10 May 2016

Mr Jim Leivers, Director of Children's Services, Oxfordshire County Council

Mr David Smith, Chief Executive Officer, NHS Oxfordshire CCG Mr Anthony Stansfield, Police and Crime Commissioner

Mr Francis Habgood, Chief Constable of Thames Valley police force

Mr Amrik Panaser, Youth Offending Service Oxfordshire County Manager

Mr Gabriel Amahwe, CEO, Community Rehabilitation Company

Ms Angela Cossins, Deputy Director NPS, South West and South Central

Ms Maggie Blyth, Chair of Oxfordshire Local Safeguarding Children Board

Dear local partnership

Joint targeted area inspection of the multi-agency response to abuse and neglect in Oxfordshire

Between 7 March 2016 and 12 March 2016, Ofsted, the Care Quality Commission (CQC), HMI Constabulary (HMIC) and HMI Probation (HMIP) undertook a joint inspection of the multi-agency response to abuse and neglect in Oxfordshire.[1] This inspection included a 'deep dive' focus on the response to child sexual exploitation (CSE) and those children missing from home, care or education.

This letter, to all the service leaders in the area, outlines our findings about the effectiveness of partnership working and of the work of individual agencies in Oxfordshire.

Following the challenges presented by a high profile investigation, local partners have responded robustly to child sexual exploitation. Oxfordshire now has a highly developed and well-functioning approach to tackling exploitation. The local authority Strategic Lead for Child Sexual Exploitation provides clear direction and the Oxfordshire Safeguarding Children's Board (OSCB) effectively oversees this through its CSE sub-group. The specialist, multi-agency child sexual exploitation team, Kingfisher, is pivotal to the operational responses of the local authority, police and health services, and this ensures that there is a high standard of inter-agency working with sexually exploited children. A significant strength of the key agencies is their ability to learn lessons from joint investigations and to use these to improve performance. For instance, they now work closely and collaboratively with exploited children and young people to understand their perspectives and to help them keep

[1] This joint inspection was conducted under section 20 of the Children Act 2004.

safe. However, the high quality of practice seen in child sexual exploitation and missing children cases is not always replicated across the services offered to other children and families when they are first referred to children's services. Although no children were identified as at risk of harm, in some cases poor processes and practice were seen at the 'front door'. This is the first point of contact for all children and young people not identified as at risk of exploitation or abuse.

This means that not all children and young people receive the same safe and responsive level of service as exploited young people. Although senior leaders in children's services have firm plans in place to improve this situation, implementation of these has been too slow to take effect, given the pressure on the service.

Key Strengths

- Significant financial resources and time have been expended by the local authority, police and health agencies, following a high profile investigation into child sexual exploitation in the county. This investigation commenced in 2011. The Oxfordshire Safeguarding Children's Board (OSCB) has strategically and effectively led the development of a robust multi-agency response to child sexual exploitation. Senior leaders of all partner agencies, led by the Director of Children's Services, the council's Head of Paid Service, and senior politicians, demonstrate a thorough understanding of the issues involved in child sexual exploitation, and a willingness and commitment to tackle those issues in partnership. This approach is successfully coordinated by the partnership's Strategic Lead for Child Sexual Exploitation, who is based within children's social care services. Young people in Oxfordshire are significantly safer from sexual exploitation as a result of all agencies' heightened levels of understanding and investment.

- Oversight of practice is successfully maintained across all agencies through the OSCB, which is well sighted on child sexual exploitation through its effective CSE sub-group. The CSE sub-group undertakes themed audits and appropriately reviews multi-agency data from a number of sources, such as children missing from home and prevalence data, so that it can identify themes and patterns, and problem-solve any areas of concern. A particularly strong feature of the partnership's approach is learning from multi-agency investigations of child sexual exploitation to improve the quality of services provided. For instance, there was feedback from young people, such as those who participate in the Children in Care Council and those who have experienced abuse through exploitation, that investigating officers did not give the voice of the child sufficient consideration. All professionals now work hard to engage with potential victims of exploitation, to understand them and to build relationships with them. This promotes young people's safety by helping them to understand the risks, and to keep themselves safe.

- Oxfordshire's Kingfisher team is pivotal to how the local authority, police and health services join up the response to sexual exploitation. The team's multi-agency information-sharing meetings ensure that a comprehensive set of information about the risk of exploitation is communicated in a timely manner, and this means that young people's risk of exploitation is identified early. Effective information sharing results in robust action planning to reduce risk and to support successful disruption techniques. Multi-agency plans are well coordinated, with a clear focus on reducing risk factors for vulnerable young people and on keeping them safe. Team members appropriately provide specialist advice to colleagues, and this means that cases of sexual exploitation reviewed during the inspection, held both within the Kingfisher and mainstream social work teams, were well managed and of a high standard overall.

- Post-abuse therapeutic work is well considered and embedded in practice. The local authority and health joint commissioners have commissioned a specialist resource, the Child and Adolescent Harmful Behaviour Service (CAHBS), which is complemented by the Horizon Service that provides advice to professionals and a range of effective therapeutic interventions for children, young people and their families across Oxfordshire who have experienced sexual abuse

- A clear and coherent action plan of disruption activity has been developed by the CSE sub-group and local community safety partnerships. This includes a 'hotel watch' scheme that provides hotels with guidance and direction in 'signs to watch out for' in respect of child sexual exploitation. Intelligence received from hotels about young people at risk of exploitation has increased in volume since this work started and is being used by the police. In addition, a comprehensive screening and training programme is now in place for taxi drivers. All are now vetted, and attend compulsory training in safeguarding matters as a condition of being issued with a licence. Drivers already licensed are also undertaking the safeguarding training. These are important steps in building community confidence in the recognition and reporting of safeguarding issues.

- The persistent approach to raising awareness of child sexual exploitation across the community has led to increased numbers of children being identified and referred for services. The effective use of service-specific screening tools has assisted referrers to assess risk and correctly apply the threshold for services. This means that agencies recognise the signs of sexual exploitation, and refer promptly to each other where they have concerns. For example, in the Youth Offending Team (YOT), where the specific tool is helping them in identifying risk. Immediate action is taken when an incident or crime involving possible child sexual exploitation is reported to police officers, and concerns are generally shared quickly with children's social care services. Almost all referrals to school nurses are timely. Swift responses at all levels ensure that multi-agency safeguarding measures to protect children are put into place quickly.

- The Multi-agency Safeguarding Hub (MASH) forms the 'front door' to services and has a strong interface with the Kingfisher team, which ensures a timely and thorough response where sexual exploitation is known or suspected at the point of referral. Where agencies understand thresholds, MASH arrangements result in effective practice. Good examples seen by inspectors of timely information sharing included routine domestic violence referrals by police to children's social care services, and referral of pertinent issues by the YOT to the MASH.

- Collaboration between health providers is a strength. In the MASH, this is demonstrated by the easy accessibility of information from databases used by two NHS trusts. This enables the appropriate sharing of information about individual children. Several examples of good work from health partners were seen by inspectors, including the provision of discrete, specialist services, such as those for unaccompanied asylum seekers; hospital emergency departments' close working with children's social care out-of-hours services; and work with the Designated Officer in cases where an adult has abused a position of trust.

- Effective learning from prior experience means that agencies understand very well the complexities of child sexual exploitation, the harm it does to children, and the challenge in responding effectively and consistently. Screening tools are used well by professionals as part of assessments to inform decision making, and recommendations made following assessments are therefore well targeted and appropriate. For young people identified as being at immediate risk of significant harm from exploitation, multi-agency enquiries made under Section 47 of the Children Act 1989 are of good quality. Examples were seen of thorough social care assessments that clearly identified all risks, needs and strengths and made effective use of historical information. Written analyses demonstrate that assessing social workers understand the children and families well, and have effectively identified vulnerabilities and potential risks. In some cases examined, police officers had taken positive action and apprehended suspected perpetrators of exploitation without relying on the vulnerable victims making formal complaints.

- A clear commitment to safeguarding children at risk of exploitation is evident from young people's case records. Line managers in the multi-agency team and mainstream social work teams maintain oversight of the direction of cases, and effective supervision had supported some of the cases tracked to achieve good outcomes. Overall, there is effective decision making at all points in the sexually exploited children's journey to safety.

- A multi-agency Missing Children Panel carefully monitors children and young people who go missing repeatedly. Effective panel meetings ensure that robust assessment, monitoring and a review of risk and impact is considered for each child. Where risk of exploitation is identified, suitable investigative responses and

strategies to disrupt perpetrator activity are put in place. Inspectors observed appropriate professional challenge and escalation of action, with the meeting's chair providing clear strategic direction to ensure that children received timely and appropriate support in order to mitigate the risk to them.

- Senior leaders interviewed by inspectors know their services well and are able to describe with confidence and a shared sense of purpose their agency's approach to sexual exploitation and child protection. Thames Valley police force demonstrates a clear understanding of risk, threat and harm and effectively directs its actions and activities to mitigate the risk of harm across the force area. The force displays strong leadership and a clear understanding of the steps needed to protect children. The effective prioritisation of child sexual exploitation is evident in the resources it has allocated and the training it has delivered to staff. In investigations, police officers work hard to engage children and families and to build rapport.

- Managers of the YOT have a clear understanding of risks that young people face, both as perpetrators and potential victims of exploitation. The YOT systematically assesses all young people whom they case manage for the risk of sexual exploitation. Where young people who have offended are considered to be at risk, the YOT appropriately refers cases to the Kingfisher team for assessment. Managers in the National Probation Service and the Community Rehabilitation Company demonstrate effective knowledge and understanding of safeguarding practice. In the small number of cases held by the Community Rehabilitation Company where exploitation has been identified as a potential risk, there is a clear record of inter-agency communication about the safeguarding needs of vulnerable children.

- Leadership and commissioning arrangements, between health partners for safeguarding children and young people at risk of sexual exploitation, are particularly strong. Professional accountabilities, for intervening early, reporting concerns and sensitively engaging young people and their families, are clearly recognised and effectively championed at all levels within health services. For instance, forensic medical services for children experiencing trauma are readily available and accessible round the clock, ensuring that children receive an appropriate sensitive response when needed.

- The quality of joint working in health is highly developed, underpinned by a shared vision and purpose between local health providers and joint commissioners. In health, a personal and organisational commitment and energy is driving innovative work in reaching 'hidden' individuals or groups, such as young men. Positive recognition and support for young people whose sexual orientation or gender identity is an element in their vulnerability to grooming or exploitation is evidenced across the partnership, including thorough holistic

assessment and individually tailored therapies. Management oversight and support for frontline practitioners undertaking this complex work is evident. Good attention is paid to developing the skills of frontline health staff through a range of learning and development activities, underpinned by regular case consultation, peer review and supervision to support continuous professional development. Additional resourcing for safeguarding leadership across primary care, community health and the hospital sector effectively supports the development of frontline professional confidence and expertise, and ensures that there is effective health service provision to vulnerable young people.

Case study: highly effective practice

Oxfordshire child protection agencies place children and young people who have experienced child sexual exploitation at the heart of their practice.

One young person who had been subjected to exploitation said he had received a comprehensive service from his social worker. He said he has experienced sustained and trusting relationships with the social worker. He felt the help he received had been timely and well targeted, and he felt well supported and better protected. The young person received support to develop his understanding of exploitation, insight into the risks and help to undertake self-protective strategies. The young person felt that his social worker has contributed to ensuring that outcomes for him improve generally. For example, through assistance with housing needs, emotional support through Child and Adolescent Mental Health Services, finances, improved relationships with parents, as well as completing 'Real Love Rocks' to understand healthy relationships. The young person spoken to stated 'I don't know where I'd be without my social worker right now. She is great!'

Areas for improvement

Leadership and management

- Senior leaders within children's social care have not yet achieved the same good standard of practice across all services. They are full and effective partners in initiatives to improve partners' responses to sexual exploitation, such as the Kingfisher team and services to support missing children. However, the quality and standard of this integrated model of service delivery is not replicated for all children and young people at the point of referral to children's services for reasons other than exploitation. These problems in the provision of mainstream 'front door' services are well recognised, and the council has identified solutions.

However, action to improve the service offered has not been appropriately expedited, and this means that not all vulnerable children receive a timely response when they are first referred, or are referred for services that are not required.

The Local Safeguarding Children Board

- Currently, the LSCB does not set baselines and targets to measure against when they are monitoring partners' performance. Partners gather a wide range of information to aid their understanding of current performance. When concerns are identified, the LSCB report these to the agencies concerned. However, the lack of a baseline makes it difficult to monitor the effectiveness of any action taken. In the case of the MASH, this is reducing the LSCB's ability to monitor how solutions being pursued by the local authority, the police and health partners will improve the situation.

Identifying and managing risk of harm at the 'front door'

- The MASH is currently operating as an information-sharing forum where decisions are made as to whether a single assessment is required. From cases seen by inspectors, thresholds for intervention are not generally well understood or appropriately applied by by some agencies in particular schools, which have a limited understanding of how the MASH operates. Schools described inconsistent responses to their referrals from the MASH, and they do not always understand how decisions are made. This results in the MASH receiving a high percentage of referrals (75%) that lead to no further action or are stepped down to early help. Many of these referrals should have been sent directly to the early intervention team. While this practice ensures that children and young people are safe, processing of these additional referrals is time consuming and is not an effective use of resources needed to safeguard children.

- Some referrals to the MASH were of a good standard, but others particularly those from schools, lacked key information. This again places additional pressure on staff in the MASH to gather the required information. Some of the representatives from schools did not know who their agency representative was in the MASH. This is a missed opportunity to network, to educate partners on thresholds and to build relationships to ease the information flow.

- Information requests from the MASH to police, health and probation are dealt with quickly if any potential risk to a child has been identified. However, general requests for information on cases that would support assessments are delayed. At the time of the inspection, the police reported a queue of approximately 100 cases waiting to be processed, and the National Probation Service (NPS) were only responding effectively in cases where risk had been identified.

- The quality of analysis and information gathering within assessments undertaken by social workers in children's social care assessment teams is variable. While some good quality assessments were seen, not all are sufficiently robust, well evidenced or comprehensive, and this leads to poor decision making and drift in some cases. Assessments do not routinely record how frequently children have been seen, or if they have been seen alone. Some examples were seen of optimistic social work assessments that placed an over-reliance on the word of parents, particularly in domestic violence cases.

- Children's social work caseloads at the 'front door' are variable, and some very high caseloads adversely affect workers' ability to produce good quality written assessments. For example, in one assessment team, some members of which are newly qualified, social workers are responsible for managing between 22 and 65 cases each. As a result of this unacceptably high workload, vulnerable children do not always receive a consistent service from children's social care.

- Recording of discussions and actions agreed at some multi-agency strategy meetings to determine the best way to investigate concerns and to protect children is not consistently robust or sufficiently comprehensive. Resulting action plans do not routinely identify named individuals to complete specific actions, or expected timescales. Some strategy meetings were not timely and key information from partner agencies was not consistently used to inform decision-making processes. In some cases, meetings were only held once it was recognised that concerns about a child's safety were a partnership issue. This meant that cases, including cases of sexual exploitation, continued to be supported by a single agency when the threshold had been reached for multi-agency intervention. As a result, some young people did not receive the full range of services that they needed.

- While individual social workers know their children well, some records outside the Kingfisher team do not show how young people had been engaged, or how they had contributed effectively to social work assessment and planning processes. Their views and experiences are not well reflected or considered in social work case records, in contrast to the clear and effective recording of young people's views and wishes in school nursing and sexual health records seen. Social care case recording in the frontline teams is mostly out of date. Records do not routinely reflect key information. For example, some home visits to see children are not recorded on social workers' case notes months after they occurred. Record keeping is reported by social workers to have been adversely affected by demanding workloads and competing demands. A good range of multi-agency activity, such as raising awareness of neglect, or community engagement on sexual exploitation, has increased demand, while social work resources have not kept pace and are unable to meet need. Senior managers are aware of this

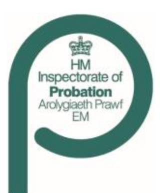
problem and have firm plans in place to address it, although their response needs to accelerate.

- Social work supervision at the 'front door' and management sign-off of assessments do not sufficiently challenge poor practice, such as gaps, missing information or poor recording. This includes not checking that children are visited when they should be and that they are seen alone and their views recorded. Management oversight does not effectively tackle drift and delay in casework. For example, only one third of cases are reported by managers to meet MASH timescales, and those rated as a low priority do not receive a timely response. This delay was also seen in cases rated as low priority by the police and probation services. This means that potential risk to vulnerable children is not always being mitigated in a timely manner.

Case study: area(s) for improvement

Many children and young people referred to the MASH experience delays in decision making for a variety of reasons.

In one case, a potentially vulnerable child was referred to the MASH on 6 January 2016 following concerns expressed by the Children and Family Court Advisory Service about the child's father. When the MASH accepted the referral, the referrer had not sought the consent of the mother to proceed. The MASH then spent a great deal of time and effort trying to gain consent from a mother whose first language was not English. The child's case was still in the MASH at the time of the inspection two months later. The child had not been assessed for services, nor had a decision been made that no further support was required. Despite taking up time and resources, no purposeful work had been undertaken with the child or their family. Eventually, consent was obtained from the father and agency checks showed no concerns for the child. The case was closed, as the mother had not engaged. The lack of understanding of what was required when making a referral led to additional work and an unacceptable delay in decision making in the MASH. The child's case has drifted, as it was difficult to make progress.



Next steps

The Director of Children's Services should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving the LSCB, police, NPS, schools and NHS Oxford CCG, Oxford Health NHS Foundation Trust and Oxfordshire University Hospitals NHS Foundation trust. The response should set out the actions for the partnership and, where appropriate, individual agencies.[2]

The Director of Children's Services should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 15 August 2016. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely

Ofsted	**Care Quality Commission**
Bradley Simmons Regional Director	Sue McMillan Deputy Chief Inspector
HMI Constabulary	**HMI Probation**
Wendy Williams Her Majesty's Inspector of Constabulary	Helen Davies Assistant Chief Inspector

[2] The Children Act 2004 (Joint Area Reviews) Regulations 2015 www.legislation.gov.uk/uksi/2015/1792/contents/made enable Ofsted's chief inspector to determine which agency should make the written statement and which other agencies should cooperate in its writing.