Division(s):

HEALTH & WELLBEING BOARD – 5 NOVEMBER 2015

THE INCREASE IN CHILD PROTECTION CASES REPORT CARD

Report by Children, Education & Families

1. The following report card sets out the growth in activity in the child protection (CP) system and its impact across the partnership.

   Key issues to note:

   - A rapid and continuing increase in activity in both child protection and children in care.
   - A changing profile of risk with older children becoming a larger proportion of children subject to CP plans.
   - An increase in sexual offences especially against girls.
   - An analysis the demonstrates that all professionals are more attuned to identifying and understanding risk, leading to a growth in numbers subject to CP plans and in care, and reduced effectiveness of preventative services.
   - An increased pressure on social workers' caseloads and the capacity of all professionals to respond to demand.
   - Recognition that the county council is facing budget cuts which increases the risk to children and this is being addressed by a restructuring of services.
   - Recognition that all public sector organisations are in similar straitened curcumstances which could compromise the partnership's capacity to respond effectively to vulnerable children's needs.

RECOMMENDATION

2. **The Health and Wellbeing Board is recommended to consider any additional measures to mitigate against the risks set out in the report card.**

Jim Leivers
Director, CEF.

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23 October 2015

Increase in Child Protection Cases
Report card

1. There has been an increase in child protection cases in Oxfordshire over a number of years. This has been greater than the increase nationally.

2. This is not necessarily bad and may simply demonstrate that we are protecting more children. The growth is in line with other areas that have had high profile CSE cases. Also authorities judged 'good' by Ofsted have overall seen a bigger rise in numbers than the national average. The change in numbers for inadequate authorities is mixed - though for example, in Buckinghamshire they dropped by 35% in the 3 year period when Oxfordshire's increased by 50%. The only ‘good’ authority which has seen a decrease is Essex, where numbers have more than halved.

3. The number of older girls on plans has increased. This coincides with an increase in girls who are the victims of crime - especially sexual offences. Child protection is changing and new threats are developing. As the age profile of ‘at risk’ children changes, so does the response. Managing risks for adolescents focusses on both the community and the home.

4. There is a significant impact on resources across the system (e.g. police, health visitors, social care, GPs, education etc.). Failure to address this may mean we stop protecting children well. The greater the number of children subject to statutory oversight, the lower the capacity to work preventatively with children in need. This in turn fuels the growth in child protection numbers.

5. The key reasons for the growth in numbers are:
- Greater sensitivity to risk of abuse/neglect by professionals
- More older children, particularly girls, with high levels of risk being identified.
- Services for children in need / edge of social care are not having the preventative effect we might expect, despite the increase in CAFs etc.

6. The current focus of the work, and performance monitoring, is focussed on the social care management of children at risk, rather than the source of harm (e.g. victims of crime, children attending A&E as a result of intentional injuries etc.). Organisations are currently highly sensitised to children’s services’ responsibilities to safeguard children as victims, rather than addressing the threats within communities and building children’s resilience.

7. Practice has become more defensive in the light of both local and national issues. If we are to change our risk management practice to be less defensive, decision-making needs to be supported at senior level across organisations with a strong accountability and assurance framework. We have successful practice to learn from in the Kingfisher Team’s emphasis on controlled caseloads linked to good child in need planning and quality assurance. This is a similar model to Essex, which has a ‘good’ inspection judgement.

8. To ensure we continue to protect children and manage the pressures in the system we need to improve the impact and effectiveness of services for children in need / edge of statutory services. The county council is currently consulting on changes to its early intervention services but this entails reductions in funding. There is a need to create a new multi-agency model of family support, led by the Children's Trust and held to account by the safeguarding board. Whilst the most efficient model to deliver this agenda will be developed within the resources available there is a risk that the combination of reduced budgets and increased activity could adversely affect the ability of local services to keep vulnerable children safe and prevent harm at an early point. The Children's Trust considered this report at its September meeting. The Oxfordshire Safeguarding Children Board received this report at its Full board meeting on 22nd October 2015 and has requested all representative agencies to undertake an impact assessment of the savings they are required to achieve.

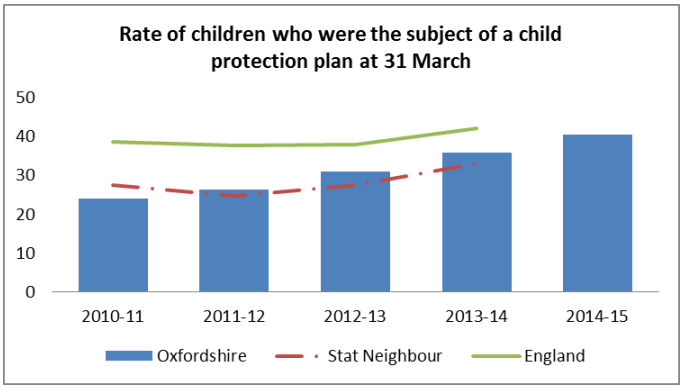
9. The Health and Wellbeing Board is recommended to consider any additional measures to mitigate against the risks set out below.

Introduction

1. This report was commissioned by the Performance, Quality Assurance and Audit subgroup of the Safeguarding Board in response to the growing safeguarding activity across all agencies alongside reducing public sector budgets. It was co-ordinated by the county council, but includes input from all agencies across the partnership. A copy of this report will be presented to the Children's Trust, the Safeguarding Board and the Performance Scrutiny Committee of the County Council.

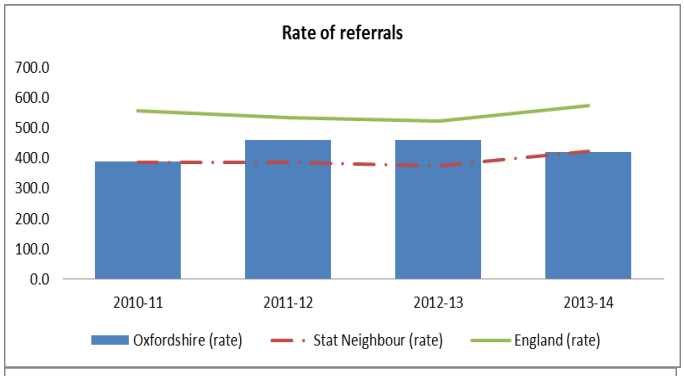
Comparative data and trends

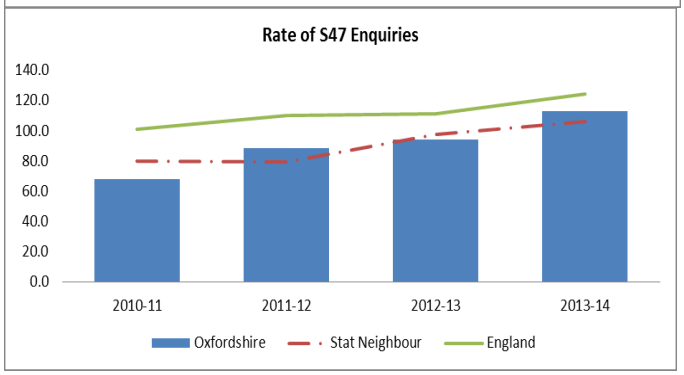
2. The rate of children subject of a child protection plan is rising more quickly in Oxfordshire than elsewhere. Between March 2011 and March 2014 it rose by 50% compared to 21% for statistical neighbours and 9% nationally. In 2014/15 in Oxfordshire there was a further rise of 13% and in the first quarter of 2015/16 another increase of 11%, with 634 children now subject of a child protection plan.



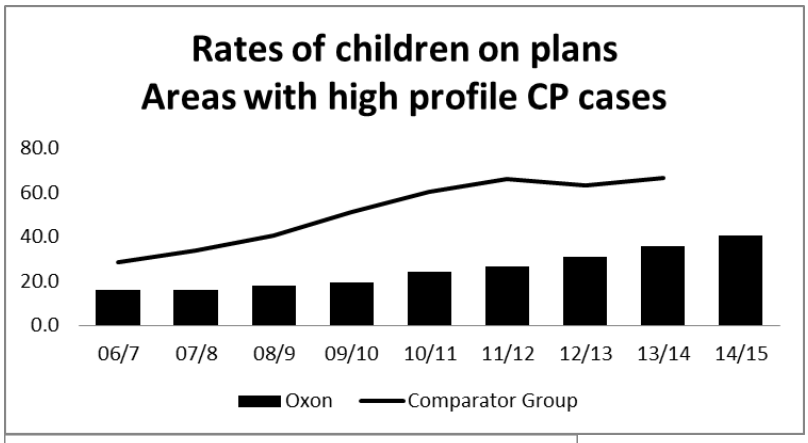
3. The increase has not been driven by an increase in referrals which, in line with the rest of the country, has remained constant. There has however been an

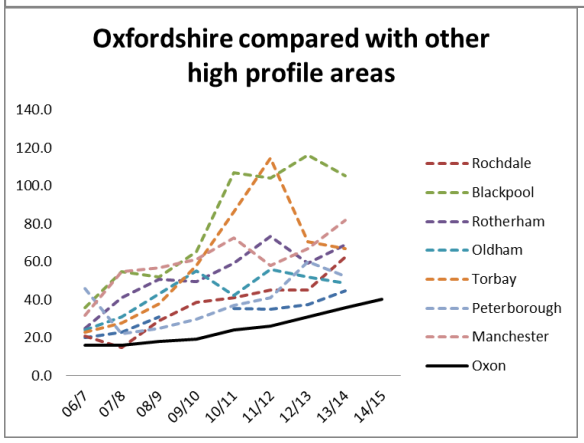
increase in section 47 (child protection) investigations of 63% in Oxfordshire compared with 43% for statistical neighbours and 23% nationally.





4. When Oxfordshire's increase in child protection cases is compared to those in other areas which have been through high profile CSE cases, a common trend is detected. Derby, Rochdale, Blackpool, Rotherham, Oldham, Torbay, Peterborough, and Manchester have all seen steep rises in their numbers of children subject of a child protection plan. Oxfordshire's rate of growth is slightly below the group average, increasing by 124% since 2006/7 compared with 134% for the whole group. Oxfordshire also has the lowest rate of children on a plan of any of these areas.





5. The local impact on practice of this, added to national changes in policy and regulation (such as the Francis enquiry) has led to more defensive practice across the system. Although audits have repeatedly shown that thresholds around child protection have not changed, this growth in defensive practice has made people across the system more readily favour child protection plans as a response to risk rather than using alternatives. If alternatives are to be used it will require a more integrated model of support across the localities to allow professionals sufficient time to work effectively with families, as well as an accountability framework that ensures staff are supported by their senior leaders in managing risk.

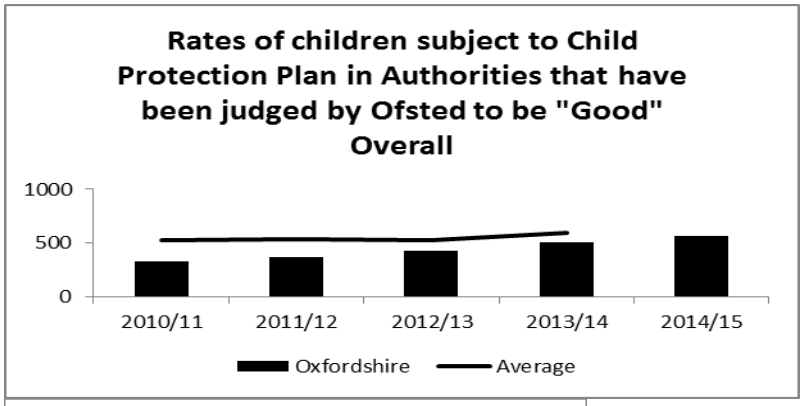
> "It can't be yes (being safe) all the time – you can't feel safe all the time"
>
> Child

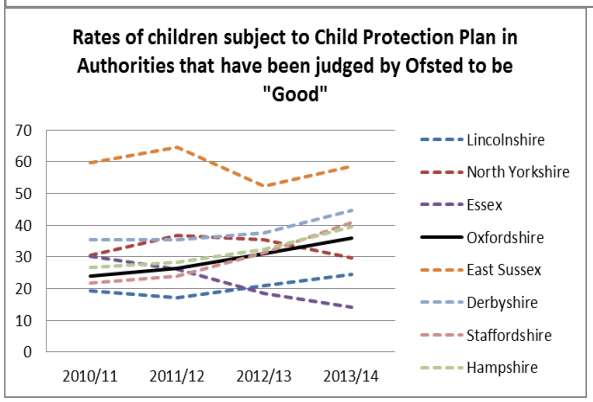
6. So far 58 out of 152 authorities have had their children's services inspected by Ofsted within their latest inspection methodology. Of these 14 have been described as 'good' overall; 30 'require improvement' and 14 were 'inadequate'. On the specific judgements of children who need help and protection 14 were 'good' overall; 33 'require improvement' and 11 were 'inadequate'. Oxfordshire was good in both categories as were 11 other authorities[1] 8 of which were shire authorities. The rate of growth of children on plans in the 8 shire authorities rated as 'good' in both categories over the 4 years is 16% (compared with a national average of 9%). Patterns across these authorities are not consistent, 3 have had

[1] The authorities rated as good in both categories are Derbyshire; East Sussex; Essex; Hampshire; Hartlepool;
Leeds; Lincolnshire; North Yorkshire; Oxfordshire; Salford; Staffordshire; Trafford

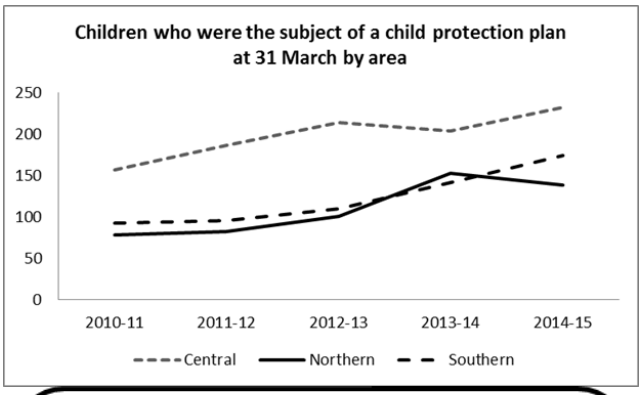
falling numbers with the rate halving in Essex and 5 have seen increases. Oxfordshire's increase is in line with Hampshire, but below that of Staffordshire.

7. Essex County Council has adopted a concerted strategy to reduce its child protection and looked after populations by improving the effectiveness of multi-agency services to children in need, thereby preventing children from entering the statutory systems. Key features of this strategy are low caseloads for social workers (12 - 15 children) and improved quality assurance and inter-agency confidence in CIN planning through the use of independent chairs' oversight. This has entailed significant investment from the local authority. However, savings from the care system are helping to offset the costs.





8. Within Oxfordshire, although there has been a growth in each area of the county it has been less pronounced in the central area where it grew by 48%, compared to 78% in the north and 87% in the south.



"Every month I have a core meeting. I say what I want and people listen. I understand what gets said at those meetings. They check back with me that I've understood".

Child

9. The biggest increase has been in older girls. In the four years the number of children over 10 on a plan rose by 115% compared to 65% for the under 10s. Despite this most children on plans remain under 10 with 71% at the end of March 2015. A higher proportion of children under 10 are on a plan in Oxfordshire than elsewhere.

% increase in cases 2011 to 2015

Ages	Increase
0 to 4	64%
5 to 10	167%
11 to 15	216%
16 to 17	210%
Total	177%

% increase in cases 2011 to 2015

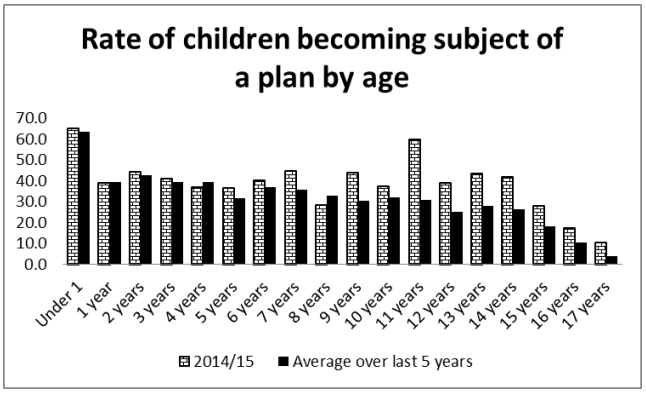
Gender	Increase
Female	85%
Male	66%

10. Schools have suggested that a key trigger for a child may be when they transfer from primary to secondary school. The attached graph looks at how many children become subject to a child protection plan per 10,000 population both last year and over the last 5 years. Over the last 5 years the likelihood of any child becoming the subject of a plan drops with each year they live. However last year this pattern changed with a growth in the 9-15 year olds starting a plan. Last year, 11 year olds were the second most frequent age for children becoming subject of a plan. Providing appropriate support from schools

"If they (the girls) are lonely or not getting what they need at home then they are going to look for it elsewhere"

Parent

and other appropriate professionals to vulnerable children in this transition period will be important to manage risk.



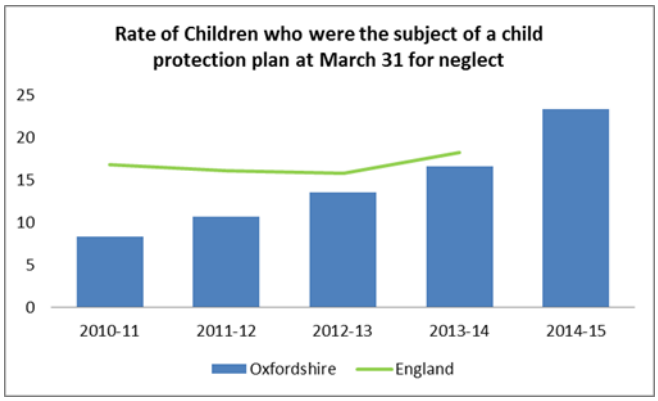
11. It had been suggested that school attendance prior to starting a plan could be a good predictor of whether a child would become the subject of a plan. This does not seem to be the case. 24% of children had 100% school attendance in the term before they came onto a plan, and 67% had more than 85% attendance. Schools need to continuously examine a range of data and ask questions about it to ensure they are managing risk. Attendance is frequently an issue raised in serious case reviews as an early indicator of concern. However some children seek the refuge and safety of school when the home environment is less stable so any simple correlation would not be expected.

> "Schools need to work more with Social Services".
>
> *Child*

> "School were like 'she's too much trouble let's let her go'"
>
> Child

12. Learning from serious case reviews both locally and nationally has highlighted the vulnerability of older children. There is now greater awareness of their vulnerability and risk particularly in relation to neglect. This may partially account for increased numbers of referrals to services including social care. Also the impact of child abuse via social media which represents a risk or vulnerability that previously would not have been considered or identified.

13. Most children are the subject of a plan because of neglect - at the end of March 2015, 56% of children were on a plan for neglect. This compares with 47% for statistical neighbours and 43% nationally. The rate of children on a plan for neglect is now considerably higher than nationally.



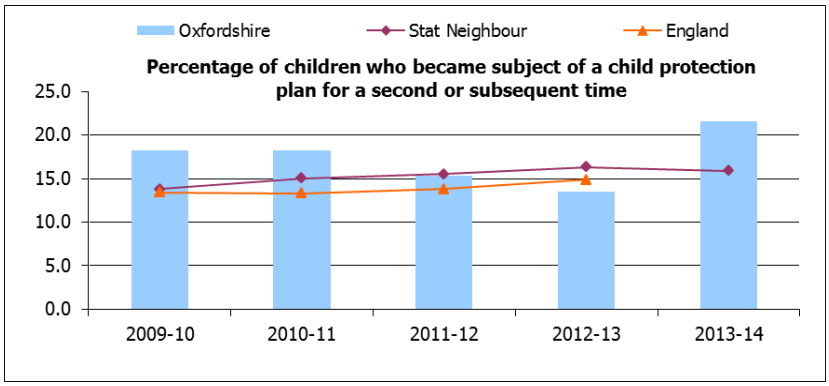
"Most things they find out, the majority or things. I don't even know how, they just seem to know"

Child

14. Since April 2011, 2361 children have ceased to be on a plan. On average they were on a plan for 303 days. Each of the individual years (11/12; 12/13; 13/14; 14/15 and 15/16 to date) is within 10% of the 303 days with no discernible trend. The growth of numbers is about more children becoming subject of a plan rather than them staying on a plan for longer.

15. However children do stay on plans for slightly longer in Oxfordshire than elsewhere. The latest comparative data is for 2013/14 when 9.3% of children in Oxfordshire who ceased being on a plan had been on a plan for 2 years compared to 4.5% nationally. In 2014/15 this fell to 6.3%. It is well-established that the greater the number of children on child protection plans, the longer children will stay on a plan.

16. The number of children subject to repeat plans in Oxfordshire is consistently higher than elsewhere. (This is not the measure in the dataset, but a measure of any repeat plan as opposed to one in 18 months). Previous audits of children becoming subject of a second or subsequent plan has shown that the improvements made during the child protection plan have not subsequently been sustained. Intervention services for children at the edge of social care therefore have to be enhanced for both step up (those that support a child before they reach the threshold for statutory services) and step down (supporting a child leaving statutory services).



2 Shift away from voluntary interventions

17. Since 2013, the number of children being worked with under Child In Need (CIN) plans has reduced. The following is a snapshot showing the increasingly statutory nature of children's social care's interventions

	July 2013	July 2014	July 2015	% change
Child Protection	422	454	626	48.3%
Looked After	427	500	555	30%
Children in Need Plan	2451	2243	1801	-26.5%

18. Previous interventions: Of the 630 children who became the subject of a Child Protection plan in 2014/15:
    - 26 (4%) were subject to a children in need plan in the 6 months prior to their child protection plan.
    - 112 (18%) were known to early intervention in the 6 months prior to their child protection plan.

3 Impact of Early Intervention

19. In the academic year 13/14 there were 816 completed Common Assessment Frameworks (CAFs). This was the 7th consecutive year of increasing CAFs and a 9% increase on the previous year. In 2014/15 between September to June 761 CAFs were completed and logged, so there is a degree of confidence that the number will grow again. The number of referrals to social care that had a preceding CAF also remains above the target of 5%. The actual number is believed to be higher than this with some CAFs not adequately reported. However despite this increase it still remains a relatively small number compared to the 17,889 contacts made with social care in 2014/15 and 5663 referrals.

20. A recent audit of 40 early intervention cases held by the council's early intervention services showed that 30% of the cases they were holding were being co-worked with social care. The number of open cases in the service is around 2100 whereas the social care case list is around 4000 - so by extension an estimated 15% of the social care case-list are co-worked. The risk factors identified in these cases mirrored those identified in social care cases.

21. Where cases were referred to the MASH and directed to early intervention - in a sample of 46 cases - there was a substantial (43%) reduction in referrals to social care after early intervention involvement with the service. Given the sample size care needs to be taken in extrapolating the results, but the impact of appropriate early intervention in reducing demand can be seen.

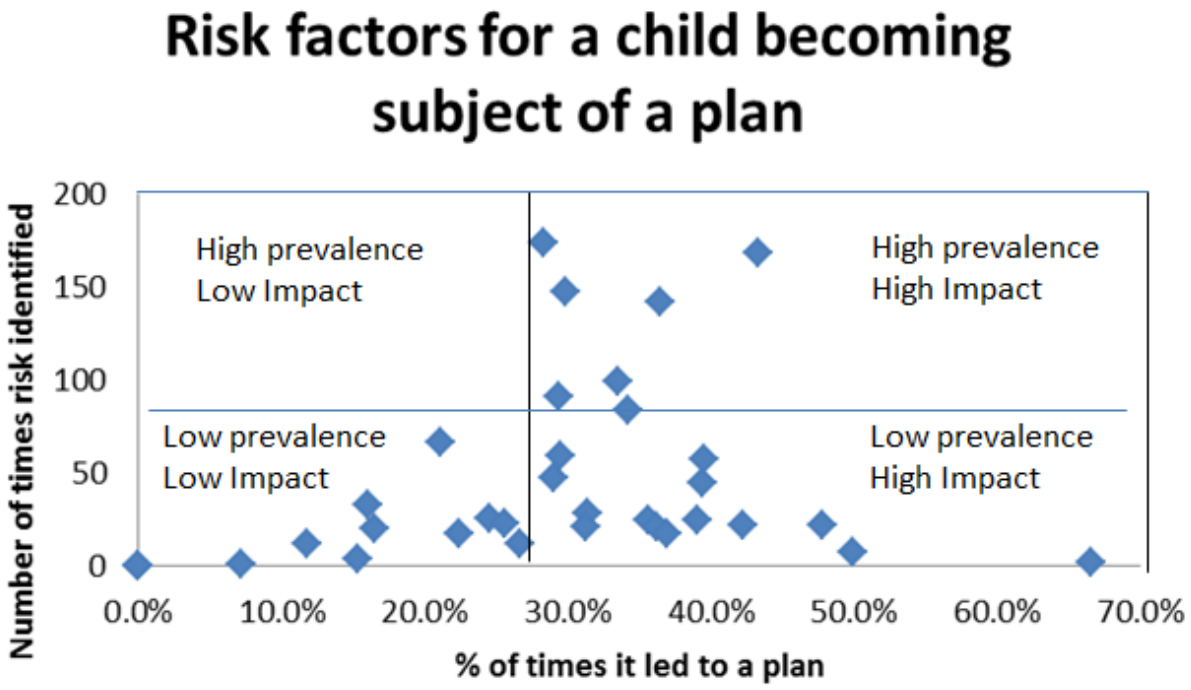
4 Risk factors

22. The following table identifies the 10 most common risk factors identified at social care assessment that led to a child becoming the subject of a child protection plan. 630 children became the subject of a plan in 2014/15. In 28% of cases one of the risk factors identified was parental domestic violence. However in 439 other assessments in the year, domestic violence was identified as a risk, but the child did not end up on a plan - so only 28% of times when parental domestic

violence was identified in the assessment, did the child end up on a plan. In slightly fewer cases (27%) child emotional abuse was identified as a risk factor, but in 43% of cases where it was identified as a risk factor at assessment did the child become the subject of a plan.

Risk Factor	How often a child went on a plan where this risk factor was recorded		Number of assessments identifying this risk	% of times it went to a plan
	No	**%**		
Parent Domestic Violence	174	27.6%	613	28.4%
Child Emotional Abuse	168	26.7%	388	43.3%
Parent Mental Health	147	23.3%	492	29.9%
Child Neglect	142	22.5%	389	36.5%
Parent Alcohol Misuse	99	15.7%	295	33.6%
Child Physical Abuse	91	14.4%	309	29.4%
Parent Drugs Misuse	84	13.3%	245	34.3%
Child Domestic Violence	66	10.5%	312	21.2%
Child Unacceptable Behaviour	59	9.4%	200	29.5%
Child Sexual Abuse	57	9.0%	144	39.6%

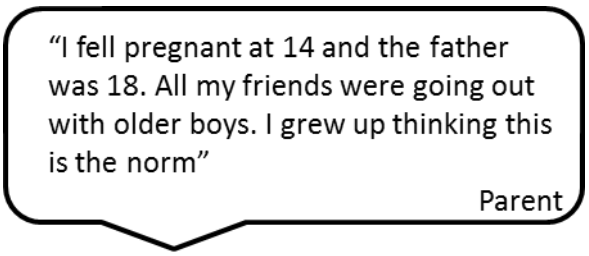
23. The chart below looks at how often a risk is identified in assessment and if it identified the likelihood that the child will be placed on a plan.



High prevalence / Low Impact	**High prevalence / High Impact**
	Child Emotional Abuse Child Neglect Parent Drugs Misuse Parent Alcohol Misuse Parent Mental Health

	Child Physical Abuse Parent Domestic Violence
Low prevalence / Low Impact Child Alcohol Misuse Child ASC Parent Physical Disability Child Drugs Misuse Child Domestic Violence Child Physical Disability General Other Other Physical Disability Child Learning Disability Other Learning Disability Child UASC Child Privately Fostered Child Gangs	**Low prevalence / High Impact** Child Trafficking Parent ASC Other Alcohol Misuse Other Drugs Misuse Child Sexual Abuse Other Domestic Violence Child Sexual Exploitation Parent Learning Disability Child Missing Child Self Harm Child Young Carer Other Mental Health Child Unacceptable Behaviour Child Mental Health

24. Clearly a key factor is to ensure that services work with the whole family and where issues such as parental mental health, drug abuse or domestic violence are key risk factors appropriate information is shared with all colleagues both on the child and on the adults in the family.



25. Health visitors across Oxfordshire receive domestic abuse notifications where there is a child under 5 years. The service received a total of 2,805 notifications during 2013-2014 and 1,922 notifications during 2014-2015. This represents a decrease of 31.3%. Thus domestic abuse does not appear to be a factor associated with increased health visitor workload. (This data however does not provide data about level of risk). This seems to be in line with other agencies data, but work is needed to understand this more fully. We do not have data about children 5 -18 years.

5 Care system

26. Overall the number of looked after children has increased and within the Looked After system a higher proportion of the children are subject to care orders, especially full care orders. The growth in looked after children has not been as great as that of children on plans and the number of looked after children in Oxfordshire remains relatively low. However any such growth in looked after numbers places additional pressures across the system

Legal Status @ 31 March 2015	2010/11	2011/12	2012/13	2013/14	2014/15	Change 10/11 to 14/15
Full Care Order	127	145	142	170	189	48.8%
Interim Care Order	96	103	63	78	61	-36.5%
All Care Orders	223	248	205	248	250	12.1%
Placement Order	26	48	57	58	65	150%
Voluntary - Section 20	177	154	153	155	197	11.3%
Remand	0	0	1	1	0	0.0%
Police Protection or Emergency Protection	1	0	0	1	2	100%
Total	**427**	**450**	**416**	**463**	**514**	20.4%

27. Within the care system there has been a steep rise in the number of unaccompanied asylum seeking children in the last year. Nearly all these children are accommodated rather than the subject of orders. Many unaccompanied asylum seeking children attend the orientation programme run by the Children's Society for Oxfordshire. Not all unaccompanied asylum seeking children are over 16, some are of a school age.

31st March:	2010/11	2011/12	2012/13	2013/14	2014/15	Change from 31st March 14
No. LAC who are UASC	34	30	26	24	49	104%

6 Impact of growth in activity on social care caseloads

28. The data below relates to the family support teams in children's social care as these are the teams which carry case responsibility for all the child protection and children in need cases of non-disabled children. These teams also work with non-disabled looked after children as they enter care and those in care proceedings. Looked after children transfer to looked after/leaving care teams once they become accommodated (by agreement with parents) or subject to full care orders. The central area has three family support teams, south and north areas have two teams respectively.

> "Yes sometimes they are in a hurry or rush. When I've got something to say and I say it at the end when there's only 10 minutes left but she [social worker] has to go to another call. And I don't like to make her late or let other people down so then I don't say it"
>
> Child

29. The average Family Support social worker's caseload across the county is 20 children. This is a low estimate as it does not take into account variations in

individual social workers' working hours. In the last year caseloads have increased from an average of 15/16. Children's social care has an ambition to reduce caseloads to a maximum of 14 per fte social worker. The range is great, between 14-32 cases. This range reflects differences in working hours and also the impact on experienced workers of recruiting newly qualified workers who have protected caseloads for one year.

	South	Central	North
Total family support caseload by area	417	578	498
Child Protection cases by area	163	223	208
Looked after cases in family support teams by area	51	58	36
Children in Need cases by area	203	297	254
Family support team caseload	209	192	249
Average caseload by worker	22	18	20
Unallocated Child Protection cases	0	0	0
Unallocated Children in need cases	37	17	7

30. Despite huge pressures in the teams caused by the rise in child protection and looked after cases, and difficulties in recruiting to vacancies, the teams allocate all their child protection and looked after cases. These cases are allocated immediately, or at worst, wait for only one or two days before being allocated. However, the growth in activity has an impact on the teams' capacity to work with children in need, leading to some unallocated work. This is notable in the south area where recruitment to vacancies has been especially challenging. Unallocated cases at these levels are a recent phenomenon, emerging as a significant factor in the last year.

> "It's annoying when my social worker is out of the office. Sometimes it's important [what I want to tell them is important to me] and it's frustrating and annoying not being able to get hold of them. The office say 'do you want to leave a message' but I say no, because it's important to me and I can't say what I wanted"
>
> Child

31. The three disabled children teams separately work with over 500 complex disabled children and include all statuses: children in need, child protection, looked after children and leaving care. Demand has risen amongst all children with special educational needs (SEN).

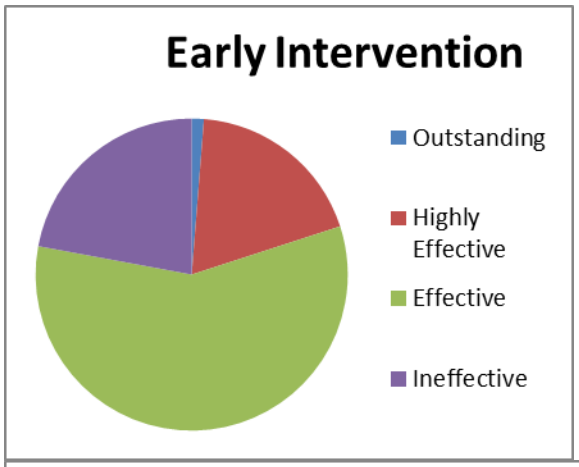
	2011	2015
Number of children with statements of SEN	1981	2245
Children and young people with SEN/Disability in county placements	96	146
The number of children supported by the autism advisory team	1115	1406
Number of disabled children receiving short break support	1269	1350
% of children accessing short break services identified as having highly challenging behaviour	22%	42%

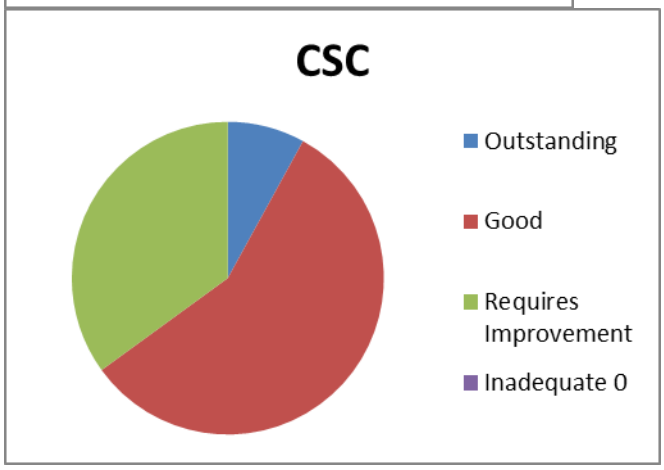
% of children accessing short break services who have complex health needs	11%	14%

32. The Kingfisher CSE Team has average caseloads of 7-10 children. The team has developed a 'persistence' model of working which entails allocating a consistent worker from first identification of high risk of CSE through to post-court support. These cases are typically very challenging, time-intensive and emotionally demanding for staff. However, as a model of working to lower caseloads the team provides some important learning for future service development in children's social care.
    - The average length on a child protection plan for Kingfisher is 208 days i.e. almost 7 months. For children in family support teams most plans range from 12-18 months. This is another indicator of the impact of caseload on the time taken to achieve progress.
    - Although Kingfisher is dedicated to working with children at high risk, the team is not placing large numbers of children on child protection plans. At 31st March 2015, 13 (17%) out of 76 children were subject to child protection plans. The same number were in care. 49 children were subject to child in need plans or were being worked with in different ways without requiring statutory interventions.
    - All the children's cases open to Kingfisher are subject to quality assurance by a dedicated independent reviewing officer (IRO) who provides oversight and challenge to the team to ensure children are progressing towards safety and improved outcomes. The CSE Stocktake audits provided strong evidence that the practice is sound and the impact is good.
    - The similarities with practice in Essex (low caseloads/high scrutiny) stand out as significant features.

7 Qualitative findings

33. Between April 2014 and March 2015 children's social care and early intervention audited 614 cases. The outcomes of these audits were





- Of the 440 cases audited by Early Intervention 80% were rated effective or above.
- Of the 68 cases audited by Children's Social Care 66% were good or outstanding
- Outcome Star performance at the end January 2015 indicated that 79% of cases had a positive impact overall across Children's Centres, Hubs and Thriving Families.

34. The findings that may impact upon the increase in the number of child protection cases are:

35. From Early Intervention Services:
    - There has been an improvement in early intervention services use of the assessment, planning, review process, which has improved the focus of work with families.
    - An increased use of actuarial measures and outcome tools by early intervention workers (such as Family Outcomes Star) to identify risk e.g. Strengths & Difficulties Questionnaire; Neglect Tool; Three Houses; Signs of Safety case mapping
    - There is an increased attendance at core groups and child protection conferences by early intervention workers
    - Early intervention services report difficulties in accessing documentation from children's social care and YOS.

- Little evidence of referrals being made to early intervention where cases are closed after one child protection episode by children's social care.
- A lack of clarity and joint focus between early intervention plans and children's social care plans on the same child

36. These findings may indicate that improved assessment and monitoring by early intervention workers are enabling them to establish 'significant harm' earlier than before.

37. The increase in attendance at child protection conferences and core groups indicate that early intervention workers are more involved in child protection cases, but their planned focus may not be effectively joined with social workers on child protection plans and therefore not supporting the child protection planning and intervention sufficiently.

38. From Children's Social Care:
    - Where there is a clear and reviewed plan, outcomes for children are more effective.
    - Where there is evidenced multi-agency working, including support for placements, outcomes for children are more effective.
    - Planning and engagement is less evident as children reach 18
    - Supervision is regularly taking place and is reflective and positively impacting upon case management across both services
    - The views and experiences of children were not adequately captured within child protection plans and in 40% of cases children had not been seen on their own after the initial investigation.

> "I felt more safe, everyone got involved. Most of them gave me a lot of help. It was the right help. It needed to be done"
>
> *Child*

39. These findings suggest that an accurate picture of any changes in the family functioning is too reliant upon the parents or carers view and children are not involved in identifying and reporting progress with change.

40. Additional work from Education and Learning shows:
    - Where there is effective leadership, good schools work well with other agencies ensuring effective outcomes for pupils
    - When all agencies focus on the achievement of pupils and closing the gap for vulnerable learners, children's outcomes are improving and their self-esteem and independence grows.
    - Where there is strong parental engagement with schools, attendance is high and closely monitored.
    - Where leaders engage actively with local hubs, early intervention is a powerful tool. This practice is inconsistent.

> "I trust teachers more than parents sometimes, Sarah [a teacher] she's good to talk to – she's done it been there, got the t-shirt" *Child*

41. The Neglect Pilot in the North of the county shows:

- Importance of strong multi-professional working to support and challenge families, with key services including social care, education, health and community support. Central to this is a shared understanding among professionals and the family of the changes that are needed to improve things.
- Engagement of the family is critical to enabling change. Families must understand what needs to change and feel involved in decisions about how to make that change.
- Understanding, and planning for, the needs of the whole family are vital to achieving better outcomes. Services for children, and those for adults, need to work together to provide coherent support to families, not just individuals within the family.
- Enabling professionals to participate in joint training sessions, and in particular for social workers to share their knowledge with practitioners in universal services, builds confidence and understanding across local networks.
- Benefits for families with children on child protection plans receiving support from workers other than just their social worker. Different professionals bring different skills and expertise which they can use to bring about positive change for children.
- Importance of families receiving intensive, practical support to help bring about change, including introducing routines and boundaries

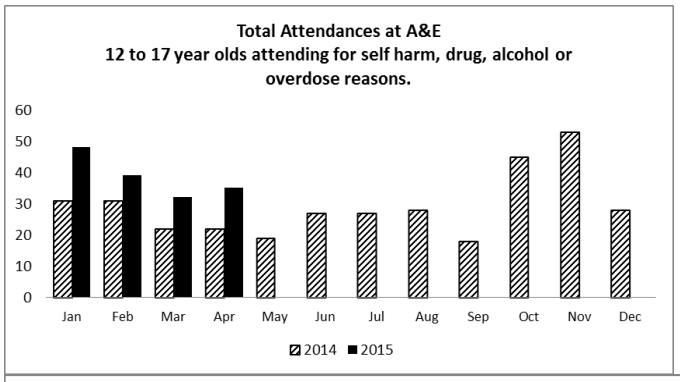
42. Work from Thriving Families shows:

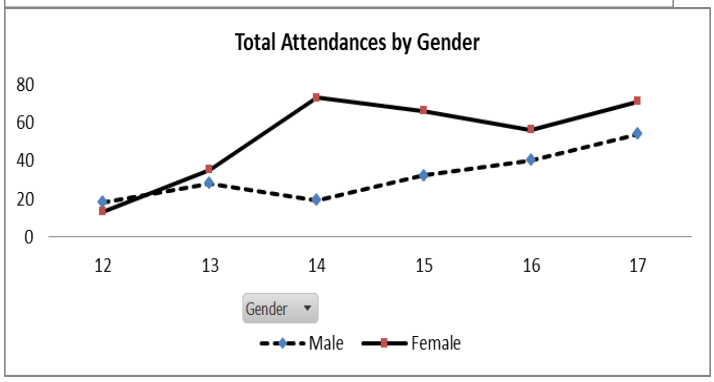
- Importance of having one worker that understands the needs of the whole family and is able to spend time with the family to understand how they function as a unit
- Benefits of workers having low caseloads meaning they have the flexibility to offer practical support when it is needed, including accompanying the family to appointments and supporting the development of routines
- Enabling workers to focus on supporting families to make sustainable changes, rather than only having capacity to respond to crises, is important in order to address the root cause of problems
- Use of tools such as the 'outcome star' with individuals and families enables everyone to see the progress being made
- Co-ordinated working between key agencies such as social care, health, schools, the Police and youth justice services and the Department of Work and Pensions is key to enabling families achieve changes

8 Growth in activity in other services

<u>Activity in the Oxford University Hospital (OUH)</u>

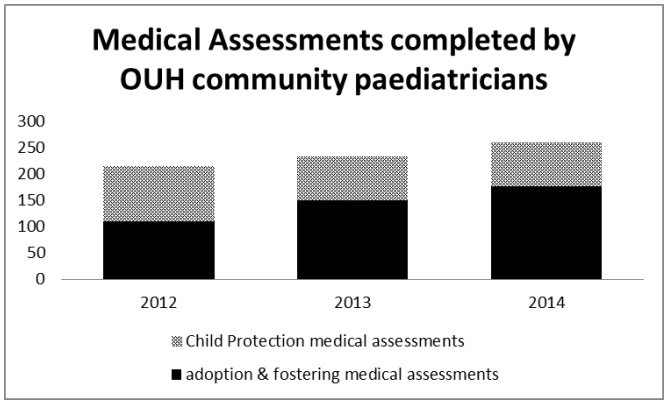
43. The following graph shows how often 12-17 year olds have presented in A&E for self harm, drug, alcohol or overdose reasons. In the first 4 months of the year there has been a 45% increase in attendance as 9 children per week are attending A&E for these categories. 62% of attendances have been girls, reflecting the pattern seen in other services.



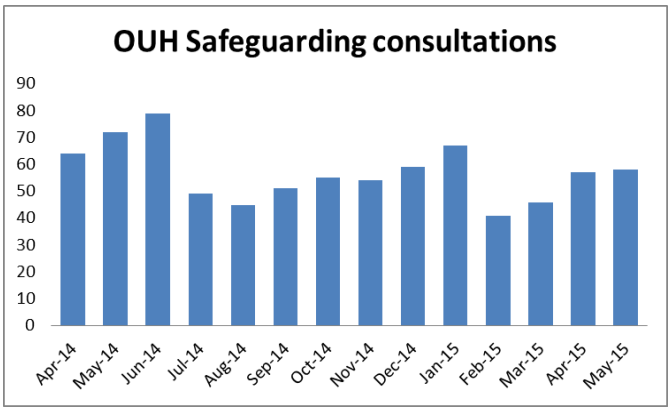


44. A third of a attendances were for self harm; 28% for drug abuse; 27% for overdoses and 12% for alcohol abuse.

45. Between 2012 and 2014 the number of medical assessments completed by community paediatricians grew by 21%. In 2014 there were 84 child protection assessments, by June 2015 there had already been 62.



46. In 2014/15 there were 682 safeguarding consultations in the OUH acute trust, averaging 57 per month.



Oxford Health Foundation Trust:
Child & Adolescent Mental Health Services (CAMHS)

47. In the CAMHS service there has been a 45% increase in accepted referrals over the past 3 years, which is leading to an increase in waiting times. Waiting times at March 2015 for PCAMHS were that
    - 6% were being seen within 4 weeks
    - 17% within 8 weeks and
    - 25% were seen within 12 weeks

48. In CAMHS this was
    - 34% in 4 weeks
    - 46% in 8 weeks
    - 64% in 12 weeks.

49. Since March the service has introduced the “Waiting Time Initiative” which is reducing waiting lists.

50. The short term focus is to provide extra locum staff to undertake a focused assessment/ intervention programme alongside some local changes in practice in tier 2 services
    - PCAMHS ways of working have been overhauled. They are offering more group work, which maximises greater reach of the service, more efficiently whilst maintaining effective evidence based treatment. This will free up more time for clinical staff to offer assessments in a more timely fashion
    - Introduction of a range of group work options for young people with similar conditions where clinically indicated. Group work is being offered as the initial preferred treatment option where clinically indicated.
    - All cases on the waiting list have been reviewed to assess the suitability for group work.
    - Where appropriate, assessments and follow up sessions will be carried out over the phone or by using FaceTime/Skype
    - There has been a review of staff working practices resulting in allocation of extra assessments. Locum clinical staff 3.8 fte have been employed to assist with this waiting-list initiative on a short term basis.
    - Alongside this Tier 3 CAMHS assessment clinics are being overhauled to ensure capacity to assess in a timely manner.

51. The longer term plan: (doing things differently)
    - Remodelling mental health services for children and young people. The current model needs reviewing in response to the increased need and developing evidence base. There is also a strategic plan to work closely with the county council to give better outcomes for children and young people to avoid duplication and offer a more efficient service.

Health Visitors

52. Health Visitors work with children and families from 0-5 years. They are routinely involved in children protection cases for this age group. The impact on work load with increased child protection cases include attendance at case conference and core groups, increased number of home visits, report writing, liaison with other professionals and child protection supervision. Often those cases that lead to court proceedings also include writing a report for court and court attendance. Once a child becomes looked after then health assessments are required. The increase in child protection work by health visitors may affect their capacity to undertake early intervention and preventative work.

School Health Nurses:

53. A new model of School Health Nurses (where all secondary schools have a nurse based within the school) has meant that they have increased contact with young people and hence more referrals. Although this is very positive, school health nurses are reporting that young people are disclosing significant vulnerabilities such as self-harm, relationship issues, emotional health difficulties. This in turn is expected to result in an increased number of referrals to social care.

Safeguarding Nurses:

54. The safeguarding nurses in Oxford Health form a team to provide consultation and advice to colleagues when they have a safeguarding concern. In the last 3 months the team have completed 393 consultations. While most (62%) come from colleagues in the children and family directorates 150 consultations were provided to colleagues in adult directorates, who in their work with the adult had concerns over the welfare of children.

Number of Children's Consultations undertaken by Oxford Health Safeguarding team

Month	Children and Families Directorate	Adult Directorate	Older Adult 75+ Directorate
April 2015	82	51	0
May 2015	76	52	1
June 2015	85	46	0

55. Specifically there were 55 consultations from CAMHS, 45 consultations from School Health Nurses and 61 consultations from Health Visitors. Across the system people are experiencing a growth in child protection consultations

56. The community children's nurse team (CCN) are describing an increased role in safeguarding / child protection work. The children have more complex health needs that are now being managed in the community. This is coupled with

increased life expectancy. Also, an increased number of disabled young people now stay on in education post-16 and hence have a longer period of engagement with school based care provision.

57. The Kingfisher nurse post was introduced in November 2013. The caseload has steadily expanded and now stands at around 70 children. The commissioners have recognised that there needs to be increased health input into the team, and an additional full time band 6 post has now been funded.

Thames Valley Police

58. Over the last 3 years (2012/13 to 2014/15)
    - There has been a 23% increase in the victims of crime aged under 17
    - This includes a 43% increase in victims of sexual offences
    - Since 2009/10 the number of victims of sexual offences has more than doubled (from 281 in 2009/10 to 581 last year)
    - The number of missing children has risen by 10% (from 630 to 694) and those missing on 3 or more occasions has risen from 77 to 132
    - Girls in all areas are being subjected to increased sexual offences and the numbers are high in all areas, but remain lower in West Oxfordshire.

> "In our area … if there is a lad grooming girls people re-post and news articles get shared. We post their pictures so we can let others know and we know to watch out for them"
>
> *Parent*

    - Crime rates are rising in all areas except in the Cherwell area where crime is showing a slight fall.
    - Crime rate for boys who are aged 17 or under is falling in the Vale of White horse area.

> "I didn't want to go to the police, but other than to go to the police, who do you turn to? Who do you go to for some friendly advice? Who do you go to instead of the police, is there anyone? "
>
> *Parent*

    - In the last two years girls are more likely to be subjected to crime compared to males in all areas.
    - Oxford has the highest crime rate and West Oxfordshire has the lowest crime rate.
    - The victim rates for robberies are very low in all areas for the under 17 year olds.

59. The police are working on doubling the size of the child abuse investigation teams across the force over the next two years due to the fact that workload will have doubled by then.

9 Possible explanations for the increased activity and changing profile

Oxfordshire is experiencing greater levels of deprivation and need? No current evidence.

60. At the end of 2012/13, Oxfordshire had a rate of 30.9 children on a child protection plan for every 10,000 children and young people countywide. Whilst this is lower than the national rate of 37.9, when it is weighted for the number of income deprived children/young people, Oxfordshire has a higher rate than would be expected. Nationally, for every 60 deprived children/young people, there is one on a child protection plan. In Oxfordshire the ratio is one child on a plan for every 40 deprived children/young people.

Thresholds are lower? No current evidence.

61. Dip-sampling is undertaken at intervals to test the threshold at which a child enters a child protection plan does not indicate a risk-averse culture or a lowering of the threshold at this point, but rather a greater awareness amongst the professionals of the potential for serious harm in a child's situation. All agencies have developed their identification and assessment processes to be more aware and responsive to children at risk of harm. Defensive practice across the system may indicate that professionals feel more safe when a child is on a child protection plan as opposed to a children in need plan or early help

Child in Need planning is not having a preventative effect? Yes there is evidence

62. Child in need planning is not taking place as much as before (reduction of 26.5% since 2013). 18% of early intervention cases convert to child protection plans within 6 months, indicating that complex cases are 'leap-frogging' the child in need system and entering child protection planning as risks are identified within schools, universal settings and early help services.

63. Findings from children's social care audits indicated that for children in need plans there was often a lack of multi-agency working or support for older children and the plans did not sufficiently address education, health or social needs. The reasons for this may be part of a vicious cycle:
    - Social workers' case priorities are currently child protection cases due to the increase in numbers.
    - Children in need cases are getting less attention and consequently multi-agency professionals have less confidence in the effectiveness of Section17 plans and support. This drives a demand for child protection plans.
    - Cases of children with complex needs who do not receive timely, effective risk-focussed interventions get worse and 'tip into' child protection planning
    - At child protection conferences professionals are highly unlikely to agree to a children in need plan as an effective way of managing cases that straddle thresholds.
    - Nationally there is an increased awareness of abuse and a climate of fear being created for any professional who fails to recognise this and take action

Greater sensitivity to risk of abuse/neglect by professionals? Yes there is evidence

64. Greater sensitivity to risk amongst professionals and in the community may be having an effect. When Oxfordshire's rate of increase in child protection numbers

is compared against the rates in other local authorities which have been through high profile CSE cases, a common trend upwards is detected. In Oxfordshire this has not led to significantly more referrals; it has led to more referrals converting into assessments and child protection plans. This would indicate more in-depth appreciation of risk and responsibility. There is a better recognition of the combined accountability of professionals to identify and protect children. The Stocktake Report provides evidence that partnership working to identify and mitigate risk is being undertaken pro-actively, including by professionals who did not historically see child protection as their core business, for example district council workers, housing providers.

65. In addition there has been recent multi agency training on the use of assessment tools i.e. the threshold of needs matrix, neglect tool kit and CSE screening tool. These tools inform the assessment process and facilitate a more accurate and thorough risk assessment, leading to a higher number of S47 referrals. A current audit of referrals into MASH from Oxford Health may provide some data to support this. This work will be completed in September 2015.

66. Also, there may be increased awareness of child protection issues amongst professionals working in adult health services, as a result of the Think Family agenda. This encourages practitioners to consider the needs of children within a family, if they are working directly with an adult. This is borne out by the data from Oxford health which shows 28% of chid protection consultations with the safeguarding nurses came from people working with adults.

67. A recent audit of thresholds on child protection cases looked at 18 cases in which the Principal Social Worker assessed that 4 may have been managed under Section 17/ family support in the past. This was generally due to a difference in professionals' awareness of the long term impact of abuse upon a child; which appears to suggest that the 'potential' for significant harm is a major deciding factor for professionals now in relation to making child protection plans. Previously evidence of actual harm was a significant threshold factor.

Older children, particularly girls, with higher levels of risk identified by referrers, than previously? Yes there is evidence

68. Over the last four years the Oxfordshire partnership has worked together to increase professionals' awareness and understanding of risk across in older children and teenagers. 'Everyone on alert' has been key learning from the Bullfinch serious case review. Schools, health professionals, police, housing and children's services have increased their understanding of the safeguarding significance of older children's behaviours i.e. looking beyond the presenting issue and recognising the symptoms of abuse and exploitation. This cultural change was evidenced in the Stocktake report. The recent OSCB partnership review of agencies actions (2013-15) in safeguarding a large group of teenage victims of CSE, provides additional evidence of a much improved child-centred culture.

10 Summary

69. Oxfordshire's pattern of increased growth does not follow the national pattern, however it is more in line with authorities that have had a high profile CSE issue and/or are judged as good by Ofsted, with both groups showing a greater increase in child protection activity than the national figure. This appears to be because of greater awareness of both professionals and the public and more responsive services.

70. Across all agencies we now appear to be reaching a point where demand is outstripping supply and without improved capacity then there is a danger that Oxfordshire will not safeguard children in future, leading to more harm and family breakdown. The impact of the growth of child protection work falls across all agencies e.g. GPs are now unable to attend all case conferences due to the number taking place at the same time.

71. Additionally, the local authority and partner agencies may attract a 'requires improvement' or 'inadequate' inspection judgement unless we do things in a fundamentally different way.

72. There has been a growth of children in secondary schools more readily recognised as vulnerable children rather than difficult adolescents, in previous years. The number of adolescents presenting in A&E this year has risen and the number of adolescent girls who have been the victim of crime is increasing.

73. With increased multi agency working it has become apparent that children's social care data tends to drive the debate across the partnership, when it is evident that other sources e.g. the police data on victims of crime can help to describe the picture of how safe children are in Oxfordshire.

11 What needs to be done?

74. Recognise that the increase in activity does not reflect poor performance but improved identification of risk leading to very high usage of child protection planning. A reduction in resources, without addressing the current configuration of early help services and social care, may lead to children not being protected. Changes need to be co-ordinated across all agencies to ensure children are best protected.

75. The Children's Trust should create a coherent multi-agency model of family support, within which all agencies' resources are directed towards collaborative working, without duplication or gaps. The Trust should be held to account by the Oxfordshire Safeguarding Children Board.

76. The nature of child protection is changing and new threats are developing (e.g. revenge porn). As the age-profile changes, so does the response. Managing risk for adolescents is a home and community-based risk, whereas for younger children it is primarily a home-based risk. Going forward there is a need to continue to build safeguarding capacity in schools and the community.

77. Across the system we need to move from management of risk for children to reducing the sources of harm - from cure to prevention. This includes the

development of support to schools and community services to build resilience, including best use of the voluntary sector, and supporting initiatives in community safety. Successful schemes such as the school nurses should be identified and lessons learnt.

78. The level of multi-agency support for children in need and children on the edge of statutory services needs to be improved. This will entail adopting the learning from the multi-agency Neglect pilot project which strengthens core group working, holding agencies to account in achieving safeguarding objectives.

79. The council is currently consulting on the future of its social care arrangements, to meet savings targets over the next four years. Key features of this model aim to address the findings of this analysis and include:
    - Recognising that statutory safeguarding must be protected
    - Retention of the current area based social care team structure: North area covering Cherwell and West Oxfordshire District Councils; South area including Vale of White Horse and South Oxfordshire District Councils; Central area covering Oxford City Council
    - Ending or reducing the local authority's role in delivering universal services
    - Development of a new locality support service to offer advice to schools and community services, to support the shift from 'cure to prevention'.
    - Development of a more robust child in need casework system to address children's needs effectively without immediate resort to child protection planning. The management of risk outside the statutory system requires a clear accountability and assurance framework led by senior managers in all agencies.
    - Delivering both child in need and child protection plans via a new Family Support Service supporting 0-19 year olds (25 years if young people have additional needs). This brings together some of the functions of the current Early Intervention Service with those of the Family Support Teams currently within Children's Social Care.
    - Maximising the capacity of staff to keep caseloads low enough to support high quality practice.
    -

Whilst the most efficient model to deliver this agenda will be developed within the resources available there is a risk that the combination of reduced budgets and increased activity could adversely affect the ability of local services to keep vulnerable children safe and prevent harm at an early point. The OSCB has requested at it Full Board meeting on 22nd October 2015 that each representative agency should undertake an impact assessment of the savings it is having to achieve. The Children's Trust considered the content of this report at its September meeting. The Health and Wellbeing Board is recommended to consider any additional measures to mitigate the risks and the Oxfordshire Safeguarding Children Board will continue to monitor the impact of these developments.
END