OXFORDSHIRE COUNTY COUNCIL

Performance Scrutiny Committee
Thursday, 16 March 2017

ADDENDA

3. Minutes (Pages 1 - 6)

The meeting of 9 March 2017 deferred consideration of the minutes of the meeting held on 5 January 2017 which are now attached

The minutes of the meeting held on 9 March 2017 will be circulated when available.

9. Overview of OCC Response to Serious Case Reviews (Pages 7 - 18)

12.10

An overview report summarising Children's Safeguarding Serious Case Reviews in the last year with focus on the outcome, actions taken, identifying improvements and assurance.

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PERFORMANCE SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 5 January 2017 commencing at 10.00 am and finishing at 1.20 pm.

Present:

Voting Members:	Councillor Liz Brighouse OBE – in the Chair
	Councillor Janet Godden (Deputy Chairman) Councillor Sam Coates Councillor Yvonne Constance OBE Councillor Mark Gray Councillor Patrick Greene Councillor Jenny Hannaby Councillor Stewart Lilly Councillor Sandy Lovatt Councillor Charles Mathew Councillor John Sanders

Officers:

Whole of meeting	Steven Jones, Policy and Performance Officer Colm Ó Caomhánaigh, Committee Secretary

Part of meeting

Agenda Item	**Officer Attending**
5	Lorna Baxter, Chief Finance Officer
6 & 7	Kate Terroni, Director for Adult Services
6	Benedict Leigh, Strategic Commissioner (Adults)
7	Ian Dyson, Assistant Chief Finance Officer (Assurance); Lucy Butler, Director for Children's Services; Hannah Farncombe, Deputy Director Children's Social Care
8	David Etheridge, Chief Fire Officer; Simon Furlong, Deputy Chief Fire Officer; Julian Green, Station Manager Strategic Risk & Assurance
9	Chris Kenneford, Planning Regulation Service Manager; Howard Cox, Infrastructure Funding Manager; Susan Halliwell, Acting Deputy Director Strategy & Infrastructure Planning

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting, together with a schedule of addenda tabled at the meeting and agreed as set out below. Copies of the agenda, reports and additional documents are attached to the signed Minutes.

1/17 DECLARATIONS OF INTEREST - GUIDANCE NOTE ON BACK PAGE OF THE AGENDA

(Agenda No. 2)

In relation to Agenda Item 7, Councillor Stuart Lilly declared that he occasionally acts professionally, as a property advisor, for Home Farm Trust.

2/17 MINUTES

(Agenda No. 3)

The minutes of the meeting held on 15 December 2016 were approved and signed as a correct record subject to the following corrections:

Minute 57/16: Second paragraph, delete: "look at the reviews" and replace with "review the responses".

Minute 59/16: Third paragraph, add "at this point" to the end of the second sentence.

3/17 SERVICE AND RESOURCE PLANNING 2017/18 - 2020/21 AND CAPITAL BUDGET 2017/18

(Agenda No. 5)

Ms Baxter introduced the report which set out the main points arising from the Local Government Finance Statement which was published on the 15 December.

Members discussed the following points:

- The New Homes Bonus will only be paid on housing growth above 0.4% of the local authority's housing stock as opposed to the consultation proposal which was 0.25%. This and other changes will yield £241m nationally to fund the Adult Social Care Support Grant in 2017/18.
- The Government's proposal abating the Bonus in circumstances where planning permission for a new development has only been granted on appeal was criticised by some Members. The Government will consult on this in 2018/19.
- The changes in the Adult Social Care Precept and Grant will not mean more on-going money for Adult Social Care. £5m demographic funding which was to come from corporate resources can now be funded by the precept and grant. However, this £5m from corporate resources must be transferred to other funds in order to balance the budget. Members expressed frustration that more money could not be allocated to Adult Social Care but supported the Chief Finance Officer's approach given the current financial circumstances.
- Ms Baxter stressed that the 3% increase in the Adult Social Care Precept was a one-off measure for the next 2 years and so the money could not be used for on-going spending but could be used for up-front funding.
- Members asked if the extended rights under Home to School Transport (HST) would increase pressure on the Council finances. Ms Baxter stated that the grant was not new and if reduced would not put pressure on HST funding.

- Members expressed concern at the spiralling costs of Adult and Children's Social Care and urged that the two be considered together.
- Members also called for a greater role for councillors in the Transformation process.

4/17 DAYTIME SUPPORT CONSULTATION

(Agenda No. 6)

The Chairman agreed to requests to speak on this item from Councillor Michael Waine and Mr Michael Hugh-Jones.

Mr Hugh-Jones, a member of the National Pensioners' Convention, called on the Director for Adult Services to reconsider the formula for eligibility for Council support and in particular the lack of an income limit.

Councillor Waine said that both options proposed in the consultation were historic and property-based not geographic. He believed that they didn't take into account growth in the east of the County.

Ms Terroni introduced the report and stated that the consultation period closed on 20 December so the information is still being analysed. She stressed that people are assessed according to national guidelines.

Points that have emerged from the consultation so far include:

- A preference for the Sustainability Fund over the Innovation Fund.
- More money is needed to aid transition.
- More help is needed for people deciding how to use direct payments.
- A preference for Option A over Option B.

Mr Leigh summarised the advantages and disadvantages of both options. Option A is cheaper, uses existing buildings and provides better opportunities for people to mix. However, people have to travel further and there would be less choice. Option B would mean shorter travel, more choice and more staff time per person. However, it costs more, groups are smaller and those with higher needs will need to travel further.

Members raised a number of points including the following:

- Members in rural areas said that the Comet bus service doesn't work in their areas because the cost of the travel time is too great.
- Will staff have to be able to drive? Will cars need to be provided to some staff? Mr Leigh agreed that case workers will have to be able to drive. Cars may have to be provided. An advantage is that trained staff will provide the transportation.
- Concerns have been expressed about the multi-functional spaces. Ms Terroni said that staff were confident they could make them work well.
- Members expressed concerns that voluntary groups will lose funding. Officers explained that they will be able to bid for funding. Overall, the funding available will drop from £900,000 to £250,000. There will be a fair and transparent process to decide.

Officers noted questions asked during the discussion and committed to circulating further information and clarification to Members of the Committee after the meeting.

The Chairman summarised the outcome of the discussion:

- The model must be financially sustainable in all its parts.
- A transition package must be in place.
- It must ensure the sustainability of organisations that are currently meeting needs.
- Transport is of particular concern – especially the cost of booking the Comet in rural areas.
- The possibility of combining aspects of Options A & B should be considered.

5/17 Q2 CORPORATE PERFORMANCE

(Agenda No. 7)

The Chairman invited Members to identify issues from the report that may require closer study. Several points were taken away to be scheduled for further consideration.

Members expressed concern about the increasing number of children being placed in homes out-of-county. This has been compounded by a delay in providing new centres. It was agreed that Members who would like to pursue this further can attend a meeting of the Corporate Parenting Panel. Councillors Hannaby, Greene, Gray and Mathew indicated that they were interested in attending.

Members discussed with Officers the problems in recruiting enough staff for reablement. Ms Terroni reported that the new contract had delivered more reablement in its first month – even with less staff than any of the previous 12 months, but there were still not enough staff available despite efforts by agencies to recruit. The workforce must have the right skills.

6/17 OXFORDSHIRE FIRE AND RESCUE SERVICE ANNUAL REPORT 2015-16

(Agenda No. 8)

Chief Fire Officer Dave Etheridge introduced the report and thanked the Committee for their support over his tenure which is due to end in April this year. He appreciated the way in which the Council had invested in him as a member of staff and given him great development opportunities.

Mr Etheridge stated that Oxfordshire is one of the safest counties in the UK. He drew attention to the introduction of a fire inspectorate in April 2018. Mr Etheridge thanked Deputy Chief Fire Officer Simon Furlong, the incoming Chief Fire Officer, for his support.

Mr Furlong drew attention to a number of points:

- There were no accidents involving OFRS staff during the last year.
- They achieved their targets in the 10 year vision.

- They have implemented co-responding with the ambulance service.
- Although there had been an increase in significant fires the overall trend was still down.
- He provided the additional briefing document to provide more detail on integration.

Asked why only 24 stations are involved in co-responding with the ambulance service, Mr Furlong responded that any scaling up would be at the request of the ambulance service.

In response to questions relating to the legislation going through Parliament to enable Police and Crime Commissioners to make a business case to take on responsibility for the fire service Mr Etheridge made the following points:

- This seems to be the current direction of travel.
- It's important that nobody thinks it would be a straight-forward move.
- There is room for increased efficiencies through collaboration.
- It's important that we don't complicate collaboration through governance issues.

Mr Etheridge responded to other points as follows:

- Training for users of mobility scooters is something they could look at.
- The service's new vision commits more cadet spaces for Looked After Children and this would include work experience.
- He would like to roll out the work done with Police Community Support Officers across the county. They can play roles in safety advocacy, safeguarding and Prevent.

Members thanked Mr Etheridge for his commendable service and wished him well in the future.

7/17 S.106 AGREEMENTS & THE COMMUNITY INFRASTRUCTURE LEVY (CIL)
(Agenda No. 9)

Mr Kenneford introduced the report which had been prompted by a set of questions from Members of the Committee arising from meetings with Officers last year.

He reported that the Single Response system had been well received. The system coordinates the County Council's responses to City and District Council planning applications. Mr Cox explained that City and District Councils have to negotiate S106 agreements with developers but the County Council is responsible for the key services for which financial contributions are required – especially education and transport. He described how the Single Response system is used to manage that situation.

Officers responded to questions from Members on the following points:

- They were aware of pressures on General Practitioners' services in the Vale of White Horse area. This is primarily the responsibility of the District Council through its local plan.

- The release of monies has been relatively slow in the last year. Sometimes it's necessary to renegotiate the use of monies and this can take time.
- Officers have met with District Councils and have received assurances that there will be no more bipartite agreements with developers.
- Members asked about enhancing the role of local councillors. Mr Kenneford said that officers are available to meet with councillors.
- The Government's announcement of proposed Garden Villages and Towns was raised and the infrastructural problems that would be created by those proposed in Oxfordshire. Mr Cox responded that he would expect such developments to include S106 agreements.
- It was agreed that it would be useful for the locality meetings to get the papers for this Agenda Item, updated with matters that have arisen in this discussion.
- Mr Cox said that the tools used to calculate population increases as a result of developments take local variations into account.

The Chairman asked Members if this way of scrutinising an aspect of the Council's work had been beneficial. Members agreed that it was useful for some Members to have meetings with Officers in advance of a report coming to the full Committee in order to determine the questions that need to be addressed.

..... in the Chair

Date of signing 2017

Division(s): All

PERFORMANCE SCRUTINY COMMITTEE – 16 March 2017

Report by the Interim Deputy Director for Children's Social Care and Chair of the Case Review and Governance subgroup of the Oxfordshire Safeguarding Children Board (OSCB)

Summary Report on Serious Case Reviews

1. Introduction:

This update is provided by the Chair of the Case Review and Governance (CRAG) subgroup – a subgroup of the Oxfordshire Safeguarding Children Board. It covers information on cases considered, cases reviewed and action taken over the last 13 months.

2. Local context

The subgroup comprises members drawn from Thames Valley Police, the County Council's children's services and legal services, the OCCG Designated Doctor and Designated Nurse and a Head teacher representative. The purpose of the group is to support the OSCB in fulfilling its statutory duty to undertake reviews of cases both where the criteria[1] is met and where it is not met in order provide valuable information on joint working and areas for improvement.

The OSCB has worked on six serious case reviews since the last report to Performance Scrutiny, one of which (Child J) was also a domestic homicide review. Of those six reviews: two were signed off in 2015/6, two in 2016/17, one is active and one has been completed as far as possible, pending other processes. The published reports are Child J (February 2016), Baby L (September 2016), Child Q (January 2017), Child A and Child B (February 2017). They can be read in full on www.oscb.org.uk

[1] Working Together to Safeguard Children 2015

3. National Context

Since the last report national guidance and reforms have been released. In time this will impact on local work. In April 2016 the '*Learning in to practice: improving the quality and use of the Serious Case Reviews*[2]*'* was published, which set out quality markers and principles of good practice in case reviews. In May 2016 the government published 'The Children and Social Work Bill', which includes a set of clauses that set out arrangements for a new Child Safeguarding Practice Review Panel. The national Panel will identify a number of serious or complex child safeguarding cases which raise issues of national importance and will review cases which they believe will result in learning. The intention is that the majority of SCRs will be locally-driven. In May 2016 the national triennial review of case reviews was published. This considered nearly 300 SCRs relating to incidents which occurred over three years to 31 March 2014. Some of the key findings help provide broader context to the work in Oxfordshire:

- There has been no change in the number of child deaths linked to maltreatment and if anything a reduction in all except the older adolescent group. However the higher proportion of reviews on those aged 16 years and over was not a statistically significant increase.
- There has been an overall increase in SCRs, a steady increase in activity across the system and a dramatic increase in children with a child protection plan.
- Once a child is known to be in need of protection and a plan is in place, the system generally works well.
- Only 12% had a Child Protection plan in place at the time of their death or serious harm.
- Pressure points in terms of increased risk or vulnerability are identified at 'step up' or 'step down' in care.
- Fewer than half had current involvement with Childrens Social Care (CSC) and almost two thirds had at some point been involved with CSC.

[2] Serious Case Review Quality Markers – supporting dialogue about the principles of good practice and how to achieve them. SCIE &NSPCC 2016

A national repository of all case reviews is held by the NSPCC, which also produces learning documents based on thematic findings.

4. Cases considered for review by the subgroup

The decision making criteria for serious case reviews has changed over time to permit different types of reviews and strengthen the conditions which apply to inter-agency learning. Serious Case Reviews are conducted when abuse or neglect are indicated in child death or serious injury. The current Working Together (DfE 2015) guidance is attached at Annex 1.

Since the last report to Performance Scrutiny four new cases were brought to the attention of the OSCB for consideration in 2016/17. One was referred by Thames Valley Police and three were referred by Children's Social Care. Of these four referrals one serious case review was commissioned, one was deemed not to meet the criteria but led to a Partnership Review and two are still pending a decision at the time of writing.

All cases considered by the CRAG must be referred to the National SCR Panel. This independent expert panel of four colleagues was established through Working Together (Department for Education 2013). It advises Local Safeguarding Children Boards (LSCBs) and the DfE on aspects of SCR procedure and reviews *all* decisions. The panel members will challenge LSCBs where they do not feel the criteria have been applied correctly. This has led to a tighter focus on the criteria and evidence based decision making. Of two Oxfordshire cases submitted to the National SCR Panel in 2015/16 one was contested. The OSCB reviewed this decision independently and remains of the view that it does not meet the criteria.

5. OSCB SCR Methodologies

Working Together (DfE 2015) gives LSCBs permission to be innovative in the range and types of reviews commissioned and proportionate with respect to the scale and complexity of the issues being reviewed.

OSCB reviews have been completed using a range of approaches. Of the six cases worked on since the last report one used the systems methodology developed through the Social Care Institute for Excellence (SCIE), two were 'reviewer-led' and

three were the Working Together (2010) style of serious case review. The CRAG has not arrived at one recommended approach but considers the best approach for each case based on the scale and complexity of issues.

6. Family contribution

As reports are written for publication, it is essential to involve families in reviews. Family members have contributed to all reviews which has added a layer of complexity but also provided valuable learning. The OSCB has valued the support of the family liaison officers (FLOs) at Thames Valley Police, social workers from the County Council, the engagement team at the County Council, local Mencap services and probation officers who have facilitated family meetings.

7. **Reviews: subject details and safeguarding themes**

The details of the cases are:

- The six different serious case reviews have concerned seven children.
- Four of the children were under the age of four years – one of which was a baby. Three were adolescent children.
- Four were female. Two were male

The majority of cases concerned pre-school female children; however the cases concerning adolescents resonated with one another to some extent and highlighted serious issues in supporting vulnerable adolescents with a range of needs. It highlighted that a step change is required as to how we understand and respond to domestic abuse as well as the need to move from 'incident based models' to understanding the nature and impact of coercive control. Over the last year the themes covered by case reviews have been: the long-lasting impact of neglect; physical abuse; self-harm; child and parental emotional wellbeing; peer violence (domestic abuse) and parental substance misuse. The issue of neglect is a repeated theme in terms of the risks it presents to young children and the impact it continues to have as they grow up. In Oxfordshire neglect is the most common reason for a child to be subject to a child protection plan and continues to be a top priority for OSCB.

8. Learning points in common with other Oxfordshire case reviews

The OSCB has conducted a number of case reviews over the last five years and seeks to draw out common themes where possible. From the four recently published these are the most common learning points:

- The importance of thinking carefully about the role of the father in the family system as well as communication with and involvement of fathers and male carers.
- The need for curiosity about the families' past history, relationships and current circumstances that moves beyond reliance on self-reported information.
- There are more challenges faced by professionals working with vulnerable families where neglect is an embedded issue.
- The impact of the parent's mental health problems on the safety and wellbeing of the child.
- Understanding of substance misuse and interventions, the changing levels of risk, and the impact on the child.
- Normalising and misinterpreting children's behaviour - linked to Special Educational Needs.
- Identifying the increased safeguarding risks for children with learning disabilities and Special Educational Needs and the fact that signs of abuse and neglect may be masked by, or misinterpreted as due to, underlying impairments.
- Identification of physical and sexual abuse and following safeguarding processes thoroughly.
- Multi-agency work must be well co-ordinated in order to share planning and to better understand what is happening to the child
- Effective risk management requires systematic planning across the multi-agency partnership.
- The capacity of adolescents, with impaired emotional development, to protect themselves can be overestimated and this can mean that proactive steps to protect them are not always implemented with sufficient authority or rigour.

The OSCB has produced a 'user-friendly' learning summary for each published review and also held learning events picking up on the key themes from the reviews. The learning events have involved: the story / learning from the SCR; the child's perspective; lessons for practice; local resources and networking opportunities for local practitioners. In the last year they focused on – domestic abuse in the family home and between peers; grooming and staying safe online; the importance of building relationships with young people and understanding what 'identity' means as they go through adolescence.

9. Report recommendations and agency actions from case reviews

The four case reviews signed off since the last report led to 26 multi-agency recommendations. At the time of publication progress reports outlining outcomes and actions were published for two of these reports on the OSCB website. Two of the reports had more specialist actions. One concerned communications between and by health agencies on a routine basis as well as out of hours. The other concerned changes to specialist provision such as special guardianship of children. All recommendations form part of the OSCB business plan and drive the direction of work e.g. the OSCB 2016/17 priority to improve practice focuses on working to address neglect and working to safeguard adolescents.

Monitoring of Actions

The recommended actions are monitored through the OSCB Executive Group. Any actions being led by individual agencies are monitored through the OSCB Performance, Audit and Quality Assurance Group (PAQA). Outcomes are then reported into the Executive and are summarised in the annual report of the PAQA subgroup.

Outcomes

The published progress reports provide insight to work on specific recommendations but some broad headlines over the last year would be:

- ***The involvement of fathers in Child Protection care plans*** *is tracked and attendance at conferences by fathers is reported by Independent Chairs of Case Conferences to be at higher levels. A learning summary was produced*

and the OSCB contributed to the recently published 'Future proofing fathers work' by the Oxfordshire Parenting Forum.

- ***Strengthening core groups as part of the child protection planning process****: ensuring meetings take place as planned by arranging a 'deputy' to cover in a social worker's absence; ensuring that there is consistent, good quality administration so that all parties know what has been agreed. This has led to improved attendance (and consistency of support) which is regularly monitored through the OSCB quality assurance subgroup.*

- ***The shared use of tool kits****: The updated Threshold of Needs Matrix and the new Early Help Assessment have drawn on learning from case reviews. They provide clear thresholds and pathways for escalation and de-escalation and more robust approach to early help. These have been reviewed with wide professional, child and family consultation and are the subjects of a full programme of multi-agency training sessions.*

- ***The use of chronologies for children who are on Child Protection plans*** *to ensure shared understanding. This is provided by social workers and is used by core group members. This also forms part of the information provided when cases are being transferred. The effectiveness of handovers is being monitored by Independent Chairs of case conferences and core groups and any concerns escalated through established internal management processes.*

- ***Identification of physical abuse and following safeguarding processes thoroughly.*** *A rolling programme of workshops for Children's Social Care staff commenced in 2016 which has included guidance about the management of incidents on open cases and strategy meetings.*

- ***A review of the 'pathway through services'*** *for vulnerable young people aged 16-24 years, who find it difficult to engage with services in order to keep them safe, was undertaken. Guidance and the pathway on working with young people where there is peer on peer abuse has also been disseminated. The focus on vulnerable adolescents is improving as the numbers supported by a*

child protection plan have increased. The county council is in the process of reviewing the care leavers strategy in line with new legislative responsibilities. An application to the Department for Education's Innovation Programme has been made for grant funding.

- ***A new service for children who have experienced sexual abuse*** *Horizon started in January 2016 and receives an average of 2.5 referrals per week[3]. This service draws on skills from Oxford Health NHS Foundation Trust and local community group Safe! It reports into the OSCB subgroup on child sexual exploitation where safeguarding themes are analysed and take up of the service checked.*

- ***The Complex Case Panel*** *is a multi-agency senior level panel which problem solves for the riskiest children and young people by working collaboratively and by ensuring that issues of high concern are escalated and addressed. This includes high risk domestic abuse or offending behaviour, CAMHS and child sexual exploitation. The panel has developed a policy to determine the most appropriate mechanism for managing risk/concerns for children and young people who do not meet Multi-Agency Public Protection Arrangements (MAPPA) criteria or court orders. This has been tested through case studies and shown to be providing good support.*

In conclusion

The OSCB has two ongoing Serious Case Reviews, one Partnership Review and two current cases that are being considered for a review.

[3] Figures as of Sept 2016

Annex 1

The Working Together (DfE 2015) guidance requires a Serious Case Review to be undertaken for every case where abuse or neglect is known or suspected[4] and either:

- a child dies; or
- a child is seriously harmed and there is cause for concern as to the way in which the local authority, LSCB partners or other relevant persons have worked together to safeguard the child.

This includes cases where a child died by suspected suicide. Where a case is being considered where the child was seriously harmed unless there is *definitive evidence that there are no concerns about interagency working*, the LSCB must commission an SCR.

Seriously harmed includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following:

a. a potentially life-threatening injury;
b. a serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred.

[4] The threshold for 'suspect' should be consistent with s47 Children Act 1989 "reasonable cause to suspect". The following question should be asked: given what we now know should this incident have led to a child protection investigation? If "yes" and the child has been seriously harmed then a Serious Case Review should take place.

Annex 2

Background information on each published review

(1) Summary:	SCR / DHR for seventeen year old girl who was killed by her ex-partner.
Review commissioned:	January 2014
Review type:	Working Together (DfE 2013), Home Office DHR guidance
Status:	Completed Dec 2015. Published March 2016
(2) Summary:	SCIE review of a baby who died by drowning whilst in the family home.
Review commissioned:	September 2014
Status:	Completed October 2015 and published January 2017
Review type:	Working Together (DfE 2013), SCIE model
(3) Summary:	Review of a baby who died having suffered an impact to the head using review model developed by Jane Wonnacott
Review commissioned:	January 2015
Status:	Completed Summer 2016 and published October 2016
Review type:	Reviewer led. No IMRs. No multi- agency practitioner events.
(4) Summary:	Review of two young children who were sexually assaulted whilst in the care of their special guardian
Review Commissioned:	July 2015
Status:	Completed Autumn 2016 and published February 2017
Type:	Reviewer led. Short chronologies. IMRs and interviews.

Annex 3

Glossary

CP	Child Protection
CRAG	Case Review and Governance Group
CSC	Children's Social Care
DfE	Department for Education
FLO	Family Liaison Officer
IMR	Individual Management Review
LSCB	Local Safeguarding Children Board
OCC	Oxfordshire County Council
OCCG	Oxfordshire Clinical Commissioning Group
OSCB	Oxfordshire Safeguarding Children Board
PAQA	Performance Audit and Quality Assurance Subgroup
SCR	Serious Case Review

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