserve the anonymity for the children in this family, the LSCB has:

- represented the children by names from children's literature which do not necessarily reflect their gender;
- represented people other than the children by use of initials;
- avoided the use of exact dates; and,
- removed details about local services which could lead to the recognition of the children and family

## 1. Background to review

1.1 In August 2017, police attended the family home of Martha, Mary and Ben. At that point, Martha and Mary were 2 years old and Ben was almost 5 years old. The police were investigating a burglary which they suspected had been committed by the children's mother (MC) and their maternal great uncle (GUC) who lived at the property.

1.2 Officers were concerned that the atmosphere was smoky and smelled of burning heroin and that the children and adults all appeared 'drowsy and incoherent'. Drugs paraphernalia was found upstairs. The electricity meter had been bridged. There was no food in the kitchen. Although Ben was said to be living only temporarily with maternal grandmother (MGM), officers found no evidence that he was a member of the household. The layout of the property led the officers to suspect that MC and GUC were in an intimate relationship. GUC was arrested and removed from the family home.

1.3 Over the course of the next three weeks, there was a period of intensive visiting. Professional concerns mounted that Martha and Mary, in particular, were suffering the effects of neglect and of MC's illicit drug use. Professionals were concerned about their pale, thin appearance and their alternately sleepy and anxious presentations. Ben continued to be largely absent from the family home. At the beginning of September 2017, seeing no improvement in Mary and Martha's circumstances, CSC determined to seek legal orders to remove all three children. In the meantime, MC agreed to their being accommodated by the local authority. Hair-strand testing undertaken during subsequent care proceedings revealed that, over the previous six months, Martha, Mary and Ben had been exposed to significant levels of drugs; including cocaine, heroin and cannabis. The test was unable to state conclusively whether those drugs had been ingested or passively inhaled.

1.4 On 11 December 2017, the Practice Review Panel (PRP) of Sefton LSCB considered whether a Serious Case Review (SCR) should be undertaken, based on information provided by the children's Independent Reviewing Officer (IRO) about how agencies and organisations had worked together prior to the children becoming looked after. The PRP discussed the IRO's referral with reference to Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 which requires LSCBs to undertake reviews of serious cases in specified circumstances.

1.5 In this case, the PRP concluded that it would recommend to the Chair of the LSCB, Paula St Aubyn, that an SCR should be undertaken as:

i. abuse or neglect of a child was suspected
ii. a child had been seriously harmed, and
iii. there was cause for concern as to the way in which the local authority, their LSCB partners or other relevant persons had worked together to safeguard the child.

1.6 The Chair endorsed the PRPs recommendation and, on 20 December 2017, she notified the National Panel of Experts on Serious Case Reviews of her decision. The LSCB Chair noted that the key issues were of neglect, domestic violence and drugs misuse. The LSCB received acknowledgement from the National Panel of Experts the following working day.

1.7 The LSCB subsequently appointed an SCR Panel, comprising senior managers from relevant agencies and organisations, to set the terms of reference for the SCR and to manage the process. The SCR Panel agreed that the review period would be from 1 November 2014 – 7 September 2017: that is, from the time that MC booked-in with maternity services with Martha and Mary until the court granted interim care orders in respect of all three children.

1.8 The SCR Panel agreed that the review should be conducted using a hybrid systems approach. This would include structured conversations with practitioners and managers; Individual Management Reviews (IMRs) from relevant services; and, a learning event for those involved in the case. Relevant family members would also be asked if they would like to contribute to the review process.

1.9 The LSCB appointed a Chair for the SCR Panel; Debbie Fagan, Chief Nurse, NHS South Sefton Clinical Commissioning Group and NHS Southport & Formby Clinical Commissioning Group. A suitably qualified and experienced independent reviewer, Isobel Colquhoun was commissioned: the reviewer would lead conversations with staff, facilitate the learning event and would be responsible for providing the final report.

1.10 The SCR Panel commissioned chronologies from all relevant agencies and organisations to give an overview of professional involvement with family members during the review period. On review of the chronologies, the SCR Panel determined that the key lines of enquiry for the review should be:

i. How effectively was the children's mother's vulnerability assessed?
ii. How effective was the provision of support for the family?
iii. How effective was the assessment of the risk of harm to the children?
iv. How effective was the communication between disciplines, agencies and organisations and across geographical boundaries?
v. How was the lived experience of the children understood?

1.11 The SCR Panel comprised:

i. Head of Service, Children's Social Care, Sefton Council
ii. Designated Nurse for Safeguarding Children, NHS South Sefton Clinical Commissioning Group and NHS Southport & Formby Clinical Commissioning Group (CCG)
iii. Service Manager, Safeguarding and Quality Assurance, Sefton Council
iv. Named GP, Sefton CCG
v. Detective Chief Inspector, Merseyside Police
vi. Matron for Quality (Sefton), North West Boroughs Healthcare NHS

vii. Team Manager, Merseyside Community Rehabilitation Company
viii. Associate Director of Safeguarding Children and Adults, Liverpool Women's Hospital & Aintree University Hospital
ix. Named Nurse Safeguarding Children, Mersey Care NHS Foundation Trust
x. Head of Service, Early Help, Sefton Council
xi. Assistant Director of Safeguarding, Alder Hey Children's NHS Foundation Trust

1.12 The Designated Doctor who would normally form part of the SCR Panel had had direct contact with two of the children who are the subjects of this SCR, during the period under consideration. For that reason, she participated as a practitioner in the review. Support was sought from neighbouring CCG but could not be facilitated within current capacity. It was agreed, therefore, that SCR Panel membership would remain as above but that if additional oversight were required, further efforts would be made to secure this.

1.13 The SCR Panel was supported by the LSCB Business Manager, the Business Administrator and the LSCB Legal Advisor. The reviewer attended and contributed to SCR Panel meeting discussions. SCR Panel meetings took place on 19 March 2018, 30 April 2018 and 4 July 2018.

1.14 IMRs were provided by:

i. School Readiness Services, Sefton Council
ii. Merseyside Police
iii. Mersey Care NHS Foundation Trust
iv. Liverpool Women's NHS Foundation Trust
v. Children's Social Care, Sefton Council (CSC)
vi. Children's Centre, Sefton Council
vii. Northwest Boroughs Healthcare NHS Foundation Trust (NWB)
viii. Alder Hey Children's NHS Foundation Trust
ix. GP practice

1.15 Sefton Council's legal services notified the children's mother of the SCR on 19 April 2018 and invited her to participate in the process. A social worker, known to the family, hand-delivered a copy of the same letter on the same day. Sefton Council's Legal Services also made contact through the children's mother's legal advisor, who has been representing her during care proceedings.

1.16 An introductory practitioner event was held in April 2018 as a means of explaining the review process to those who would be participating in it. This was followed by a number of structured conversations, either individually or in small groups, with professionals who had worked with the children and families. These sessions were mainly led by the independent reviewer. The LSCB Business Manager acted as second reviewer in the majority of sessions and a SCR Panel member in two.

1.17 The learning event was held in May 2018. The day-long session provided practitioners and managers with the opportunity to consider the full description of events and to reflect on single and multi-agency practice.

1.18 The final report was presented to Sefton LSCB on 11 July 2018. The LSCB is responsible for disseminating agreed learning; for ensuring the implementation of changes based on agreed learning; and, for measuring the impact of changes.

## 2. Information gathered about family members and events prior to the review period

2.1 Although there were gaps in the information which was available to professionals during the review period; important details were known to some or all of those working with Ben, Martha and Mary. The following information has been gathered from the combined chronology of agency involvement and IMRs.

2.2 During her childhood, MC lived in a neighbouring local authority where, for some years, she attended a special school. When she was about 6 years old, she and her siblings were made the subjects of child protection plans. Some records suggested that MC had been looked after. MC's own mother (MGM) was known to have a history of drugs misuse and mental health problems. She was said by professionals in her home authority to be frequently 'agitated and aggressive'.

2.3 The children's great uncle (GUC) is MGM's brother. He was living in the same household as MC and the children during the review period. GUC has a history of chronic drug use and of mental health problems. When MC was around 5 years old, GUC was sentenced to 8 years for robbery. He was released five years later under licence. GUC has subsequent convictions for violent offences. It is suspected that GUC is the father of Ben, Martha and Mary, although this has been consistently denied by MC.

2.4 When MC was around 15 years old, she reported that she had been the victim of a serious sexual offence but, reportedly fearful of reprisals, she did not want the police to take action in relation to this assault.

2.5 Ben was born at home when MC was 18 years old. MC and the infant were taken by ambulance to hospital. This had not been MC's first pregnancy. Before and after Ben's birth, anonymous allegations were made to the neighbouring local authority about MC being sexually exploited by MGM and family members. MC denied these allegations. Enquiries made by the neighbouring authority found the allegations to be unsubstantiated.

2.6 In 2014, MC moved to Sefton with Ben: the family had been identified in health visiting records as vulnerable. At that point, Ben was meeting his developmental milestones. MC told the health visitor that she had had episodes of anorexia in the past.

## 3. Summary of events and analysis of professional practice during the review period

3.1 In November 2014, MC (aged 20) attended a late booking-in appointment with midwifery services. She was pregnant with twins. MC had previously considered whether she should continue with the pregnancy. MC said that the twins' and Ben's father was the same person, but added that she was not in a relationship with him and had not told him that she was pregnant.

3.2 Midwifery services appropriately identified the various medical and social risks associated with MC's late booking; her twin pregnancy; her previous history; and, her current circumstances. In particular, the midwife asked MC about a note on her records that she had disclosed being abuse by an uncle. MC vehemently denied both having been abused by her uncle or having said that she had been. A range of referrals for support and specialist assessment were made, although the twins' arrival three weeks later meant that some appointments were no longer required. The referral to CSC was accepted and progressed to assessment.

3.3 The allocated social worker spoke to the midwife and to Ben's health visitor about their knowledge of MC and their involvements with her and Ben. She also obtained brief information about MC's contact with the neighbouring authority where she had previously lived. As a result, CSC quickly identified some of MC's vulnerabilities and the impact that these might have on her capacity to care for three young children.

3.4 On visiting the family home, however, the social worker found it to be appropriate for a family with young children. MC did not immediately seem to have learning difficulties or mental health needs, although her appearance gave the impression of 'someone who was vulnerable'. The social worker had no concerns about Ben. She had no reasons to suspect that MC was using drugs. MC again denied being sexually abused by GUC.

3.5 In the meantime, the health visitor had made a referral to the school readiness service to tell MC about the 2-year nursery offer which could benefit Ben. MC told the school readiness worker (SR) that she had learning difficulties, OCD and dyslexia. She said that she could read but she struggled with forms. MC was, however, 'chatty' and 'very calm'. Everything was very neat and tidy and MC said that 'she would clean all the time'. Ben appeared to be friendly and outgoing. His development was good and he enjoyed taking part in play activities. SR felt that MC and Ben had 'a lovely relationship'. MC seemed to be keen to start home play sessions with SR as she 'didn't want Ben to be like her'.

3.6 GUC appeared to be 'very polite' and to be caring towards MC. As she got to know the family, however, SR found that his caring did not always translate into helpful actions (for example, when it came to getting the children out of the house and into social activities). MC seemed to be quite reliant on him and SR came to feel that GUC was 'quite dominant'.

3.7 In December 2014, MC was in labour and was admitted to hospital by ambulance. Martha and Mary were delivered quickly at just less than 30 weeks gestation. Babies born before full term (before 37 weeks) are vulnerable to problems associated with prematurity and, the earlier in the pregnancy a baby is born, the more vulnerable they are[1]. In this case, however, both babies were, generally, 'in good condition': they were transferred to the Neonatal Intensive Care Unit (NICU) for their immediate care.

3.8 Four hours after the babies were born; MC discharged herself from hospital and went home. MC had been offered the opportunity to stay in hospital along with Ben but chose not to. It was expected that the twins would be in hospital for about six weeks. MC had said that travel costs would be a problem for visiting. MC left the ward, however, before the hospital was able to put arrangements to assist in place.

3.9 The following day, MC did not visit the children as she had no money. SR provided practical help, including travel cards. Ben's nursery offered some additional sessions over the Christmas period to facilitate MC's attending hospital but this offer was not taken up. MC and GUC visited the twins the next evening. From that point, MC continued to visit the children most days.

3.10 When the twins were three days old, significant conversations took place between CSC and NICU. The records of the two organisations of these conversations are, however, quite different. The hospital record refers to GUC's visiting the children with MC and the implications of his visiting in the light of allegations that GUC had sexually abused MC. It notes that the question would be discussed further at a strategy meeting which had been arranged to take place three days later. In the meantime, it is recorded that CSC had no objections to his visiting. By contrast, the CSC record of a conversation the same day refers to the twins 'presenting with withdrawal symptoms'. This increased the social worker's concerns about the welfare of the children. It is notable, however, that the hospital has no record of suspicions that the babies were withdrawing from drugs.

3.11 The social worker made a home visit the next day. She attempted to discuss the issue of the babies' drug withdrawal symptoms but MC became upset and denied drug use. The social worker also spoke to GUC about his drugs use. GUC said that he had been drug free since 2011 but that he attended drugs and alcohol services when he needed to. When asked about his offending history, GUC became very aggressive and the social worker was asked to leave. Ben was present throughout this time. The community midwife arrived just as the social worker was on the doorstep. The midwife made an arrangement to visit two days later with a colleague.

3.12 A child protection strategy meeting was held. No representative from the NICU was able to attend, 'but information had been sent'. The strategy meeting discussed the reasons for referral and there was reference to 'historical information about domestic abuse

[1] Premature Labour and Birth: NHS choices

incidents involving MC, MGM and GUC'. Concerns were expressed about MC's capacity to care for three very young children. The absence of a representative from the hospital where there twins were in-patients was a gap. A hospital representative might, at least, have clarified the issue of the twins' 'withdrawal symptoms' as this remained an open question in CSC record.

3.13 An appropriate plan for further assessments and additional support was agreed. CSC informed the hospital of the outcome of the strategy meeting. There is no evidence, however, that MC was made aware of the decision and plan. Arrangements were made to hold an initial child protection conference (ICPC) should this be needed. A specialist assessment for parents with learning disabilities was to be undertaken in respect of MC. GUC was also to be assessed as he was caring for the children. The involvement of the local family centre was proposed.

3.14 It is notable that the strategy meeting took place on the last Friday before the Christmas period began when the local authority would also move into a period of restricted services. This meant that there would be no normal day-time service for 13 of the next 16 days[2]. Although immediate safeguarding and child protection matters would be dealt with, normal services would not be resumed within the local authority until 5 January 2015. At that point, problems which had arisen during the Christmas break would also require more in-depth attention.

3.15 Two days after Christmas in 2014, police were called to MGM's house. GUC was threatening MGM that he would kill her. This incident was unknown to CSC Sefton.

3.16 By the time that the local authority and the allocated social worker returned to their normal working arrangements; more than two weeks had passed since the strategy meeting had taken place. No social work visits to the family home and no work had been undertaken with MC, GUC or Ben. There had been no contact with the substance misuse service.

3.17 Although the only new information which had emerged in the social worker's absence was that MC was providing good care to the twins in hospital, efforts by CSC to gain an understanding of family functioning effectively came to an end. Despite having earlier identified MC's vulnerabilities; from that point forward, social work conversations with hospital staff reflected a focus on whether or not the local authority had evidence that GUC posed a risk of harm to the children. And, in that regard, the social worker was coming to the conclusion that it had not. The basis for that opinion, however, was weak.

[2] 6 days would be weekends; 3 days would be bank holidays; and, for a further 4 days, the local authority would be operating a reduced social work service as staff were 'required to take unpaid leave as part of a series of cost saving measures' (Sefton Council press release, reproduced in full at: http://www.formbyfirst.org.uk/2014/12/sefton-council-services-at-christmas-and-new-year.html)

3.18 A visit to the family home and a visit to the twins in hospital appear to have served to reinforce the social work view that there were no child protection issues for the children in this family. This is likely to have been an example of 'confirmation bias' which is a natural tendency of human beings 'to become attached to their judgements and to employ strategies to ensure that new challenging evidence is not recognised or gathered[3]

3.19 In mid-January 2015, the CSC team manager agreed with the social worker's view. It was decided that the case should close. It is notable, however, that the actions set out at the strategy meeting were not reviewed and the implications of their not having been completed were not considered. The hospital had been informed that case closure was likely, but there is no evidence that partners who had participated in the strategy meeting were either consulted prior to that decision being made or informed of it immediately afterwards. These are gaps.

3.20 The hospital continued to make arrangements for the twins' discharge. The community health IMR highlights that there was effective information sharing by telephone between the health visiting service and health visitor liaison at the hospital. It acknowledges, however, that no formal discharge planning meeting took place. It is noted that current practice is that NICU has weekly discharge meetings attended by members of the hospital Safeguarding Children Specialist Nurses team.

3.21 In the following ten days, the health visitor had seven attempts to complete the primary/ birth visit, despite speaking to MC by phone after each attempt to rearrange. Towards the end of the month, the health visitor spoke to the social worker who said that the case had been closed to CSC.

3.22 On the day that she was told the case was closed to CSC, the health visitor spoke to the Safeguarding Children Specialist Nurse and made a referral. In the event, the case had not been recorded as closed in CSC and so, this new information could have promoted a review of the decision that had been made. Instead, however, CSC appears to have focused on the positive elements of the report of a recent visit by SR and insufficient significance was attributed to a possible connection between the family's withdrawal from the health visiting service and Ben's non-attendance at nursery. This suggests a continuation of confirmation bias. As a result, the decision to close the case was unchanged: the case closed to CSC on at the beginning of February 2015.

3.23 A week later, the health visitor contacted the social worker to find out whether an assessment had been completed. She was told that the case had been closed to CSC as MC was engaging with SR. There is no record that the health visitor challenged CSC's decision. Indeed, there appears to have been an acceptance of CSC's view that there was no evidence that the children were at risk of significant harm, although the circumstances which had given rise to professional concerns were essentially unchanged.

[3] Kirkman and Melrose: Clinical Judgement and Decision-Making in Children's Social Work: An analysis of the 'front door system'. Departments for Education, research report April 2014

3.24 Shortly after CSC ended its involvement with the children, MC dropped out of contact with SR and resisted contact by the children's centre. Ben did not attend nursery. From February 2015 – February 2017, the most significant professional contact with the family was through the health visiting service. By the time that the twins were six months old, however, only two home visits had been achieved by the health visitor, despite numerous attempts. MC had brought the twins, three times to clinic. During this time, when the twins had been weighed, Martha's weight had 'dropped off below the 0.4th centile' and MC had been unable to provide an explanation for Martha's poor weight gain.

3.25 In the same period, the twins had been discharged from three outpatient clinics as MC had not taken them for appointments. Specifically MC had missed: 3 ophthalmology appointments; 2 audiology appointments and 3 neonatal follow-up appointments. It is very unusual for parents not to take their premature babies for neo-natal follow up. The community health IMR acknowledges that discussion should have taken place with the Safeguarding Children Specialist Nurse when the consultant neonatologist expressed concerns that the children had not been seen.

3.26 In June 2015, the first of four changes of health visitor during the review period took place. This first change was at MC's request: other changes reflected issues of recruitment and retention within the service. Each of the five health visitors brought with them different levels of experience; different expectations; and different approaches to their work with the family. The lack of continuity is likely to have affected the extent to which the service could make a difference.

3.27 Home visits by the second health visitor were achieved in June 2015; August 2015; November 2015; January 2016; and, April 2016. Throughout this time, Martha's weight remained around 0.4$^{th}$ centile and her gross motor skills were found to be delayed. The health visitor made referrals for hospital outpatients' appointments for Mary and for Ben. Mary had a squint and Ben had chronic constipation. MC did not take either child to their appointments. Ben did not attend nursery, despite the health visitor's securing a place for him. The health visitor records had begun to refer to the twins being 'taken upstairs' after they had been weighed.

3.28 In April 2016, GUC attended for initial assessment with the local substance misuse service. This was not known to child care professionals. GUC reported taking heroin and crack cocaine in addition to his prescribed methadone. A risk assessment was completed but GUC did not reveal that he was living with young children: he reported that he was estranged from a previous partner and their child.

3.29 Over the next six months, there were seven failed visits by health visitors. The second health visitor left the service and casework responsibility transferred to the third health visitor. The third health visitor made one visit to the family home. MC had no concerns about Ben's development, but he was still constipated and was not yet toilet trained. MC had not yet taken him to hospital. When weighed, Mary was on 9$^{th}$ centile: Martha was

on 0.4th. The health visitor was concerned that Martha looked thin. MC described a diet that included three meals, two snacks and 2 pints of cows' milk daily. The health visitor advised MC to take Martha to GP for a weight review. Mary's squint had resolved, without treatment. The health visitor also repeated advice which had previously been given to register the children with a dentist and to brush their teeth twice daily. This health visitor had no further contact with the family.

3.30 Throughout this period, all three practitioners gave appropriate health advice; actively promoted the children's centre and nursery; and, made appropriate referrals to paediatric services. There is no doubt either that each of the health visitors was concerned about Martha's growth; about missed hospital appointments; and, the apparent lack of access by the children to opportunities to socialise outside the house. These were not, however, clearly articulated as indicators of potential neglect and, over time, there was no consistent intervention plan. It is acknowledged that the number of 'no access' visits is likely to have contributed to difficulties in establishing a systematic approach but, more significantly, they appear also to have led to a shift of focus on potential neglect to simply 'getting in'. In that regard, health visitors demonstrated significant tenacity.

3.31 The pattern of contact suggests that MC was most accepting of pre-arranged contacts which took place where she, or GUC, could control key elements of the setting. MC was also able to provide a narrative of intention to comply with professional expectations which served to disguise her actual non-compliance. As a consequence, when contact was established, or re-established after a number of attempts, professionals appear to have been, on the whole, more reassured than alarmed. There was little direct challenge to MC either in relation to her accounts (for example, of the twins' diet) or her failure to carry out her intentions. GUC's presence in the family had begun to appear commonplace.

3.32 In December 2016, when the twins' 2-year developmental review was due, good use was made of some temporary additional capacity when an experienced health visitor/family nurse practitioner joined the health visiting team. A case review was undertaken and the practitioner was able to make a good engagement with MC on her first home visit.

3.33 At that visit; the twins, Ben and GUC were present with MC. The living room was warm and there was evidence of age-appropriate toys. Ben was bright and chatty and there appeared to be warm relationships between the adults and him. MC was seen to be setting appropriate boundaries for Ben and he was responsive to her. Ben appeared to be a healthy weight.

3.34 The twins were in clean pyjamas but they appeared pale. Elements of both twins' development were behind would be expected for children of their age. Mary weighed between 3rd and 8th centile: her height was on the 2nd centile. Martha's height and weight were both on 0.4th centile. The twins were naked when weighed and the health visitor had no concerns about their presentation.

3.35 MC said that she could not read or write and that she struggled to fill in forms: she needed GUC's assistance to do so. It was noted that GUC lived as a member of the household. MC said that he was supportive and a warm bond with the children was observed. MC agreed to attend the children's centre to collect vitamins; to register the children with a dentist; and, to have Martha's weight reviewed. The health visitor referred the twins to community paediatrician for developmental review.

3.36 The following day, MC took Martha was taken to see the GP as she had agreed. The GP found that she was underweight and referred her to paediatric rapid access clinic.

3.37 The twins were allocated funded placements at the children's centre nursery but they did not attend.

3.38 In January 2017, the health visitor made an opportunistic visit to the family home. Ben was seen at the window of property with no adult in sight. The health visitor tried to get the attention of the adults she suspected were in the house, but without success. As a result, she was obliged to call the police. On their arrival, MC opened the door: she was agitated and was verbally abusive to the health visitor. The police ushered MC into the house and the visit was abandoned. The police ensured that the children were safe and notified Sefton's Multi-agency Safeguarding Hub (MASH).

3.39 The health visitor contacted the Safeguarding Children Specialist Nurse (SCSN) to discuss whether a referral should be made to MASH. Based on their joint reading of Sefton's then 'threshold document'; the health visitor and SCSN agreed that the incident and ongoing concerns did not reach threshold for a child protection referral. They believed that MC would not consent to an Early Help or 'child in need' referral being made. An assessment of risk for practitioners visiting the home was, however, required before further visits could be offered. A letter was, therefore, sent to MC asking her to attend clinic in the immediate future for children's health assessments.

3.40 Four days later, the health visitor was informed that MC had not taken Martha to the paediatric clinic. As a result, she sent a referral to CSC in respect of Martha and Mary. Ben was not included in the referral.

3.41 A second appointment for Martha at paediatric clinic was failed at the end of the month. The consultant wrote to the GP, MC and the health visitor indicating that she shared the GP's concerns about Mary being significantly low weight. In the context of the history of MC's not taking Martha for follow up appointments with neonatal services, she supported the referral to children's social care. The consultant asked the GP and the health visitor to speak to MC about the importance of attending these hospital appointments and to let her know the outcome of those conversations.

3.42 Ten days later, having had no response to her referral, the health visitor contacted the MASH to find out what progress had been made. She was told that the referral had not

been taken forward 'as parents had not been informed'. The health visiting team manager, therefore, sent a letter to MC advising her that a referral had been made.

3.43 The following day, CSC accepted the referral which was allocated for assessment two days later.

3.44 Throughout the first two years of their lives, while Mary's weight and height hovered around the 9th centile; Martha's growth could be described as 'faltering'. The reason for this was not established. The community health IMR acknowledges there was a lack of consistency by health visitors in the application of national guidelines for growth monitoring in children. That IMR indicates that this has been factored into the service's training needs analysis and that revised training will be delivered to practitioners when the 'faltering growth pathway' has been updated.

3.45 The community health IMR also recognises the impact of maternal 'disguised compliance' on practitioner effectiveness. Disguised compliance has been defined as 'a parent or carer giving the appearance of co-operating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention'[4].

3.46 On this occasion, the allocated social worker was newly qualified, practising under the national Assessed and Supported Year in Employment (ASYE) programme. The ASYE programme aims to help social workers in the first year post-qualification to develop their skills, knowledge and professional confidence. The social worker was one of four ASYE social workers in the relevant team: she was supervised and mentored by the team's lead practitioner.

3.47 To gain a picture of individual and family functioning, the social worker first visited the family home: MGM was present. Family members, however, did not accept the legitimacy of the concerns raised in the referral. MC offered explanations as to why Martha had missed her hospital appointments and why Ben was not attending nursery. MC suggested that the health visitor had made a referral to CSC because she had not allowed the health visitor into the house as the visit had not been pre-arranged. From the point when discussion moved to the children missing appointments, MGM became 'verbally aggressive' and the visit was terminated.

3.48 The social worker found that home conditions were 'immaculate' and there were 'lots of toys around'. The children were appropriately dressed. The social worker noted good interaction between MC and the children: GUC appeared relaxed with the children and they seemed comfortable with him. The social worker talked to MC about having alopecia for which she wore a hat all the time: MC said that it did not affect her confidence. She stated that she did not smoke, drink alcohol or take illicit drugs. MC

[4] NSCC Factsheet: Disguised Compliance 2010

described the children's routines which included her report that the twins (aged 2 years, 2 months) could dress and wash themselves.

3.49 The social worker also spoke to SR, the children's centre and health visiting service as part of her assessment. Those professionals described their perceptions of family circumstances and the difficulties they had experienced in making contact with MC and the children.

3.50 On a second social work visit, MC talked about the difficulties in her early life, including having been raped in 2009. GUC gave signed consent share his personal information. MC revealed that GUC used to take drugs, but now only had methadone. The social worker did not pursue this matter or contact the substance misuse services for further information.

3.51 The day after the social worker's visit, GUC was seen by a senior nurse practitioner in relation to his substance misuse. Responsibility for providing substance misuse services had recently changed to a different organisation and the nurse practitioner was reviewing the treatment plans for service users who had not had a medical review during that time. The service users concerned were still receiving prescriptions but did not appear on allocated caseloads. GUC was one of those individuals.

3.52 During the consultation, GUC reported no relationships or dependents: he confirmed that he lived with niece. He made no reference to the children. The nurse practitioner did not, however, explore MC's circumstances and there was no consideration of the impact on her, as a member of the same household, of his current drugs use; illness; and, mood. This is recognised by the substance misuse service IMR author who acknowledges the importance of ensuring that a 'whole family' emphasis underpins assessments of adults within substance misuse team.

3.53 GUC was invited to attend a health and wellbeing clinic two days later due to his gaunt, underweight appearance. GUC attended the base as recommended and completed the paperwork but he left before the clinic appointment.

3.54 At the end of February 2017, MC and GUC took Martha to general paediatric appointment in relation to her slow/ faltering growth: this was now more than 2 months after the first appointment had been offered. Martha was unhappy to be examined and remained upset throughout. The paediatric consultant found no signs of wasting and thought that Martha looked 'symmetrically petite'. MC was shown growth charts and was advised to increase Martha's calorie intake. Martha was prescribed iron supplements. The plan was to review her progress in 2 months. The out-patient records indicate, however, that 'parent cancelled' 3 further appointments; in April, June and July 2017.

3.55 The fifth health visitor started working with the family around the time that the social worker proposed that the children should have multi-agency child in need support plans.

The assessment which underpinned the plan, however, did not clearly articulate the impact on the children's development and wellbeing of not being taken to health appointments or of not having opportunities to socialise with other children. It did not consider either whether there was a link between the problems as expressed by professionals at this point and the concerns which had been identified previously. As a result, there was no effective exploration of the impact on parenting capacity of MC's known vulnerabilities; of the roles played by GUC and MGM in family life; or of GUC's drug use.

3.56 Before the Child in Need plans began, health visitors and other community practitioners had tried on many occasions to persuade MC of the importance of attending health appointments with the children and many arrangements had been made to ease MC and the children into attending the family centre or going to nursery. Their efforts had had limited success. Despite this being a firmly embedded pattern, the Child in Need plans essentially recommended 'more of the same'. There is no evidence that Sefton's neglect screening tool was used. In addition, it was not until the fifth child in need meeting that the suggestion was made to use the recommended multi-agency assessment tool for neglect: Graded Care Profile 2. As a consequence, there was little prospect of effecting change.

3.57 Five Child in Need meetings took place. Visits and attempted visits by the social worker and the health visitor continued throughout this period. The social worker referred Ben to the paediatric continence nurse. There were more frequent references to the children being 'brought downstairs' to see professionals.

3.58 In mid-April 2017, MC and GUC took Martha and Mary to developmental clinic for appointment with a Consultant Community Paediatrician. This particular consultant is also Sefton's Designated Doctor for Children's Safeguarding. During this consultation, the children were crying, clingy and reluctant to be examined. They appeared to have some developmental delay 'more marked in language skills', although Martha's development was less immature than Mary's. The paediatrician gave MC advice about the importance of 1:1 play, on the floor, using language and engaging in lots of laptop and singing games. MC reported that the twins would be attending nursery at the children's centre and that there was input from a member of school readiness team. GUC said that CSC were involved 'due to a mix-up' but was unable to say what the nature of involvement was.

3.59 As appropriate services appeared to be in place, the paediatrician planned to review in a year's time. In the meantime, she sought confirmation of CSC involvement: there was some delay before this was confirmed. She was not invited to interpret her findings within the context of Child in Need planning.

3.60 GUC continued to have contact with substance misuse services but, by April 2017, he was beginning to drop out of daily methadone use. He was being strongly advised to seek medical care in respect of his physical wellbeing. The changes to the process by which GUC accessed his methadone prescription appear to have been problematic for him. He

was seen to be gaunt and thin: he was also experiencing symptoms of physical ill health. He was strongly advised to seek medical help and, within the service, his prescriptions were altered in response to his reported circumstances. GUC's mood was said to be low and he had 'no recovery goals'.

3.61 For much of April and May 2017, it was not always apparent where Ben, in particular, was living. He appears to have been spending an increasing amount of time with MGM who was taking him to nursery. After an initial period of settling-in, Ben began to make progress and by June 2017, he was out of nappies and was being prepared for school in September 2017.

3.62 In mid-June 2017, the final Child in Need meeting was held. Since she had first met the family, the social worker had faced considerable levels of hostility and abusive behaviours, particularly, but not exclusively from MGM. This had made it difficult to talk about difficult issues. Over time, MC had also increasingly dropped out of her limited engagement with professionals. Her contact had become more irascible and combative. Most recently, MC had indicated that she had no intention of taking part in any programme of work.

3.63 As MC did not attend the Child in Need meeting, a professionals' meeting took place instead. The children's centre manager had attended on behalf of the nursery. The children's centre manager asked about the Graded Care Profile and was surprised that this had not already been employed. She suggested that one of the trained children's centre staff could support SR to complete the profile as she was the professional who had the best relationship with MC.

3.64 The meeting concluded that if parental cooperation did not improve, then a strategy meeting would be held. This contingency had previously been agreed with the social worker's manager. Within a week, however, the social worker and her manager decided that the plan should end. They acknowledged the positives that Ben was in nursery and that the twins had been seen by paediatricians. Although the twins were not attending nursery as proposed, there was 'plenty of time for that later'. From their perspective, professionals were 'really getting nowhere' and 'there was a lack of evidence of harm'. There seemed, therefore, to be 'no reason to keep the case open'.

3.65 The social worker emailed SR to say that 'her manager had advised that case should be closed' as there were 'no safeguarding or wider child care concerns'. SR sent the email to the children's centre manager. Both were taken aback both by the decision itself and by the fact that the decision was made outside of the Child in Need process. At that point, however, they did not make any formal challenge. At the end of June 2017; the case was closed to CSC as 'MC did not wish to engage'. The health visitor also later accepted the social worker's statement that 'there was not enough evidence to proceed'.

3.66 Around this time, GUC dropped out of contact with the substance misuse service, despite efforts to keep him involved.

3.67 Within days of the case closing to CSC, Martha was found to have a dental abscess when MC was advised by the GP to take her to A&E. It is highly likely that this would have been extremely painful for Martha and, as a result, she would have been in some distress. It is also likely to have affected her eating and sleeping. Yet, MC did not take her for follow up appointment for 3 weeks. At that point, she was found to have severe dental decay requiring extraction of 14 of her 20 baby teeth.

3.68 In mid-August 2017, during police investigations into a burglary; CCTV footage showed MC and GUC using stolen cards at various locations. Police attended the family home on suspicion of MC's and GUC's involvement in the burglary. Officers were concerned that children and adults all appeared 'drowsy and incoherent' and that the atmosphere was smoky and smelled of burning heroin. Martha cried throughout the time that officers were present (even in her sleep) and Mary was silent and 'stared at her own legs throughout the entire search'. The electricity meter had been bridged, leaving exposed wires.

3.69 There was only one bed in the property and officers suspected that MC and GUC were in an intimate relationship, although MC denied this. The bedroom contained drugs paraphernalia. MC reported having depression and was seen to have 'fresh scabs or blisters on her arms and face'. There was no evidence that Ben lived as part of the household. It has been reported by a number of professionals that one of the officers went out to buy food for the children.

3.70 GUC was arrested and remanded to appear at court the following day. As MC was also to be arrested that day, police requested a social worker be present, in case the children would need to be provided with alternative accommodation and care. A third social worker attended with the police officer from CID.

3.71 The social worker was satisfied that the children were not at immediate risk of harm, given the good conditions of the family home and the small amount of basic food items in the freezer. Police checks in respect of a 'friend of the family' (FF), who was present, revealed no cause for concern that he posed a risk of harm to children. MGM was informed of MC's impending arrest and she said she would take over the care of children.

3.72 The police referral to MASH suggested multi-dimensional problems which could have a serious impact on the children's health and wellbeing. In addition, a child in need plan had ended two months earlier; in reality, with no progress having been made. In those circumstances, a strategy meeting should have been held at this point to determine whether child protection enquiries were required. The MASH social worker's report, however, focussed on the immediacy of the circumstances in the family home rather than taking into account the wider circumstances of both the incident and the history. The social worker recommended a new children and families assessment.

3.73 On the same day, the GP phoned MASH about his and the dental surgeon's concerns about Martha's oral health and was advised that the case was closed. Arrangements were agreed by MASH to have further discussion within 24 hours, but despite efforts on both sides to communicate, it was 48 hours before this was confirmed. There is no record of this discussion in CSC chronology, although the enquiry was prompted by a concern about neglect and could therefore have been significant to decision-making about how to respond to events in the family home. Neither the GP nor the dental surgeon made a subsequent child protection referral.

3.74 There was a delay of 6 days from the point of police referral before the first visit to the family home took place: this included a 3-day holiday weekend. This was a gap which the CSC IMR acknowledges as it suggests that the visit could more properly have taken place on the Friday before the long weekend began.

3.75 The allocated social worker was appropriately concerned about the children's health and asked the health visitor to undertake an assessment. The health visitor suggested that, in the circumstances, a specialist child protection examination would be more appropriate. The social worker did not think this would be necessary. The health visitor said that the children should be seen by a GP, but agreed to make a joint visit later that day. She weighed the twins and made arrangements for Ben to be seen by the GP.

3.76 By this stage, a strategy meeting had been arranged, although the reason why it was not due to take place for another 5 days is unclear. In discussion, the assessment team manager acknowledged that the delay in arranging a strategy meeting in this case was unusual and that the record gives no justification for it.

3.77 As the hospital IMR suggests; a more timely strategy meeting would have offered the opportunity to seek specialist medical in respect of the physical medical assessments of the children. It might also have given an opportunity to consider the significance of the report from the paediatric dental/oral and maxillofacial surgeon in relation to Martha and of the issues relating to the investigation of Ben's constipation.

3.78 A timely strategy meeting could also have brought the substance misuse service into the professional decision-making for the first time, although it is notable that when the meeting actually took place, they were not invited to participate.

3.79 CSC continued its assessment. On this occasion, CSC's approach to MC and MGM was both supportive and challenging. This, combined perhaps with GUC's absence, allowed more access to the family home than had previously been given, both for social workers and family centre workers. MC acknowledged that she had been using illicit drugs since 2013. MGM said that she had also had concerns about the nature of GUC's relationship with MC.

3.80 Social workers' observations of the twins led them to be concerned that they were being adversely affected by exposure to drugs. When this was discussed with MC and MGM,

they were both angry and upset. Nevertheless, MC agreed to child protection medicals for the twins. She would not, however, allow paternity tests.

3.81 At the beginning of September 2017, the twins were taken with MC and MGM for child protection medicals. Ben was not included. The social workers wanted to know whether the children were suffering the effect of exposure to MC's drugs use. At the hospital; physical examination was challenging for the examining doctor as both Martha and Mary became distressed if anyone looked at them. He was unable to get height or weight measurements, but Mary looked 'well-nourished' bigger than Martha who appeared to be 'adequately nourished'. Both children appeared to be clean and appropriately dressed. The examining doctor confirmed that Martha had marked signs of dental decay.

3.82 Such physical examinations as were possible during the consultation revealed no immediate cause for concern. During the consultation, however, MC and MGM began to argue; resulting in a 'prolonged verbally aggressive episode between them'. The consultant noted indicated that the twins' had an 'unusual and extreme reaction' to this aggression; initially going very quiet and then flopping to the point of appearing asleep.

3.83 These reactions have been described as 'freeze/flop'. The consultant later commented that, although he had not witnessed this in his clinical practice, the flop response is thought to be a recognised response to trauma or aggression. Its purpose appears to be both to reduce the likelihood of injury in case of impact and, as the child 'completely shuts down' to help from psychological point of view.

3.84 The examining doctor was unable to draw conclusions about exposure to drugs on the day of the consultation. Specimens of urine were taken for toxicology but those results would not be immediately available. Following discussion with the physician, the social worker understood that there was no evidence of immediate concern for the children's health and wellbeing. They did not realise that the doctor was also concerned that the children might have been exposed to trauma. It is notable that the doctor's observations of the children's behaviours were similar to those which had been described by family centre workers when they visited.

3.85 At the child protection strategy meeting, there was a full discussion of history and recent circumstances although, as noted above, information from substance misuse service was missing. It was agreed that an initial child protection conference would be arranged. Following the strategy meeting, social workers went to the family home to tell MC about the outcome. From that point, events began to move quickly; as social workers became increasingly alarmed about the twins' presentation, while the adults looking after them (MC and FF) appeared to have been using illicit drugs.

3.86 CSC concluded that action was required to remove the children from what were the immediate dangers of this situation. In anticipation of problems which might arise, the police were called to assist at the family home. In the event, police officers secured MC's consent to allow the local authority to accommodate all three children. Martha and

Mary were appropriately placed with foster carers, while Ben remained with the relative in whose care he was already living.

3.87 Three days later, all three children were made the subjects of interim care orders. Hair strand drug tests were undertaken during the course of proceedings: those confirmed that the children had been exposed to significant levels of drugs during the previous six months.

## 4. Key lines of enquiry

### a. How effectively was the children's mother's vulnerability assessed?

4.1 Although, in the learning event, professionals working with the family could identify MC's vulnerabilities without difficulty; throughout the course of the review, the significance of those vulnerabilities was not adequately assessed. MC was often (but not always) described as having learning difficulties, but the nature of those disabilities and their impact on her everyday life were never clearly established. Although she was known to have attended special school as a child, the details of her assessment of special educational needs were not sought. MC and MGM gave different accounts of how MC's learning needs affected her abilities to read and write. This was not clarified.

4.2 It was known that MC had been the subject of a child protection plan but the nature of the concerns and the outcome were not ascertained. MGM was said to have been a long term drugs user with mental health problems: there was no understanding of the impact that this had on MC's childhood experience or assessment of how this might have affected MC's capacity to care for her own children. There were reports that the person who sexually assaulted MC was a visitor to MGM's home, but the circumstances of the assault and their significance were not explored. CSC and community health workers were unaware that details of the incident, gathered contemporaneously, were held in hospital records.

4.3 Allegations had been made that MC had been sexually exploited by family members. MC's denials appear to have been accepted without further question and details were not sought of the rationale for finding that the allegations were unsubstantiated. At the same time, there were professional suspicions that MC might have been involved in sex work during the period of the review, but these were never clearly articulated or discussed with MC.

4.4 Importantly, the nature of MC's relationship with GUC was unknown. There was a clear reference on MC's midwifery record to MC having said that she was sexually abused by her uncle, but the review has been unable to establish what action was taken as a result of that allegation having been made. MC has consistently denied having made such an allegation. MC's denial was effectively accepted, although doubts remained.

4.5 At the same time, there was no consideration of the nature of the continuing relationship between GUC and MC. Their living arrangements were unusual, but there is no evidence that GUC was asked why he was living in the same household as his niece and her young children. MC's description of his being a source of support appears to have been generally accepted at face value.

4.6 It was known that GUC had a history of drugs use; mental health problems; violence including domestic abuse; and, criminality. The possibility that GUC might be controlling or exploiting MC was not, however, developed as a working hypothesis, despite MC's

recorded vulnerabilities, including to sexual abuse. Insufficient information was gathered about important aspects of their living arrangements and daily life to determine whether GUC was exercising coercive control over MC. Over time, professionals appear to have become more accepting of their relationship; on occasion, for example, suggesting that GUC might help her by reading her post to her.

4.7 MC appears to have had no friends or support other than from MGM or GUC. One or other or both were generally present when visits to the family home took place. MC was rarely seen alone. In addition, as is acknowledged in the CSC IMR; all three adults could become challenging and aggressive when difficult issues were raised and this was often in the presence or hearing of the children. As a result, these conversations were often terminated either due to workers' concerns about the children's safety or their own. The only other 'family friend' who was seen by professionals was F, who appeared after GUC was arrested. His reasons for being present are unknown.

4.8 Health visitors routinely asked MC about her emotional health and wellbeing and findings were recorded: MC's responses did not give cause for concern. The record suggests that MC's physical appearance had deteriorated over time; losing weight, with thinning hair and skin lesions. There was, however, little professional enquiry about this. Towards the end of the review period, MGM suggested that MC's GP had said that MC was suffering from stress. Information from MC's personal medical record has not been obtained as it has not been possible to secure her consent.

### b. How effective was the provision of support for the family?

4.9 The effectiveness of family support is predicated on there being a good understanding of the nature of the challenges the family faces and that account has been taken of the views from family members about what they think would be helpful.

4.10 In this case, MC, GUC and MGM generally denied that there were problems that would require professional intervention; they acted to impede professional efforts to gain insight into their family life; and, when professional concerns were identified, they did not accept their validity. This made for a challenging environment for professionals who were not always equipped to respond adequately. Most professional contact was focused on MC, who, as the children's mother and the only person with parental responsibility, was assumed to be the principal care giver and decision maker in respect of Mary, Martha and Ben.

4.11 MC did not, on the whole, seek help. In the early period of the review, she sought some support from SR and the children's centre, but this was mainly for financial or material help. SR and the children's centre tried to build on the rapport that SR had established with MC. In trying to promote learning activities that involved children and adults, they took into account MC's practical circumstances with three small children. But, from February 2015, MC withdrew from contact with SR.

4.12 During the brief period of CSC's first involvement, there was no multi-agency planning and, as noted, the case closed without a formal support plan being agreed. The involvement of the local authority family centre with its experienced family support workers had been proposed as part of the strategy meeting, but this did not happen.

4.13 Efforts continued to make it possible for MC to take the children to community resources. These varied from encouraging suggestions; delivering newsletters and invitations to attend; home visits; support for settling in sessions; and, personal interventions when MC had let places go or had not applied as she had said she would.

4.14 From around five months old, Martha's weight was faltering and was recorded as falling below the 0.4$^{th}$ centile. Advice was given to MC about feeding, vitamins and weaning. This did not, however, lead to improving her rate of growth. The community health IMR suggests that there was insufficient assessment of the twins' feeding history and unsatisfactory follow up and referral to GP, paediatrician and dietician.

4.15 As the pattern of MC's non-compliance for attendance at health appointments became entrenched; health visitors offered advice about the importance of taking the children to appointments; reminded MC when appointments were due; and, made new referrals when appointments were failed. Again, these actions had little impact in bringing about change.

4.16 The CSC IMR acknowledges that during the period that the children had Child in Need plans, support and intervention did not address concerns or improve outcomes for the children. Some very small improvements were made but not sustained. Then, MC's eventual refusal to engage led to case closure, despite the previously agreed contingency of progressing to child protection enquiries.

4.17 CSC was aware, by this stage, of GUC's involvement with substance misuse services but there was no communication with the agency. As a result, their concerns about his health and wellbeing were unknown and the impact of his drugs use on MC and the children was not assessed. No formal continuing support plan was put in place before the child in need plan ended.

4.18 Within a short time of CSC ending its involvement, there were new concerns about the children's welfare and about illicit drugs use in the family home. Ben's living arrangements were unclear. The situation quickly became critical and, in less than 2 weeks, all three children became looked after.

### c. How effective was the assessment of the risk of harm to the children?

4.19 The risk of harm to the children was not effectively assessed. The assessment of the likelihood of harm requires an evaluation of the combined effect of both positive features of family life and of factors which increase risk. In this case, the home conditions and Ben's chatty, engaging personality had a powerfully reassuring effect on professionals

working with the family. Practitioners also noted warm relationships between MC and the children. GUC was seen to attend to their needs.

4.20 At the same time, when the children were first referred to CSC, a range of risk factors were identified, including: the children's ages and the twins' prematurity; MC's vulnerabilities (and possible drug use); GUC's history; and, the nature of the relationship between GUC and MC. However, the assessment was curtailed and the risk of harm was not adequately evaluated. In addition, professionals from partner agencies were not sufficiently consulted or involved. Poor feedback in respect of decision-making in CSC meant that partners were uncertain as to why enquiries had been concluded identifying no child protection concerns. Despite this uncertainty, however, partners did not challenge the validity of CSC's findings or decisions. As a consequence, professionals working with the family, from that point, appear to have assumed that the concerns identified at the strategy meeting had diminished or had been resolved.

4.21 Before the twins were born, MC already had a pattern of reluctant involvement with health professionals, as was evident from her previous contact with maternity and health visiting services. When the twins were discharged from hospital, this pattern became ingrained and many important health appointments were missed. For example, in the early weeks of their lives, in addition to MC's cancelling or rearranging community health appointments, Mary and Martha missed all but one of the out-patient appointments that were offered to ensure that there were no new or continuing effects of the their prematurity. In addition, Mary was not taken for an appointment in relation to a squint. It should be noted that squints, if untreated, can lead to complications, including to the loss of sight in the affected eye[5]. MC would have been aware of this as the referral letter for Mary stated that MC had a squint and sight loss in one eye.

4.22 The reasons why MC did not take the children for follow up appointments were not understood and the implications for the children of not being taken were not clearly articulated. Both the GP IMR and the community health IMR acknowledge that the risk to the children of persistently not being taken for hospital appointments should have been addressed in a timely way and should have led to a consideration of whether MC was neglecting the children's twins' needs[6].

4.23 Although, for a period, a degree of regularity in health visitor contact was achieved; overall, the pattern of 'no access' visits continued for pre-arranged appointments. In addition, Ben was not taken to several rearranged out-patient appointments, despite his showing signs of chronic constipation, including frequent soiling. There was a suggestion this was one of the reasons he was still in nappies, aged 4. Martha also missed appointments relating to her faltering weight before the second CSC assessment began. There was no evidence that the children had been registered with a dentist.

[5] RNIB: Childhood Squints

[6] Was Not Brought - Take Note! Think Child! Take Action! Child Abuse Review Vol. 26: 165–171 (2017) Published online in Wiley Online Library (wileyonlinelibrary.com) DOI: 10.1002/car.2476

4.24 In the meantime, the family's and the children's social isolation continued. Children have a right to play (Article 31 of the Convention on the Rights of the Child). In its Declaration on the Importance of Play (2014) , the International Play Association describes how play has an intrinsic value to a child, in terms of the enjoyment and pleasure it affords. Play with other children also encourages the development of personal and social skills and contributes to all aspects of learning. Having the opportunity to play in this way is also a form of participation in everyday life. In addition, for children who may be at risk of harm or neglect, being visible to other people, outside the family, can also be a protective factor.

4.25 In this case, health and community professional focus had been on trying to persuade MC to take the children to nursery and the children's centre. When their efforts were not successful, however, health visitors questioned whether non-attendance could be considered an indicator of neglect, given that parents can chose not to make use of these resources. Yet, despite MC's denials, there was no evidence that the twins, in particular, were being taken out of the family home into the wider community or that they were having the opportunity to mix with other children. Indeed, the evidence was that Martha and Mary were spending all their time in one bedroom. They were quite hidden from professional and community gaze. It was in the context of that wider isolation, therefore, that the risks to the children of not attending children's centre and nursery needed to be seen.

4.26 CSC undertook a second assessment but the complexity of the family circumstances were not explored. Safeguarding concerns were not sufficiently recognised and, although practitioners thought neglect might be an issue; they did not use the standardised tools available. As already identified, there was no communication between children's services and adult substance misuse services. The substance misuse services had not considered whether GUC's drugs use posed any risks of harm to children as they were unaware of the children in his household.

4.27 Although Martha had been seen by two paediatricians during this period and Mary by one; paediatricians were not invited to contribute to the assessment. It was generally understood that Ben was not always being cared for by MC, but as he was now attending nursery; his living with MGM was viewed relatively positively, despite MGM's history as a care-giver. As noted earlier, the plan to undertake child protection enquiries was not enacted. Partners did not challenge this CSC decision. The community health IMR states that thought should have been given to discussing the case with the Safeguarding Children's Specialist Nurse for consideration to escalate concerns to CSC.

4.28 The question of MC's neglect of Martha's health needs was raised again following Martha's attendance at A&E with a dental abscess. There is evidence that the paediatrician and the GP were concerned but, although health records refer to communication with the health visitor and MASH, there is no record of referral to CSC.

The GP services IMR author has provided an update which states that the GP 'attempted phoning for two days and had not been able to speak to anyone that could help'.

4.29 In the meantime, CSC's focus was on events in the family house, following the police search of the premises. The decision in MASH not to hold a strategy meeting impeded both the evaluation of new and historic information and the development of a multi-agency plan to assess the risk of harm to the children. Although there was an early decision within CSC assessment service to hold a strategy meeting, it was set for a date 12 days after the police arrested GUC. The CSC assessment, therefore, began without a sense of urgency or clear direction.

4.30 Soon after assessment visits began; concerns about the twins' wellbeing increased as MC and MGM revealed more about drugs use and family circumstances. Social workers were most concerned about the twins' presentation and, as they suspected that they might be suffering from exposure to illicit drugs, a child protection medical appropriately took place. As noted earlier, the medical was inconclusive in relation to exposure to drugs, but an opportunity to gain an understanding of the wider risks to the children was lost when there was no joint consideration of the implications of the paediatrician's observations of the twins' 'freeze/flop' reaction. Ben's wellbeing did not form part of practitioners' immediate concerns, as he was not often present when they visited.

4.31 The day after the child protection enquiries began; the children became looked after, when MC agreed to them being accommodated. Care proceedings followed. This was a rapid development in the levels of intervention. Medical examination, just over 3 weeks later, concluded that Martha and Mary had been exposed to extreme neglect and were at risk of developmental/neuro-developmental delay and learning difficulties. Ben's initial health assessment for looked after children concluded that he had age appropriate social and dressing skills with delayed toilet training. Effects of his chronic constipation were still evident. All three children had been exposed to drugs.

## d. How effective was the communication between disciplines, agencies and organisations and across geographical boundaries?

4.32 The communication between professionals from different disciplines, agencies and organisations was variable, as was the communication across geographical boundaries. Throughout the period of the review, there were only 7 multi-agency meetings: 2 strategy meetings and five Child in Need meetings. Most recorded communication between professionals from different disciplines or agencies was, therefore, written or by telephone.

4.33 At the point that MC came to live in Sefton with Ben, the health visitor was alerted to MC's mild learning difficulties; her volatile relationship with MGM; and to the history of involvement with children's social care. Reference was also made to the unsubstantiated

allegations that MC was a sex worker. As a result, the health visiting service offered an additional targeted visiting schedule above the core national healthy child programme.

4.34 As noted earlier, midwifery services identified various medical and social risks in respect of MC and her twins. A range of referrals for support and specialist assessments were made, although the twins' early birth meant that some of these were redundant. An appropriate referral was sent to CSC. CSC followed up the referral by seeking further information from the midwife. CSC also sought information from the neighbouring authority about their contact with MC and family members. The information which was provided identified a range of relevant concerns but it was generally superficial. The local authority's understanding of context into which the twins had been born would have been enhanced by further reference to the record.

4.35 The NICU was made aware of the child protection concerns which had been expressed, particularly in respect of GUC and of the allegations that MC had been sexually exploited by family members. Staff at the hospital were not entirely satisfied with CSC view that there was no reason to restrict GUC's visiting the twins so they informed the neo-natal consultant of the circumstances. He advised close supervision of GUC and to await further guidance following the strategy meeting which was due to take place two days later. The maternity hospital IMR acknowledges that this was good practice, but suggests that it would have been more appropriate to seek guidance from safeguarding practitioners who could have acted as a conduit between the hospital and the local authority. Had the safeguarding team been made aware of the concerns, they might also have been in a position to attend the strategy meeting on behalf of the hospital. The hospital was not aware that the local authority understood that the twins had suffered 'withdrawal symptoms' at birth.

4.36 In the two weeks following the strategy meeting, as has been noted earlier, communication between the maternity hospital and CSC was affected by limited availability of CSC staff during the Christmas and New Year period. The decision by the local authority to end child protection enquiries without reference to partners and the lack of formal challenge have also been discussed above.

4.37 The absence of a formal discharge plan in respect of the twins has already been identified and the current improved practice acknowledged. Despite there being no formal support plan for MC and the children, at that point; good communication has been reported between the health visiting service, the children's centre, and the school readiness service during the time prior to Child in Need plans being established.

4.38 Referrals for investigation or services formed a considerable proportion of written inter-disciplinary and inter-agency communication. There were also examples of what the children's hospital refers to as 'DNA' responses. The children's hospital IMR indicates that clinicians adhered to the 'Pan Mersey DNA Pathway' and that they reviewed the children's records after each failed appointment. When the decision was made to discharge the children because they had not been taken for appointments, the GP was

always advised in writing. As already described, this was acknowledged by the GP IMR but, in the surgery; there was no equivalent enactment of the pathway, so that alerts were not logged and acted upon. Remedial action was recommended by the GP IMR and it has been reported that recommended measures have been implemented.

4.39 The hospital IMR also refers to evidence of good verbal communication between the health visitor and the paediatrician who was reviewing Martha's growth. The health visitor was copied into hospital letters to the GP with outcomes of out-patient reviews; Martha's attendance at A&E; and, the children's child protection assessment.

4.40 Health visitors twice made what they assumed would be accepted as referrals by MASH. On both occasions, there were problems in creating referrals which were only identified when the health visitors requested an update about progress made.

4.41 Levels of communication between professionals involved in the Child in Need plan appears to have been good, although the assessment and interventions were limited. As noted above, the failure to follow up contact with the substance misuse service in respect of GUC was a significant gap.

4.42 As before, CSC made the decision to close its involvement without reference to other practitioners. And again, this was not formally challenged. Discussion with practitioners about this suggests that, for some, there was a sense of being in a hierarchy of perceived competence in safeguarding and that their personal/ professional point of view was less valuable or valid than the social work opinion.

4.43 The communication between professionals towards the end of the review period is generally covered in the sections above.

4.44 Frustrations were also expressed during the course of the review about differing expectations of what information can be shared with other professionals, in the contexts of confidentiality; consent; data protection; and the appropriate timely sharing of information in order to safeguard and promote the welfare of children.

4.45 Specifically, while MASH had little involvement in this case, a number of concerns were raised by professionals either individually, through records or during practitioner learning event. These included: the difficulty getting through on the phone; restrictions on the availability to the Assessment Team in CSC of information collected during MASH enquiries; and, not getting back to referrer.

4.46 In respect of the reported difficulty in getting through to MASH on the phone; the CSC SCR Panel representative noted that the current communications system in MASH should ensure that there is a quick response to callers who have been unable to speak to a MASH worker on their first attempt. The MASH team manager will, however, monitor the effectiveness of these arrangements in practice.

4.47 The CSC SCR Panel representative has reported that the issue of sharing information collected by the MASH team with CSC assessment teams is currently under review.

4.48 In relation to measures to ensure that referrers are given feedback as to the outcome of referrals; the SCR Panel noted that this has been highlighted previously by health organisations as an issue. The CSC SCR Panel representative reports that there have been changes to administrative personnel within the MASH team and that the lead administrator will ensure that all staff are aware of their responsibilities in terms of feedback to referrers. As there have always been clear processes in place, however, it is likely that barriers to compliance are more complex.

## e. How was the lived experience of the children understood?

4.49 It is clear from the review that the lived experience of the children was not understood. The children lived with their mother and the person who was legally their maternal uncle but who might also have been their father. Although his paternity cannot be confirmed, his everyday relationship with the children appears to have been parental. MGM was a frequent visitor to the family home. Ben appears to have been living with MGM and, possibly his maternal aunt, at different times throughout the period of this review.

4.50 The family lived in private rented accommodation in an area of Sefton characterised by high levels of deprivation. The household income was not established and financial arrangements between the adults were unknown. MC seems, however, to have been without funds at different times.

4.51 The family was socially isolated. The children were not seen out and about in the local community. There is no record of the family referring to any social activity. The curtains in the house were kept closed 'against nosy neighbours'. Professional contact and assessments did not reveal details of the family's daily routine: their living; eating; and, sleeping arrangements were unknown. MC's reporting of the children's diet and dental care routines were not consistent with the evidence of the children's presentations. The roles that MC and GUC had, separately and together, in caring for the children were not established.

4.52 The relationships between the children and the adults in their lives were observed at different times to be warm: the adults were kind and appropriate and Ben, in particular, was responsive to them. On the other hand, neither Martha nor Ben was taken in a timely way for medical help when they must clearly have been suffering pain and discomfort. Mary was consistently noted to be markedly bigger than Martha in all ways; but it was not known whether they were treated differently.

4.53 As time went on, the twins' distress prevented professionals from engaging with them. Ben was not spoken to alone and he was less frequently seen at the family home. As a result, his thoughts and feelings were not explored.

4.54 All three children were known to have been present when the adults in their lives were displaying anger and aggression. The children's reactions were observed at different times; their reactions suggest that this was a common experience for them.

4.55 The family appears increasingly to have lived upstairs. At the end of the review period, the twins had a small table and chairs in their mother's bedroom where they ate. They seem to have slept in her double bed. They were not being offered the kind of stimulation they needed and they were exposed to adults' illicit drug use.

## 5. Lessons learned from this review

5.1 Lessons have been learned at different levels throughout the course of this review. Practitioners took advantage of structured conversations to reflect on their individual experiences in this case and to highlight the factors which contributed to the decisions they had made and the actions they had taken. The information they provided in structured conversations provided a depth and colour which was absent from the combined chronology.

5.2 In addition, bringing practitioners and managers together in the multi-agency learning event offered further learning opportunities both for individuals and for groups of workers. Again, their joint learning has influenced the findings of this SCR report.

5.3 The Individual Management Reports which were prepared as part of the SCR process each addressed the key lines of enquiry as they related to their agencies and organisations. They subsequently identified the lessons they had learned and drew up related recommendations. Reference has been made to some of those lessons and recommendations throughout this overview report. The IMRs have made a considerable contribution to the learning from this review.

5.4 Central to professional reflection and examination of practice, however, is the knowledge that Martha, Mary (and Ben?) were found to have suffered severe neglect, despite their being known to services as vulnerable children throughout their lives. They had previously had multi-agency support plans (Child in Need plans) but the extent to which their needs had been neglected had not been recognised prior to their becoming looked after. The children had not, for example, had child protection plans at any point. The most significant feature of this SCR review is, therefore, neglect.

5.5 As can be seen from Sections 3 and 4 of this report, there were significant shortcomings in single- and multi-agency practice throughout the period of the review. In particular, there was a tendency to focus on what was observable, rather than taking a more analytical approach which would have involved active hypothesising about family functioning.

5.6 There was limited evidence of professional curiosity about the dissonance between what was being seen on most occasions and what was seen when family members were challenged or taken unawares. There was little exploration of the link between the individual and joint histories of adults involved in the children's lives and their capacity to keep the children safe and to promote their welfare. MC's denials that she had been abused by GUC or that she had been sexually exploited were effectively accepted at face value. The nature of the relationship between MC and GUC was not understood.

5.7 While professionals were concerned both about MC's failure to take the children for medical appointments and about the children's social isolation; there was no evidence of reflection on why this was happening, either within the practitioner group or in

supervision. There was no recognition of the impact of high levels of hostility and aggression from the adults on practitioners' capacity to challenge the ways in which the children were being cared for. There were clear shortcomings in decision-making in CSC; but when decisions were made, they were generally accepted without challenge. In circumstances where there were barriers to spending time with the children; there is little indication that practitioners attempted to view family life from their perspective.

5.8 The interrelated features of practice and management suggest that the identified shortcomings are unlikely to be limited to this single case. The nature of the issues which have been identified suggests that they are established characteristics of local practice and that enduring change is only likely to be brought about through a 'whole systems' approach.

5.9 As a result, the contribution that can be made through this SCR is likely to be limited, at least in its immediate effect. For that reason, lessons identified in this section will include a number where remedial actions could produce 'quick wins', where proposed changes are relatively easy to implement and anticipated improvements delivered within a short time. Where pertinent, recommendations for action will link work already being undertaken by the LSCB, the local authority and partner agencies.

## a) Strategy meetings and child protection enquiries

5.10 Lesson 1: <u>Child protection strategy meetings are fundamental to good safeguarding planning and practice. Child protection enquiries should not be ended without taking into account the actions agreed at strategy meetings.</u>

5.11 In the early stages of this review, concerns were raised that the children might be at risk of significant harm of abuse or neglect. The nature of that harm was not clearly articulated but a multi-agency child protection strategy meeting agreed that, as part of child protection enquiries, two specific assessments should be completed; relating to both MC and GUC. As has been noted earlier, a decision was made to end CSC involvement without there being an adequate consideration of the risk of harm to the children. This decision had a serious and continuing impact on the progress of the case.

5.12 For that reason, when contemplating closing child protection enquiries with no further action; reference must be made back to the strategy meeting. Where actions are outstanding, explicit consideration must being given to the potential impact on the child/ren of those actions not being completed. This is particularly important when no formal support plan is to be offered, as 'there may be no further contact and so no chance of realising that judgement on safety was wrong'[7].

[7] Munro Effective Child Protection: Second Edition Sage Publications

5.13 The views of professionals from partner agencies should also be taken into account. The rationale for the manager's decision-making should be clearly recorded and shared with other safeguarding professionals working with the family.

5.14 The factors which contributed to the decision to end child protection enquiries in this case are acknowledged in Sections 3 and 4.

## b) Identifying indicators of neglect and taking action

5.15 Lesson 2: There were shortcomings in the early recognition and identification of the signs of neglect and a subsequent delay in efforts to provide the family with the right help at the right time.

5.16 Neglect is the most common form of child maltreatment in England. Tackling neglect is strategic priority for Sefton LSCB[8]. The strategic plan has been active for three years. It identifies eight priority areas which are supported by detailed actions, many of which have been completed.

5.17 Yet, despite high levels of activity across the partnership, this review has found that a significant proportion of practitioners, from all disciplines, would identify with the statement that 'it is extremely difficult for professionals working with families 'to identify indicators of neglect; to assess whether they need to take action; and, to decide on what the best action would be'[9].

5.18 Brandon, Glaser, Maguire et al (ibid) describe some of the characteristics of neglect which may make it harder for professionals to recognise that a threshold for action has been reached. Two in particular were features of this review:

i. the chronic nature of neglect leading to professionals becoming 'habituated' to the child's circumstances and failing to question a lack of progress; and,
ii. the experience of neglect rarely produces a crisis that demands active, authoritative action.

5.19 Indeed, it is notable, that it was not as a result of their long term neglect that the children became looked after: rather it was due to concerns for their immediate health and welfare.

5.20 For the two years between 2015 and 2017, it was quite clear that MC and GUC were evading contact with services and that MC was not acting on health practitioners' advice. Despite increasing cause to believe that the children's health and development was being negatively affected by their circumstances, practitioners did not consistently identify MC's lack of appropriate action as a potential indicator of neglect.

[8] Sefton LSCB Annual Report 2015-2016
[9] Brandon, Glaser, Maguire et al Missed Opportunities: indicators of neglect – what is ignored, why, and what can be done? Department for Education Research report 2014

5.21 Similarly, although health visitors and family practitioners recognised that the children were not socialising in the community (despite advice and offers of support), they did not generally associate this with neglect.

5.22 There was no evidence that practitioners or managers lacked knowledge about how to make a referral for Early Help or to CSC. Staff and managers referred to Sefton's Level of Need Guidance and there was evidence of its use informing referrals. In some instances, however, practitioners described their reluctance to refer to CSC with certain issues of neglect, as similar referrals had been rejected in the past.

5.23 Discussion took place about what information should be provided to support referrals where early indicators of neglect had been identified. It was generally agreed that referrals should articulate the experience of neglect as actually, or likely, to be perceived by the child. As noted in the community health IMR, 'this will help ensure that important information does not become lost when shared between multiple agencies (NSPCC 2014)'.

5.24 Factors which contributed to inconsistent responses by health practitioners and family workers in this case are acknowledged in Sections 3 and 4.

5.25 Since 2017, The National Institute for Health and Care Excellence (NICE) has produced two sets of guidance and guidelines which might have assisted practitioners in the case. The first, Child Abuse and Neglect, helps identify features that should alert practitioners to the possibility of neglect. It also provides an analytical framework to support thinking and decision-making about what to do next[10]. The second, Faltering Growth[11], covers recognition, assessment and monitoring of faltering growth in infants and children. It includes a definition of growth thresholds for concern and identifying the risk factors for, and possible causes of, faltering growth. It also covers interventions, when to refer, service design, and information and support.

## c) Assessing need where neglect is an issue and offering services

5.26 Lesson 3: Where neglect is an issue, Child in Need assessments and plans are likely to be enhanced by the use of the Graded Care Profile.

5.27 Lesson 4: The decision to end Child in Need plans must be made in a child in need meeting to allow professionals from partner agencies to contribute to the decision-making.

5.28 Lesson 5: In circumstances where consensus among agencies cannot be gained to ending a child in need plan, consideration should be given to using the LSCB conflict resolution/ escalation procedure

[10] Child Abuse and Neglect: Guidance and Guidelines NICE 2017
[11] Faltering growth: recognition and management of faltering growth in children NICE 2017

5.29 As noted earlier, the assessment of need which was undertaken by CSC in 2017 did not sufficient take account of the complexity of family circumstances. The indicators that the children might be experiencing harm as a result of neglect were not adequately explored.

5.30 As part of its neglect strategy, Sefton has collaborated with the NSPCC to trial the Graded Care Profile 2 (GCP 2) as the recognised method for helping practitioners to assess family circumstances where neglect is thought to be a feature.

5.31 GCP2 is a tool for the multi - agency assessment of neglect which can be completed by all suitably trained members of staff from all agencies working with families where neglect is an issue. It is most effective in the early detection of neglect. The GCP2 is designed to be completed collaboratively with parents. Its use encourages openness between parent and practitioner, and so, can help develop trust and more effective working relationships.

5.32 For those reasons and in line with current LSCB expectations, consideration should always be given to employing the GCP2 in such assessments and support planning. Where there are indications that its use would not be appropriate, these should be discussed in the multi-agency group and with the parents. The rationale for not using the tool should be clearly recorded on the child's file in all agencies working with the family.

5.33 In this case, it has not been established why no consideration was given to employing GCP2 in the early stages of the assessment and support planning. With little new information being gathered and in the absence of a new perspective, as has been noted was essentially 'more of the same'. Nevertheless, as has also been acknowledged, child in need plan ended, despite as described in the CSC IMR 'concerns were arguably increasing, outcomes were worsening for the children and child in need planning had been ineffective in securing any positive change'.

5.34 A CSC's single agency recommendation is that 'any decision to close a case due to non-engagement by adults, where outcomes are not improving, must include a multi-agency meeting chaired by a team manager in CSC to support decision-making'.

5.35 Where agreement about ending child in need plans cannot be reached and there is recourse to the LSCB escalation process; records of discussions must be maintained by all the agencies involved throughout each stage of the escalation process. The LSCB has published an Escalation Flowchart which identifies timescales.

## d) Working together with substance misuse services when children are vulnerable and/or may be at risk of abuse or neglect

5.36 Lesson 6: The impact of drugs' use is a significant aspect of assessment of need and risk of abuse or neglect. Where previous or current involvement with substance misuse services is acknowledged, there should be appropriate information sharing between the two services.

5.37 It is not suggested that all parents who use illicit drugs are unable to provide their children with the care they need. Parental substance misuse can, however, have a negative impact on children at each stage of their development. Additional factors such as domestic abuse, parental mental health problems or learning disabilities also increase the likelihood that children will suffer significant harm.

5.38 In this case, despite being aware that GUC was a methadone user, the impact of this on family life was not explored and no contact was made with the local substance misuse service as part of the assessment which being undertaken in CSC. At the same time, the risk assessment in the substance misuse service was overly narrow in its form and professionals were insufficiently curious about the impact of GUC's problem drug use on MC and on his relationships with other members of his family.

5.39 Had the connection between the two services been made, it would have revealed that GUC's drugs had become more chaotic and that he had been experiencing physical ill health. Frank discussion about drugs' use in the household, if this could have been achieved, might also have encouraged MC to disclose her own drugs use at an earlier stage.

5.40 Many serious case reviews have identified the importance of closer working relationships between children's and substance misuse services where drugs' use is a feature of family life. The recommendations of the Advisory Council on the Misuse of Drugs (ACDM)'s report 'Hidden Harm: Responding to the needs of children of problem drug users'[12]are well known and have influenced safeguarding policy and practice in both agencies for fifteen years.

5.41 The substance misuse service IMR has recognised that in the assessments of adults' needs 'emphasis should be given to any caring responsibilities or impact of children living within the same household and not just assessing the risks to any biological children'.

5.42 When an adult in the household is known to use illicit drugs and there is reason to believe that children may be at risk of significant harm; a representative from the substance misuse team should attend the multi-agency child protection strategy meeting where the parameters of future involvement should be agreed.

### e) Severe or extensive tooth decay as an indicator of potential neglect

5.43 Lesson 7: Where there is ready access to a free dental service, persistent failure to attend to children's tooth decay should alert health practitioners and dentists to consider neglect and to respond accordingly.

[12] ACMD Hidden Harm; Responding to the needs of children of problem drug users, HM Government 2003

5.44 A recent survey of the dental health of children in England that where children experienced severe or extensive decay this appeared to correlate with indices of multiple deprivation. Within that overall context, however, Missed Opportunities states that untreated dental disease is increasingly being recognised as an indicator of broader child neglect. It indicates that the 'wilful or persistent failure' to meet a child's basic oral health needs can result 'not only in the impairments of oral health but may also compromise the child's general health or development'. This is also recommended under NICE guidance and guidelines[13].

5.45 The Designated Nurse and member of the SCR Panel, reports that NHS England (Primary Care Commissioning) have advised that access to NHS dental services for children should not be problematic; although there can often be seasonal difficulties in getting a routine dental appointment. Access to dental services is monitored by Health Watch. CCG PALS (Patient Advice and Liaison Service) also receive complaints from the public; PALS has not identified access to an NHS dentist as an issue. It is acknowledged, however, that a child's being registered with a dentist does guarantee regular attendance.

## f) Establishing the nature of a parent's disabilities and the implications for service delivery

5.46 Lesson 8: Professionals working with children and families must be cognisant of their own and their agency's or organisation's duties and responsibilities to parents with learning disabilities

5.47 Parents with learning disabilities can experience difficulties accessing services for their children and may require additional support to ensure that they are able to provide the care that the children need to support their development. When child protection concerns arise, parents with learning difficulties are also likely to need support to ensure that they are able to participate fully in that process. The problems experienced by parents with learning disabilities are likely to be compounded if their children are subjects of care proceedings as, indeed, the children went on to be. Those are among the reasons, that early identification of a parent's learning disabilities, and their impact on the individual's parenting capacity, is crucial.

5.48 Throughout the review period, professionals gained different impressions of MC's cognitive abilities and she, and family members, gave different accounts of how any impairment affected her life. It is acknowledged that MC was not cooperative with services and that she rarely sought support. At no time, however, was there any consideration of whether MC was entitled, for example, to an assessment of her own needs or whether MC could be a 'disabled person' under Equality Act 2010. No specific

[13] Child Abuse and Neglect: Guidance and Guidelines NICE 2017

adjustments appear to have been made to the ways in which services were offered or provided.

## 6. Recommendations

Recommendation 1:

**Child protection procedures in relation to child protection (S47) enquiries should be amended to include:**

- ***'S47 enquiries should not be ended with 'no further action' without:***
  - ***i. Evaluation of any outstanding actions from strategy discussion/meeting; and,***
  - ***ii. Taking into account the views of professionals from partner agencies'.***

Recommendation 2:

**As part of their scheduled review of the implementation of the Neglect Strategy; the LSCB, local authority and partner agencies should take into account the findings of this SCR in determining how improved multi-agency practice can be delivered.**

Recommendation 3:

**Where there are issues of neglect in early intervention or working with children who may be in need:**

i. **practitioners and managers must use the Graded Care Profile; and,**
ii. **a process should be established to monitor compliance and evaluate reasons for non-compliance**.

Recommendation 4:

a) **Revision of Child in Need procedures**

**The LSCB has identified that existing multi-agency Child in Need procedures state that the recommendation to end a child in need plan must be made by the multi-agency meeting, for consideration by the CSC team manager. These procedures should be revised to include:**

i. ***Where the evaluation of risk of harm is obscured by non-engagement by parents, that meeting must be chaired by a CSC team manager;***
ii. ***The meeting must address the impact of non-engagement by parents; and,***
iii. ***The rationale for all decisions and actions must be clearly recorded on the child files in all relevant agencies.***

b) **Measuring and improving decisions to end child in need plans.**

**The LSCB should require an audit of decisions to end child in need plans with an accompanying action plan, if necessary, to secure improvement.**

Recommendation 5:

**LSCB agencies and organisations must ensure that professionals working with children and families are aware of the LSCB dispute resolution and escalation processes and that they are suitably equipped and supported to work within its provisions.**

Recommendation 6:

**In order to improve safeguarding of children where substance misuse is an issue, the LSCB should require CSC and the commissioners of the Substance Misuse Service to develop an information sharing protocol for all potential points of communication from general enquiries/advice to working together under child protection plans**.

LSCB training programme should be informed by that protocol.

Recommendation 7:

**As part of its review of the Neglect Strategy; the LSCB should ensure that there are specific actions in respect of the identification and assessment of dental neglect as a safeguarding issue. These should be linked to NHS England Direct commissioning team which is responsible for commissioning dental services both in the community and in secondary health services.**

The LSCB should consider the merits of working on a pan-Merseyside basis in respect of this recommendation.

Recommendation 8:

**In respect of parents with learning difficulties or disabilities, the LSCB should consider commissioning a 'task and finish' group to:**

i. **review existing policy and procedures in the light of the current legal framework; and,**
ii. **to produce good practice guidance for professionals working with parents who may have learning difficulties or disabilities.**

The LSCB might consider the merits of working with neighbouring LSCBs on this.

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# 7 minutebriefing

# Learning from Serious Case Review (SCR1)

## 1 Serious Case Review (SCR)

Sefton LSCB has a statutory duty to undertake a Serious Case Review (SCR) on cases where abuse or neglect is known or suspected and **either:** a child dies; or is seriously harmed and there are concerns about how professionals worked together to safeguard the child. *(Working Together to Safeguard Children—DfE)*

The LSCB reviews these cases to extract learning to help prevent similar incidents occurring in the future.

Sefton LSCB has published a SCR undertaken on 3 children Martha, Mary & Ben *(pseudo names for the purpose of this review)*

## 2 Background

The SCR involved 3 siblings under the age of 5 years who were found to have suffered severe neglect. The children resided with their Mother and Great Uncle.

The Mother had a learning disability. The Mother was known to Children's Social Care when she was a child.

Substance misuse, criminality, mental health, coercive control and disguised compliance were all features identified with the adults in the family.

## 3 Key Findings

a) Limited evidence of professional curiousity.
b) Failure to recognised the impact on the children of the hostility and aggression displayed within the family.
c) Shortcomings in single and multi-agency practice, with a tendency to focus on what was observable, rather than taking a more analytical approach.
d) The lived experience of the children was not understood
e) Early recognition and identification of the signs of neglect was lacking
f) Little exploration of the link between the individual and joint histories of the adults involved in the children's lives

## 4 Key Findings.

g) Communication between different professionals, agencies and organisations was variable.
h) The risk of harm to the children was not effectively assessed.
i) The impact of the family and children's social isolation was not recognised.
j) Insufficient information was not gathered about important aspects of the family's living arrangements and daily life experiences.
k) Relationships between family members was not understood.
l) Professionals did not consider an array of missed health appointments as an indicator of neglect.
m) No evidence of formal professional challenge when decisions reached were not collectively agreed within the Child Protection p
n) Differing expectations between professionals of what information can be shared between agencies.

## 5 Lessons

1. Actions agreed at strategy meetings should be understood in relation to Child Protection enquiries.
2. Using the Graded Care Profile (GCP) assessment tool will support the early recognition and identification of signs of neglect.
3. Partner agencies must contribute to the decision making process before the Children in Need (CIN) plan is ended.
4. Professionals should follow the LSCB Escalation Procedure for formal challenge.
5. Information sharing between agencies should be shared willingly and legally.

## 6 Lessons

6. The impact of drug misuse is a significant aspect of assessment of need and risk of abuse or neglect.
7. Professionals must consider the link between children's tooth decay and/or missed medical appointments as an alert for neglect.
8. Professionals must follow their duties and responsibilities in responding specifically to the needs of an individual, where (learning) disability is known.
9. Professionals must take time and be given the opportunity, to reflect on their practice through professional supervision.

## 7 Further Information

**This SCR identified a significant amount of learning. Whilst this briefing provides a flavour of the findings, Sefton LSCB would urge all professionals to read the SCR to digest and understand the lived experience of this family.** ***(Do not read this briefing in isolation).***

The full SCR report with detailed recommendations can be found **here**

**Additional Information & Support**

LSCB 7 Minute Briefings—Professional Curiosity & Newsletters
LSCB Escalation Procedure & Flow Chart
Neglect Screening Tool
LSCB Graded Care Profile Training (Nov/Dec 2018)

**Further Guidance**

Child Abuse and Neglect: Guidance NICE 2017

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| **Report to:** | Overview and Scrutiny Committee (Adult Social Care and Health)<br><br>Overview and Scrutiny Committee (Regulatory, Compliance and Corporate Services)<br><br>Overview and Scrutiny Committee (Regeneration and Skills)<br><br>Overview and Scrutiny Committee (Children's Services and Safeguarding) | **Date of Meeting:** | 4 September 2018<br><br>11 September 2018<br><br>18 September 2018<br><br>25 September 2018 |
| **Subject:** | Effectiveness of Local Authority Overview and Scrutiny Committees – Government Response to DCLG Select Committee Report | | |
| **Report of:** | Head of Regulation and Compliance | **Wards Affected:** | All |
| **Cabinet Portfolio:** | Adult Social Care<br>Children, Schools and Safeguarding<br>Communities and Housing<br>Health and Wellbeing<br>Locality Services<br>Planning and Building Control<br>Regeneration and Skills<br>Regulatory, Compliance and Corporate Services | | |
| **Is this a Key Decision:** | No | **Included in Forward Plan:** | No |
| **Exempt / Confidential Report:** | No | | |

**Summary:**

To advise Members on the Government's response to the Communities and Local Government Select Committee report titled "Effectiveness of Local Authority Overview and Scrutiny Committees"

**Recommendation:**

That:-

(1) the report be noted;

(2) a further update be submitted to the Committee once the Government have published updated guidance in respect of recommendations 1 (a) to (e) and 6 and further consideration has been given to recommendation 2; and

(3) if consultations are allowed to be undertaken as referred to in paragraph 4 then the views of the Overview and Scrutiny Management Board and individual Overview and Scrutiny Committees be obtained for inclusion in the consultation process.

**Reasons for the Recommendation(s):**

To make Overview and Scrutiny Committees aware of current issues affecting local authority scrutiny functions.

**Alternative Options Considered and Rejected:** (including any Risk Implications)

No alternative options have been considered.

**What will it cost and how will it be financed?**

There are no direct financial implications arising from this information report. Any financial implications arising from the implementation of updated Government guidance regarding the scrutiny function will be set out in future reports at the appropriate time.

**(A) Revenue Costs –** see above

**(B) Capital Costs –** see above

**Implications of the Proposals:**

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|---|
| **Resource Implications (Financial, IT, Staffing and Assets):** None |
| **Legal Implications:** None |
| **Equality Implications:** There are no equality implications. |

**Contribution to the Council's Core Purpose:**

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|---|
| Protect the most vulnerable: None directly applicable to this report. |
| Facilitate confident and resilient communities: None directly applicable to this report |
| Commission, broker and provide core services: None directly applicable to this report. |
| Place – leadership and influencer: None directly applicable to this report. |

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| Drivers of change and reform: None directly applicable to this report. |
| Facilitate sustainable economic prosperity: None directly applicable to this report. |
| Greater income for social investment: None directly applicable to this report. |
| Cleaner Greener: None directly applicable to this report. |

**What consultations have taken place on the proposals and when?**

**(A) Internal Consultations**

The Head of Corporate Resources (FD 5215/18) has been consulted and notes the report indicates no direct financial implications arising for the Council. The Head of Regulation and Compliance (LD4439 /18) has been consulted and has no comments on the report.

**(B) External Consultations**

Not applicable

**Implementation Date for the Decision**

Immediately following the Committee meeting.

| | |
|---|---|
| **Contact Officer:** | Paul Fraser |
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**Appendices:**

The following appendices are attached to this report:

- First Report of Session 2017–19 Effectiveness of local authority overview and scrutiny committees
- Government Response to the Communities and Local Government Committee First Report of Session 2017-19 on the Effectiveness of Local Authority Overview and Scrutiny Committees

**Background Papers:**

There are no background papers available for inspection.

**1. Introduction/Background**

1.1 The Communities and Local Government (CLG) Select Committee, on 24 January, 2017 launched an inquiry into overview and scrutiny in local government; as the CLG Committee wanted to consider whether overview and scrutiny arrangements in England were working effectively and whether local communities were able to contribute to and monitor the work of their councils.

1.2 The CLG Committee had noted that overview and scrutiny arrangements were introduced by the Local Government Act in 2000 as a counterweight to increasing decision-making powers of Leaders and Cabinets or directly elected mayors; and had made reference to shortcomings that had been exposed, following a number of high profile cases, including child sexual exploitation in Rotherham, poor care and high mortality rates at Mid Staffordshire NHS Foundation Trust and governance failings in Tower Hamlets.

1.3 Clive Betts MP, Chair of the CLG Committee, said:

"This inquiry is long overdue. Local authority executives have more powers than ever before but there has not been any review about how effectively the current overview and scrutiny arrangements are working since they were introduced in 2000.

Local authorities have a considerable degree of discretion when it comes to overview and scrutiny. We will examine these arrangements and consider what changes may be needed to ensure decision-makers in councils and local services are better held to account."

**2. Publication of the CLG Report**

2.1 The report of the Select Committee, titled "Effectiveness of Local Authority Overview and Scrutiny Committees" was published by the House of Commons on 15 December 2017; and a copy of the published report is attached as **Appendix 1.**

**2.2** The proposed revisions to Government guidance on Overview and Scrutiny Committees contained in the report were as follows:-

- That overview and scrutiny committees should report to an authority's Full Council meeting rather than to the executive, mirroring the relationship between Select Committees and Parliament.
- That Scrutiny committees and the executive must be distinct and that executive councillors should not participate in scrutiny other than as witnesses, even if external partners are being scrutinised.
- That councillors working on scrutiny committees should have access to financial and performance data held by an authority, and that this access should not be restricted for reasons of commercial sensitivity.
- That scrutiny committees should be supported by officers that are able to operate with independence and offer impartial advice to committees. There should be a greater parity of esteem between scrutiny and the executive, and committees should have the same access to the expertise and time of senior officers and the chief executive as their cabinet counterparts.
- That members of the public and service users have a fundamental role in the scrutiny process and that their participation should be encouraged and facilitated by councils
- That overview and scrutiny committees should be given full
- access to all financial and performance information, and have the right to call witnesses, not just from their local authorities, but from other public

bodies and private council contractors. They should be able to follow and investigate the spending of the public pound.

- That the DCLG works with the Local Government Association and the Centre for Public Scrutiny to identify councils to take part in a pilot scheme where the impact of elected chairs on scrutiny's effectiveness can be monitored and its merits considered.

## 3. Government Response to the CLG Report

3.1 The Government's response to the CLG report was published on 12 March 2018; and the 8 CLG recommendations and accompanying Government responses are set out below in paragraphs 3.2 to 3.9. A full copy of the Government response is attached to the report as **Appendix 2**.

3.2 **Recommendation 1:**
Proposed revisions to Government guidance on scrutiny committees
(Note: this recommendation was in five parts (a) to (e) and the individual recommendation and Government response are set out consecutively)

**Government Response:**
The Government acknowledges that the current guidance was issued in 2006 and is happy to ensure it is updated. New guidance will be published later this year.

a) That overview and scrutiny committees should report to an authority's Full Council meeting rather than to the executive, mirroring the relationship between Select Committees and Parliament.

**Government Response:**
a) The Government notes the evidence supplied to the Committee. Updated guidance will recommend that scrutiny committees report to the Full Council.

b) That scrutiny committees and the executive must be distinct and that executive councillors should not participate in scrutiny other than as witnesses, even if external partners are being scrutinised.

**Government Response:**
b) The Government accepts the need to limit the executive's involvement in the scrutiny meetings. Updated guidance will make clear that members of the executive should not participate in scrutiny other than as witnesses.

c) That councillors working on scrutiny committees should have access to financial and performance data held by an authority, and that this access should not be restricted for reasons of commercial sensitivity.

**Government Response:**
c) Scrutiny committees already have powers to access documents and updated guidance will stress that councils should judge each request to access sensitive documents on its merits and not refuse as a matter of course. We will also have discussions with the sector to get a better understanding of the issues some scrutiny committees appear to have in accessing information and whether there are any steps the Government could take to alleviate this.

d) That scrutiny committees should be supported by officers that are able to operate with independence and offer impartial advice to committees. There should be a greater parity of esteem between scrutiny and the executive, and committees should have the same access to the expertise and time of senior officers and the chief executive as their cabinet counterparts.

**Government Response:**
d) Updated guidance will make clear that support officers should be able to operate independently and provide impartial advice. It will also stress the need for councils to recognise and value the scrutiny function and the ways in which it can increase a council's effectiveness. However, the Government believes that each council should decide for itself how to resource scrutiny committees, including how much access to senior officers is appropriate to enable them to function effectively.

e) That members of the public and service users have a fundamental role in the scrutiny process and that their participation should be encouraged and facilitated by councils.

**Government Response:**
e) The Government fully believes that local authorities should take account of the views of the public and service users in order to shape and improve their services. Scrutiny is a vital part of this, and scrutiny committees should actively encourage public participation. Updated guidance will make this clear.

3.3 **Recommendation 2:**
That DCLG works with the Local Government Association and Centre for Public Scrutiny to identify willing councils to take part in a pilot scheme where the impact of elected chairs on scrutiny's effectiveness can be monitored and its merits considered.

**Government Response:**
The Government will give further consideration to this recommendation.

The Government fully accepts that the chair of a scrutiny committee can have a great impact on its effectiveness. As the then Minister told the Select Committee at the oral evidence session on 6 November 2017, a chair needs to have the requisite skills, knowledge and acumen to take on the functions and achieve the outcomes that the scrutiny committee needs to achieve.

The Government also accepts that, in some instances, the election, rather than the appointment, of a chair might help ensure that the right individual is ultimately selected, but feels that this is a decision for every council to make for itself - we note that the Select Committee is "wary of proposing that [election] is imposed upon authorities by Government".

A local authority is already free to elect a chair if it wishes, and the updated guidance will recommend that every council bears this in mind when deciding on a method for selecting a chair.

The Government is happy to explore with the sector how best to establish the

impact of elected chairs on scrutiny committees' effectiveness, but is not yet convinced that running pilot schemes is the best way to achieve this. The Government will therefore discuss this recommendation with the sector, including the Local Government Association and Centre for Public Scrutiny, and write to the Select Committee on this matter when we publish updated guidance.

3.4 **Recommendation 3:**
Councils should be required to publish a summary of resources allocated to scrutiny, using expenditure on executive support as a comparator.

**Government Response:**
The Government does not accept this recommendation.

Many councils do not have dedicated scrutiny support staff - officers work on issues and engage with committees as part of the flow of business - so this would make quantifying the support that scrutiny committees receive very difficult. In the Government's view, the quality of the support is the more important issue.

The Government firmly believes that each individual authority is best-placed to decide for itself how to support scrutiny most effectively.

3.5 **Recommendation 4:**
That the Government extend the requirement of a Statutory Scrutiny Officer to all councils and specify that the post-holder should have a seniority and profile of equivalence to the council's corporate management team. To give greater prominence to the role, Statutory Scrutiny Officers should also be required to make regular reports to Full Council on the state of scrutiny, explicitly identifying any areas of weakness that require improvement and the work carried out by the Statutory Scrutiny Officer to rectify them.

**Government Response:**
The Government does not accept this recommendation.

As the then Minister outlined during the oral evidence he gave to the Select Committee, decisions about the allocation of resources for the scrutiny function are best made at a local level. Each council is best-placed to know which arrangements will suit its own individual circumstances. It is not a case of one size fits all.

The key requirement for effective scrutiny is that the culture of the council is right. Where councils recognise the benefits effective scrutiny can bring, and put in place suitable arrangements, it is working well. Local authorities with a strong culture of scrutiny may invite regular reports to full council on the state of scrutiny in the council and this idea will be reflected in the updated guidance.

3.6 **Recommendation 5:**
The Department to put monitoring systems in place and consider whether the support to committees needs to be reviewed and refreshed. We invite the Department to write to us in a year's time detailing its assessment of the value for money of its investment in the Local Government Association and on the wider effectiveness of local authority scrutiny committees.

**Government Response:**
The Government does not accept this recommendation.

Local authorities are independent bodies and it is for them to ensure that their scrutiny arrangements are effective.

The Government firmly believes that every council should be able to access the training it needs to carry out its functions effectively, and recognises that Government itself has a role to play in making this happen. That is why we provide funding to the Local Government Association for sector-led improvement work. It should be noted that this funding is to support local authorities on a wide range of improvement work. It is not purely to assist with overview and scrutiny.

The funding is determined annually and for 2017/18 is £21 million. The package of work that is funded from the grant is set out in a jointly agreed Memorandum of Understanding between the Department and the Local Government Association, which is refreshed annually to ensure that it remains relevant to the sector's needs.

The Government is, of course, very keen to ensure that this funding provides value for money and that local authorities feel that the training on offer serves their needs. To this end, the Department has quarterly performance monitoring and review meetings with the Local Government Association, which are chaired by the Director-General for Local Government and Public Services.

The Government notes that not all the councillors who provided evidence to the Select Committee felt that the scrutiny training provided was as effective as they would have liked, and that the Local Government Association wrote to the Committee on 20 December 2017 to provide more information on the feedback it received on its support work.

The Government will ensure that the 2018/19 Memorandum of Understanding with the Local Government Association clearly sets out our expectation that they remain responsive to feedback they receive to ensure all training, including scrutiny training, remains relevant and effective.

3.7 **Recommendation 6:**
Scrutiny committees must be able to monitor and scrutinise the services provided to residents. This includes services provided by public bodies and those provided by commercial organisations. Committees should be able to access information and require attendance at meetings from service providers and we call on DCLG to take steps to ensure this happens
.

**Government Response:**
Updated guidance will remind councils of the requirements set out in regulations that allow scrutiny members to access exempt or confidential documents in certain circumstances. As mentioned in response to the Select Committee's recommendation on guidance, the Department will also have discussions with the sector to get a better understanding of the issues some scrutiny committees appear to have in accessing information and whether there are any steps the Government could take to alleviate this.

In terms of service providers' attendance at meetings, when councils are tendering contracts with external bodies they should carefully consider including requirements to ensure they are as open and transparent as appropriate. Ultimately, however, it is up to each council to decide how best to hold to account those who run its services.

3.8 **Recommendation 7:**
The Government to make clear how LEPs are to have democratic, and publicly visible, oversight. We recommend that upper tier councils, and combined authorities where appropriate, should be able to monitor the performance and effectiveness of LEPs through their scrutiny committees. In line with other public bodies, scrutiny committees should be able to require LEPs to provide information and attend committee meetings as required.

**Government Response:**
The Government agrees on the importance of clear and transparent oversight of Local Enterprise Partnerships (LEPs). The Industrial Strategy made clear the continuing important role of LEPs in delivering local economic growth.

The MHCLG Non-Executive Director Review (published in October 2017), looked at a range of governance issues for LEPs. The Review made a series of recommendations that we have accepted in full and are now implementing. As part of this we have published guidance for LEPs on a range of issues including publication of agenda and papers for LEP Board meetings. This will make the proceedings of LEPs more transparent for local people.

The National Assurance Framework for LEPs states that democratic accountability for the decisions made by the LEP is provided through local authority leader membership of LEP Boards. In places where not all local authorities are represented directly on the LEP board it is important that their representatives have been given a mandate through arrangements which enable collective engagement with all local authority leaders. Many LEPs already go much further in allowing democratic scrutiny of their decision making.

The MHCLG Non-Executive Director Review into LEP governance and transparency explored the extent to which scrutiny was embedded into LEP decision making. The review acknowledged that each LEP had their own arrangements to reflect: legal structure, the complexity and needs of the locality and local requirements to ensure value for money; engagement; and democratic accountability. The Review concluded that it was not appropriate to be prescriptive on the specific arrangements that all LEPs needed to adopt due to the variation in LEP operating models.

The Government committed in the Industrial Strategy White Paper to reviewing the roles and responsibilities of LEPs and to bringing forward reforms to leadership, governance, accountability, financial reporting and geographical boundaries. Working with LEPs, the Government committed to set out a more clearly defined set of activities and objectives in early 2018. MHCLG will write to the Select Committee following the conclusion of this Ministerial review into LEPs to provide an update.

3.9 **Recommendation 8:**
We are concerned that effective scrutiny of the Metro Mayors will be hindered by under-resourcing, and call on the Government to commit more funding for this purpose. When agreeing further devolution deals

and creating executive mayors, the Government must make clear that scrutiny is a fundamental part of any deal and that it must be adequately resourced and supported.

**Government Response:**
The Government accepts this recommendation.

At the Budget it was announced that the government will make available to mayoral combined authorities with elected mayors a £12 million fund for 2018-19 and 2019-20, to boost the new mayors' capacity and resources. Combined Authorities could use some of this resource to ensure that scrutiny and accountability arrangements within the CAs are effectively resourced and supported.

Further to this, the recent Combined Authorities (Overview and Scrutiny Committees, Access to Information and Audit Committees) Order 2017, developed with assistance from the Centre for Public Scrutiny and the National Audit Office, provides for the rules of operation for local overview and scrutiny and audit committees to robustly hold combined authorities and mayors to account. The order ensures that there are strong scrutiny arrangements in place consistently across every combined authority area and sets out clear requirements, strengthened appropriately to match the new powers and budgets being devolved, for the arrangement of overview and scrutiny and audit committees in all combined authorities.

Combined authorities are subject to existing relevant legislation applying to local authorities, including the strong finance and audit requirements around ensuring value for money and sustainability. Local democratic accountability, including through the scrutiny of directly-elected mayors, is a crucial and fundamental aspect of devolution.

**4. Centre for Public Scrutiny Involvement**

It has been established from a recent County/Unitary Scrutiny Network meeting involving Ed Hammond at Centre for Public Scrutiny (CfPS), that CfPS are hoping to be commissioned to help the Government produce the updated statutory Scrutiny Guidance which was promised in the response to the CLG Select Committee's report on the Effectiveness of Local Authority Scrutiny. If so, CfPS will seek to obtain the views of a wide range of interested parties during the drafting stage and there may be the possibility for the Council's Overview and Scrutiny Management Board and Committees to contribute as part of the consultation phase.

House of Commons

Communities and Local Government Committee

# Effectiveness of local authority overview and scrutiny committees

## First Report of Session 2017–19

*Report, together with formal minutes relating to the report*

*Ordered by the House of Commons to be printed 11 December 2017*

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## Communities and Local Government Committee

The Communities and Local Government Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department for Communities and Local Government.

### Current membership

Mr Clive Betts MP *(Labour, Sheffield South East)* (Chair)

Mike Amesbury MP *(Labour, Weaver Vale)*

Bob Blackman MP *(Conservative, Harrow East)*

Helen Hayes MP *(Labour, Dulwich and West Norwood)*

Kevin Hollinrake MP *(Conservative, Thirsk and Malton)*

Andrew Lewer MP *(Conservative, Northampton South)*

Fiona Onasanya MP *(Labour, Peterborough)*

Mr Mark Prisk MP *(Conservative, Hertford and Stortford)*

Mary Robinson MP *(Conservative, Cheadle)*

Liz Twist MP *(Labour, Blaydon)*

### Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the internet via www.parliament.uk.

### Publication

Committee reports are published on the Committee's website at www.parliament.uk/clg and in print by Order of the House.

Evidence relating to this report is published on the inquiry publications page of the Committee's website.

### Committee staff

The current staff of the Committee are Edward Beale (Clerk), Jenny Burch (Second Clerk), Craig Bowdery, Tamsin Maddock, Nick Taylor (Committee Specialists), Tony Catinella (Senior Committee Assistant), Eldon Gallagher (Committee Support Assistant), Gary Calder and Oliver Florence (Media Officers).

### Contacts

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# Contents

# Summary

Overview and scrutiny committees were introduced by the Local Government Act 2000 and were tasked with acting as a counterweight to the increased centralised power of the new executive arrangements. Whilst some authorities were not covered by the changes brought in by the Act, the Leader and Cabinet system is the predominant model of governance in English local authorities. However, since the Localism Act 2011, councils have had the option of reverting to the committee system of governance. Some authorities that have chosen to do so have expressed dissatisfaction with the new executive arrangements, including concern at the limited effectiveness of scrutiny. Noting these concerns, and that there has not been a comprehensive assessment of how scrutiny committees operate, we decided to conduct this inquiry. The terms of reference placed an emphasis on considering factors such as the ability of committees to hold decision-makers to account, the impact of party politics on scrutiny, resourcing of committees and the ability of council scrutiny committees to have oversight of services delivered by external organisations.

We have found that the most significant factor in determining whether or not scrutiny committees are effective is the organisational culture of a particular council. Having a positive culture where it is universally recognised that scrutiny can play a productive part in the decision-making process is vital and such an approach is common in all of the examples of effective scrutiny that we identified. Senior councillors from both the administration and the opposition, and senior council officers, have a responsibility to set the tone and create an environment that welcomes constructive challenge and democratic accountability. When this does not happen and individuals seek to marginalise scrutiny, there is a risk of damaging the council's reputation, and missing opportunities to use scrutiny to improve service outcomes. In extreme cases, ineffective scrutiny can contribute to severe service failures.

Our inquiry has identified a number of ways that establishing a positive culture can be made easier. For example, in many authorities, there is no parity of esteem between the executive and scrutiny functions, with a common perception among both members and officers being that the former is more important than the latter. We argue that this relationship should be more balanced and that in order to do so, scrutiny should have a greater independence from the executive. One way that this can be achieved is to change the lines of accountability, with scrutiny committees reporting to Full Council meetings, rather than the executive. We also consider how scrutiny committee chairs might have greater independence in order to dispel any suggestion that they are influenced by partisan motivations. Whilst we believe that there are many effective and impartial scrutiny chairs working across the country, we are concerned that how chairs are appointed can have the potential to contribute to lessening the independence and legitimacy of the scrutiny process.

Organisational culture also impacts upon another important aspect of effective scrutiny: access of committees to the information they need to carry out their work. We heard about committees submitting Freedom of Information requests to their own authorities and of officers seeking to withhold information to blunt scrutiny's effectiveness. We believe that there is no justification for such practices, that doing so is in conflict with the

principles of democratic accountability, and only serves to prevent scrutiny committees from contributing to service improvement. We have particular concerns regarding the overzealous classification of information as being commercially sensitive.

We also considered the provision of staff support to committees. Whilst ensuring that sufficient resources are in place is of course important, we note that if there is a culture within the council of directors not valuing scrutiny, then focussing on staff numbers will not have an impact. We are concerned that in too many authorities, supporting the executive is the over-riding priority, despite the fact that in a time of limited resources, scrutiny's role is more important than ever. We also consider the skills needed to support scrutiny committees, and note that many officers combine their support of scrutiny with other functions such as clerking committees or executive support. It is apparent that there are many officers working in scrutiny that have the required skills, and some are able to combine them with the different skill set required to be efficient and accurate committee clerks. However, we heard too many examples of officers working on scrutiny who did not possess the necessary skills. Decisions relating to the resourcing of scrutiny often reflect the profile that the function has within an authority. The Localism Act 2011 created a requirement for all upper tier authorities to create a statutory role of designated lead scrutiny officer to promote scrutiny across the organisation. We have found that the statutory scrutiny officer role has proven to be largely ineffective as the profile of the role does not remotely reflect the importance of other local authority statutory roles. We believe that the statutory scrutiny officer position needs to be significantly strengthened and should be a requirement for all authorities.

We believe that scrutiny committees are ideally placed and have a democratic mandate to review any public services in their area. However, we have found that there can sometimes be a conflict between commercial and democratic interests, with commercial providers not always recognising that they have entered into a contract with a democratic organisation with a necessity for public oversight. We believe that scrutiny's powers in this area need to be strengthened to at least match the powers it has to scrutinise local health bodies. We also call on councils to consider at what point to involve scrutiny when it is conducting a major procurement exercise. It is imperative that council executives involve scrutiny at a time when contracts are still being developed, so that all parties understand that the service will still have democratic oversight despite being delivered by a commercial entity. We also heard about the public oversight of Local Economic Partnerships (LEPs), and have significant concerns that public scrutiny of LEPs seems to be the exception rather than rule. Therefore, we recommend that upper tier councils, and combined authorities where appropriate, should be able to monitor the performance and effectiveness of LEPs through their scrutiny committees.

We recognise that the mayoral combined authorities are in their infancy, but given the significance of organisational culture in effective scrutiny, it is important that we included them in our inquiry to ensure that the correct tone is set from the outset. We are therefore concerned by the evidence we heard about an apparent secondary role for scrutiny in combined authorities. Mayors are responsible for delivering services and improvements for millions of residents, but oversight of their performance is currently hindered by limited resources. We therefore call on the Government to ensure that funding is available for this purpose. We also argue that when agreeing further

devolution deals and creating executive mayors, the Government must make it clear that scrutiny is a fundamental part of any deal and must be adequately resourced and supported.

# Introduction

1. This inquiry was initially launched in January 2017 by our predecessor committee. However, the dissolution of Parliament and the General Election prevented any oral evidence sessions from taking place. Following the Committee's reconstitution, we considered carefully which issues we should initially pursue in our work and how best we could build on the work of our predecessors. It was clear to us from the level of interest and concern expressed in the evidence received that the effectiveness of overview and scrutiny committees in local authorities was something that we should investigate as an immediate priority. We therefore relaunched the inquiry in September 2017 and undertook to take account of the wealth of written evidence provided by councils, officers, members and stakeholders prior to the election.

2. We are extremely grateful to everyone who contributed to our inquiry. Scrutiny varies significantly across the country, and the level of interest in the inquiry has enabled us to hear from a wide range of authorities and form a representative picture of local authority scrutiny in England. To assist us in forming this picture, and to ensure we spoke with as many authorities as possible, we supplemented our oral evidence sessions with a less formal workshop event in October 2017. Our workshop was attended by over 45 councillors and officers working in scrutiny across the country and we thank them all for their attendance and contributions.

3. This report will consider why scrutiny is important and what the role of scrutiny committees should be in local authorities. We do not believe that certain models should be imposed on councils, but we do believe that there should be an organisational culture that welcomes constructive challenge and has a common recognition of the value of scrutiny, both in terms of policy development and oversight of services. In order to achieve this, we believe that scrutiny committees must be independent and able to form their own conclusions based on robust and reliable data, and that decision-makers should not seek to obstruct their role by withholding information. We also consider the role of the public in local scrutiny, both in terms of their participation in committees' work and in how scrutiny committees can represent their interests to service providers, even when those providers are external commercial organisations. The final chapter of this report considers the role of scrutiny in the recently created mayoral combined authorities in an attempt to help these organisations to establish positive working practices as early as possible. Throughout this report we call on the Government to revise the guidance on scrutiny that it issues local authorities. For clarity, the specific points that we believe should be covered by such a revision are listed below.

## Proposed revisions to Government guidance on scrutiny committees

- That overview and scrutiny committees should report to an authority's Full Council meeting rather than to the executive, mirroring the relationship between Select Committees and Parliament.
- That scrutiny committees and the executive must be distinct and that executive councillors should not participate in scrutiny other than as witnesses, even if external partners are being scrutinised.
- That councillors working on scrutiny committees should have access to financial and performance data held by an authority, and that this access should not be restricted for reasons of commercial sensitivity.
- That scrutiny committees should be supported by officers that are able to operate with independence and offer impartial advice to committees. There should be a greater parity of esteem between scrutiny and the executive, and committees should have the same access to the expertise and time of senior officers and the chief executive as their cabinet counterparts.
- That members of the public and service users have a fundamental role in the scrutiny process and that their participation should be encouraged and facilitated by councils.

# 1 The role of scrutiny

4. Before considering whether scrutiny committees are working effectively, it is important to consider what their role is and what effective scrutiny looks like. Local authorities are currently facing a number of challenges and competing demands, from an ageing population to budget shortfalls to promoting local growth in an often-hostile economic environment. It is therefore imperative that all expenditure is considered carefully and its impact is measured. However, measuring the impact of overview and scrutiny committees can be a significant challenge. Whilst identifying 'good' scrutiny is not always possible, the consequences of ineffectual scrutiny can be extreme and very apparent.

5. The Francis Report[1] was published in 2013 following failings at the Mid Staffordshire NHS Trust. Whilst the failings were not attributed to local committees, the report was critical of local authority health scrutiny, highlighting a lack of understanding and grip on local healthcare issues by the members, little real interrogation and an over-willingness to accept explanations. Similarly, the Casey Report[2] in 2015 on Rotherham Council cited particular failings in Rotherham's approach to scrutiny, noting that "Inspectors saw regular reports to the Cabinet and Scrutiny committees, but not the effective challenge we would expect from elected Members."[3] The report also found that scrutiny had been undermined by an organisational culture that did not value scrutiny and that committees were not able to access the information they needed to hold the executive to account. Mid Staffordshire and Rotherham are two of the most high-profile failures of overview and scrutiny committees, but the issues raised in the two reports can easily occur in other local authorities, and we consider some of them in this report.

6. Overview and scrutiny committees were created by the Local Government Act 2000 and were designed to off-set increased centralised power established by the new executive arrangements. The Act replaced the committee system whereby decisions were made either by meetings of the full council or in cross-party committees which managed council services. For proponents of the committee system, one of its strengths was that all members had an active role in decision-making. However, as Professor Colin Copus from De Montfort University told us, it was "an illusion of power. If you put your hands up at the end of a meeting you feel, "I am powerful. I am making something happen". I am sure I am not giving any trade secrets away, but most of those decisions are made two nights before in the majority party group meetings."[4] With the exception of councils with a population under 85,000, the 2000 Act created a requirement for authorities to establish an executive of a leader, or elected mayor, and cabinet members.[5] Mirroring the relationship between Parliament and government, the Act also required the non-executive members of councils to scrutinise the executive by creating at least one overview and scrutiny committee.

1 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, HC947, February 2013
2 Report of Inspection of Rotherham Metropolitan Borough Council, HC1050, February 2015
3 Report of Inspection of Rotherham Metropolitan Borough Council, HC1050, February 2015 p65
4 Q38
5 There was also initially an option for Mayor and council manager executive, but this was later repealed. Smaller authorities were able to retain the committee system, as long as there was at least one overview and scrutiny committee. The Localism Act 2011 extended this option to all authorities, but the requirement of a designated scrutiny committee was removed.

However, beyond some statutory requirements (for example designating committees to scrutinise health bodies, crime and disorder strategies, and flood risk management), how councils deliver scrutiny is a matter of local discretion.

7. Some councils have multiple committees that broadly align with departmental functions, while others have fewer formal committees but make greater use of time-limited task and finish groups. Similarly, as the Centre for Public Scrutiny (CfPS) identifies, different councils use different labels for their scrutiny work, including "select committees, policy development committees, or a number of other names. The use of different terminology can prove confusing [but] This is probably a good thing–it reflects the fact that scrutiny has a different role in different places, which reflects local need rather than arbitrary national standards".[6] Throughout this report references to 'scrutiny' and 'scrutiny committees' mean all committees and work associated with the overview and scrutiny committees required by the Local Government Act 2000.

8. Whilst acknowledging that scrutiny fulfils different roles in different areas, we believe that at its best, scrutiny holds executives to account, monitors decisions affecting local residents and contributes to the formation of policy. We therefore support CfPS's four principles of good scrutiny, in that it:

- Provides a constructive "critical friend" challenge;
- Amplifies the voices and concerns of the public;
- Is led by independent people who take responsibility for their role;
- Drives improvement in public services.[7]

9. We believe that as well as reacting to decisions and proposals from local decision makers, effective scrutiny can also be proactive and help to set a policy agenda. For example, Birmingham City Council's Education and Vulnerable Children Overview and Scrutiny Committee carried out a review of the council's work to tackle child sexual exploitation. As a result of the Committee's work, the executive responded and addressed the issues raised:

> The committee heard much harrowing evidence but produced a hard hitting report containing 19 strong recommendations. As a result of the report extra resources were allocated to the team co-ordinating CSE on behalf of the city. The council also undertook to strengthen its approach to safeguarding children by reviewing its statement of licensing and being more pro-active in using its executive powers of "the protection of children from harm".[8]

10. Pre-decision scrutiny is also a vital part of a committee's role. By commenting on and contributing to a decision before it has been made, scrutiny committees are able to offer executives the benefit of their ability to focus on an issue in greater depth over a longer period of time. For example, the London Borough of Merton's Children and Young People Overview and Scrutiny Panel considered a site proposal for a new secondary school. As a

6 Centre for Public Scrutiny (OSG098) para 6
7 Centre for Public Scrutiny (OSG098) para 38
8 Birmingham City Council (OSG087) part 3

result of its work, the Panel was "able to provide a detailed reference to Cabinet focusing on how to optimise use of the selected site and mitigate any negative impact", helping the Cabinet to make a more informed and considered decision.[9]

11. The role of scrutiny has evolved since its inception. The 2000 Act empowers committees to review decisions made by the executive and to make reports and recommendations for the executive's consideration. In the seventeen years since, the way in which scrutiny committees perform their function has understandably changed. One such way has been an increase in scrutiny of external bodies, most notably health bodies. Councils have delivered services through increasingly varied partnership arrangements - including contracting to private companies, creating arms-length bodies or working with other public bodies - and scrutiny has responded by adjusting how it scrutinises the issues that matter to local residents. The Department for Communities and Local Government (DCLG) highlights that "To support local councils adopting good practice, the Department for Communities and Local Government issues statutory guidance, to which councils must have regard when developing their localist scrutiny arrangements."[10] This guidance was last issued in 2006[11] and predates several legislative changes as well as changes to ways of working such as an increasing focus on external scrutiny and public participation (both discussed later in this report). When we asked Marcus Jones MP, Minister for Local Government, about the guidance, he told us:

> It has been some time since we looked at the guidance on scrutiny … The initial evidence that you have taken indicates that in many places scrutiny is working well, but there are also instances in which overview and scrutiny committees could improve. It is therefore important that once we see the outcome of this Committee in the report that you provide, I take those recommendations very seriously. If there are areas where it is sensible and pertinent to update the guidance, we will certainly consider that.[12]

12. We welcome the Minister's willingness to consider our recommendations carefully. We believe that there are many instances across the country where scrutiny committees are operating effectively and acting as a voice for their communities, however there remains room for improvement for too many and we believe that updated guidance from the Department is long overdue. ***We therefore recommend that the guidance issued to councils by DCLG on overview and scrutiny committees is revised and reissued to take account of scrutiny's evolving role.***

13. Throughout our investigations, we heard about a range of positive examples of effective scrutiny, some of which we have referenced in this report. ***We call on the Local Government Association to consider how it can best provide a mechanism for the sharing of innovation and best practice across the scrutiny sector to enable committees to learn from one another. We recognise that how scrutiny committees operate is a matter of local discretion, but urge local authorities to take note of the findings of this report and consider their approach.***

9 London Borough of Merton (OSG037) page 12
10 Department for Communities and Local Government (OSG122) para 5
11 Department for Communities and Local Government, *New council constitutions: guidance to English Authorities* (May 2006)
12 Q111

# 2 Party politics and organisational culture

## Organisational culture

14. As discussed above, councils across the country deliver scrutiny in a wide range of different ways. We are of the view that whichever model of scrutiny a council adopts it is far less important than the culture of an organisation. Council leaders, both politicians and officials, have a responsibility to set the tone and create an environment that welcomes constructive challenge and democratic accountability. Jacqui McKinlay from the CfPS explained to us:

> If you have buy-in to scrutiny at the top of the organisation—that is the leader, the cabinet and the chief executive—it tends to follow that scrutiny is resourced … However, if you do not get buy-in to a scrutiny approach—that openness and transparency and the willingness to be questioned, seeing the value of scrutiny—it tends to follow that it is not resourced as well and you do not get that parity of esteem … If your leadership is closed to that sort of challenge, it does not just affect scrutiny; it affects a lot of how the organisation is run.[13]

15. The Minister for Local Government echoed this view when he told us:

> I think that where scrutiny is done properly in local authorities that have the right culture, and where scrutiny is taken seriously, it can perform an excellent function in relation to how the executive works by holding them to account and putting them in a position where they probably make decisions that are more in the interests of the people they represent and local residents than they otherwise might be.[14]

16. All of the examples of effective scrutiny that we have heard about have in common an organisational culture whereby the inherent value of the scrutiny process is recognised and supported. Senior councillors and officers that seek to side-line scrutiny can therefore miss out on the positive contributions that scrutiny is capable of, and put at risk a vital assurance framework for service delivery. The Nottingham City Council Overview and Scrutiny Committee explains that:

> there can be a perception that overview and scrutiny is an 'add on' rather than an integral part of the organisation's governance arrangements… [with the executive arrangements] there can be a tendency for council officers to feel that they are primarily accountable to one councillor which risks overlooking the important role of other councillors, including those engaged in scrutiny activities, within the decision making structure. As a result the function is not always afforded the prominence it deserves and opportunities to make the most of its potential can be missed.[15]

13 Q15
14 Q109
15 Nottingham City Council Overview and Scrutiny Committee (OSG024) para 1.3

## The relationship between scrutiny and the executive

17. We are concerned that the relationship between scrutiny and the executive has a tendency to become too unbalanced. With decision-making powers centralised in the executive, scrutiny can be seen as the less-important branch of a council's structure. Professor Copus highlighted that there is no parity of esteem in the eyes of many councillors:

> One of the things I have noted in all of the work I have done on scrutiny since 2002 is I have only ever once come across a councillor who said, "If you offered me a place in the cabinet, I would reject it. I want to stay a chair of scrutiny". I am sure there are more than the one I have met, but that is an indication.[16]

18. Professor Copus argued that this imbalance in esteem is also reflected in council officers:

> I found many officers will know the council leader's name and the name of the portfolio-holder for their particular area of interest, but they might not know the scrutiny chairperson's name. Once you start to see that, you see the whole thing begin to crumble.[17]

19. If neither councillors or officers explicitly recognise the importance of the scrutiny function, then it cannot be effective. Part of the challenge lies in identifying what effective scrutiny actually looks like, as discussed earlier in this report, as councils are more likely to allocate diminishing resources to functions where there can be a quantifiable impact. **However, all responsible council leaderships should recognise the potential added value that scrutiny can bring, and heed the lessons of high profile failures of scrutiny such as those in Mid Staffordshire and Rotherham.**

20. Council leaderships have a responsibility to foster an environment that welcomes constructive challenge and debate. However, opposition parties also have a key role to play in creating a positive organisational culture. We agree with the Minister who told us that:

> At the end of the day, if an opposition takes a reasonable view on these things and treats the executive with respect, but challenges them when challenge is necessary, rather than just for the sake of challenge, I think you can get to a situation where you have—not much of an agreement politically, probably, but there could be mutual respect. That would serve the scrutiny function well.[18]

## The role of Full Council

21. Parliamentary select committees have a well-established independence from the executive in that they do not report to the Government, but to the House of Commons as a whole. In contrast, it is less clear where local authority scrutiny committees report to, with most reporting to the executive that they are charged with scrutinising. The Institute

16 Q4
17 Q15
18 Q137

of Local Government Studies (INLOGOV) at the University of Birmingham argues that it should be made clear in guidance that scrutiny reports and belongs to Full Council, not the executive:

> As of now, most scrutiny committees report to the Executive–with only some inviting the scrutiny chair and members who have written a report to present it. A few present reports to the full council. When they do so, this has the opportunity to create a relevant and interesting debate on a matter of local concern which has been investigated in depth by a group of councillors. Such a debate enables other councillors to see what scrutiny has done, and to add their own experiences. Councils should be required to have Reports from scrutiny on all council agendas.[19]

22. Cllr Mary Evans told us that she welcomed the suggestion that scrutiny should be accountable to Full Council.[20] We also heard from Cllr John Cotton from Birmingham City Council, whose scrutiny committees do report to Full Council. He told us that:

> speaking from Birmingham's perspective, due to the fact that everything reports through to full council we have been able to preserve some of that independence of approach, but from the conversations I have been having that certainly needs to be echoed in other authorities.[21]

23. ***To reflect scrutiny's independent voice and role as a voice for the community, we believe that scrutiny committees should report to Full Council rather than the executive and call on the Government to make this clear in revised and reissued guidance. When scrutiny committees publish formal recommendations and conclusions, these should be considered by a meeting of the Full Council, with the executive response reported to a subsequent Full Council within two months.***

## The impact of party politics

24. Scrutiny committees must have an independent voice and be able to make evidence-based conclusions while avoiding political point-scoring. In order to do this, they need to be sufficiently resourced, have access to information (both discussed in greater detail below) and operate in an apolitical, impartial way. Committees of local councillors will always be aware of party politics, but sometimes this can have too great an influence and act as a barrier to effective scrutiny. Jacqui McKinlay from the CfPS told us that "We often say that local government scrutiny is a perfect system until you add politics to it. In our last survey, 75% of people say that party politics affects scrutiny."[22] Professor Copus also recognised the party-political dynamic to scrutiny when he described to us:

> members from opposing political parties, one seeing their role as using scrutiny to attack the executive and the other seeing it as a forum in which to defend the executive. If that is the interaction, you are not going to get executive accountability … In terms of a lot of the issues that are problematic for overview and scrutiny, the interplay of party politics is often at the

19 Institute of Local Government Studies, The University of Birmingham (OSG053) page 6
20 Q68
21 Q68
22 Q12

> heart of it. I will quite often hear councillors, even from majority groups, admitting that one of the reasons scrutiny is not as effective as it can be is because of the relationship between the opposing groups.[23]

25. The Local Government Act 2000, and the guidance issued by DCLG, specifies that members of a council's executive cannot also be members of overview and scrutiny committees. A Private Members' Bill in 2009[24] made provisions to allow executive members to sit on committees during scrutiny of external bodies (on the basis that in such instances, it was not the executive that was being scrutinised). The Bill did not pass through the House of Commons, and we are wary of any such attempts to dilute the distinction between executive and scrutiny functions. We heard of instances at the workshop of executive councillors effectively chairing scrutiny committee meetings where the NHS was under scrutiny, and are concerned by such practices. **We believe that executive members should attend meetings of scrutiny committees only when invited to do so as witnesses and to answer questions from the committee. Any greater involvement by the executive, especially sitting at the committee table with the committee, risks unnecessary politicisation of meetings and can reduce the effectiveness of scrutiny by diminishing the role of scrutiny members. *We therefore recommend that DCLG strengthens the guidance to councils to promote political impartiality and preserve the distinction between scrutiny and the executive.***

## Committee chairing arrangements

26. Political impartiality can also be encouraged through the process for appointing chairs of committees. Overview and scrutiny committees are required to have a membership that reflects the political balance of a local authority, but there are a range of different approaches for appointing the chairs and vice chairs of committees. Many authorities specify that committee chairs must come from opposition parties, others allocate chair positions proportionally among the parties on the council and others reserve all committee chair positions for the majority party. The Centre for Public Scrutiny states that:

> Legally, the Chairing and membership of overview and scrutiny committees is a matter for a council's Annual General Meeting in May. Practically, Chairing in particular is entirely at the discretion of the majority party. Majority parties can, if they wish, reserve all committee chairships (and vicechairships) to themselves … the practice of reserving all positions of responsibility to the majority party is something which usually happens by default, and can harm perceptions of scrutiny's credibility and impartiality.[25]

27. Chairs from a majority party that are effectively appointed by their executive are just as capable at delivering impartial and effective scrutiny as an opposition councillor, but we have concerns that sometimes chairs can be chosen so as to cause as little disruption as possible for their Leaders. **It is vital that the role of scrutiny chair is respected and viewed by all as being a key part of the decision-making process, rather than as a form of political patronage.**

23 Q12
24 Local Authorities (Overview and Scrutiny) Bill 2009–10
25 Centre for Public Scrutiny (OSG098) paras 130–132

28. Cllr Mary Evans, chair of the scrutiny committee at Suffolk County Council, told us of her efforts to keep party politics out of scrutiny as a chair from a party with a sizeable majority: "We do it by involving the membership of the scrutiny committee at every point of an inquiry … we had a workshop just after our elections in May to look at what our forward work programme would be. The membership together has picked the programme."[26] When asked whether the size of her party's majority made this easier, Cllr Evans explained that "When I first chaired scrutiny, in 2015, we had a majority of only one. I wanted to work across the committee. I did not have the luxury of a large majority … We try to be as open and transparent as scrutiny should be, so the membership is engaged and involved in every aspect of the inquiry."[27] Cllr John Cotton, lead scrutiny member at Birmingham City Council, is also a scrutiny chair from a majority party and he told us that whilst it is important to acknowledge the role of party politics, scrutiny works best when non-partisan:

> In terms of the discharge of the scrutiny function, certainly we proceed on a very non-partisan basis. All of our full scrutiny reports go to full council. I can only recall one occasion in the last 15 years where we have had a minority report because there has been a partisan division. Frequently those reports are moved by the chair and seconded by a member from an opposition party. You then have collective ownership of those recommendations, because they are taken by full council. The scrutiny process draws its strength from the fact that we have those inputs from members across the piece … There is a little bit of grit in the system, if you like, which comes from the party-political roots of members, which you do not want to remove entirely.[28]

29. Cllr Sean Fitzsimons, chair of the Scrutiny and Overview Committee at Croydon Council, echoed this view when he told us that as a chair from a majority party that made critical recommendations of his executive "you have to go along with it if you believe that scrutiny is a function of the backbenches and that you have to put aside your party loyalties in the short term."[29] However, Cllr Fitzsimons argued that scrutiny is at risk of becoming more partisan and that the process for choosing a chair needed consideration:

> My worry is that, as people have drifted away, over time, from what the original aspect of overview and scrutiny was, party politics have played a greater role. If I was looking at this issue, I would look at the political culture of each political party. In the Labour group, under the standing orders of the national party, [scrutiny chairs are] not appointed by the leadership of the Labour group, so I am independent of my leader, so I have a little bit of leeway. My two best chairs that I ever had from the opposition group were so good at scrutiny that they were sacked by their political leader when he was in power. Within the Conservative group, chairs of scrutiny can be appointed effectively by the leader of the council or by the cabinet, and I do think the political cultures of the parties really influence it.[30]

26 Q65
27 Q66
28 Q66
29 Q66
30 Q66

30. **We believe that there are many effective and impartial scrutiny chairs working across the country, but we are concerned that how chairs are appointed has the potential to contribute to lessening the independence of scrutiny committees and weakening the legitimacy of the scrutiny process. Even if impropriety does not occur, we believe that an insufficient distance between executive and scrutiny can create a perception of impropriety.** We note, for example, the views of the Erewash Labour Group:

> The Scrutiny Committee in this Authority protects the Executive rather than holding them to account. If they are ever held to account it is within the privacy of their own Political Group Meetings which are not open to the public. Most of the important decisions are first made in the Group Meetings … The opposition have made some very sensible suggestions during Scrutiny debates only to be told "We have already decided this." Cabinet Members may not attend Scrutiny Meeting unless by the invitation of the Chair. This rule was brought in to stop Cabinet Members exerting any undue pressure on members by their presence. Now they simply exert pressure in other ways such as by the choice of member selection and also the selection of the chair.[31]

31. It is clear to us that scrutiny chairs must be seen to be independently minded and take full account of the evidence considered by the committee. We note the evidence from the Minister who outlined the Government's prescription that chairs of scrutiny in the new mayoral combined authorities must be from a different political party to the executive mayor in order to encourage effective challenge.[32] Similarly Newcastle City Council where all scrutiny chairs are opposition party members, states that:

> This has taken place under administrations of different parties and we believe that it adds to the clout, effectiveness and independence of the scrutiny process; it gives opposition parties a formally-recognised role in the decision-making process of the authority as a whole, more effective access to officers, and arguably better uses their skills and expertise for the benefit of the council.[33]

32. In 2010, recommendations from the Reform of the House of Commons Committee's report 'Rebuilding the House'[34] were implemented to change the way Parliament worked. One such recommendation was the introduction of elections for select committee chairs by a secret ballot of all MPs. In 2015, the Institute for Government published an assessment of parliamentary select committees and their impact in the 2010–15 Parliament. The report found that electing chairs had helped select committees to grow in stature and be more effective:

> Every chair we spoke to told us that, since the introduction of elections for committee chairs, they had felt greater confidence and legitimacy in undertaking committee work because they knew they had the support of their peers rather than pure political patronage.[35]

31 Erewash Labour Group (OSG013) page 1
32 Q131
33 Newcastle City Council (OSG015) para 10
34 Reform of the House of Commons Select Committee, First Report of Session 2008–09, *Rebuilding the House*, HC1117
35 Institute for Government, *Select Committees under Scrutiny: The impact of parliamentary committee inquiries on government* (June 2015), page 34

33. The positive impact of elected chairs for parliamentary committees has led some to suggest that local authority scrutiny chairs should also be elected by their peers. Under such a system scrutiny chairs, regardless of whether they come from the majority party or the opposition, are more likely to have the requisite skills and enthusiasm for scrutiny by virtue of the election process. Electing chairs would also dispel the notion that being appointed scrutiny chair is a consolation prize for members not appointed to the cabinet. The CfPS argue that:

> such a process would encourage those seeking nomination and election as chairs to set out clearly how they would carry out their role; it would also mean that they would be held to account by their peers on their ability to do so. The legitimacy and credibility that would come from this election could also embolden chairs to act more independently[36]

34. When we asked the Minister about the prospect of electing scrutiny chairs, he was concerned that doing so could actually increase political pressures, but stated that "The important thing is that we have the right person chairing a scrutiny committee with the requisite skills, knowledge and acumen to take on the functions and achieve the outcomes that the scrutiny committee needs to achieve."[37]

35. **We believe that there is great merit in exploring ways of enhancing the independence and legitimacy of scrutiny chairs such as a secret ballot of non-executive councillors. However, we are wary of proposing that it be imposed upon authorities by government.** ***We therefore recommend that DCLG works with the LGA and CfPS to identify willing councils to take part in a pilot scheme where the impact of elected chairs on scrutiny's effectiveness can be monitored and its merits considered.***

36 Centre for Public Scrutiny (OSG098) para 133
37 Q138

# 3 Accessing information

36. Fostering the positive organisational culture discussed in the previous chapter can also determine another important aspect of effective scrutiny: access to information. When we asked Jacqui McKinlay whether scrutiny committees are able to access the information they need, she told us that:

> The very determined ones can. I met one last week that had put an FOI request in to its own organisation in order to get the information. You should not have to do that, but there are ways there. There needs to be persuasion and influence in order to say, "This is an issue around flooding", or whatever it might be, "that is really important".[38]

37. **Scrutiny committees that are seeking information should never need to be 'determined' to view information held by its own authority, and there is no justification for a committee having to resort to using Freedom of Information powers to access the information that it needs, especially from its own organisation. There are too many examples of councils being uncooperative and obstructive.** For example a submission from a spouse of a scrutiny chair argues that it can seem to not be in council officers' interests to divulge information freely:

> There is an element of 'siloism' within the Authority whereby Directors or Heads of Service do not release, explain or otherwise divulge their operational objectives, strategies or tactics for fear of being challenged. This makes it almost impossible to scrutinise, for after all how can one scrutinise what you don't know? There is also a reluctance by officers to divulge operational (in)efficiencies in case it shows that there is an excess of staff ratios for particular tasks. It leads to obfuscation of such measures in order to protect their fiefdom.[39]

38. Similarly, the Minister told us of the example of an authority to which he used to belong and how culture can affect councillors' ability to scrutinise:

> When I was in opposition on the district authority of which I was a member, the controlling group at the time had this unfortunate situation where they used to bring out their budget at the budget-setting council in March. They used to bring it out through the cabinet at 4 o'clock. That mini-meeting used to finish at 5 and then we used to go straight into the full council at 6 to approve the budget. Where you have that type of culture, even if you have resource and access to information, you are not going to get the outcomes that are in people's best interests.[40]

39. Professor Copus highlighted to us another challenge for scrutiny committees seeking to understand an issue:

> I often think, "If someone is willing to give you something you have just asked for, what are they hiding? Why are they being overly enthusiastic?" It is because it is not causing them any problems. The information that

38 Q31
39 Anonymous submission (OSG006)
40 Q119

> scrutiny really needs is the stuff that people are a little bit more reluctant to hand over, whether that is the council itself or an external body. I hear quite often … of councillors using FOIs against their own council for the want of any other way. It is a sign of an immense frustration among members that they have to do that.[41]

## Commercial confidentiality

40. A particular challenge for councillors wishing to access information in order to scrutinise an issue is related to commercial confidentiality. Jacqui McKinlay told us that "Every councillor I meet will talk about the barrier of commercial confidentiality. They will talk about, "We cannot give that information" and a lack of transparency."[42] Local authorities are required by statute to publish all information relating to decisions taken and service delivery, however there are certain categories of information that they can withhold. For example information relating to an individual's circumstances is considered exempt, as is information relating to the financial or business affairs of any particular person - including the authority holding that information. As a consequence, many councils argue that publicly releasing specific details of a contract or a procurement framework such as cost or the details of rival bidders for a contract are withheld on the basis that such information is commercially sensitive and exempt from the access to information rules. Professor Copus told us that:

> Commercial confidentiality is always another cloak behind which people who do not want to provide information can hide. There is a need for a much tighter definition of what is acceptable as an exemption for commercial confidentiality. It is not just not wanting to tell somebody what they have asked you. There needs to be a much tighter definition for scrutiny purposes.[43]

41. Whilst we acknowledge that it is not always in the public interest for local authorities to publish all information and make it available to the public, we cannot see a justification for withholding such information from councillors. Councillors have regular access to exempt or confidential information, often distinguished on agendas by use of different colour paper. As Cllr Marianne Overton told us, "Councils are used to dealing with confidential information, and we recognise if it is on pink paper it is confidential. There is no question about it. There should not be any problem with sharing information with elected members. We are already under rules."[44] **Councils should be reminded that there should always be an assumption of transparency wherever possible, and that councillors scrutinising services need access to all financial and performance information held by the authority.**

42. Legislation dictates what information should and should not be released to councillors. Regulations in 2012[45] clarified the position and granted additional access rights to members of overview and scrutiny committees. The Regulations state that

41 Q32
42 Q30
43 Q32
44 Q32
45 The Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 (SI2089)

scrutiny members can access any confidential material if they can demonstrate a 'need to know' in that it relates to any action or decision that that member is reviewing or scrutinising, or on any subject included on a scrutiny work programme. **We do not believe that there should be any restrictions on scrutiny members' access to information based on commercial sensitivity issues. Limiting rights of access to items already under consideration for scrutiny limits committees' ability to identify issues that might warrant further investigation in future, and reinforces scrutiny's subservience to the executive.** ***Current legislation effectively requires scrutiny councillors to establish that they have a 'need to know' in order to access confidential or exempt information, with many councils interpreting this as not automatically including scrutiny committees. We believe that scrutiny committees should be seen as having an automatic need to know, and that the Government should make this clear through revised guidance.***

## Getting data from multiple sources and external advisors

43. Council officers are the primary source of information for many committees, however if they do not present the full picture, then those committees can get very limited assurances about the service they are scrutinising. Whilst scrutiny should be able have access to whatever information it needs, this also serves to emphasise the importance of scrutiny committees seeking to use data from multiple sources and challenge that which they are told. Professor Copus described to us how effective scrutiny should operate:

> In some councils … they are too reliant on officers and too reliant on a single source of advice. In too many councils the flexibility that scrutiny has over the committee system is not used … sometimes, when you examine scrutiny agendas and scrutiny reports, and observe scrutiny meetings, what you see is a committee, and a one-off event that leads to not very much. In other councils, those that have really supported and understood scrutiny, you get a process … Where you get scrutiny viewed as not a single event but a process, then the outcomes are much more effective, and there is a greater access to a wider range. What scrutiny should be doing is not taking one source of evidence and going, "That is from the officers. Great. That is okay. We agree the recommendations". They should be looking at conflicting evidence. There is always conflicting evidence with big policy issues. They need to sift that evidence.[46]

44. Cllr Marianne Overton, Leader of the Independent Group of the LGA, agreed that effective committees seek to triangulate data to build a fuller picture: "That is part of what scrutiny is about … one of the issues about scrutiny is that the whole point is that you can call all kinds of different witnesses … You are not just sitting, looking at the papers that you have been fed."[47] We are concerned that too many committees are overly reliant upon the testimonies of council officers, and that they do not make wider use of external witnesses. Very few councils have the resources to provide independent support to both the executive and scrutiny, and in light of the uneven balance between the two functions discussed earlier, most resources are prioritised upon the executive. This means that officers working in a service department are supporting executive members to develop and implement decisions, and the same officers are then supporting scrutiny committees as

46 Q28
47 Q28

they seek to understand the impact of decisions and performance of departments. Whilst departmental officers may be able to distinguish the two roles and cater their support accordingly, we are concerned that too few councils are hearing alternative perspectives. However, we acknowledge that councils are operating on reduced budgets and that making use of specialist advisors can come at too high a cost for many committees. The LGA explains that:

> Employing specialist external advice as part of oversight and scrutiny arrangements is not common … Where councils do bring in external experts, it is because specific knowledge and skills are needed that are not available in house. Procuring specialist advice comes at a cost and, given the pressures on council budgets, not all committees have funding available to increase their standard staffing compliment, commission professional advice, secure external witnesses or even refresh recruitment of co-optees.[48]

45. We are disappointed that committees do not make greater use of expert witnesses. At the informal workshop event hosted by the Committee, we spoke with councillors and officers on their use of experts such as local academics. One attendee told us that it could sometimes be possible to engage a local academic at the start of an inquiry to help members understand an issue, but it was seldom possible to sustain this engagement throughout the life of an inquiry. ***We note that few committees make regular use of external experts and call on councils to seek to engage local academics, and encourage universities to play a greater role in local scrutiny.***

## Service users' perspective and public experiences

46. While recognising the constraints that committees operate under, we believe that it is possible to bring in a wider range of perspectives for limited expenditure, and that the benefits of doing so are significant. We note, for example, the case study presented by the LGA of Brighton & Hove City Council's scrutiny panel on equality for the transgender community:

> The panel's review was underpinned by an effective and sensitive engagement strategy enabling the views of a hard to reach community to inform recommendations for action. The panel worked in partnership with the Council's Communities team, the city's LGBT Health Improvement Partnership, and a local charity which supported transgender people, co-opting experts to help better inform the process, and directly engaging through community events and specially designed workshops. A significant amount of time was devoted to the consultation process which was pivotal in helping to build up trust. The Panel's findings were well received by the transgender community and partners, with all 37 recommendations adopted by the Cabinet.[49]

47. Bringing in the perspectives of service users undoubtedly leads to more effective scrutiny, both in developing policy such as the example from Brighton & Hove and in monitoring services. Officers from the London Borough of Hackney described an example of effective scrutiny in their monitoring of services for disabled children in the borough.

48 Local Government Association (OSG081) paras 10.1–10.3
49 Local Government Association (OSG081) paras 13.8 – 13.10

Rather than only using the testimony of the council officers delivering the service, "A major part of the evidence base for this review was the views of parents and carers of disabled children, as well as disabled children and young people themselves about the services they receive and the barriers they face in accessing current services."[50] **We commend such examples of committees engaging with service users when forming their understanding of a given subject, and encourage scrutiny committees across the country to consider how the information they receive from officers can be complemented and contrasted by the views and experiences of service users.**

50 Overview and Scrutiny team, London Borough of Hackney (OSG110) page 9

# 4 Resources

## Reducing council budgets

48. Local government has experienced significant reductions in funding in recent years, leading many authorities to choose to reduce their scrutiny budgets. Whilst understandable in the context of wider reductions, it is regrettable that the resources allocated to scrutiny have decreased so much. The Centre for Public Scrutiny (CfPS) explains that:

> There are now significantly fewer "dedicated" scrutiny officers employed by English councils. In 2015 this dropped below one full time equivalent officer post providing policy support to scrutiny per council. In many councils, there might be only 0.2 or 0.3 FTE to carry out this role–or nothing at all. (We would describe a "dedicated" scrutiny officer as one whose sole duties involve providing policy advice to scrutiny councillors.)[51]

49. Cllr John Cotton from Birmingham City Council also described a significant reduction in resources in recent years:

> if I look at staffing for scrutiny in Birmingham, if we go back to 2010–11, we had 19.4 full-time equivalent staff. We are now working with 8.2, so there has clearly been a substantial reduction and we have seen a similar reduction in the number of committees and so forth … it does come back to this issue that, if you value something, you have to invest in it.[52]

50. Birmingham City Council explain that this reduction in resources has matched a reduction in the amount of scrutiny carried out:

> Birmingham has had five standing O&S Committees for the last two years, whereas there were on average ten committees in the ten years prior to that. Whilst this is line with the reduction in council budgets overall, it should be noted that the main impacts are the negative effect on the breadth and depth of work that can be covered by each committee, plus the reduced capacity to research, reach out to external partners and to residents and service users–and so to "act as a voice for local service users".[53]

## Officer support models and required skill sets

51. The CfPS also note that increasingly the officers providing day to day support to scrutiny committees are those whose role is combined with wider democratic services functions or with a corporate policy or strategy role.[54] Whilst those working in combined roles are able to provide effective support to scrutiny, there is a significant risk that non-scrutiny functions can take precedence. For example, democratic services officers supporting scrutiny must balance effective guidance, research and advice with the immediate time pressures and statutory deadlines of agenda publication and meeting administration. In such roles there is a risk that scrutiny is relegated to an 'add-on' that is only done once

51 Centre for Public Scrutiny (OSG098) para 100
52 Q46
53 Birmingham City Council (OSG087) page 6
54 Centre for Public Scrutiny (OSG098) paras 101–105

all other tasks are complete. Several officers attending our workshop expressed this view, with one officer explaining that she worked full time but her time was split with a wider corporate policy role and she estimated that no more than a quarter of her time was spent working on scrutiny matters. The ability of council officers to effectively support scrutiny can often depend entirely upon the personalities and enthusiasm of those officers. For example, when we asked Cllr Mary Evans from Suffolk County Council whether she felt that she had sufficient officer support, she told us: "I would say, "Yes, but". Yes, we are adequately resourced, but it depends upon the fact that we have two extremely dedicated and experienced scrutiny officers who are working at full stretch."[55]

52. We heard evidence that the skill sets of officers is just as important as the number of officers allocated to support scrutiny. Professor Copus for example told us that when considering whether an authority's scrutiny function is effective, he asks:

> Is the scrutiny function well supported by officers and by the right sort of officers? I used to be a committee clerk, so I am not decrying that grand profession, but scrutiny committees need access to policy officers; they need access to people who can manipulate statistics, for example. They need the right sort of support.[56]

53. Jacqui McKinlay also highlighted that certain skills are needed to effectively support scrutiny. She told us that:

> We used to say a dedicated scrutiny officer [was the optimum approach, but] … As long as they have the passion, dedication and commitment to the principle of scrutiny and the specialist skills to do it, I would say we should leave councils to configure how that happens. We do need to acknowledge that we do now have the internet, and the days of research and how that happens have changed. However, it is wrong to presume that councillors themselves will have the time and the capacity to do the level of research that is sometimes needed to do good scrutiny on complex issues. Fundamentally, it needs the bedrock of good scrutiny skills within the team to do that.[57]

54. From speaking with officers and councillors at our workshop, it is apparent that there are many officers working in scrutiny that have these skills, and some are able to combine them with the different skill set required to be efficient and accurate committee clerks. However, we heard too many examples of officers working on scrutiny who did not possess the necessary skills. One councillor told us that in her authority scrutiny officers had become little more than diary clerks, with reports and data now coming from the service departments across the council, which were invariably overly optimistic about performance and unchallenging of the status quo.

55 Q45
56 Q4
57 Q23

## Scrutiny's profile and parity with the executive

55. Whilst we regret that the level of resources allocated to scrutiny has diminished, we believe that the bigger issue relates to our earlier conclusions on organisational culture. In this respect, we agree with Cllr Sean Fitzsimons from Croydon Council who told us:

> Yes, it clearly does make a difference where the level of resource is, but it is too easy to put the blame on scrutiny not being at its best because we do not have the right officer or the right amount of resource in place. To me, it is clear that it is the power relationship between scrutiny, the executive and the officers. That really is the focus of where strengths and weaknesses are. You could have a very well-resourced scrutiny with officers who know their subject, but if you cannot get the chief executive or the executive director of a department to feel that you have a legitimate role, you can bang your head against the wall for as long as you like. For me, resources would come if we had that power balance right, rather than starting to look at resources first.[58]

56. We are concerned that in many councils, there is no parity of esteem between scrutiny and the executive. Resources and status are disproportionately focussed around Leaders and Cabinet Members, with scrutiny too often treated as an afterthought. Professor Copus told us that:

> in many councils, scrutiny lacks a parity of esteem with the executive. As a consequence, resources and focus are placed on the executive. For example, chief executives will find the time and have little problem in working directly with a council leader or with the cabinet. Expecting a chief executive then to work with the scrutiny process is always somewhat problematic. As soon as you differentiate between scrutiny and the executive with its officer base and its officer support, you start to chip away at the esteem that scrutiny has. One way around that, without expecting chief executives to work with every scrutiny committee, is to make sure that the scrutiny function has the resources to be able to produce evidence-based policy suggestions that the executive want to take on board, because they recognise scrutiny has done something they have not, which is spend three or four months looking at a particular issue in detail; cabinets cannot do that.[59]

57. As well as the disproportionate allocation of resources, we are also concerned that the uneven relationship between executives and scrutiny committees means that those officers supporting scrutiny can find themselves conflicted. Scrutiny officers can find themselves in the position of having to balance corporate or administration priorities with the challenge role of scrutiny, conscious that those they are scrutinising can make decisions regarding future resourcing and their personal employment prospects. Advice from officers must be impartial and free from executive influence. Cllr Fitzsimons told us that:

> You have to trust your officers and you also have to understand that they will have careers outside scrutiny … We need to make certain that they do not become part of the rock-throwing contingent, and that they are not seen

58 Q45
59 Q15

> as part of the group of officers supporting councillors who are making life difficult. I believe officers can be impartial, but they need to network and to network strongly within the council. If you really want to know what is going on in a department, you need an officer advising you in scrutiny who has those contacts within that highways department, as well as being good with the figures and being able to produce a report. You need impartiality, but you also need great networking skills.[60]

58. We believe that if a local authority does not adequately resource the scrutiny function, such impartiality is harder to ensure. With officers supporting both the executive and scrutiny, there is a significant risk that real or perceived conflicts of interests can occur. For example, an officer from a London Borough explained that in her authority following reductions in scrutiny support, designated senior officers from service departments act as 'scrutiny champions':

> The scrutiny champion's role includes supporting the committee with finalising its work programme for the municipal year, and includes directing departmental officers to produce the scoping report for the area the Committee will undertake an 'in-depth' scrutiny review on in that year. As the same officers provide direct support to the executive, one can immediately see the defect in this model–officers supporting the scrutiny function are not independent of, and separate from, those being scrutinised.[61]

## Allocating resources

59. Councils are under extreme budgetary pressures, but we are concerned that decisions regarding the resourcing of overview and scrutiny can be politically motivated. Professor Copus told us that:

> In some councils, councillors have said to me, "It is a deliberate ploy that we under-resource scrutiny so that it cannot do anything and it cannot challenge the executive. It has very little role to play." Because of the financial constraint, supporting scrutiny is a soft and obvious target for reductions. It is a false economy, because good, effective scrutiny can save councils money, and indeed save other organisations money as well.[62]

60. When we asked the Minister about resourcing scrutiny committees, he told us:

> What we have to consider here is that we have not got a scrutiny function that is in the pockets of the executive and the senior management team. We need a scrutiny function where those senior officers have a relationship with the scrutiny function and the people conducting the scrutiny get to see how the executive works and understand the executive, but that does not take away the fact that we need to make sure that scrutiny committees are properly resourced. That is not necessarily, in certain places, about having a

60 Q53
61 An officer from a London Borough (OSG091) para 3
62 Q22

> dedicated officer; it is more about having access to the information, support and, at times, research, to make sure that they do a good job of scrutinising the executive.[63]

61. **We acknowledge that scrutiny resources have diminished in light of wider local authority reductions. However, it is imperative that scrutiny committees have access to independent and impartial policy advice that is as free from executive influence as possible. We are concerned that in too many councils, supporting the executive is the over-riding priority, with little regard for the scrutiny function. This is despite the fact that at a time of limited resources, scrutiny's role is more important than ever.**

62. ***We therefore call on the Government to place a strong priority in revised and reissued guidance to local authorities that scrutiny committees must be supported by officers that can operate with independence and provide impartial advice to scrutiny councillors. There should be a greater parity of esteem between scrutiny and the executive, and committees should have the same access to the expertise and time of senior officers and the chief executive as their cabinet counterparts. Councils should be required to publish a summary of resources allocated to scrutiny, using expenditure on executive support as a comparator. We also call on councils to consider carefully their resourcing of scrutiny committees and to satisfy themselves that they are sufficiently supported by people with the right skills and experience.***

## The role of the Statutory Scrutiny Officer

63. The Localism Act 2011 created a requirement for all upper tier authorities to create a statutory role of designated scrutiny officer to promote scrutiny across the organisation. The Act does not require that the officer be of a certain seniority, or be someone that works primarily supporting scrutiny. The Institute of Local Government Studies (INLOGOV) at the University of Birmingham explains that:

> The intention was to champion and embrace the role of scrutiny. In reality, in most councils, the designated post-holder, while willing, is a shadow of the other posts required by legislation–the Head of Paid Service, Section 151 Officer, and Monitoring Officer. It is seldom an officer with a level of seniority sufficient to ensure that scrutiny is taken seriously when the Executive (both cabinet members and senior council staff) seek to close ranks.[64]

64. We believe that the role of a statutory 'champion' of scrutiny is extremely important in helping to create a positive organisational culture for an authority. However, we are concerned that the creation of this role has resulted in too many instances of Statutory Scrutiny Officers fulfilling the role in name only, with little actual activity. At our workshop, councillors described to us how Statutory Scrutiny Officers were often 'too low down the food chain', while officers told us of the need for a higher profile for the role, arguing that officers from across the council should know who their Statutory Scrutiny Officer is in the same way they do for monitoring officers. We agree with INLOGOV that the creation of the post has "proved largely ineffective"[65] and believe that reform

63 Q114
64 The Institute of Local Government Studies, The University of Birmingham (OSG053) page 6
65 The Institute of Local Government Studies, The University of Birmingham (OSG053), page 1

is needed in order to achieve the aspirations of the Localism Act 2011. The Association of Democratic Services Officers (ADSO) argue that the profile of the Statutory Scrutiny Officer role should be on a par with the Statutory Monitoring Officer[66] and the County and Unitary Councils' Officer Overview and Scrutiny Network argue that the requirement for a Statutory Scrutiny Officer should be extended to all councils.[67] We note the positive example of Stevenage Borough Council choosing to fund a scrutiny officer despite not being covered by the provisions of the Act:

> Some years ago this authority created a post of Scrutiny Officer and this has greatly helped with the running of an effective scrutiny function. We have prioritised this over other funding options. It is increasingly difficult to do so as this is not a statutory function at a District level, and the further funding cuts we face over the next three years place extreme pressure on existing budgets.[68]

65. ***We recommend that the Government extend the requirement of a Statutory Scrutiny Officer to all councils and specify that the post-holder should have a seniority and profile of equivalence to the council's corporate management team. To give greater prominence to the role, Statutory Scrutiny Officers should also be required to make regular reports to Full Council on the state of scrutiny, explicitly identifying any areas of weakness that require improvement and the work carried out by the Statutory Scrutiny Officer to rectify them.***

66 Association of Democratic Services Officers (OSG123) page 7
67 Council and Unitary Councils' Officer Overview and Scrutiny Network (OSG114) para 8.1
68 Stevenage Borough Council (OSG060) page 1

# 5 Member training and skills

## The importance of training

66. Unlike the quasi-judicial council committees of planning and licensing, members of scrutiny committees are not required to have any specialist skills or knowledge. We have heard evidence suggesting that this can hinder the effectiveness of committees, and are concerned that some councillors might not take their scrutiny role as seriously as others. For example, an anonymous spouse of a scrutiny chair states that:

> Whilst most Authorities have educational classes for members they are not well attended for the following reasons. Members who are in full time employment are not willing to attend in their 'nonworking hours'; those who are long standing members think it beneath them and those who work for a political party are 'instructed' by the party's position on the subject.[69]

67. If scrutiny members are not fully prepared and able to ask relevant questions, the committee will not be able to fully interrogate an issue and committee meetings can become little more than educational sessions for councillors to learn about a service, rather than scrutinise it. An officer from a London Borough explains that scrutiny meetings are:

> typically between scrutiny members and senior officers where the temptation to ask questions to simply learn more about a subject matter is greater … The Council's Member Development Officer, together with Democratic Services Officers, do arrange training for scrutiny members when opportunities arise; but this has proved insufficient as members infrequently display the required level of listening and questioning skills to make scrutiny impactful. Too many discussions at meetings are based on requests for more information, without expressing why it is required or how it will facilitate good scrutiny.[70]

68. Jacqui McKinlay from CfPS explained that training for scrutiny members usually fell into one of two categories:

> One is the generic skills element—questioning skills, and understanding data and performance management information. We then also run training, which is around children's services, understanding health and social care integration, whatever it might be. We are getting into the nitty-gritty then to give people enough knowledge… [However,] it is about who comes forward and accesses that. The people who come forward and access that tend to come from good organisations.[71]

## The suitability of training provided

69. Without the legal requirement for training such as on quasi-judicial committees, councils are not able to ensure that scrutiny members have all of the skills or knowledge

69 Anonymous submission (OSG006)
70 An officer from a London Borough (OSG091) para 10
71 Q30

that they need to deliver effective scrutiny, and those that need it most are the least likely to engage. However, we also note the view of Professor Copus, who highlighted that the value of councillors is that they are lay persons:

> There is a danger that we end up training councillors to be elected officers, and that has to be avoided. Officers are there to do their role. Councillors require a different type of skill and training. I am a great fan of council officers and I am not unfairly criticising them, but in many cases the training that is provided to members is what officers need members to understand, rather than what members need to understand.[72]

70. We agree that councillors require a different type of training from officers and that knowing a subject is not sufficient to ensure good scrutiny. The ability to question effectively, as well as actively listen to responses, is fundamental to successful scrutiny. Cllr Fitzsimons told us:

> Indeed, some of the simpler questions are some of the most pertinent questions going. Someone coming in not knowing too much about a subject can almost get more from a session than someone who has drifted into data nirvana or something like that, where they are really drilling down and finding out why this figure does not match this other one.[73]

## The quality of training available and DCLG oversight

71. We are concerned that there is no mechanism to ascertain whether scrutiny councillors are able to fulfil their vital role or that the training they do receive is fit for purpose. We asked councillors about the training and support that they had received from the Local Government Association (LGA), and responses were mixed. Cllr Fitzsimons for example told us:

> the LGA runs some really interesting courses, which I have attended. They outsource some of it to the Centre for Public Scrutiny. I am not particularly a fan of the way they do things, and their training has not really moved on for a long time. The skills training that a councillor has for a meeting about questioning-and-answering skills are good training sessions.[74]

72. He argued that fundamental requirements for training included more emphasis on a self-reflective approach:

> I remember going to do a training session with the London Borough of Richmond in 2006, and my challenge to the councillors who were doing scrutiny was, "How much backbone do you have?" and I just do not see that within the training. Are you willing to ask difficult questions? Are you willing, in your own political group, after you have done a scrutiny meeting, to have people say to you, "You were a bit harsh on the leader"? They do not get that self-reflective type training about, "What is your role? Are you really going to hold to account?"[75]

72 Q32
73 Q59
74 Q64
75 Q64

73. Cllr Fitzsimons also criticised national conferences and networking events for having an insufficient emphasis on frontline scrutiny members:

> You do not see ordinary councillors leading the events … ultimately the LGA is focused on the executive and their whole setup. Scrutiny, I believe, is an add-on, and that is just a reflection of the way it works, because the people who are influential in LGA are more likely to be council leaders and cabinet members than the ordinary scrutiny people. Individual training is good, but overall I do not think it is hitting the mark.[76]

74. The Minister told us that the Department allocated £21 million to the LGA "so that it could support various activities to improve the governance in local authorities; and it is why we are absolutely committed to working with the LGA and its delivery partners—organisations such as the Centre for Public Scrutiny".[77] DCLG states that:

> The Government does not monitor the effectiveness of overview and scrutiny committees–which is a matter for the authorities themselves. However, the Secretary of State may intervene in authorities which have failed in their best value duty, as happened in 2014 in Tower Hamlets and in 2015 in Rotherham.[78]

75. We are concerned that DCLG gives the LGA £21 million each year to support scrutiny, but does not appear to monitor the impact of this support or whether this investment represents best value. When we questioned the Minister about his Department's monitoring of scrutiny effectiveness and the extent to which this was delegated to the LGA, he told us that DCLG "will look very carefully at the recommendations that are made by the Committee."[79]

76. **It is incumbent upon councils to ensure that scrutiny members have enough prior subject knowledge to prevent meetings becoming information exchanges at the expense of thorough scrutiny. Listening and questioning skills are essential, as well as the capacity to constructively critique the executive rather than following party lines. *In the absence of DCLG monitoring, we are not satisfied that the training provided by the LGA and its partners always meets the needs of scrutiny councillors, and call on the Department to put monitoring systems in place and consider whether the support to committees needs to be reviewed and refreshed. We invite the Department to write to us in a year's time detailing its assessment of the value for money of its investment in the LGA and on the wider effectiveness of local authority scrutiny committees.***

76 Q64
77 Q113
78 Department for Communities and Local Government (OSG122) para 19
79 Q125

# 6 The role of the public

77. Earlier in this report, we discussed the need for scrutiny committees to have greater legitimacy and independence from their executives. A key way of delivering this is to ensure that members of the public and local stakeholders play a prominent role in scrutiny. By involving residents in scrutiny, the potential for a partisan approach lessens and committees are able to hear directly from those whose interests they are representing. Many local authorities have been very successful in directly involving their residents through open meetings, standing agenda items and public appeals for scrutiny topics. Other authorities, and indeed parliamentary select committees, can learn from such positive examples.

## Case studies of public engagement

78. Devon County Council argues that "Scrutiny serves as almost the only bastion of opportunity for local people to voice an opinion on changes to a wide range of services, not just those provided by the Council." The authority also cites an example where scrutiny considered a national issue which had a local manifestation. Search and Rescue services were previously provided by RAF Chivenor, but when this changed "Local People were very concerned about the loss of the service and scrutiny reviewed the evidence in an independent way. The subsequent report helped to reassure local people that the evidence supported the change as well as to establish a baseline from which to challenge future incidents."[80]

79. At its most effective, we believe that scrutiny amplifies the concerns of local residents and of service users. A positive example of this is in Exeter where the City Council established a 'Dementia Friendly Council' task and finish group. As part of its work, the group "invited members of the Torbay Dementia Leadership Group to visit the Customer Service Centre to observe the front line service and facilities from the point of view of a person with dementia and to see if the Council could make any improvements to the existing customer experience." Subsequent recommendations to improve the service have since been made.[81]

80. At our workshop with councillors and officers, one councillor explained that she did not like the term 'public engagement' and instead preferred to think of it as 'listen and learn'. This approach was evident in the example of Surrey County Council, cited by the LGA.[82] Surrey conducted extensive pre-decision scrutiny of the authority's cycling strategy to help inform the final strategy. Following an independent consultation, it was apparent that there were mixed views on the proposals within the strategy and a joint meeting of two scrutiny committees was held to consider them, with a public forum to allow residents to express their views. The outcome was a better-informed and more successful strategy:

> Having heard and considered the voice and concerns of the public on the Council's proposed Cycling Strategy, the committees made recommendations to ensure the final strategy was acceptable to Surrey residents. These included: ensuring benefits for local businesses; including

80 Devon County Council (OSG008) page 2
81 Exeter City Council (OSG011) para 7
82 Local Government Association (OSG081) paras 13.5–13.7

> cycling infrastructure schemes on highways maintenance programmes; lobbying central government so that unregulated events were regulated; working with boroughs & districts to develop cycling plans; and amending the strategy to ensure roads would only be closed with strong local support.[83]

## Digital engagement

81. The examples above are illustrations of the value that greater public involvement can bring both to the scrutiny process and an authority's decision making process. However, we are also aware that the majority of scrutiny committees across the country are not well-attended by the public. Involving the public in scrutiny is time and resource intensive, but the rewards can be significant. In this context, it should also be noted that many members of the public do not want to engage with public services in the same way that they used to. Digital engagement is becoming increasingly important, with some councils embracing new media better than others (for example the twitter feed of Doncaster Metropolitan Borough Council recently received national attention for effective engagement regarding the naming of two gritters[84]). Jacqui McKinlay told us:

> There are some real challenges about what public engagement looks like in the future. It is not necessarily the village hall where we are expecting people to turn up on a wet Wednesday. We need to start to accept that when we engage with people they do not necessarily always speak the same language as we do, particularly on contentious issues. People are very angry. They are very upset. In scrutiny and public services generally, we have to think about what engagement looks like in the future. We are also in a digital and social media world where the conversations now, probably in the last six months, are happening in WhatsApp. They were happening in Facebook earlier. That is something that scrutiny is really going to have to manage if it is going to stay relevant and part of the dialogue.[85]

82. ***The Government should promote the role of the public in scrutiny in revised and reissued guidance to authorities, and encourage council leaderships to allocate sufficient resources to enable it to happen. Councils should also take note of the issues discussed elsewhere in this report regarding raising the profile and prominence of the scrutiny process, and in so doing encourage more members of the public to participate in local scrutiny. Consideration also need to be given to the role of digital engagement, and we believe that local authorities should commit time and resources to effective digital engagement strategies. The LGA should also consider how it can best share examples of best practice of digital engagement to the wider sector.***

83 Local Government Association (OSG081) paras 13.5–13.7

84 "*David Plowie or Spready Mercury? Council asks public to name its new gritters*", The Telegraph, 17 November 2017

85 Q39

# 7 Scrutinising public services provided by external bodies

## The conflict between commercial and democratic interests

83. We heard a lot of evidence that scrutiny committees are increasingly scrutinising external providers of council services, both in an attempt to avoid politically 'difficult' subjects and as a reflection that services are being delivered in increasingly diverse ways.[86] We believe that scrutiny committees are ideally placed, and have a democratic mandate, to review any public services in their area. However, we have heard of too many instances where committees are not able to access the information held by providers, or the council itself, for reasons of commercial sensitivity (as further discussed in Chapter 3 of this report). Jacqui McKinlay from CfPS told us that there can be an "unbelievable barrier" with commercial organisations as they "do not recognise they are contracting with a democratic organisation that has democratic governance processes."[87]

84. The conflict between commercial and democratic interests means that many companies are not set up to accommodate public accountability. This is in contrast with health services, which have a more established history of engagement (backed up by legislative requirements). The London Borough of Hackney explains that:

> Health scrutiny has been luckier than other areas in that the duties to attend meetings and engage with scrutiny are well established and accepted. For health scrutiny in Hackney there is an understanding that if invited to attend to be held to account on an issue, the invitation cannot be refused. Where service providers have appeared reluctant to attend scrutiny is often linked to their accountability to local government and whether their management structures are local. We have found where structures are regional or national and the organisation has very limited local accountability there can be difficulty with engagement in the local scrutiny function.[88]

## Scrutiny powers in relation to external organisations

85. Overview and scrutiny committees have a range of powers that enable them to conduct scrutiny of external organisations. The Health and Social Care Act 2012 gives local authorities the power to scrutinise health bodies and providers in their area or set up joint committees to do so. They can also require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions. Scrutiny also has powers with regard to the delivery of crime and disorder strategies, with those bodies which are delivering such strategies also being required to attend meetings and respond to committee reports. However, for all other organisations delivering public services, be they public bodies or commercial entities, their participation depends upon their willingness of both parties to do so and the ability of scrutiny committees to forge a positive working relationship. Attitudes to local scrutiny are varied, as Cllr Sean Fitzsimons from Croydon Council explained to us:

86 See for example Q9
87 Q30
88 Overview and Scrutiny Team, London Borough of Hackney (OSG110) para 11

> I would say that the smaller the organisation the better they are at coming along. The most difficult one I ever dealt with was probably the Metropolitan Police. Borough commanders do not think we have any legitimacy. Sometimes, you can see they are thinking about other things. As someone who has sat on a riot review panel, led by a judge, to get someone there was an effort. They may want to come and talk about a certain thing, but the moment you ask them anything specific it is like, "I cannot talk about it". Policing is a really difficult area, and it is actually within our remit. The fire brigade has been quite a useful organisation, and they are quite keen. The ambulance service is desperate to turn up.[89]

## Scrutinising council contracts

86. A significant obstacle to effective scrutiny of commercial providers is an over-zealous classification of information as being commercially sensitive (as discussed in relation to council-held information in paragraph 40). Council officers are wary of sharing the terms of contracts as they do not want to prejudice future procurements, and contractors do not always see why they should share information. As discussed earlier in this report, we can see no reason for withholding confidential information from scrutiny councillors, who can then consider it in a private session if necessary. We believe that councils and their contractors need to be better at building in democratic oversight from the outset of a contract. We note for example the views of Cllr Fitzsimons, who argued that scrutiny often gets involved in contracting situations too late:

> It is only when the major recommendations can go to cabinet that you can say, "I am unhappy with that and I will bring it in." My experience, particularly in my local authority, is that the failure of the authority, at the time, to engage in scrutiny early on in the process so that we could help shape the outcomes meant that a decision had been taken by the relevant cabinet member, and really it allowed itself to drift into party political flag-waving, to say, "We are just not happy with the letting of this contract." If we had been allowed to look at it six months or a year beforehand, we may have been able to have had some influence for the betterment of the service. I have found that contractors are quite keen to talk, but what it again goes back to is how comfortable the executive is having their decisions challenged, when they may have done 18 months or two years of private work on it and they think they already have the answer.[90]

87. It is imperative that executives consider the role of scrutiny at a time when external contracts are still being developed, so that both parties understand that the service will still have democratic oversight, despite being delivered by a commercial entity. Scrutiny committees have a unique democratic mandate to have oversight of local services, and contracting arrangements do not change this. We therefore support the recommendations made by the scrutiny committee at Suffolk County Council, as described to us by Cllr Evans:

89 Q77
90 Q52

> We had a task and finish group that did a lot of work on procurement and contracting, and we are asking that, in future, when the council signs any contracts, those people who are making the contract are aware that we could well expect to see them in front of scrutiny at some point. They cannot sign a contract with the authority and expect never to be put on the spot and be accountable.[91]

88. We heard examples where committees had successfully engaged external providers, such at Suffolk County Council where the contractors for highways and for social care come to scrutiny willingly.[92] However this is not always the case and such variance is an issue of concern for us. We are of the view that scrutiny committees must be able to scrutinise the services provided to residents and utilise their democratic mandate and we therefore agree with the Minister, who told us:

> When councils put contracts out to external bodies, they should look at that in the context of how open and transparent those arrangements can be. That can quite often be difficult because of commercial confidentiality, but, as I say, that should not be a cover-all for everything. I think that that should be considered in the context of when a contract is let, in terms of making sure that a particular provider can be called to a scrutiny committee. However, when a particular local authority lets a contract to a particular company, I do not think it should lead to a situation where that particular local authority is able to sit back and just blame its contractor. The local authority in question should, when tendering out, put together a process over which it has a level of control that enables it to scrutinise a particular contractor and take enforcement action should that contract not be fulfilled.[93]

## Following the 'council pound'

89. The CfPS highlight the difficulties that scrutiny committees can have monitoring services delivered in partnership, and notes that scrutiny has been effective when its formal powers give it a 'foot in the door':

> We would therefore like to see these powers balanced across the whole local public service landscape. We would like to see the law changed and consolidated, to reflect the realities that local authorities now face–particularly the fact that much council business is now transacted in partnership. We would like to see an approach which uses the "council pound" as the starting point for where scrutiny may intervene–that is to say, that scrutiny would have power and responsibilities to oversee taxpayer-funded services where those services are funded, wholly or in part, by local authorities.[94]

91 Q50
92 Q52
93 Q148
94 Centre for Public Scrutiny (OSG098) paras 149–151

90. ***Scrutiny committees must be able to monitor and scrutinise the services provided to residents. This includes services provided by public bodies and those provided by commercial organisations. Committees should be able to access information and require attendance at meetings from service providers and we call on DCLG to take steps to ensure this happens. We support the CfPS proposal that committees must be able to 'follow the council pound' and have the power to oversee all taxpayer-funded services.***

## Scrutiny of Local Economic Partnerships

91. We are also extremely concerned at the apparent lack of democratic oversight of Local Economic Partnerships (LEPs). There are 39 LEPs in operation across England, tasked with the important role of promoting local economic growth and job creation. However, we fear that they vary greatly in quality and performance, and that there is no public assurance framework, other than any information they themselves choose to publish. LEPs have been charged with delivering vital services for local communities and do so using public money, and so it is therefore right and proper that committees of elected councillors should be able to hold them to account for their performance. LEPs are key partners of mayoral combined authorities and we note that the relationship in London seems established. Jennette Arnold OBE AM, Chair of the London Assembly, told us:

> The responsibility for the LEPs falls within the Mayor's economic strategy, so for us the buck stops with the Mayor. He then has a LEP board. There are local authority councillors and businesspeople on that. There is a Deputy Mayor who is charged with business and economic growth in London. Both members of that LEP board and that Deputy Mayor have appeared in front of our Economy Committee. We also had questions about skills, because skills was linked, so our education panel raised questions. Business as usual for us is that where there is a pound of London's money being spent, we will follow that and we will raise any issues as relevant.[95]

92. We applaud this approach and welcome the oversight of the London LEP provided by the London Assembly. In the next chapter we will consider the role of scrutiny in combined authorities, where we have concerns over the capacity of the newer organisations. Their relative infancy when compared to the London Assembly is reflected in unclear relationships with their local LEPs. Cllr Peter Hughes, Chair of the West Midlands Combined Authority Overview and Scrutiny Committee, told us:

> There are non-voting LEP representatives on the board of the combined authority and there has been since the day it started. I have LEP representatives on the Overview and Scrutiny Committee. Again, they are non-constituent members, as are some of the rural authorities. Their commitment to overview and scrutiny and to audit is patchy, to say the least. There is one big authority or LEP area that does not contribute to scrutiny or audit … We have not done so yet, but I am sure before the 12 months are up that the LEP involvement in the combined authority's work will be looked at.[96]

95 Q103
96 Qq104–106

93. Whilst we welcome the established arrangements in London and the intentions of the newer mayoral combined authorities, we are concerned that there are limited arrangements in place for other parts of the country. We do note that examples exist, and call for such arrangements to be put in place across the country. Wiltshire Council states that:

> Wiltshire Council is one of the few local authorities nationally to have a OS task group actively engaging with the region's Local Enterprise Partnership, providing extra public accountability to the LEP funding spent within the county. All LEP reports and expenditure are published to facilitate further scrutiny by members of the public.[97]

94. In October 2017, a review of LEP governance arrangements was published by DCLG. The review makes a number of recommendations and noted that while many LEPs have robust assurance frameworks, approaches vary. For example, LEPs are required to publish a conflict of interest policy and the review found that "Whilst LEPs comply with this requirement, the content of policies and approach to publication varies considerably and is dependent on the overall cultural approach within the organisation."[98] The review also noted that:

> A number of LEPs, but not all, refer to the role of scrutiny in overseeing their performance and effectiveness. Some LEPs are scrutinised from time to time by their accountable body Overview and Scrutiny function. This is an area for further development which would give increased independent assurance. Given the different structures across LEPs it is not appropriate to specify any particular approach to scrutiny. It is an area which could benefit from the sharing of good practice/'what works' to assist LEPs in shaping their own proposals.[99]

95. When we asked the Minister about the democratic oversight of LEPs, he told us that local authorities will usually have representation on LEP boards and that expenditure will often be monitored by the lead authority's Section 151 finance officer. When we asked him about more public methods of scrutiny, he told us that:

> in terms of the scrutiny there are ways in which a LEP can be scrutinised. At this point I do not believe that those arrangements need to be changed, but I will certainly be interested—I know you have asked this of a number of the witnesses at this Committee—in their views on local enterprise partnerships. Certainly that will be a Government consideration once the Committee has submitted its report.[100]

96. ***In light of our concerns regarding public oversight of LEPs, we call on the Government to make clear how these organisations are to have democratic, and publicly visible, oversight. We recommend that upper tier councils, and combined authorities where appropriate, should be able to monitor the performance and effectiveness of LEPs through their scrutiny committees. In line with other public bodies, scrutiny committees should be able to require LEPs to provide information and attend committee meetings as required.***

97 Wiltshire Council (OSG034) para 10
98 Department for Communities and Local Government, *Review of Local Enterprise Partnership Governance and Transparency* (October 2017), para 6.1
99 Department for Communities and Local Government, *Review of Local Enterprise Partnership Governance and Transparency* (October 2017), para 9.3
100 Q146

# 8 Scrutiny in combined authorities

97. We recognise that the mayoral combined authorities are in their infancy, but given how important organisational culture is, it is important that we include them in our inquiry to ensure that the correct tone is set from the outset. We are therefore concerned by the evidence we heard about an apparent secondary role for scrutiny. Mayors will be responsible for delivering services and improvements for millions of residents, but oversight of their performance will be hindered by limited resources.

## The London Assembly

98. The London Assembly has 25 members elected to hold the Mayor of London to account and to investigate any issues of importance to Londoners. London Assembly Members are elected at the same time as the Mayor, with eleven representing the whole capital and fourteen elected by constituencies. The Mayor holds all executive power and the Assembly's ability to override decisions is limited to amending budgets and rejecting statutory strategies. The most visible accountability tool is Mayor's Question Time, when the Mayor of London is required to appear in public before the Assembly ten times a year to answer for decisions made and their outcome. Oversight is also provided by ten thematic scrutiny committees. In 2016/17 the London Assembly controlled a budget of £7.2 million, of which £1.5 million was allocated to scrutiny and investigations, with the remainder used for other member services and democratic services functions. This compares with the Mayor's budget of around £16 billion.[101] The Chair of the Assembly, Jennette Arnold, told us:

> You will see that we have been learning and changing over the last 16 years. I would say we are a much more robust body than we were, say, eight years previously because we have taken on learning. We set out to make sure that the centrepiece of our work, which is detailed scrutiny, is evidence-based, well resourced and is disseminated as widely as possible. We have two tracks: the first track is to follow the Mayor, i.e. we ensure mayoral accountability; and the other track we have is about any issue of public concern to London. I would say the combined authorities should look and see the clarity that we have. This is what good scrutiny looks like: it is separate; it has its own officers; it has its own budget; and there is money that is required to do that work.[102]

## The mayoral combined authorities

99. We welcome and applaud the approach of the London Assembly, however the wide discrepancy in the approach to scrutiny in the newer mayoral combined authorities which has come to light during our inquiry is an issue of concern. Combined authorities have a far smaller budget and do not have an equivalent body to the London Assembly, with scrutiny instead being performed by members of the constituent councils. The Local Government Research Unit at De Montfort University argue that:

101 London Assembly, *The London Assembly Annual Report 2016–17*, page 57
102 Q83

> An opportunity was missed in the creation of combined authorities–because of the focus on leadership–to recreate a London Assembly style directly elected body with the responsibility to hold the mayor of any combined authority (and other organisations) to account. A directly elected scrutiny body with its own staff and resources may seem an expensive innovation, but … serious governance failures resulting in damage to public services and the public can occur where O&S is inadequate or fails.[103]

100. In contrast with the London Assembly, Cllr Peter Hughes of the West Midlands Combined Authority told us:

> The regulations for the combined authority actually state "a scrutiny officer", as it stands at the moment. This has been the case for the last 18 months. The combined authority scrutiny chair, whether it is me or anybody else, is supported by a part-time person who is lent out from our own authority. That is the case across all of the other issues. Effectively, the West Midlands Combined Authority is run on the basis of good will and people, chief executives and directors, giving up their time. That is exactly the same with scrutiny. At the moment, we have a person who is lent, with no financial refund to Sandwell, to the combined authority. That has not yet been formalised.[104]

101. We recognise that the resourcing levels are not necessarily decisions for the combined authorities themselves, with Government funding dictating that they be organisations with minimal overheads. However, we also acknowledge that the absence of an allocated budget or a directly-elected scrutiny body does not mean that the approach to scrutiny in combined authorities is necessarily wrong. Cllr Hughes for example told us how he will be measuring the effectiveness of his committee:

> Part of scrutiny is not just the questioning and scrutiny aspect of it; it is also that we are adding value to the work of the combined authority. As you have just said, it is in the very early stages at the moment. We feel that we can actually add value to some of the policy decisions that are being taken or being formed by actually taking specific pieces of work and drilling down and calling upon evidence from the local authorities beneath us to add value to the work of the combined authority itself.[105]

102. Susan Ford, Scrutiny Manager of the Greater Manchester Combined Authority, also told us that successful scrutiny in Greater Manchester will enable the Mayor and officers to:

> understand the value that scrutiny can bring, and… sense-checking what might cause issues in particular districts and bringing that kind of wealth of in-depth knowledge that scrutiny members bring in with them. The scrutiny function also has a duty to the public to try to simplify some of what can be seen as a very complicated governance arrangement. Having different governance arrangements across different devolved areas has not helped. Mayors in different city region areas have different powers, so

103 Local Government Research Unit, De Montfort University (OSG022) para 4
104 Q87
105 Q85

> there is a duty to members of the public. There is also a duty to broaden the engagement in terms of thinking about things like younger people and the way in which elected members actually engage with their constituents. We have to support them to be able to make devolution governance and decision-making intelligible.[106]

103. We raised the issue of scrutiny of combined authority mayors with the Minister, who argued that the scrutiny arrangements were sufficient:

> I consider that the scrutiny arrangements in that sense are stronger than they are for local authorities … Certainly the powers that were being transferred to Mayors were generally powers that hitherto had been held by Secretaries of State and, therefore, on a virtually daily basis when this House was sitting there was a method, potentially, of scrutinising the decisions that were being made, and their outcomes … That said, and I have mentioned this a number of times, I do not think there is any room, in this sense, for complacency. I would say that, in the same way as we are now talking about the scrutiny arrangements from the Local Government Act 2000 having bedded in … the question is: should there now be more changes to update things because time moves on? There will legitimately be the question, as time moves on: how have those scrutiny arrangements worked? Do we need to change anything going forward to make sure that we are responding to circumstances that arise?[107]

104. We welcome the approach to scrutiny by new mayoral combined authorities such as the West Midlands and Greater Manchester, but we are concerned that such positive intentions are being undermined by under-resourcing. This is not a criticism of the combined authorities - which have been established to be capital rich but revenue poor - as they do not have the funding for higher operating costs. However, we would welcome a stronger role for scrutiny in combined authorities, reflecting the Minister's point that the Mayors now have powers hitherto held by Secretaries of State. ***We are concerned that effective scrutiny of the Metro Mayors will be hindered by under-resourcing, and call on the Government to commit more funding for this purpose. When agreeing further devolution deals and creating executive mayors, the Government must make clear that scrutiny is a fundamental part of any deal and that it must be adequately resourced and supported.***

106 Q85
107 Qq131–132

# Conclusions and recommendations

## The role of scrutiny

1. *We therefore recommend that the guidance issued to councils by DCLG on overview and scrutiny committees is revised and reissued to take account of scrutiny's evolving role.* (Paragraph 12)

2. *We call on the Local Government Association to consider how it can best provide a mechanism for the sharing of innovation and best practice across the scrutiny sector to enable committees to learn from one another. We recognise that how scrutiny committees operate is a matter of local discretion, but urge local authorities to take note of the findings of this report and consider their approach.* (Paragraph 13)

## Party politics and organisational culture

3. However, all responsible council leaderships should recognise the potential added value that scrutiny can bring, and heed the lessons of high profile failures of scrutiny such as those in Mid Staffordshire and Rotherham. (Paragraph 19)

4. *To reflect scrutiny's independent voice and role as a voice for the community, we believe that scrutiny committees should report to Full Council rather than the executive and call on the Government to make this clear in revised and reissued guidance. When scrutiny committees publish formal recommendations and conclusions, these should be considered by a meeting of the Full Council, with the executive response reported to a subsequent Full Council within two months.* (Paragraph 23)

5. We believe that executive members should attend meetings of scrutiny committees only when invited to do so as witnesses and to answer questions from the committee. Any greater involvement by the executive, especially sitting at the committee table with the committee, risks unnecessary politicisation of meetings and can reduce the effectiveness of scrutiny by diminishing the role of scrutiny members. *We therefore recommend that DCLG strengthens the guidance to councils to promote political impartiality and preserve the distinction between scrutiny and the executive.* (Paragraph 25)

6. It is vital that the role of scrutiny chair is respected and viewed by all as being a key part of the decision-making process, rather than as a form of political patronage. (Paragraph 27)

7. We believe that there are many effective and impartial scrutiny chairs working across the country, but we are concerned that how chairs are appointed has the potential to contribute to lessening the independence of scrutiny committees and weakening the legitimacy of the scrutiny process. Even if impropriety does not occur, we believe that an insufficient distance between executive and scrutiny can create a perception of impropriety. (Paragraph 30)

8. We believe that there is great merit in exploring ways of enhancing the independence and legitimacy of scrutiny chairs such as a secret ballot of non-executive councillors. However, we are wary of proposing that it be imposed upon authorities by government.

*We therefore recommend that DCLG works with the LGA and CfPS to identify willing councils to take part in a pilot scheme where the impact of elected chairs on scrutiny's effectiveness can be monitored and its merits considered.* (Paragraph 35)

## Accessing information

9. Scrutiny committees that are seeking information should never need to be 'determined' to view information held by its own authority, and there is no justification for a committee having to resort to using Freedom of Information powers to access the information that it needs, especially from its own organisation. There are too many examples of councils being uncooperative and obstructive. (Paragraph 37)

10. Councils should be reminded that there should always be an assumption of transparency wherever possible, and that councillors scrutinising services need access to all financial and performance information held by the authority. (Paragraph 41)

11. We do not believe that there should be any restrictions on scrutiny members' access to information based on commercial sensitivity issues. Limiting rights of access to items already under consideration for scrutiny limits committees' ability to identify issues that might warrant further investigation in future, and reinforces scrutiny's subservience to the executive. *Current legislation effectively requires scrutiny councillors to establish that they have a 'need to know' in order to access confidential or exempt information, with many councils interpreting this as not automatically including scrutiny committees. We believe that scrutiny committees should be seen as having an automatic need to know, and that the Government should make this clear through revised guidance.* (Paragraph 42)

12. *We note that few committees make regular use of external experts and call on councils to seek to engage local academics, and encourage universities to play a greater role in local scrutiny.* (Paragraph 45)

13. We commend such examples of committees engaging with service users when forming their understanding of a given subject, and encourage scrutiny committees across the country to consider how the information they receive from officers can be complemented and contrasted by the views and experiences of service users. (Paragraph 47)

## Resources

14. We acknowledge that scrutiny resources have diminished in light of wider local authority reductions. However, it is imperative that scrutiny committees have access to independent and impartial policy advice that is as free from executive influence as possible. We are concerned that in too many councils, supporting the executive is the over-riding priority, with little regard for the scrutiny function. This is despite the fact that at a time of limited resources, scrutiny's role is more important than ever. (Paragraph 61)

15. *We therefore call on the Government to place a strong priority in revised and reissued guidance to local authorities that scrutiny committees must be supported by officers that can operate with independence and provide impartial advice to scrutiny councillors. There should be a greater parity of esteem between scrutiny and the executive, and committees should have the same access to the expertise and time of senior officers and the chief executive as their cabinet counterparts. Councils should be required to publish a summary of resources allocated to scrutiny, using expenditure on executive support as a comparator. We also call on councils to consider carefully their resourcing of scrutiny committees and to satisfy themselves that they are sufficiently supported by people with the right skills and experience.* (Paragraph 62)

16. *We recommend that the Government extend the requirement of a Statutory Scrutiny Officer to all councils and specify that the post-holder should have a seniority and profile of equivalence to the council's corporate management team. To give greater prominence to the role, Statutory Scrutiny Officers should also be required to make regular reports to Full Council on the state of scrutiny, explicitly identifying any areas of weakness that require improvement and the work carried out by the Statutory Scrutiny Officer to rectify them.* (Paragraph 65)

## Member training and skills

17. It is incumbent upon councils to ensure that scrutiny members have enough prior subject knowledge to prevent meetings becoming information exchanges at the expense of thorough scrutiny. Listening and questioning skills are essential, as well as the capacity to constructively critique the executive rather than following party lines. *In the absence of DCLG monitoring, we are not satisfied that the training provided by the LGA and its partners always meets the needs of scrutiny councillors, and call on the Department to put monitoring systems in place and consider whether the support to committees needs to be reviewed and refreshed. We invite the Department to write to us in a year's time detailing its assessment of the value for money of its investment in the LGA and on the wider effectiveness of local authority scrutiny committees.* (Paragraph 76)

## The role of the public

18. *The Government should promote the role of the public in scrutiny in revised and reissued guidance to authorities, and encourage council leaderships to allocate sufficient resources to enable it to happen. Councils should also take note of the issues discussed elsewhere in this report regarding raising the profile and prominence of the scrutiny process, and in so doing encourage more members of the public to participate in local scrutiny. Consideration also need to be given to the role of digital engagement, and we believe that local authorities should commit time and resources to effective digital engagement strategies. The LGA should also consider how it can best share examples of best practise of digital engagement to the wider sector.* (Paragraph 82)

## Scrutinising public services provided by external bodies

19. *Scrutiny committees must be able to monitor and scrutinise the services provided to residents. This includes services provided by public bodies and those provided by*

*commercial organisations. Committees should be able to access information and require attendance at meetings from service providers and we call on DCLG to take steps to ensure this happens. We support the CfPS proposal that committees must be able to 'follow the council pound' and have the power to oversee all taxpayer-funded services.* (Paragraph 90)

20. *In light of our concerns regarding public oversight of LEPs, we call on the Government to make clear how these organisations are to have democratic, and publicly visible, oversight. We recommend that upper tier councils, and combined authorities where appropriate, should be able to monitor the performance and effectiveness of LEPs through their scrutiny committees. In line with other public bodies, scrutiny committees should be able to require LEPs to provide information and attend committee meetings as required.* (Paragraph 96)

## Scrutiny in combined authorities

21. *We are concerned that effective scrutiny of the Metro Mayors will be hindered by under-resourcing, and call on the Government to commit more funding for this purpose. When agreeing further devolution deals and creating executive mayors, the Government must make clear that scrutiny is a fundamental part of any deal and that it must be adequately resourced and supported.* (Paragraph 104)

# Annex: summary of discussions at an informal workshop with councillors and officers

As part of the inquiry, the Committee hosted a workshop in October 2017 attended by over 45 council officers and councillors from across the country. Split into four groups, attendees discussed their experiences of overview and scrutiny, with each group considering three questions. The following provides an edited summary of the discussions held and is not intended to be verbatim minutes. Comments are not attributed to individuals or organisations, but seek to reflect the variety of statements made and opinions expressed. This summary and its content does not necessarily reflect the views of the Committee, or all of the attendees present at the workshop.

### *Q1) Do local authority scrutiny committees operate with political independence and in a non-partisan way*

**Officers:**

- Scrutiny is only non-partisan on the surface: most of the discussion and debate takes place in group meetings, which officers and the public cannot see
- Scrutiny chairs often don't want to challenge their Leaders, so do more external scrutiny or pick 'safe' topics that are less controversial
- The ways that committee chairs are appointed means that chairs more likely to 'keep quiet', use the role as a way to prepare for a Cabinet position, or see it as a consolation prize for not being in the Cabinet
- Personalities of chairs and the ability to work well with executive colleagues is key
- Officers in combined roles struggle to adequately support scrutiny: the roles of scrutiny officer and committee clerk are fundamentally different with different skill sets needed
- Clerking a committee changes how officers are treated, with the value placed on their expertise and guidance lessened so they are treated as little more than admin assistants
- Task and finish groups are less partisan and work effectively cross-party. However, witness sessions are usually held in private with only the reporting of findings being in public. External scrutiny is also less partisan, and so can achieve much more while enthusing councillors
- Third party organisations can sometimes be reluctant to be scrutinised by lay persons. It takes significant time to build positive relationships
- There should be debate at Full Council for topic selection for scrutiny committees
- Committees need more power to force changes on executives

- There is too much executive control over what is scrutinised
- In some local authorities, cabinet members and the Leader attend health scrutiny meetings when the NHS is being scrutinised and sometimes lead the questioning of witnesses
- Appointment of members to scrutiny committees is in the hand of controlling political groups, so there will never be full independence

**Councillors:**

- Focussing on the impact we want, like improved health and wellbeing, gets rid of the party-political aspect because we've agreed on what we want to achieve
- The better the quality of the opposition, the better the contribution it makes. Currently, we have a very weak opposition and I don't think they understand the difference between scrutiny and opposition
- One problem is engagement of one's own backbenchers to participate in scrutiny. It's often the poor relation, and shouldn't be
- Is aiming for political independence realistic and necessary? If you have people from both sides on committee, as long as they challenge effectively, that's all that matters
- I want to know about value for money, so I ask awkward questions. Politics comes into it when members score points to get votes. It suits my nature to be challenging and ask probing questions. But you need knowledge of subject to do this. A lot of colleagues don't have this
- The role of the Leader is key: they have to believe in good governance. Scrutiny's success depends on the attitude of the Leader, who needs to recognise that good scrutiny reflects on the reputation of council. Too many Leaders seek to block scrutiny
- Scrutiny is improved in authorities where scrutiny reports go to Full Council and not the executive
- Officers have to be supportive of scrutiny. It's not just about the Leader
- Some chairs can be fiercely independent regardless of which party has control. An effective chair of a scrutiny committee need to be apolitical and work collaboratively across party lines. A lot depends on the group of individuals on the committee
- A lack of political independence is often more pronounced in small shire district councils where there is often too much domination by strong leaders and executives
- There is a problem with committees lacking teeth - the executive will often not listen regardless of what scrutiny committees say

- Joint scrutiny often works well, sometimes with different chairs. Working groups also increase political independence
- Decisions on who will chair a committee is often whipped vote, and there is considerable remuneration which binds chairs' approach
- The executive has control over scrutiny funding and budgets which is a big problem

### *Q2) Do officers and members working on scrutiny have sufficient resources, expertise and knowledge to deliver effective scrutiny?*

**Officers:**

- Limited access to expertise is a bigger issue than resources: committees struggle to access expert advisors and find it hard to build relationships
- Scrutiny support is often combined with wider a corporate policy role, meaning officers often spend relatively little of their time actually working on scrutiny
- There is a tension in trying to scrutinise people with whom you might later seek to work with or for
- The reduced resources allocated to scrutiny has led to a corresponding reduction in scrutiny committees: local authorities cannot have committees that mirror each portfolio like in Parliament, leading to committees with extremely large remits
- Districts need to work better with upper tier authorities: on their own, districts are limited in what they can influence
- Scrutiny has fewer resources, but increasingly wide remits: it's not possible to do everything justice
- Health scrutiny has a huge workload so committees often struggle to do much more that the statutory requirements
- Scrutiny has become much leaner, but this is not necessarily a bad thing: it is more focussed now so that it achieves more impact and demands greater attention
- Accessing outside experts is easier in London as they are always relatively nearby
- Questioning skills for members are key, and remain the biggest training need
- Getting input from external experts such as academics is possible at the start of an inquiry, but sustaining this engagement throughout an inquiry is difficult
- There should be a separate budget for scrutiny, commissioning research and recommending options
- In authorities that are reducing staff numbers for budgetary reasons, more resources for scrutiny is often unrealistic

- In many councils, there are enough resources, but they aren't allocated appropriately: there needs to be a top-down reallocation of resources, with more priority given to the scrutiny team
- There is often a lot of resistance to scrutiny at the senior officer level. Many actively seek to keep scrutiny to a minimum, as they don't want to be challenged in what they're doing
- Information requested from senior officers is often sanitised or of limited usefulness. Officers need to realise they work for all councillors, not just the executive

**Councillors:**

- I'm not impressed by the quality of members. They need more training–it's only then they have the knowledge to ask probing questions
- We have people on our Committee with no expertise
- The way round the resource problem is to get members to do more work themselves.
- It is incumbent on members who chair committees and task and finish groups to take on knowledge and expertise and motivate other members to do so too
- The clerks don't prepare papers, someone from the relevant department (e.g. health and social care) does it
- We have found that scrutiny officers have taken on the role of being nothing more than glorified diary clerks. We need to motivate them to become more involved in the background and research. If you rely on reports from individual departments, they are too optimistic
- The key is understanding which questions to ask
- It's about the officers understanding the key role of scrutiny and not seeing it as a nuisance
- Commercial confidentiality is a big issue which impedes scrutiny committees
- Investment in member development is insufficient, but also hampered by large turnover of committee members
- Individual committees often have too wide a remit to cover individual issues sufficiently
- There is a growing trend to merge scrutiny function with corporate policy team. This negatively impacts on scrutiny because of conflicts of interest among officers
- Too many scrutiny committees remain talking shops. There should be more emphasis on measuring how effective scrutiny is in influencing policy and decisions
- Scrutiny staff must be completely separated from the executive

- There has been a trend towards fewer members on scrutiny committees in recent years. This has negatively affected good scrutiny
- To give scrutiny more agency scrutiny reviews should be regularly produced which go to the full council for consideration
- More focus of scrutiny committees should be placed on upstream policy formation

### *Q3) If you could make a single change, what would you change about the way scrutiny in your authority operates?*

**Officers:**

- The whole process should be more independent of departmental officers: chairs are reluctant to challenge or disagree with senior officers
- Having opposition chairs would get much better engagement and input from other members
- More members need to actually read their committee papers–however some officers make the papers intentionally long to dissuade members from doing so
- There is a capacity issue for 'double-hatted' councillors, and those who work in outside employment
- With meetings being held in the evenings, discussions can go on quite late: with many of the best councillors having demanding day jobs, it's unrealistic to expect high performance
- Scrutiny committees should share expected questions with witnesses before meetings to ensure all information is available in advance: it shouldn't be a closed-book exam as some officers can deflect questions by promising to look into an issue and write back later
- Scrutiny in general needs a higher profile, including the role of statutory scrutiny officer: people across the council should know who it is with their status being far closer to that of the monitoring officer
- Scrutiny has become too broad and complex over the years: it is not achievable to do everything asked of it. There needs to be a clear remit for scrutiny with up to date guidance from Government
- Scrutiny will only succeed if the Leader and Chief Executive think it is important–strong scrutiny chairs and strong scrutiny managers are required when they do not
- Ensuring legislation is enforced regarding undue interference from the Leader and cabinet
- Resident-led commissions help to improve scrutiny. Broadening the scrutiny process out to involve the public and prominent campaign groups, inviting them onto task groups, or to serve as chairs of commissions

- There should be an independent secretariat for scrutiny committees with separate ring-fenced budget, independent of the council, to create greater organisational autonomy
- Councils should be able to compel witnesses to attend from publicly funded bodies, such as housing associations
- Legislation relating to scrutiny powers should be simplified, putting them all into one place
- Removing conflicts of interests where scrutiny committees are supported by officers responsible for the policies that are being scrutinised

**Councillors:**

- Better selection of candidates to be councillors, as well as improving their calibre through training
- We need full time councillors: the part time nature of the role means variable quality
- It should be constitutionally established that scrutiny is on a level with cabinet
- Greater public involvement: if you want to be effective, what really changes a Leader's mind is people and residents, and if you don't get them to meetings, you won't make changes
- Statutory Scrutiny Officers are too low down the food chain to influence people. This statutory post has to be a similar level and have access to the corporate management level
- We've also got to make use of modern technology. It's about getting the message out through facebook and twitter
- One of the changes is taking meetings out in the community
- Political groups need to treat each other with fairness and respect
- Completely disconnect all aspects of scrutiny (formation, governance, resources) from the executive
- Increase connection with residents and public through co-opted members. More witnesses and public evidence sessions
- Clearer feedback loops to quantify scrutiny influence
- Council leadership should be assessed on how they take into account work of scrutiny committees, for example through annual report on scrutiny considered by full Council or annual evidence sessions with cabinet members
- Allocate chairs on the basis of political proportionality
- All scrutiny work should be considered by Full Council, rather than the cabinet

# Formal Minutes

## Monday 11 December 2017

Members present:

Mr Clive Betts, in the Chair

| | |
|---|---|
| Mike Amesbury | Fiona Onasanya |
| Bob Blackman | Mark Prisk |
| Helen Hayes | Mary Robinson |
| Kevin Hollinrake | Liz Twist |
| Andrew Lewer | |

Draft Report (*Effectiveness of local authority overview and scrutiny committees*) proposed by the Chair, brought up and read.

*Ordered*, That the Draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 104 read and agreed to.

Summary agreed to.

Annex agreed to.

*Resolved*, That the Report be the First Report of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned until Monday 18 December at 2.15 p.m.

# Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

| | *Question number* |
|---|---|
| **Monday 16 October 2017** | |
| **Professor Colin Copus**, Director of the Local Governance Research Unit, De Montfort University; **Jacqui McKinlay**, Chief Executive, Centre for Public Scrutiny (CfPS); **Councillor Marianne Overton**, Leader of the Independent Group, Local Government Association | Q1–43 |
| **Monday 30 October 2017** | |
| **Councillor Mary Evans**, Chair of Scrutiny Committee, Suffolk County Council; **Councillor Sean Fitzsimons**, Chair of Scrutiny and Overview Committee, Croydon Council; **Councillor John Cotton**, Lead Scrutiny Member, Birmingham City Council | Q44–82 |
| **Jennette Arnold OBE AM**, Chair, London Assembly; **Ed Williams**, Executive Director, Secretariat, London Assembly; **Susan Ford**, Scrutiny Manager, Greater Manchester Combined Authority, **Councillor Peter Hughes**, Chair, Overview and Scrutiny Committee, West Midlands Combined Authority | Q83–107 |
| **Monday 6 November 2017** | |
| **Marcus Jones MP**, Minister for Local Government, Department for Communities and Local Government | Q108–152 |

# Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

OSG numbers are generated by the evidence processing system and so may not be complete.

1 B4RDS (Broadband for Rural Devon & Somerset) (OSG0006)

2 Birmingham City Council (OSG0002)

3 Chester Community Voice UK (OSG0022)

4 Councillor Tony Dawson (OSG0019)

5 Dr Laurence Ferry (OSG0017)

6 Dr Linda Miller (OSG0018)

7 F&G BUILDERS LTD (OSG0005)

8 Gwen Swinburn (OSG0015)

9 Heston Residents' Association (OSG0008)

10 Local Government and Social Care Ombudsman (OSG0007)

11 MNRAG (OSG0020)

12 Mr Bryan Rylands (OSG0003)

13 Mr Mark Baynes (OSG0009)

14 Mr Stephen Butters (OSG0001)

15 Ms Christine Boyd (OSG0013)

16 Ms Jacqueline Thompson (OSG0012)

17 Nicolette Boater (OSG0016)

18 North Lincolnshire Council (OSG0021)

19 Research for Action (OSG0014)

20 Susan Hedley (OSG0004)

The following written evidence was received in the last Parliament by the previous Committee for this inquiry and can be viewed on the inquiry publications page of the Committee's website.

1 A Journalist (OSG0004)
2 ADSO (OSG0123)
3 An Officer from a London Borough (OSG0091)
4 Anonymous (OSG0006)
5 Anonymous (OSG0065)
6 Anonymous (OSG0103)
7 Bedford Borough Conservative Group (OSG0069)
8 Birmingham City Council (OSG0087)
9 Bournemouth Borough Council (OSG0071)
10 Bracknell Forest Council (OSG0010)
11 Bristol City Council (OSG0082)
12 Broadland District Council (OSG0014)
13 Cardiff Business School (OSG0056)
14 Central Bedfordshire Council (OSG0019)
15 Centre for Public Scrutiny Ltd (OSG0098)
16 Charnwood Borough Council (OSG0080)
17 Chesterfield Borough Council (OSG0052)
18 Citizens Advice (OSG0076)
19 Cllr Jenny Roach (OSG0104)
20 Committee on Standards in Public Life (OSG0027)
21 Cornwall Council (OSG0051)
22 Councillor Ann Munn (OSG0109)
23 Councillor Charles Wright (OSG0088)
24 Councillor Chris Kennedy (OSG0106)
25 Councillor James Dawson (OSG0016)
26 Councillor James Dawson (OSG0118)
27 County and Unitary Councils' Officer Overview and Scrutiny Network (OSG0114)
28 Debt Resistance UK (OSG0094)
29 Department for Communities and Local Government (OSG0122)
30 Devon County Council (OSG0008)
31 Dr Laurence Ferry (OSG0023)
32 Dr Linda Miller (OSG0095)
33 Dudley MBC (OSG0058)
34 Durham County Council (OSG0079)
35 Ealing Council (OSG0041)
36 East Devon Alliance (OSG0040)

37 East Riding of Yorkshire Council (OSG0061)
38 Epping Forest District Council (OSG0012)
39 Erewash Labour Group (OSG0013)
40 Exeter City Council (OSG0011)
41 Federation of Enfield residents & Allied Associations (OSG0097)
42 Gloucestershire County Council (OSG0050)
43 Green group on Norwich City Council (OSG0057)
44 Hereford and South Herefordshire Green Party (OSG0119)
45 Herefordshire Council (OSG0101)
46 INLOGOV (OSG0053)
47 Institute of Local Government Studies, University of Birmingham (OSG0115)
48 It's Our County (OSG0124)
49 Julian Joinson (OSG0112)
50 Ken Lyle (OSG0032)
51 Leeds City Council (OSG0043)
52 Leicestershire County Council (OSG0036)
53 Lewisham Overview and Scrutiny Business Panel (OSG0078)
54 Liberal Democrats on Wokingham Borough Council (OSG0125)
55 Local Governance Research Unit, De Montfort University (OSG0022)
56 Local Government Association (OSG0081)
57 London Assembly (OSG0117)
58 London Borough of Enfield (OSG0075)
59 London Borough of Hackney (OSG0110)
60 London Borough of Merton (OSG0037)
61 London Borough of Tower Hamlets (OSG0105)
62 Marc Hudson (OSG0116)
63 Medway Council (OSG0021)
64 Mr G M Rigler (OSG0002)
65 Mr Gerry O'Leary (OSG0092)
66 Mr John Galvin (OSG0102)
67 Mr Martyn Lewis (OSG0003)
68 Mr Peter Cain (OSG0007)
69 Mrs Tracy Reader (OSG0009)
70 Ms Christine Boyd (OSG0086)
71 Ms Jacqueline Annette Thompson (OSG0074)
72 Newcastle City Council (OSG0015)
73 NHS Providers (OSG0064)
74 Nicolette Boater (OSG0107)

75 North East Combined Authority (OSG0084)
76 North East Councils Scrutiny Officers Network (OSG0083)
77 North Tyneside Council - Scrutiny Chairs/Deputy Chairs (OSG0028)
78 North Yorkshire County Council (OSG0018)
79 Nottingham City Council (OSG0024)
80 Officer from a Fire & Rescue Authority (OSG0121)
81 Pendle Borough Council (OSG0020)
82 Rachel Collinson (OSG0066)
83 Ryedale District Council (OSG0030)
84 Scrutiny Committee of East Devon District Council (OSG0035)
85 Sheffield City Council (OSG0073)
86 Sheffield for Democracy (OSG0025)
87 South Gloucestershire Council (OSG0113)
88 Southampton City Council (OSG0029)
89 St Albans City and District Council (OSG0099)
90 Stevenage Borough Council (OSG0060)
91 Stockton on Tees Borough Council (OSG0077)
92 Suffolk County Council (OSG0054)
93 Sunderland City Council (OSG0067)
94 Susan Hedley (OSG0038)
95 The Society of Local Authority Chief Executives and Senior Managers (Solace) (OSG0068)
96 Trafford Council (OSG0048)
97 Villages Focus Group (OSG0063)
98 Walsall Council (OSG0085)
99 West Sussex County Council (OSG0026)
100 Westminster City Council (OSG0039)
101 Wiltshire Council (OSG0034)
102 Woking Borough Council Overview & Scrutiny Committee (OSG0100)
103 Woodhouse Parish Council (OSG0111)
104 Worcestershire County Council (OSG0033)
105 Wyre Council (OSG0047)
106 Wyre Council Labour Group Of Councillors (OSG0042)

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# Government Response to the Communities and Local Government Committee First Report of Session 2017-19 on the Effectiveness of Local Authority Overview and Scrutiny Committees

Presented to Parliament
by the Secretary of State for
Housing, Communities and Local Government
by Command of Her Majesty

March 2018

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## Government Response to the Communities and Local Government Committee First Report of Session 2017–19 on the Effectiveness of Local Authority Overview and Scrutiny Committees

### Introduction

In September 2017, the Communities and Local Government Select Committee relaunched the inquiry into the effectiveness of local authority overview and scrutiny committees that had been started by its predecessor earlier that year. The Select Committee published its report on 15 December 2017: https://publications.parliament.uk/pa/cm201719/cmselect/cmcomloc/369/36902.htm.

The Government will be looking at further ways to extend and improve transparency and is grateful both to the Committee for its consideration of the effectiveness of overview and scrutiny committees and to all those organisations and individuals who provided oral and written evidence.

Scrutiny can play a vital role in ensuring local accountability on a wide range of local issues. It is one of the key checks and balances in the system and the Government is committed to ensuring councils are aware of its importance, understand the benefits effective scrutiny can bring and have access to best practice to inform their thinking.

The Government firmly believes that every council is best-placed to decide which scrutiny arrangements suit its individual circumstances, and so is committed to ensuring that they have the flexibility they need to put those arrangements in place.

The Government is pleased the Select Committee acknowledges overview and scrutiny is functioning effectively in many local authorities and that committees are playing a key role in helping executives develop and review policy. The Government accepts, however, that in some councils scrutiny is not functioning as well as might be expected.

The Select Committee has made a number of recommendations, most, but not all, of which are for the Government to consider. The response in the following pages addresses only those recommendations aimed at the Government.

**Recommendation 1: Proposed revisions to Government guidance on scrutiny committees (Page 7)**

**a) That overview and scrutiny committees should report to an authority's Full Council meeting rather than to the executive, mirroring the relationship between Select Committees and Parliament.**

**b) That scrutiny committees and the executive must be distinct and that executive councillors should not participate in scrutiny other than as witnesses, even if external partners are being scrutinised.**

**c) That councillors working on scrutiny committees should have access to financial and performance data held by an authority, and that this access should not be restricted for reasons of commercial sensitivity.**

**d) That scrutiny committees should be supported by officers that are able to operate with independence and offer impartial advice to committees. There should be a greater parity of esteem between scrutiny and the executive, and committees should have the same access to the expertise and time of senior officers and the chief executive as their cabinet counterparts.**

**e) That members of the public and service users have a fundamental role in the scrutiny process and that their participation should be encouraged and facilitated by councils.**

**Government Response:**

The Government acknowledges that the current guidance was issued in 2006 and is happy to ensure it is updated. New guidance will be published later this year.

a) The Government notes the evidence supplied to the Committee. Updated guidance will recommend that scrutiny committees report to the Full Council.

b) The Government accepts the need to limit the executive's involvement in the scrutiny meetings. Updated guidance will make clear that members of the executive should not participate in scrutiny other than as witnesses.

c) Scrutiny committees already have powers to access documents and updated guidance will stress that councils should judge each request to access sensitive documents on its merits and not refuse as a matter of course. We will also have discussions with the sector to get a better understanding of the issues some scrutiny committees appear to have in accessing information and whether there are any steps the Government could take to alleviate this.

d) Updated guidance will make clear that support officers should be able to operate independently and provide impartial advice. It will also stress the need for councils to recognise and value the scrutiny function and the ways in which it can increase a council's effectiveness. However, the Government believes that each council should decide for itself how to resource scrutiny committees, including how much access to senior officers is appropriate to enable them to function effectively.

e) The Government fully believes that local authorities should take account of the views of the public and service users in order to shape and improve their services. Scrutiny is a vital part of this, and scrutiny committees should actively encourage public participation. Updated guidance will make this clear.

**Recommendation 2: That DCLG works with the Local Government Association and Centre for Public Scrutiny to identify willing councils to take part in a pilot scheme where the impact of elected chairs on scrutiny's effectiveness can be monitored and its merits considered (Paragraph 35).**

**Government Response:**

The Government will give further consideration to this recommendation.

The Government fully accepts that the chair of a scrutiny committee can have a great impact on its effectiveness. As the then Minister told the Select Committee at the oral evidence session on 6 November 2017, a chair needs to have the requisite skills, knowledge and acumen to take on the functions and achieve the outcomes that the scrutiny committee needs to achieve.

The Government also accepts that, in some instances, the election, rather than the appointment, of a chair might help ensure that the right individual is ultimately selected, but feels that this is a decision for every council to make for itself - we note that the Select Committee is "wary of proposing that [election] is imposed upon authorities by Government".

A local authority is already free to elect a chair if it wishes, and the updated guidance will recommend that every council bears this in mind when deciding on a method for selecting a chair.

The Government is happy to explore with the sector how best to establish the impact of elected chairs on scrutiny committees' effectiveness, but is not yet convinced that running pilot schemes is the best way to achieve this. The Government will therefore discuss this recommendation with the sector, including the Local Government Association and Centre for Public Scrutiny, and write to the Select Committee on this matter when we publish updated guidance.

**Recommendation 3: Councils should be required to publish a summary of resources allocated to scrutiny, using expenditure on executive support as a comparator (Paragraph 62)**

**Government Response:**

The Government does not accept this recommendation.

Many councils do not have dedicated scrutiny support staff - officers work on issues and engage with committees as part of the flow of business - so this would make quantifying the support that scrutiny committees receive very difficult. In the Government's view, the quality of the support is the more important issue.

The Government firmly believes that each individual authority is best-placed to decide for itself how to support scrutiny most effectively.

**Recommendation 4: That the Government extend the requirement of a Statutory Scrutiny Officer to all councils and specify that the post-holder should have a seniority and profile of equivalence to the council's corporate management team. To give greater prominence to the role, Statutory Scrutiny Officers should also be required to make regular reports to Full Council on the state of scrutiny, explicitly identifying any areas of weakness that require improvement and the work carried out by the Statutory Scrutiny Officer to rectify them (Paragraph 65).**

**Government Response:**

The Government does not accept this recommendation.

As the then Minister outlined during the oral evidence he gave to the Select Committee, decisions about the allocation of resources for the scrutiny function are best made at a local level. Each council is best-placed to know which arrangements will suit its own individual circumstances. It is not a case of one size fits all.

The key requirement for effective scrutiny is that the culture of the council is right. Where councils recognise the benefits effective scrutiny can bring, and put in place suitable arrangements, it is working well. Local authorities with a strong culture of scrutiny may invite regular reports to full council on the state of scrutiny in the council and this idea will be reflected in the updated guidance.

**Recommendation 5: The Department to put monitoring systems in place and consider whether the support to committees needs to be reviewed and refreshed. We invite the Department to write to us in a year's time detailing its assessment of the value for money of its investment in the Local Government Association and on the wider effectiveness of local authority scrutiny committees (Paragraph 76).**

**Government Response:**

The Government does not accept this recommendation. Local authorities are independent bodies and it is for them to ensure that their scrutiny arrangements are effective.

The Government firmly believes that every council should be able to access the training it needs to carry out its functions effectively, and recognises that Government itself has a role to play in making this happen. That is why we provide funding to the Local Government Association for sector-led improvement work. It should be noted that this funding is to support local authorities on a wide range of improvement work. It is not purely to assist with overview and scrutiny.

The funding is determined annually and for 2017/18 is £21 million. The package of work that is funded from the grant is set out in a jointly agreed Memorandum of Understanding between the Department and the Local Government Association, which is refreshed annually to ensure that it remains relevant to the sector's needs.

The Government is, of course, very keen to ensure that this funding provides value for money and that local authorities feel that the training on offer serves their needs. To this end, the Department has quarterly performance monitoring and review meetings with the Local Government Association, which are chaired by the Director-General for Local Government and Public Services.

The Government notes that not all the councillors who provided evidence to the Select Committee felt that the scrutiny training provided was as effective as they would have liked, and that the Local Government Association wrote to the Committee on 20 December 2017 to provide more information on the feedback it received on its support work.

The Government will ensure that the 2018/19 Memorandum of Understanding with the Local Government Association clearly sets out our expectation that they remain responsive to feedback they receive to ensure all training, including scrutiny training, remains relevant and effective.

**Recommendation 6: Scrutiny committees must be able to monitor and scrutinise the services provided to residents. This includes services provided by public bodies and those provided by commercial organisations. Committees should be able to access information and require attendance at meetings from service providers and we call on DCLG to take steps to ensure this happens (Paragraph 90).**

**Government Response:**

Updated guidance will remind councils of the requirements set out in regulations that allow scrutiny members to access exempt or confidential documents in certain circumstances. As mentioned in response to the Select Committee's recommendation on guidance, the Department will also have discussions with the sector to get a better understanding of the issues some scrutiny committees appear to have in accessing information and whether there are any steps the Government could take to alleviate this.

In terms of service providers' attendance at meetings, when councils are tendering contracts with external bodies they should carefully consider including requirements to ensure they are as open and transparent as appropriate. Ultimately, however, it is up to each council to decide how best to hold to account those who run its services.

**Recommendation 7: The Government to make clear how LEPs are to have democratic, and publicly visible, oversight. We recommend that upper tier councils, and combined authorities where appropriate, should be able to monitor the performance and effectiveness of LEPs through their scrutiny committees. In line with other public bodies, scrutiny committees should be able to require LEPs to provide information and attend committee meetings as required (Paragraph 96).**

**Government Response:**

The Government agrees on the importance of clear and transparent oversight of Local Enterprise Partnerships (LEPs). The Industrial Strategy made clear the continuing important role of LEPs in delivering local economic growth.

The MHCLG Non-Executive Director Review (published in October 2017), looked at a range of governance issues for LEPs. The Review made a series of recommendations that we have accepted in full and are now implementing. As part of this we have published guidance for LEPs on a range of issues including publication of agenda and papers for LEP Board meetings. This will make the proceedings of LEPs more transparent for local people.

The National Assurance Framework for LEPs states that democratic accountability for the decisions made by the LEP is provided through local authority leader membership of LEP Boards. In places where not all local authorities are represented directly on the LEP board it is important that their representatives have been given a mandate through arrangements which enable collective engagement with all local authority leaders. Many LEPs already go much further in allowing democratic scrutiny of their decision making.

The MHCLG Non-Executive Director Review into LEP governance and transparency explored the extent to which scrutiny was embedded into LEP decision making. The review acknowledged that each LEP had their own arrangements to reflect: legal structure, the complexity and needs of the locality and local requirements to ensure value for money; engagement; and democratic accountability. The Review concluded that it was not appropriate to be prescriptive on the specific arrangements that all LEPs needed to adopt due to the variation in LEP operating models.

The Government committed in the Industrial Strategy White Paper to reviewing the roles and responsibilities of LEPs and to bringing forward reforms to leadership, governance, accountability, financial reporting and geographical boundaries. Working with LEPs, the Government committed to set out a more clearly defined set of activities and objectives in early 2018. MHCLG will write to the Select Committee following the conclusion of this Ministerial review into LEPs to provide an update.

**Recommendation 8: We are concerned that effective scrutiny of the Metro Mayors will be hindered by under-resourcing, and call on the Government to commit more funding for this purpose. When agreeing further devolution deals and creating executive mayors, the Government must make clear that scrutiny is a fundamental part of any deal and that it must be adequately resourced and supported. (Paragraph 104)**

**Government Response:**

The Government accepts this recommendation.

At the Budget it was announced that the government will make available to mayoral combined authorities with elected mayors a £12 million fund for 2018-19 and 2019-20, to boost the new mayors' capacity and resources. Combined Authorities could use some of this resource to ensure that scrutiny and accountability arrangements within the CAs are effectively resourced and supported.

Further to this, the recent Combined Authorities (Overview and Scrutiny Committees, Access to Information and Audit Committees) Order 2017, developed with assistance from the Centre for Public Scrutiny and the National Audit Office, provides for the rules of operation for local overview and scrutiny and audit committees to robustly hold combined authorities and mayors to account. The order ensures that there are strong scrutiny arrangements in place consistently across every combined authority area and sets out clear requirements, strengthened appropriately to match the new powers and budgets being devolved, for the arrangement of overview and scrutiny and audit committees in all combined authorities.

Combined authorities are subject to existing relevant legislation applying to local authorities, including the strong finance and audit requirements around ensuring value for money and sustainability. Local democratic accountability, including through the scrutiny of directly-elected mayors, is a crucial and fundamental aspect of devolution.

| | | | |
|---|---|---|---|
| **Report to:** | Overview and Scrutiny Committee (Children's Services and Safeguarding) | **Date of Meeting:** | 25 September 2018 |
| **Subject:** | Cabinet Member Report – July - September 2018 | | |
| **Report of:** | Chief Legal and Democratic Officer | **Wards Affected:** | All |
| **Cabinet Portfolio:** | Children's Services and Safeguarding | | |
| **Is this a Key Decision:** | No | **Included in Forward Plan:** | No |
| **Exempt / Confidential Report:** | No | | |

**Summary:**
To submit the Cabinet Member - Children's Services and Safeguarding report relating to the remit of the Overview and Scrutiny Committee.

**Recommendation:**

That the Cabinet Member - Children's Services and Safeguarding report relating to the remit of the Overview and Scrutiny Committee be noted.

**Reasons for the Recommendation:**

In order to keep Overview and Scrutiny Members informed, the Overview and Scrutiny Management Board has agreed for relevant Cabinet Member Reports to be submitted to appropriate Overview and Scrutiny Committees.

**Alternative Options Considered and Rejected:**

No alternative options have been considered because the Overview and Scrutiny Management Board has agreed for relevant Cabinet Member Reports to be submitted to appropriate Overview and Scrutiny Committees.

**What will it cost and how will it be financed?**

Any financial implications associated with the Cabinet Member report, which are referred to in this update, are contained within the respective reports.

**(A) Revenue Costs –** see above

**(B) Capital Costs –** see above

**Implications of the Proposals:**

| |
|---|
| **Resource Implications (Financial, IT, Staffing and Assets):** |
| **Legal Implications:** |
| **Equality Implications:**<br>There are no equality implications. |

**Contribution to the Council's Core Purpose:**

| |
|---|
| Protect the most vulnerable: None directly applicable to this report. The Cabinet Member update provides information on activity within Councillor John Joseph Kelly's portfolio during a previous two month period. Any reports relevant to his portfolio considered by the Cabinet, Cabinet Member or Committees during this period would contain information as to how such reports contributed to the Council's Core Purpose. |
| Facilitate confident and resilient communities: As above |
| Commission, broker and provide core services: As above |
| Place – leadership and influencer: As above |
| Drivers of change and reform: As above |
| Facilitate sustainable economic prosperity: As above |
| Greater income for social investment: As above |
| Cleaner Greener: As above |

**What consultations have taken place on the proposals and when?**

**(A) Internal Consultations**

The Cabinet Member Update Report is not subject to FD/LD consultation. Any specific financial and legal implications associated with any subsequent reports arising from the attached Cabinet Member update report will be included in those reports as appropriate

**(B) External Consultations**

Not applicable

**Implementation Date for the Decision**

Immediately following the Committee meeting.

| | |
|---|---|
| **Contact Officer:** | Debbie Campbell |
| Telephone Number: | 0151 934 2254 |
| Email Address: | debie.campbell@sefton.gov.uk |

**Appendices:**

The following appendix is attached to this report:

- Cabinet Member - (Children's Services and Safeguarding) Update Report

**Background Papers:**

There are no background papers available for inspection.

**1. Introduction/Background**

1.1 In order to keep Overview and Scrutiny Members informed, the Overview and Scrutiny Management Board has agreed for relevant Cabinet Member Reports to be submitted to appropriate Overview and Scrutiny Committees.

1.2 Attached to this report, for information, is the most recent Cabinet Member report for the Children's Services and Safeguarding portfolio.

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# CABINET MEMBER UPDATE REPORT

**Overview and Scrutiny Committee (Children's Services and Safeguarding) - 25th September 2018**

| Councillor | Portfolio | Period of Report |
|---|---|---|
| John Joseph Kelly | Cabinet Member for Children's Services | September 2018 |

**Appointment of Local Authority Governors**

Latest guidance on the appointment of local authority governors states that LA governors must govern in the interests of the school and not represent or advocate for the political or other interests of the local authority; it is unacceptable practice to link the right to nominate local authority governors to the local balance of political power.

For LA Governor appointments, a board should make clear its eligibility criteria including its expectations of the credentials and skills prospective candidates should possess. LAs must then make every effort to understand the board's requirements in order to identify and nominate suitable candidates. It is for the board to decide whether the local authority nominee meets any stated eligibility criteria and, if it chooses to reject the candidate on that basis, to explain their decision to the LA.

Nominations will continue to be sought from political groups but prospective governors will be recommended based on the skill requirements of the school rather than the political balance as per previous practice.

**Designated Teacher for Looked after Children**

The Department for Education recently issued statutory guidance on their roles and responsibilities of the designated teacher for looked-after and previously looked-after children under sections 20(4) and 20A(4) of the Children and Young Persons Act 2008.

The guidance brings in the new responsibilities for previously looked after children and the governing bodies of maintained schools, academy proprietors and the designated staff member at maintained schools and academies must have regard to it when promoting the educational attainment of looked-after and previously looked-after children. The local authority will be working with schools to embed the guidance.

**High Needs Funding**

High Needs Funding which supports provision for pupils with SEND is over committed and funding has been found through schools to meet the demand in the current year. This is not a sustainable position and the local authority received some funding from central government to undertake a review of SEND to provide a longer-term picture of demand and a plan to meet this. Southport schools met with the Secretary of State before schools broke up for the summer and lobbied directly for more funding to support schools and pupils with SEND.

**School Balances on conversion to an academy**

Government changed the regulations regarding balances for 'forced' academy conversions where previously negative balances remained with the local authority but positive balances transferred to the trust.

Now, the local authority can retain positive balances for these types of conversions and the Cabinet Members for Children, Schools and Safeguarding, and Corporate Services have agreed Sefton should do this in future unless there are exceptional circumstances.

**Sand Dunes Nursery school**

A consultation is underway on the proposed closure of Sand Dunes Nursery school. This follows a request from the governing body because they are unable to set a balanced budget. Officers have been working with the school for a number of years and despite all of the hard work by the school to become more efficient, rising costs and reducing income has meant they can no longer set a balanced budget. The consultation runs until October.

**SEND and the role of Schools**

The local authority has been working with schools to ensure the role of schools in supporting pupils with SEND is understood. This includes what governors should do, staff training, the role of the SENCO. Schools also need to keep parents informed and publish information on how they support pupils with SEND on their website.

**Children Social Care demand and budget**

Children social care is currently experiencing rising demand on its services, with the number of child protection and looked after children increasing, this is having a consequential knock on to the budget as many of these children and young people circumstances are complex.

| | | | |
|---|---|---|---|
| **Report to:** | Overview and Scrutiny Committee (Children's Services and Safeguarding) | **Date of Meeting:** | 25 September 2018 |
| **Subject:** | Work Programme 2018/19, Scrutiny Review Topics and Key Decision Forward Plan | | |
| **Report of:** | Chief Legal and Democratic Officer | **Wards Affected:** | All |
| **Cabinet Portfolio:** | Children, Schools and Safeguarding | | |
| **Is this a Key Decision:** | No | **Included in Forward Plan:** | No |
| **Exempt / Confidential Report:** | No | | |

**Summary:**

To seek the views of the Committee on the draft Work Programme for 2018/19; identify potential topics for scrutiny reviews to be undertaken by a Working Group appointed by the Committee; and identify any items for pre-scrutiny scrutiny by the Committee from the latest Key Decision Forward Plan.

**Recommendation:**

That:-

(1) the Work Programme for 2018/19, as set out in Appendix A to the report, be considered, along with any additional items to be included and agreed;

(2) Subject to the agreement of the Overview and Scrutiny Committee (Regeneration and Skills), the Committee is requested to agree to the establishment of a joint working group to consider post-19 provision for Special Educational Needs and Disability, and to appoint at 2-3 Members of the Committee to the Working Group;

(3) the Committee is requested to note the progress made to date by the Special Educational Needs and Disability Process of Assessment Working Group Final Report;

(4) the Committee is requested to consider items for pre-scrutiny from the Key Decision Forward Plan, as set out in Appendix C to the report, that fall under the remit of the Committee and any agreed items be included in the work programme referred to in (1) above; and

(5) Further to the outcome of the Children and Adolescent Mental Health Services (CAMHS) review, the Committee is requested to note the possibility of a future site visit to the Dewi Jones Unit, Waterloo.

**Reasons for the Recommendation(s):**

To determine the Work Programme of items to be considered during the Municipal Year 2018/19 and identify scrutiny review topics which would demonstrate that the work of the Overview and Scrutiny "adds value" to the Council.

The pre-scrutiny process assists Cabinet Members to make effective decisions by examining issues before making formal decisions.

**Alternative Options Considered and Rejected:** (including any Risk Implications)

No alternative options have been considered as the Overview and Scrutiny Committee needs to approve its Work Programme and identify scrutiny review topics.

**What will it cost and how will it be financed?**

There are no direct financial implications arising from this report. Any financial implications arising from the consideration of a key decision or relating to a recommendation arising from a Working Group review will be reported to Members at the appropriate time.

**(A) Revenue Costs –** see above

**(B) Capital Costs –** see above

**Implications of the Proposals:**

| |
|---|
| **Resource Implications (Financial, IT, Staffing and Assets):** None |
| **Legal Implications:** None |
| **Equality Implications:** There are no equality implications. |

**Contribution to the Council's Core Purpose:**

| |
|---|
| Protect the most vulnerable: None directly applicable to this report but reference in the Work Programme to various reports could impact on the Council's Core Purposes in which case they will be referred to in the report when submitted. |
| Facilitate confident and resilient communities: As Above |
| Commission, broker and provide core services: As Above |
| Place – leadership and influencer: As Above |
| Drivers of change and reform: As Above |
| Facilitate sustainable economic prosperity: As Above |
| Greater income for social investment: As Above |
| Cleaner Greener: As Above |

**What consultations have taken place on the proposals and when?**

**(A) Internal Consultations**
The Work Programme Report is not subject to FD/LD consultation. Any specific financial and legal implications associated with any subsequent reports arising from the Work Programme report will be included in those reports as appropriate.

**(B) External Consultations**
Not applicable

**Implementation Date for the Decision**
Immediately following the Committee meeting.

| | |
|---|---|
| **Contact Officer:** | Debbie Campbell |
| Telephone Number: | 0151 934 2254 |
| Email Address: | debbie.campbell@sefton.gov.uk |

**Appendices:**

The following appendices are attached to this report:-

- Appendix A - Overview and Scrutiny Committee Work Programme for 2018/19
- Appendix B - Criteria Checklist For Selecting Topics For Review
- Appendix C - Latest Key Decision Forward Plan items relating to this Overview and Scrutiny Committee

**Background Papers:**

There are no background papers available for inspection.

**Introduction/Background**

**1. WORK PROGRAMME 2018/19**

1.1 The proposed Work Programme of items to be submitted to the Committee for consideration during the Municipal Year 2018/19 is set out in **Appendix A** to the report. The programme has been produced in liaison with the appropriate Heads of Service, whose roles fall under the remit of the Committee.

1.2 Members are requested to consider whether there are any other items that they wish the Committee to consider, that fall within the terms of reference of the Committee. The Work Programme will be submitted to each meeting of the Committee during 2018/19 and updated, as appropriate.

1.3 **The Committee is requested to comment on the Work Programme for 2018/19 and note that additional items may be added to the Programme at future meetings of the Committee during this Municipal Year.**

## 2. SCRUTINY REVIEW TOPICS 2018/19

2.1 At the last meeting of the Committee held on 10 July 2018, the Committee considered a recommendation from the Special Educational Needs and Disability (SEND) Process of Assessment Working Group requesting the Committee to consider the establishment of a Working Group to examine post-19 provision for SEND. It was suggested that this could be a Joint Working Group with the Overview and Scrutiny Committee (Regeneration and Skills).

2.2 This Committee agreed that:-

> "(3) the Overview and Scrutiny Committee (Regeneration and Skills) be requested to consider the establishment of a joint working group to consider post-19 provision for Special Educational Needs and Disability, with Members of this Committee;" (Minute No. 12 refers).

2.3 At the time of drafting this report the request has been submitted to the Overview and Scrutiny Committee (Regeneration and Skills) and will be considered by that Committee at its meeting scheduled for 18 September 2018. The outcome will be reported verbally to the Overview and Scrutiny Committee (Children's Services and Safeguarding) at its meeting on 25 September 2018.

**2.4 Subject to the agreement of the Overview and Scrutiny Committee (Regeneration and Skills), the Committee is requested to agree to the establishment of a joint working group to consider post-19 provision for Special Educational Needs and Disability, and to appoint at 2-3 Members of the Committee to the Working Group.**

## 3. SCRUTINY REVIEW TOPICS 2017/18

**Special Educational Needs and Disability Process of Assessment Working Group**

3.1 At its last meeting held on 10 July 2018, the Committee considered the Final Report of the above Working Group and resolved as follows:-

"RESOLVED:

That provided the recommendations are subject to any budget implications and the inclusion of the revised recommendation 1 (h), the report and the (following) recommendations be supported and commended to the Cabinet for approval".

3.2 The Final Report was subsequently considered by the Cabinet at its meeting held on 26 July 2018, and the recommendations were approved.

3.3 A six-monthly monitoring report setting out progress made against each of the recommendations will now be submitted to the Committee at its meeting scheduled for 29 January 2019.

**3.4 The Committee is requested to note the progress made to date by the Special Educational Needs and Disability Process of Assessment Working Group Final Report.**

## 4. PRE-SCRUTINY OF ITEMS IN THE KEY DECISION FORWARD PLAN

4.1 Members may request to pre-scrutinise items from the Key Decision Forward Plan which fall under the remit (terms of reference) of this Committee. The Forward Plan, which is updated each month, sets out the list of items to be submitted to the Cabinet for consideration during the next four month period.

4.2 The pre-scrutiny process assists the Cabinet Members to make effective decisions by examining issues beforehand and making recommendations prior to a determination being made.

4.3 The Overview and Scrutiny Management Board has requested that only those key decisions that fall under the remit of each Overview and Scrutiny Committee should be included on the agenda for consideration.

4.4 The latest Forward Plan is attached at **Appendix C** for this purpose. For ease of identification, items listed on the Forward Plan for the first time appear as shaded.

4.5 Should Members require further information in relation to any item on the Key Decision Forward Plan, would they please contact the relevant Officer named against the item in the Plan, prior to the Meeting.

4.6 There is just one item within the current Plan that falls under the remit of the Committee on this occasion, namely:-

- Sand Dunes Nursery School -Outcome of the Consultation

**4.7 The Committee is invited to consider items for pre-scrutiny from the Key Decision Forward Plan as set out in Appendix C to the report, that fall under the remit of the Committee and any agreed items be included in the Work Programme referred to in (1) above.**

## 5. POSSIBLE SITE VISIT

5.1 The Committee's former Children and Adolescent Mental Health Services (CAMHS) Working Group included a recommendation as follows:-

> "(7) the Head of Regulation and Compliance be requested to approach Alder House with a view to extending an invitation to all Members of the Overview and Scrutiny Committee (Children's Services and Safeguarding) to attend a site visit to Alder House;"

5.2 Further investigations have revealed that Alder Hey Hospital NHS Foundation Trust has a Unit, known as the Dewi Jones Unit, based in Park Road, Waterloo, that provides an in-patient mental health facility for children and young people aged 5 – 14.

5.3 At the time of drafting this report attempts are being made to investigate the possibility of a potential site visit for Members of the Committee to visit the Unit. The General Manager of the Unit has indicated that a visit by Members would be welcomed and a date for a visit is being determined. Members will be advised of arrangements once they are finalised. Any further developments will be reported verbally at the meeting.

**5.4 Further to the outcome of the Children and Adolescent Mental Health Services (CAMHS) review, the Committee is requested to note the possibility of a future site visit to the Dewi Jones Unit, Waterloo.**

**APPENDIX A**

## OVERVIEW AND SCRUTINY COMMITTEE (CHILDREN'S SERVICES AND SAFEGUARDING)

## WORK PROGRAMME 2018/19

| Date of Meeting | 10 JULY 18 Re-Arranged from 19 June 2018 | 25 SEPTEMBER 18 | 13 NOVEMBER 18 | 29 JANUARY 19 | 19 MARCH 19 |
|---|---|---|---|---|---|
| **Regular Reports:-** | | | | | |
| Cabinet Member Update Report | **X** | **X** | **X** | **X** | **X** |
| Work Programme Update<br>(Debbie Campbell) | **X** | **X** | **X** | **X** | **X** |
| Information on Serious Case Reviews<br>(As & when cases arise)<br>(Vicky Buchanan) | | **X** | | | |
| | | | | | |
| **Service Operational Reports:-** | | | | | |
| Public Health Annual Report "Mental Health and Wellbeing"<br>(M. Ashton/S. Gowland) | **X** | | | | |
| Development of Family Well-Being Service – Progress Report<br>(Jacqueline Finlay) | **X** | | | | |
| Children's Social Care Annual Report<br>(Vicky Buchanan) | **X** | | | | |
| Children's Social Care Continuous Improvement Plan<br>(Vicky Buchanan) | | **X** | | | |

**APPENDIX A**

| Date of Meeting | 10 JULY 18 (Re-Arranged from 19 June 2018) | 25 SEPTEMBER 18 | 13 NOVEMBER 18 | 29 JANUARY 19 | 19 MARCH 19 |
|---|---|---|---|---|---|
| Fostering Service Annual Report (Vicky Buchanan) | | X | | | |
| Local Government Association Care Practice Diagnostic (Peer Review) (Vicky Buchanan) | | X | | | |
| Enhancing Elected Member Involvement (Vicky Buchanan) | | X | | | |
| Effectiveness of Local Authority Overview and Scrutiny Committees – Government Response to DCLG Select Committee Report (Paul Fraser) | | X | | | |
| Performance Update on the Children's Plan (Sharon Lomax) | | | X | | |
| Corporate Parenting Board (Annual Report) (Karen Gray) | | | | X | |
| School Performance and Attainment Update (Annual Report) (Mike McSorley) | | | | X | |
| Information on NEETS & SEND (Claire Maguire) | | | | X | |

| Date of Meeting | 10 JULY 18 (Re-Arranged from 19 June 2018) | 25 SEPTEMBER 18 | 13 NOVEMBER 18 | 29 JANUARY 19 | 19 MARCH 19 |
|---|---|---|---|---|---|
| School Organisation and School Places (Annual Report) (M. McSorley) | | | | | X |
| | | | | | |
| **Scrutiny Review Progress Reports:** | | | | | |
| CAMHS Working Group - Interim Report (Mike McSorley) | X | | | X | |
| Not in Education, Employment or Training (NEETs) Working Group - Implementation of Recommendations (Claire Maguire) | X | | | | |
| Licensing/Child Sexual Exploitation Working Group - Monitoring Report (Paul Fraser) | X | | | | |
| Special Educational Needs and Disability Service Process of Assessment Working Group – Final Report (Debbie Campbell) | X | | | | |
| SEND Working Group – Update Report (Debbie Campbell) | | | | X | |

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**CRITERIA CHECKLIST FOR SELECTING TOPICS FOR REVIEW**

| Criteria for Selecting Items |
|---|
| ▪ Issue identified by members as key issue for public (through member surgeries, other contact with constituents or volume of complaints) |
| ▪ Poor performing service (evidence from performance indicators/benchmarking) |
| ▪ Service ranked as important by the community (e.g. through market surveys/citizens panels) |
| ▪ High level of user/general public dissatisfaction with service (e.g. through market surveys/citizens panels/complaints) |
| ▪ Public interest issue covered in local media |
| ▪ High level of budgetary commitment to the service/policy area (as percentage of total expenditure) |
| ▪ Pattern of budgetary overspends |
| ▪ Council corporate priority area |
| ▪ Central government priority area |
| ▪ Issues raised by External Audit Management Letter/External audit reports |
| ▪ New government guidance or legislation |
| ▪ Reports or new evidence provided by external organisations on key issue |
| ▪ Others |

**CRITERIA FOR REJECTION**

| Potential Criteria for Rejecting Items |
|---|
| ▪ Issue being examined by the Cabinet |
| ▪ Issue being examined by an Officer Group : changes imminent |
| ▪ Issue being examined by another internal body |
| ▪ Issue will be addressed as part of a Service Review within the next year |
| ▪ New legislation or guidance expected within the next year |
| ▪ Other reasons specific to the particular issues. |

**Appendix B**

**SCRUTINY CHECKLIST**
**DO'S AND DON'TS**

| **DO** |
|---|
| ♦ Remember that Scrutiny<br>♦ Is about learning and being a "critical friend"; it should be a positive process<br>♦ Is not opposition |
| ♦ Remember that Scrutiny should result in improved value, enhanced performance or greater public satisfaction |
| ♦ Take an overview and keep an eye on the wider picture |
| ♦ Check performance against local standards and targets and national standards, and compare results with other authorities |
| ♦ Benchmark performance against local and national performance indicators, using the results to ask more informed questions |
| ♦ Use Working Groups to get underneath performance information |
| ♦ Take account of local needs, priorities and policies |
| ♦ Be persistent and inquisitive |
| ♦ Ask effective questions - be constructive not judgmental |
| ♦ Be open-minded and self aware - encourage openness and self criticism in services |
| ♦ Listen to users and the public, seek the voices that are often not heard, seek the views of others - and balance all of these |
| ♦ Praise good practice and best value - and seek to spread this throughout the authority |
| ♦ Provide feedback to those who have been involved in the review and to stakeholders |
| ♦ Anticipate difficulties in Members challenging colleagues from their own party |
| ♦ Take time to review your own performance |

| ♦ **DON'T** |
|---|
| ♦ Witch-hunt or use performance review as punishment |
| ♦ Be party political/partisan |
| ♦ Blame valid risk taking or stifle initiative or creativity |
| ♦ Treat scrutiny as an add-on |
| ♦ Get bogged down in detail |
| ♦ Be frightened of asking basic questions |
| ♦ Undertake too many issues in insufficient depth |
| ♦ Start without a clear brief and remit |
| ♦ Underestimate the task |
| ♦ Lose track of the main purpose of scrutiny |
| ♦ Lack sensitivity to other stakeholders |
| ♦ Succumb to organisational inertia |
| ♦ Duck facing failure - learn from it and support change and development |
| ♦ Be driven by data or be paralysed by analysis - keep strategic overview, and expect officers to provide high level information and analysis to help. |

**KEY QUESTIONS**

**Overview and Scrutiny Committees should keep in mind some of the fundamental questions:-**

| |
|---|
| Are we doing what users/non users/local residents want? |
| Are users' needs central to the service? |
| Why are we doing this? |
| What are we trying to achieve? |
| How well are we doing? |
| How do we compare with others? |
| Are we delivering value for money? |
| How do we know? |
| What can we improve? |

**INVESTIGATIONS:-**

| |
|---|
| To what extent are service users' expectations and needs being met? |
| To what extent is the service achieving what the policy intended? |
| To what extent is the service meeting any statutory obligations or national standards and targets? |
| Are there any unexpected results/side effects of the policy? |
| Is the performance improving, steady or deteriorating? |
| Is the service able to be honest and open about its current performance and the reasons behind it? |
| Are areas of achievement and weakness fairly and accurately identified? |
| How has performance been assessed? What is the evidence? |
| How does performance compare with that of others? Are there learning points from others' experiences? |
| Is the service capable of meeting planned targets/standards? What change to capability is needed. |
| Are local performance indicators relevant, helpful, meaningful to Members, staff and service users? |

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# SEFTON METROPOLITAN BOROUGH COUNCIL
# FORWARD PLAN

## FOR THE FOUR MONTH PERIOD 1 OCTOBER 2018 - 31 JANUARY 2019

This Forward Plan sets out the details of the key decisions which the Cabinet, individual Cabinet Members or Officers expect to take during the next four month period. The Plan is rolled forward every month and is available to the public at least 28 days before the beginning of each month.

A Key Decision is defined in the Council's Constitution as:

1. any Executive decision that is not in the Annual Revenue Budget and Capital Programme approved by the Council and which requires a gross budget expenditure, saving or virement of more than £100,000 or more than 2% of a Departmental budget, whichever is the greater;

2. any Executive decision where the outcome will have a significant impact on a significant number of people living or working in two or more Wards

As a matter of local choice, the Forward Plan also includes the details of any significant issues to be initially considered by the Executive Cabinet and submitted to the Full Council for approval.

Anyone wishing to make representations about any of the matters listed below may do so by contacting the relevant officer listed against each Key Decision, within the time period indicated.

Under the Access to Information Procedure Rules set out in the Council's Constitution, a Key Decision may not be taken, unless:

- it is published in the Forward Plan;
- 5 clear days have lapsed since the publication of the Forward Plan; and
- if the decision is to be taken at a meeting of the Cabinet, 5 clear days notice of the meeting has been given.

The law and the Council's Constitution provide for urgent key decisions to be made, even though they have not been included in the Forward Plan in accordance with Rule 26 (General Exception) and Rule 28 (Special Urgency) of the Access to Information Procedure Rules.

Copies of the following documents may be inspected at the Town Hall, Oriel Road, Bootle L20 7AE or accessed from the Council's website: www.sefton.gov.uk

- Council Constitution
- Forward Plan
- Reports on the Key Decisions to be taken
- Other documents relating to the proposed decision may be submitted to the decision making meeting and these too will be made available by the contact officer named in the Plan
- The minutes for each Key Decision, which will normally be published within 5 working days after having been made

**APPENDIX C**

Some reports to be considered by the Cabinet/Council may contain exempt information and will not be made available to the public. The specific reasons (Paragraph No(s)) why such reports are exempt are detailed in the Plan and the Paragraph No(s) and descriptions are set out below:-

1. Information relating to any individual
2. Information which is likely to reveal the identity of an individual
3. Information relating to the financial or business affairs of any particular person (including the authority holding that information)
4. Information relating to any consultations or negotiations, or contemplated consultations or negotiations in connection with any labour relations matter arising between the authority or a Minister of the Crown and employees of, or office holders under, the Authority
5. Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings
6. Information which reveals that the authority proposes a) to give under any enactment a notice under or by virtue of which requirements are imposed on a person; or b) to make an order or direction under any enactment
7. Information relating to any action taken or to be taken in connection with the prevention, investigation or prosecution of crime
8. Information falling within paragraph 3 above is not exempt information by virtue of that paragraph if it is required to be registered under—
   (a) the Companies Act 1985;
   (b) the Friendly Societies Act 1974;
   (c) the Friendly Societies Act 1992;
   (d) the Industrial and Provident Societies Acts 1965 to 1978;
   (e) the Building Societies Act 1986; or
   (f) the Charities Act 1993.
9. Information is not exempt information if it relates to proposed development for which the local planning authority may grant itself planning permission pursuant to regulation 3 of the Town and Country Planning General Regulations 1992
10. Information which—
   (a) falls within any of paragraphs 1 to 7 above; and
   (b) is not prevented from being exempt by virtue of paragraph 8 or 9 above,is exempt information if and so long, as in all the circumstances of the case, the public interest in maintaining the exemption outweighs the public interest in disclosing the information.

Members of the public are welcome to attend meetings of the Cabinet and Council which are held at the Town Hall, Oriel Road, Bootle or the Town Hall, Lord Street, Southport. The dates and times of the meetings are published on www.sefton.gov.uk or you may contact the Democratic Services Section on telephone number 0151 934 2068.

*NOTE:*
*For ease of identification, items listed within the document for the first time will appear shaded.*

**Margaret Carney**
**Chief Executive**

# FORWARD PLAN INDEX OF ITEMS

| Item Heading | Officer Contact |
|---|---|
| Sand Dunes Nursery School -Outcome of the Consultation | Mike McSorley mike.mcsorley@sefton.gov.uk Tel: 0151 934 3428 |

# SEFTON METROPOLITAN BOROUGH COUNCIL FORWARD PLAN

| | | | | |
|---|---|---|---|---|
| Details of Decision to be taken | **Sand Dunes Nursery School -Outcome of the Consultation**<br>To consider the outcome of the consultation exercise regarding the closure of Sand Dunes Nursery School | | | |
| Decision Maker | Cabinet | | | |
| Decision Expected | 1 Nov 2018 | | | |
| Key Decision Criteria | Financial | Yes | Community Impact | Yes |
| Exempt Report | Open | | | |
| Wards Affected | Derby; Linacre | | | |
| Scrutiny Committee Area | Children's Services and Safeguarding | | | |
| Persons/Organisations to be Consulted | Parents, Nursery staff and Governors | | | |
| Method(s) of Consultation | Meetings with parents, Headteacher, staff and Governors. Letters sent to parents | | | |
| List of Background Documents to be Considered by Decision-maker | Sand Dunes Nursery School -Outcome of the consultation | | | |
| Contact Officer(s) details | Mike McSorley mike.mcsorley@sefton.gov.uk Tel: 0151 934 3428 | | | |

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