Children and Families Scrutiny Committee
November 26th 2020

Report Title	Report of the Independent Scrutineer – interim report 19/20
Purpose of Report	To provide an update on the role of independent scrutiny in Gloucestershire and a provisional view from the Independent Scrutineer (IS) on progress being made by the Gloucestershire Safeguarding Children's Executive (GSCE) in ensuring safeguarding arrangements are robust and effective
Is this for information or decision?	For information
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Key Issues:

Both the GSCE and the IS are required to produce an annual report regarding safeguarding arrangements in the County. As outlined in the report the timescale for both has been affected by the need for agencies to prioritise their response to the pandemic.

The report gives an update on progress made since the implementation of the new arrangements first published in April 2019 which became fully operational in July 2019.

A further report will be completed by the IS in early 2021 which will provide more analysis of the performance of key partners in ensuring that children and young people are safeguarded and kept safe from harm.

Recommendations to the Committee:

That the Committee note the progress that has been made and the plans for further work to ensure that the children's safeguarding system continues to improve and keep children protected from harm.

Financial/Resource Implications:

None identified within this report

Report of the Independent Scrutineer

Gloucestershire Safeguarding Partnership

November 2020

1.1 Purpose of report

To provide an update on the role of independent scrutiny in Gloucestershire and a provisional view from the Independent Scrutineer (IS) on progress being made by the Gloucestershire Safeguarding Children's Executive (GSCE) in ensuring safeguarding arrangements are robust and effective.

1.2 Introduction

As set out together in 'Working Together to Safeguard Children' (DfE July 2018) (WT18) introduced a new and shared and equal responsibility '….to make arrangements to work together to safeguard and promote the welfare of local children including identifying and responding to their needs.'. That responsibility is held by the local authority; the clinical commissioning group; and, the chief officer of police. These are the 'safeguarding partners' (SP).

Paragraph 8, Chapter 3 - 'The purpose of these local arrangements is to support and enable local organisations and agencies to work together in a system where:

- Children are safeguarded and their welfare promoted
- Partner organisations and agencies collaborate, share and co-own the vision for how to achieve the outcomes for vulnerable children
- Organisations and agencies challenge appropriately and hold one another to account effectively
- There is early identification and analysis of new safeguarding issues and emerging threats
- Learning is promoted and embedded in a way that local services for children and families can be more reflective and implement changes to practice
- Information is shared effectively to facilitate more accurate and timely decision making for children and families'

Paragraph 9, Chapter 3 – 'In order to work effectively together, the safeguarding partners with other local organisations and agencies should develop processes that:

- Facilitate and drive action beyond usual institutional and agency constraints and boundaries

- Ensure effective protection of children is founded on practitioners developing lasting and trusting relationships with children and families'

Paragraph 10, Chapter 3 - 'To be effective, these arrangements should link to other strategic partnership work happening locally to support children and families. This will include other public boards including Health and wellbeing boards, Adult Safeguarding boards, Channel Panels, Improvement Boards, Community Safety Partnerships, the Local Family Justice Board and MAPPAs.'

(WT18 p73)

1.3 As part of those arrangements the SPs must make provision for 'independent scrutiny' the role of which '…is to provide assurance in judging the effectiveness of local multi agency arrangements to safeguard and promote the welfare of all children in a local area, including arrangements to identify and review serious safeguarding cases. This independent scrutiny will be part of a wider system which includes the independent inspectorates' single assessment of the individual safeguarding partners and the Joint Targeted Area Inspections.'(WT18 p77).

1.4 There is no prescribed model for independent scrutiny nor any methodology which leaves it to local partners to establish how the function is undertaken. Gloucestershire's published arrangements make provision for the appointment of a single person to provide independent scrutiny. Kevin Crompton ,a former Director of Children's Services, Local Authority Chief Executive and Chair of Children's Safeguarding Boards was formally appointed to the role from 1st November 2019.

1.5 In due course there will be a public facing GSCE annual report including a report from the IS. Critical to the completion of both is the biennial S11 audit through which each partner provides key evidence of their effectiveness. As outlined below, due to Covid 19, the audit has had to be delayed until December as partners capacity is fully stretched responding to the pandemic. Both reports are likely to be finalised in early 2021.

2.0 Progress in implementing WT18

2.1 A shadow GSCE was established in late 2018 and Gloucestershire published its new arrangements in April 2019 (following consultation) and were amongst the first tranche of authorities to do so. They became fully operational in July 2019 with the establishment of the GSCE and the Delivery Board as the principal governance structures.

2.2 A strategic decision was taken to focus these arrangements on Section 11 responsibilities of partners (Children Act 2004 -welfare and safeguarding). Separate work was established to focus on the Section 10 (Children Act 2004) responsibility of the Local Authority to ensure that all partners work together to promote the 'well-being' of all children and young people in the area. These two responsibilities are integrally linked and in Ofsted rated good and outstanding authorities there is clear evidence of how a focus on 'well-being ' for all is a prerequisite for strong safeguarding. Further work on this again planned for December.

2.3 The GSCE took the opportunity taken to streamline and rationalise all subgroups with a view to maximise the engagement and contribution of partners. Of note is the development of the Quality and Improvement in Practice subgroup (QIP) which holds a key role in monitoring performance and overseeing changes in practice required by recommendations from Serious Case Reviews(SCR) and the new system of Rapid Reviews(RR) and Local Child Safeguarding Practice Reviews (LCSPR).

2.4 Leadership has been delegated by the 'lead representatives' ('local authority chief executive, the accountable officer of a clinical commissioning group and the chief of police' (WT18 p73)) to the Director of Children's Services; Assistant Chief Constable (Crime, Justice and Vulnerability and the CCG Executive Nurse and Lead for Safeguarding. All three are supported by senior colleagues who undertake key roles in chairing the delivery board and subgroups. The Executive is chaired by all 3 SPs in rotation and is currently chaired by the CCG.

2.5 Early meetings of the GSCE and delivery board took stock of the legacy from the former Gloucestershire Children's Safeguarding Board (GSCB) and began the process of setting key objectives for the new partnership.

2.6 Regular meetings are held with appropriate agenda's and these meetings have been well attended and purposeful with evidence of a renewed commitment across the SPs and relevant agencies (as specified in WT18 for example the District councils and schools) to ensuring services for children, young people, families and carers are properly focussed on safeguarding and welfare.

2.7 A new system of RRs was introduced with the first being held in April 2020. Initially chaired by partners they are now independently chaired which has further strengthened the methodology. The involvement of front-line practitioners has proved to be a good evolution of the RR approach. To date there have been 11 such reviews with two leading to the next level of review – a LCSPR one of which is a thematic review of three cases involving child sexual exploitation which should be published in the spring of 2021.

2.8 Under the transitional guidance arrangements had to be made for the completion of the 9 SCRs commissioned by the outgoing Gloucestershire Children's Safeguarding Board (GSCB). All 9 were completed , 5 have been published and it is planned to publish two more in December. It is commendable that the SPs remain committed to publishing the outcomes of SCRs.

2.9 A 'tracker' has been developed to enable QIP to monitor the implementation of the recommendations from SCRs , RRs and LCSPRs. Significant work was undertaken to ensure actions are smart , deliverable and will have a tangible impact on practice. The tracker focusses on the multi-agency actions arising from reviews. It is intended to monitor the implementation of single agency actions through the S11 audit.

2.10 Learning has been derived from RRs with potential impact on practice. Partners have focussed specifically for example on the implementation and effectiveness of the multi-agency pre-birth protocol which is monitored via a task and finish group. Similarly , case audit and RRs have shown that some multi agency toolkits such as the neglect toolkit are not used by all partners leading to critical review of how to rectify this in the future.

2.11 Partners agreed to the resourcing of a part time analyst to support the improvement in reporting multi agency performance data based on the collection of a range of data from partners produced to a common timeline. The post was initially filled but became vacant and was re advertised. Interviews are being held in early December.

2.12 A revised S11 audit process was agreed by partners through which judgements can be made on the effectiveness of individual agencies in discharging their S11 duties. A separate process (S175 audit) remains in place for schools and has a 100% return record.

2.13 Partners have shown a clear commitment to working with each other to solve safeguarding issues. All three SPs have made resource commitments to ensure the operation of the Multi Agency Safeguarding Hub (MASH) which has also been a platform for reflection on current and future practice for partnership working in respect of key areas such as strategy discussions , S47 enquiries ,contacts and referrals. All the evidence available on the MASH indicates it is an effective 'front door' capable of channelling concerns to an appropriate pathway ranging from advice through early help and safeguarding response. The timeliness of partner's response to the most serious of concerns has improved consistently over the last year.

2.14 A programme of multi-agency case file audits is planned which will give QIP a greater 'line of sight' on front line multi agency practice. This will provide further evidence of how well partners work together to safeguard children and young people. The first audit has started and is on the theme of neglect. This will provide further insight into the utility of the 'neglect toolkit' developed as a response to previous SCR recommendations. A multi-agency task and finish group is progressing this work and hopes to report in December. There is also a task and finish group monitoring the use of the pre-birth protocol.

2.15 An initial framework was produced through which the IS would evaluate the effectiveness of the partnership based on some agreed criteria partly based on those used by the relevant regulators for the SPs. The partnership is also considering some emerging practice across the country which uses a framework developed by the University of Bedfordshire.

2.16 There has been greater use of the escalation process by partners. Whilst there have been instances where use of the procedure has been challenging, both in process and content ,all partners have demonstrated their willingness to engage in difficult conversations and seek solutions. A good example is the development of a programme to facilitate conversations between health agencies and children's social care on how to improve support from children and young people with complex needs including services to support children with mental health conditions.

2.17 A review of the effectiveness of the governance took place in October 2020 and revisions to the membership and functions of the delivery board agreed which are aimed at improving the delivery of the partnership's programmes including the learning from reviews. The outcome is intended to strengthen further the delegation of authority to the sub groups to allow them to act to improve practice.

2.18 There is also a national review of WT18 arrangements led by Sir Alan Wood that should report in the new year.

2.19 The IS has held some meetings with the ambassadors to explore how best to incorporate the voice of children and young people in the annual assurance process. In particular the IS wants to ensure that any report demonstrates 'language that cares' which has been a particular campaign led by the ambassadors.

2.20 Much of the above was in place by early 2020 and it would be fair to say that as we entered the year the partnership had made a good start under WT18 and was well placed to demonstrate even better effectiveness going forward. The review of governance in October also demonstrated a commitment to go

beyond transition from the old GSCB system and seek to use the flexibilities allowed under WT18 to improve partnership working.

3.0 The impact of Covid 19

3.1 2020 has been a challenging year for all partners and it is important that we take this into account when scrutinising progress against the requirements of WT18. During the pandemic partners have maintained a commitment to partnership working including participation in online meetings. Appropriate adjustments were made to meeting structures and membership to ensure that dialogue could continue.

3.2 All partners provided update reports on their response to Covid including reassurance to the GSCE that safeguarding capacity would be protected. GSCE and the delivery board worked well with the vulnerable children's cell to track how partners were monitoring support for vulnerable children during full lockdown.

3.3 Partners adjusted their service delivery models to account for lockdown and the need to maintain 'social distancing' Police teams were; for example, established to visit homes designated as 'high risk' for domestic violence and abuse. Children's Social Care put in place a whole system to ensure vulnerable children were identified and their safety monitored including being visited regularly. The CCG ensured that those with key safeguarding roles were not re deployed during the pandemic.

3.4 There is evidence to show that Gloucestershire's overall response to Covid was good and this was assisted by the improved partnership working developed post WT18. A good example of this is the sharing of single agency briefings with other partners an action that was very much welcomed by front line staff.

3.5 Some services have however come under pressure and in particular the provision of support for children with complex needs, including mental health, is being reviewed by partners.

3.6 Unfortunately though the demands on capacity have meant that some key areas of work being managed through the GSCE have been delayed and therefore the momentum which characterised the first few months has been slightly lost. In particular key work the further development of performance data; the S11 audit; and the programme of multi-agency audits was delayed.

3.7 Nevertheless it is clear that partners have worked well together and continue to do so during the pandemic. There is evidence to show this is beginning to have an impact on practice. Improved attendance of health at strategy

discussions; MASH decision making; attendance at initial child protection conferences; timely health checks for Children in Care are a few examples where things have improved.

3.8 During the pandemic the partners have sustained the RR system and they have identified key areas for improvement in important areas such as the disruption of perpetrators of CSE; services to children with complex needs and information sharing.

4.0 Ofsted Focussed visit

4.1 The outcome of the October focussed visit was published on 20th November and contains a number of points about partnership working.

4.2 The MASH was able to operate 'virtually' with no 'significant drop off in its performance'. Further more '… the MASH continues to provide a timely and proportionate response to children and families at first point of contact…'. The letter also though refers to ' the comparatively high rate of referrals' which suggests either a '… degree of risk aversion and /or a failure on the part of partner agencies to fully understand or consistently apply thresholds.' . This indicates that partners should now undertake a review of this are of partnership working.

4.3 The letter notes that partners working together well in terms of participation in and the outcomes of strategy meetings and section 47 enquiries which is another indication of the progress being made by partners as this was not the case 18 months ago.

4.4 Ofsted note that 'most children in care have up to date health assessments 'and compliments the work of the children in care nursing team. Dental health checks have however been more difficult during Covid -19 but at the recent Improvement Board the CCG confirmed that action is being taken to rectify this situation.

4.5 Ofsted also noted the challenges in delivering services to children experiencing emotional well -being and mental health and the work noted elsewhere in this report through which partners are hoping to address this issue.

4.6 The strategic partnership work underpinning the development of the 'virtual court system' is identified as a critical response to Covid 19 and compliments the Local Authority leadership and financial support for this initiative.

4.7 The quality of personal education plans is signalled as an area which needs improvement and although the virtual school has overseen a fall in fixed-term

and permanent exclusions outcome for children in care are still not good enough.

4.8 The percentage of care leavers who are not in employment, education and training has increased during the pandemic and this will be another area where partnership working is required to develop more opportunities for care leavers.

4.9 These and, other partnership matters arising from the performance reports submitted to the Improvement Board, were discussed at the recent meeting of that board which is attended by the IS. Partners present were able to report progress on work designed to address these issues which were already known to them due the improved performance and other data now available to the partnership. This is another indication that the partners are working more effectively that in the past.

5. Conclusions

5.1 The SPs are intending to review/revise priorities for the partnership in the light of the experience of working together throughout the pandemic.

5.2 The partnership has grown in confidence over the past year based on a greater understanding of how to work together and a willingness to exercise professional curiosity and challenge when reviewing performance data. This is increasingly based on abetter understanding of that data and the learning from SCRs and RRs.

5.3 The issues raised during the last Ofsted focussed visit were already known to partners which suggests a partnership that is increasingly self-aware and focussed on improving outcomes for children and young people.

5.4 The IS will produce a more structured and evidenced based assessment of the effectiveness of the safeguarding arrangements in the County following the conclusion of the S11 audit process in December 2020.

5.5 The IS believes that Gloucestershire partners have made a good start under the WT18 arrangements which now needs to be translated into evidence of improved outcomes for children and young people. There is a need to agree those areas of practice which can and need to be improved and ensure that there is a clear plan for ensure that changes are made leading to improved service for children and young people.

Kevin Crompton
Independent Scrutineer

November 2020