Annual report of the Performance, audit and quality assurance subgroup 2018/19

Introduction

PAQA takes a system-wide view on safeguarding work through multi-agency audits and an annual impact assessment. Agencies self-assessments and self-audits then enable PAQA to drill down to how well things are working at practitioner level within individual services. Views are drawn from both practitioners as well as families and children.

Quality assurance audits on working together

Three multi-agency audits covered the issues of 'strategy meetings[1]', young people who engage in harmful behaviour and safeguarding when interpreting. Findings were specific to each area of work but there are cross-cutting quality assurance themes reflected across the system: the need for partner agencies to fully understand their safeguarding duties within Working Together 2018, in particular the key partner agencies, so that they can have sustained long term impact and the benefits of sharing information through multi-agency chronologies which can shine a light on what it really means to be a child in that family.

Safeguarding work within OSCB agencies

PAQA reviewed safeguarding audits from ten services within seven agencies. Collectively the audits showed that agencies are focussed on getting core safeguarding business right. Many noted the need to 'think family' as well as the need to improve how children's views were captured to inform decisions: they were captured in many cases but most

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[1] A Strategy Meeting is normally held following an Initial Assessment which indicates that a child has suffered or is likely to suffer Significant Harm.

agencies stated that they wanted to be able to better evidence it in all cases. Whilst highlighting much good practice the themes of multi-agency chronologies, good sharing of information and co-ordinated work were noted as consistent themes for development.

Impact assessment by OSCB agencies

Organisations identified the key financial and organisational pressures in relation to safeguarding children and their families and adults with care and support needs as: recruitment & retention as well as increasing demand for services. District councils and housing organisations also noted homelessness as placing increased pressure on services. Partners identified the following areas for improvement: (1) good information sharing, working agreements & communication (2 commitment to and engagement with multi-agency work e.g. attendance at safeguarding meetings, co-ordination and shared financial responsibility to address complex issues.

Self-assessment by OSCB agencies

Information provided assurance that board member agencies across Oxfordshire have policies and procedures in place to safeguard children and adults with care and support needs and are compliant with the standards. The majority of partners are committed to ensuring safeguarding practice is embedded into their daily work including training and ongoing reflection and support for staff for around safeguarding practices.

Practitioner Views

1003 practitioners completed an online questionnaire for the OSCB. Of those surveyed 96% of staff have had training in the last three years and 97% have the opportunity to discuss safeguarding within their organisation. When asked what they would change the top three responses were:
1. Better joint working between partners e.g. communications, info sharing,

2. Better training e.g. shorter, tailored to role, using case studies
3. More positive profile of safeguarding work

Children and young people's Views

Authors of serious case reviews have spoken with children and young people who have been at risk of serious harm and neglect. Children have told us that at times they 'felt like they were missing' or simply 'not seen' by professionals. They also told us how small gestures of kindness and being noticed by professional made a big difference.

The local safeguarding data

The data shows that the local context is one of continued increasing demand on services and higher rates of escalation into child protection and care.
There is some indication that the early help work is beginning to increase and have impact: early help assessments have increased significantly; the number of troubled families worked with has risen and the timeliness of referrals through the Multi-agency Safeguarding Hub is high. However, early help data does not indicate that neglect is being identified early enough to prevent it being the main reason for children becoming subject to Child protection plans.
The demands on the statutory system are still high. Whilst the number of children subject to a child protection decreased from last year (605 at year end), it still high compared to ten years ago (250 in 2009).

A closer look at child protection data shows that the most common reason for a plan is neglect (70%). It also highlights concern in attendance: qualitative information shows that there concerns about statutory attendance; quantitative information picks up that only 44% of fathers attended conferences concerning their children last year.

Child Protection - rate per 10,000 pop
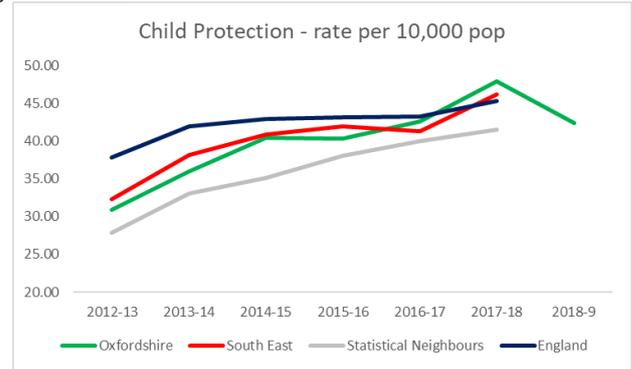
The number of children looked after by the local authority rose by 13% from 690 last year to 780 at the end of March 2019 but remains lower than national average. A large proportion of this increase is due to younger children coming in to the system with increasingly complex needs and elevated risk profiles particularly autism, mental health issues and risk of exploitation.

Children Looked After - rate per 10,000 pop
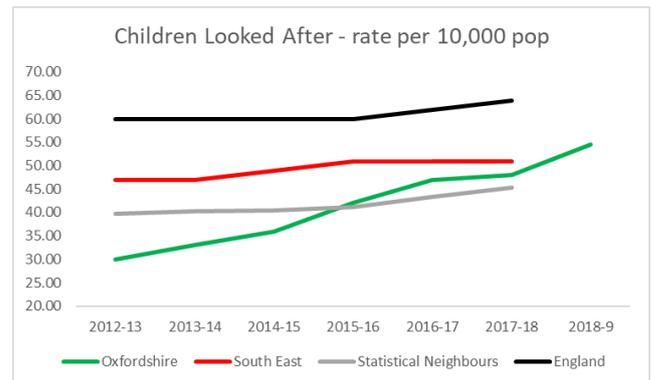
The data raises concern about adverse childhood experiences and the potential for child exploitation e.g. increases in children who go missing three times or more; in those who are victims of crime and in those where the domestic crime involves children. The statistics are similar for the vulnerable groups of children who are out of education on reduced timetables, excluded or working from home. It is notable that there is some overlap between these issues as well as attainment and achievement of pupils with special educational needs and disabilities. The percentage of children referrals to Child and Adolescent Mental Health Services who are seen within 12 weeks continues to be a cause for concern. At

the end of the year this was only 34% compared with a target of 75%. The service continues to face high levels of demand: in 2017/18 there were 566 referrals into CAMHS each month, in 2018/19 this rose to 697.

Escalated issues

PAQA's review of safeguarding data and intelligence led to the escalation of the four matters. The first concerned domestic abuse: use of the 'young people's pathway'; use of MARAC; police recording of children's voice at domestic abuse incidents; sign up to Operation Encompass. The second was about safeguarding in education: setting and reporting of performance measures to be sure that children are being kept safe in and out of school. The third was about working together and case conferences: reliable reporting on attendance and contributing. The last matter was about sufficiency of placements for children with complex mental health needs which meant that there is a delay in discharging them when they come in to hospital.

Conclusions

The child population of Oxfordshire has grown by 7% in the last ten years and is estimated to stand at 143,400 young people aged under-18[2]. Alongside this growth there has been increased demand for services particularly towards the high end of the continuum of need. Within this context there are five messages:

1. **There is much to be proud of**. The examples in the self-assessments, the evidence in the audits and feedback points to a motivated workforce that want to make a difference and get it right for children in Oxfordshire.

2. **We need to continue to focus on working well together.** Using multi-agency chronologies, sharing information and co-ordinating work is a theme for development. Everyone agrees, and audit work tells us, that these individual actions can make a difference in our system and that there is room for improvement.

3. **We need to Think Family.** We need to better involve families; from ensuring that dads attend conferences and that the views of children and their siblings are understood.

4. **We need to listen to children.** Feedback from reviews and audits indicates that children really value when they feel that they are heard and understood. Sometimes they have felt overlooked. Audits have indicated that we could do this more consistently and thoroughly

5. **The workload is high.** Data tells us that there is a continued demand on the services in the system. This impacts on services' capacity and ability to manage resources for a greater volume of children.

6. **The workload is not straightforward**. Audits and feedback emphasise that the complexity of cases and the capacity of colleagues to deal with them makes it a challenging work environment.

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[2] Source ONS Mid Year Estimates for Oxfordshire for people aged 0-17 2007 & 2017