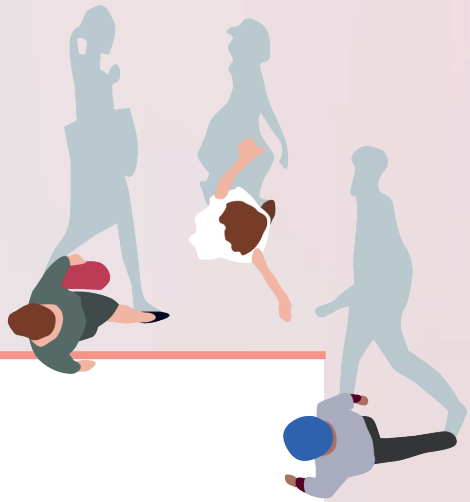
What Works *for* Children's Social Care



UNDERSTANDING SERVICE PROVISION FOR CHILDREN IN NEED IN ENGLAND

May 2022

What Works *for* Children's Social Care

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Acknowledgements

We would like to thank staff and parents at the four local authorities who participated in this study for giving their time and insights to inform our work. We are also grateful to the social workers, team managers, principal social workers and senior leaders who participated in our roundtables to help inform our research and interpret our findings. Finally we would like to acknowledge the contribution of our peer reviewers whose advice and feedback was invaluable to shaping this report.

Funding and competing interests

What Works for Children's Social Care (WWCSC) was commissioned to conduct this research by the Independent Review of Children's Social Care (IRCSC). During the research, we met regularly with the IRCSC, who were involved in formulating the research questions and designing the methodology. The analysis was conducted by the research team and the IRCSC did not influence the reporting of the findings.

About the Independent Review of Children's Social Care

The Independent Review of Children's Social Care was announced in January 2021 and will report in Spring 2022. Josh MacAlister is leading the review which has a wide ranging and ambitious scope. The review is a chance to look afresh at children's social care. It will look at issues through the perspective of children and families throughout their interactions with children's social care, from having a social worker knock on the door, through to children being in care and then leaving care. What Works for Children's Social Care is supporting the review by producing and commissioning evidence summaries, rapid reviews and new analysis.

About What Works for Children's Social Care

What Works for Children's Social Care seeks better outcomes for children, young people and families by bringing the best available evidence to practitioners and other decision makers across the children's social care sector. We generate, collate and make accessible the best evidence for practitioners, policy makers and practice leaders to improve children's social care and the outcomes it generates for children and families.

To find out more visit the WWCSC at:
whatworks-csc.org.uk

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GLOSSARY OF TERMS

ACE - Adverse Childhood Experiences

CAMHS - Child and Adolescent Mental Health Services

CAO - Child Arrangements Order. A court order which regulates arrangements relating to with whom a child resides with or spends time with and for how long.

CCE - Child Criminal Exploitation

C&F - Child and Family (assessment)

CSC - Children's Social Care

CSE - Child Sexual Exploitation

CPN - Community Psychiatric Nurse

CwD - Children with Disabilities

DfE - Department for Education

EHC(P) - Education Health Care (Plan)

FGC - Family Group Conference

FSW - Family Support Worker

IAPT - Improving Access to Psychological Therapies

MST - Multi Systemic Therapy. An intensive family and community-based intervention.

NEET - Not in Education, Employment or Training

NRPF - No Recourse to Public Funds

ONS - Office for National Statistics

S17 - Section 17 of the Children Act 1989. Places a general duty on all local authorities to 'safeguard and promote the welfare of children within their area who are in need,including with financial support.'

S47 - Section 47 of the Children Act 1989. Places a duty on CSC to carry out an investigation when they have 'reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm.'

SENCO - Special Educational Needs Coordinator

SOS - Signs of Safety model. A strengths based approach to social work practice.

UASC - Unaccompanied Asylum Seeking Child

WWCSC - What Works for Children's Social Care

EXECUTIVE SUMMARY

Background

Evidence suggests that one in seven pupils experience an intervention from children's services at some stage between the ages of 5 and 16. For the majority of children, the highest level of intervention is a Child in Need plan (76% in data from 2017), compared to a Child Protection Plan (11%) or going into care (13%) (Berridge et al., 2020). Despite the high prevalence of Child in Need plans, information on what services are provided to children and families as part of these plans has not been systematically collected at the national level since the 2008/2009 Children in Need census, which itself was quite limited (Emmot et al., 2019). There is also limited research which considers the characteristics of children who have a Child in Need plan or the support they receive. However, information about Child in Need services is held locally by local authorities (LAs). This report presents the findings from a mixed methods research study aiming to understand more about the support offered to families and children who are subject to a Child in Need plan under Section 17 of the Children Act 1989. This research was commissioned to inform the Independent Review of Children's Social Care, and is one of the first studies of its kind that we are aware of.

Research Questions

The four research questions we sought to address are as follows:

1. What are the characteristics of children and families of children who have Child in Need plans?
2. What are the reasons children and young people have Child in Need plans?
3. What support and activities are families of children who have Child in Need plans receiving?
4. Does the support provided match the needs of families of children who have Child in Need plans?

Methods

Working closely with four LAs in England, we undertook a manual review of 82 case files for children with a Child in Need plan and facilitated in-depth conversations with social workers about a further 11. We held seven focus groups with 29 social work staff (including managers), and 11 interviews with parents of children with a Child in Need plan. We also analysed administrative data about children who have a Child in Need plan, which is routinely collected at a local level in each of the four LAs. Some but not all of this data are submitted to the Department for Education (DfE) as part of routine data collection each year.

Social workers volunteered to take part. Case files and families included in the review were limited to those selected by the LAs, who agreed for their file to be included. This may also increase the likelihood that findings may be subject to a positive bias (i.e. we may have been more likely to hear from people who had positive experiences of services than those who were dissatisfied with services). Triangulating between a range of different sources of information may go some way towards addressing this risk.

The findings reported are based on the small number of LAs and case files we have been able to review. These are intended to be used to inform an initial understanding of the type and range of support received by families of children with a Child in Need plan, and to start mapping some of the challenges and gaps that should be further explored in future work. Due to the nature of the research, the findings are not necessarily generalisable to the wider population within these LAs, and are not intended to be generalised to an understanding of other LAs not included in the review.

Key findings

- There appears to be considerable variation in the reasons for using Child in Need plans, and consequently considerable variation in their length and the types and sources of intervention provided. This includes instances where there is a high level of risk, as well as those with no safeguarding concerns where there is much less need for regular active involvement from the social worker (for example children with disabilities).
- Important factors in decision making to recommend a Child in Need plan included history of concerns, the engagement of parents with children's social care, availability of family support, the level of ongoing risk and the impact of any concerns on the child.
- As a result of gaps in data, and an absence of national reporting on children with a Child in Need plan, the understanding of the characteristics of children who have a Child in Need plan as a distinct group is limited.
- Consistent with the wide range of reasons for using a Child in Need plan, we noted a wide range of support and interventions provided by the social worker, family support workers, specialist teams within the LA, and external services to which families were referred. A large part of the social worker's role involves providing advice or guidance to parents, and coordinating the multi-agency support provided. Use of direct work with parents and children is variable, with variation in the frequency of direct work, approach taken, and use of facilitation tools and resources, as well as how direct work is recorded in case files.
- Despite a range of support offered to children and families by LAs and other agencies, there are gaps in services and support available, meaning many families' needs may not be met. In particular, this involves difficulties accessing timely specialist support, particularly for child and parent mental health.
- Staff discussed the voluntary nature of Child in Need plans, and parent and child's voices were heavily emphasised in the social worker's accounts of their work, and observed in case files. However, the parents we spoke to didn't always feel involved in developing their plans, and some weren't very aware of what their goals were. Despite this, in instances where parents did know what their goals were, they did tend to agree with them, even if they hadn't felt involved in deciding them.

Recommendations for policy and practice

- **More consistent use of Child in Need plans may be warranted.** Every child's Child in Need plan should have a clear statement of purpose, and how this is going to be achieved. Our findings also suggest that there may be differences in decision making around thresholds between areas.
- **Social workers should collaborate with parents, carers and children to develop goals for their child's Child in Need plan.** This includes parents and carers setting goals, understanding the plan and having a record in an accessible format. This is important given the voluntary nature of Child in Need support.
- **Create consistency across LAs in the availability and quality of services provided for the most common areas of need.** Our findings suggest there is variation in the support available from local authorities. There should be sufficient funding to allow a more consistent or equivalent offer of support, regardless of where a family lives.
- **Improve access to external support provided by multi-agency partners,** for services including mental health and domestic abuse. This would help reduce time on a plan or delay in progress for families.
- **Local areas should consider increasing multi-agency partnerships.** Partners should agree on roles and responsibilities, and consider how the professional network can best support children and families.
- **Ensure Social Workers and Family Support Workers have sufficient time and training** to undertake direct work with children and their parents or carers.
- **There should be a better understanding of what direct work is happening with children and families** and consideration for how this is captured to ensure case recording is helpful to social workers families.
- **More and better quality data should be collected and recorded about children, families and their Child in Need plans.** This should include socio-economic factors, parent characteristics, parental engagement and what support and interventions are provided by social workers and external agencies. Critically, outcomes of plans must also be captured. In addition, children with a Child in Need plan should be identified as a distinct group in administrative data.

Recommendations for future research

Future research should:

- **Evaluate** whether support provided to children with a Child in Need plan is effective in meeting the needs of children and families.
- **Describe and explain** regional variation in the use of Child in Need plans.
- **Capture** the views and experiences of children, young people and families who have a Child in Need plan.

BACKGROUND AND RATIONALE

This piece of research has been commissioned by the Independent Review of Children's Social Care in England to understand more about the support offered to families and children who are subject to a plan under Section 17 of the Children Act 1989.

The function of Child in Need services

Under Section 17 Children Act 1989, a child will be considered in need if:

- They are unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the Local Authority (LA)
- Their health or development is likely to be significantly impaired, or further impaired, without the provision of services from the LA
- They have a disability.

Current guidance (Working Together to Safeguard Children, DfE, 2018) indicates that where the LA local authority decides to provide children's social care services, a multiagency Child in Need plan should be developed which sets out which organisations and agencies will provide which services to the child and family.

> *'The plan should set clear, measurable outcomes for the child and expectations for the parents. The plan should reflect the positive aspects of the family situation as well as the weaknesses' (p.38).*

A Child in Need plan is voluntary for families and gives children failing to thrive extra services, beyond what every child receives, to help them develop safely. A Child in Need plan doesn't have a statutory framework for the timescales of the intervention, although LAs tend to provide their own guidance on expectations for timescales.

Who is on a Child in Need plan?

Research findings show that one in seven pupils in England experiences an intervention from children's services at some stage between the age of 5 and 16 (Berridge et al., 2020). Children and young people with Child in Need plans make up the largest proportion of children with a social worker (Department for Education [DfE], 2020a). For the majority of children with a social worker, the highest level of intervention is a Child in Need plan (76% in data from 2017), compared to a Child Protection Plan (11%) or going into care (13%) (Berridge et al., 2020). Berridge et al. (2020, p.3) conclude that "In terms of volume, social work is clearly dominated by Children in Need services".

Despite the prominence of children on Child in Need plans in England, there is little understanding of who these children are, the most common reasons they are put onto these plans, what kind of support they receive, and whether that support is matching their needs.

Available evidence, including the DfE's Children in Need Review (DfE, 2019) shows that children with Child in Need plans are more likely to live in the areas with the highest level of deprivation, to be eligible for free school meals, to have special educational needs, and to experience persistent school absence relative to children without a social worker (DfE, 2018). Recent research has also found that children living in deprived neighbourhoods are more likely to receive Child in Need interventions if they are in a LA with low levels of deprivation, than if they were in a LA with high levels of deprivation. LAs with high income inequalities also had higher rates of Child in Need intervention compared to LAs with low income inequality (Webb et al. 2020).[1]

At the parental level, a report that drew on data from 111 LAs reported that the co-occurrence of parental domestic abuse, parental substance misuse, and parental mental health issues was common, with one LA estimating that these contributed from 65% to 80% of their Child in Need cases (Chowdry, 2018). While the literature suggests that these issues seem to commonly co-occur, research on the impact of these factors combined is still underdeveloped (Skinner et al., 2021). National statistics from the DfE, in their current form, do not allow for further investigation of these issues, as they do not report on the co-occurrence of family referral reasons.

The scarcity of research on the characteristics of children and families on Child in Need plans highlights the lack of understanding of who this group really constitutes.

Why are children put on these plans?

Our review of wider evidence indicated that the reasons for initiating a Child in Need plan are not recorded systematically. This information, where it is recorded, is documented in separate, non-centralised databases or spreadsheets across different local authorities (Bowyer et al. 2018). This issue has been raised in several other, including older, studies, suggesting a lack of improvement despite repeated acknowledgement of this issue. There is, however, some research on systematic reasons why children are placed on Child in Need plans.

There is significant variation in the rates of Child in Need plans geographically across England (Godar, 2017). This was highlighted by the All Party Parliamentary Group for Children (2018) which reported that almost three quarters of surveyed Directors of Children's Services reported variable thresholds for 'Children in Need' support. This means that what constitutes a 'Child in Need' largely depends on the LA, which can be attributed to the lack of established national thresholds between Early Help, Children in Need, and Child Protection (Cooper, 2021). National threshold variability adds difficulty to our understanding of the Child in Need population and service provision.

1 This phenomenon is referred to as the 'inverse intervention law', which comes from a concept in health inequalities literature (Webb et al., 2020). "This is hypothesised to have resulted from differential levels of local authority expenditure relative to need, with less financially constrained, low deprivation local authorities intervening more frequently in equivalent neighbourhoods as high cost interventions are rationed a little less stringently" (Hood et al., 2016, as cited in Webb et al., 2020)

The thresholds between Early Help and Children in Need provision may be a key factor as to why there is so much variation in Child in Need cases across England. There are several hypotheses as to why this variation exists. Professionals have speculated that Early Help services in some local authorities have increased the identification of Children in Need of support, while others say that Early Help diverts children away from child protection systems (Biehal, 2019). Another hypothesis is that different recording practices and definitions of Children in Need and Early Help assessments (Godar, 2017).

Reviewing LA guidance for thresholds highlights that where families do not engage with support, this seems to facilitate the escalation of a Child in Need plan to a Section 47 investigation, while families who were more willing to engage were more likely to be allocated to Child in Need plans. One LA specifically recommends Child in Need plans where a multi-agency response is necessary, in contrast to other LAs allowing for multi-agency coordination in the Early Help stage. Other areas of notable differences between LAs lie in the detail provided on when to recommend a Child in Need plan. Some LAs laid out discrete differences across multiple domains of child development (such as physical health, education, emotional and behavioural development, identity, family and social relationship, social presentation, and self-care skills) that can help social workers determine when to recommend a Child in Need plan. Other LAs did not appear to have this sort of details for whether threshold guidance was informed by child development milestones, and only listed the guidance as set out in the Children Act 1989.

What support are children and families receiving?

With varying thresholds and definitions of Children in Need, the support children and families receive while on Child in Need plans still remains largely unknown.

There is a noticeable gap in the systematic and quantitative understanding of what structures, processes, and interventions are being conducted within LAs across England in relation to Child in Need plans, and this has been noted by researchers throughout the years. Literature that investigates contemporary practice and interventions within LAs is patchy and inconsistent, where there is no overall national data. Information on what services are provided to children and families whose children have Child in Need plans has not been systematically collected at the national level since the 2008/2009 Children in Need census, which itself was quite limited (Emmot et al., 2019).

Variations in investments and budgets between LAs can help contextualise some of the reasoning for differences in thresholds. Research suggests that cuts to funding of children's social care services can lead to a rationing of services, where thresholds of different child protection categories shift in order to accommodate available resources. This can take the form of longer waiting times for necessary services, also known as rationing by delay (Devaney 2019).

In the absence of robust systematic data, a poll of social workers in England conducted by What Works for Children's Social Care (WWCSC) details social workers' experiences of working with families who have Child in Need plans (WWCSC, 2021). The aforementioned issue of long waiting times is reflected in our polling of social workers, where social workers reported the two

leading challenges for service provision for Child in Need plans is long waiting lists for services (reported by 64% of 103 respondents) and needed resources not being available (reported by 51% of respondents)(WWCSC, 2021). Beyond issues of resource availability, the third most commonly cited barrier to service provision was the inability to engage family members (49% of 103 respondents), which speaks to the separate issue of family voluntary engagement.

In terms of direct service provision from social workers, there is also a lack of robust evidence. Findings from the WWCSC poll of social workers showed that although most social workers (89% of 88 respondents) reported visiting families of children on a Child in Need plan at least monthly, 38% of 100 respondents reported that they would like to see children on a Child in Need plan more often than they currently do. High caseload or workload was commonly cited as a reason that prevented social workers from seeing families as regularly as they would like to (WWCSC, 2021).

Some respondents also stated that time spent visiting children on a Child Protection Plan, or doing court work, was a barrier to visiting children and families more often. Further to this, 60% of 101 social workers reported that the support given to families was fairly or very effective in meeting families' needs. Challenges in providing the right resources included long waiting lists (reported by 64% of 103 respondents), resources not being available (51% of respondents), and services closing if they cannot engage family members (49% of 103 respondents).

Does support match the level of need?

The different thresholds across LAs and lack of systematic data collection makes it difficult to understand whether children and families with a Child in Need plan are receiving the support they need. We know of no current research which examines the impact of support provided through a Child in Need plan. We briefly outline research below on the outcomes of children who have a Child in Need plan.

In terms of educational experiences, The Children in Need Review (DfE, 2019) found that children with a Child in Need plan had worse educational outcomes than children who did not have a social worker. For example, children on a Child in Need plan[2] were around 50% less likely to achieve a strong pass in English and Maths GCSEs (age 16), and four times more likely to be permanently excluded (DfE, 2019a) than children who did not have a social worker. These outcomes were similar to those of children on a Child Protection Plan. This was echoed by more detailed analyses by Berridge et al. (2020). Further evidence suggests that children who have a Child in Need plan are twice as likely to be 'off-rolled' (removed from school without using an exclusion) than pupils with no social care involvement (Jay et al., 2022).

Some of the only other systematically measured outcomes of Child in Need plans pertain to plan escalation and reentry. The DfE's Children in Need Review found that three quarters (74%) of children on a Child Protection plan, and two-thirds (62%) of children who were in care in 2017/18, were on a Child in Need plan at some point in

2 Defined as children on Child in Need and other Plans who were not on Child Protection Plans or Children in care

the previous five years (DfE, 2019a). This highlights the importance of ensuring the right effective support is provided to children and young people who are on a Child in Need plan to prevent escalation. To address issues of escalation and administering appropriate service provision, there has been some evidence of innovative work on modifications to LA guidance.

In one LA, modifications were made to differentiate a way of working with more complex and high risk Child in Need plans. This aims to provide better outcomes for the management of complex cases through prioritisation, regular management and revision, and avoidance of 'drift' (Kirk & Duschinsky, 2017). A qualitative exploration found that the protocol disrupted regular practice by allocating more resources and support to families whose cases fell below the child protection plan threshold, but were still in need of substantial support. Practitioners expressed that the protocol created a clear process that allowed for clearer management, inter-agency involvement, and ownership of responsibility that led to perceived improvements in Child in Need case management. This protocol, however, does not appear to have been rolled out to other LAs or further evaluated, so results from the study should be interpreted with caution.

While there is a lack of robust evidence around outcomes, the little evidence we do have suggests that children on Child in Need plans are not reaching their full potential compared to their peers, and that there is a high amount of case drift between different child protection categories. Innovation can occur to address this, but this innovation is rare and has not been robustly evaluated.

Gaps in the evidence base

This evidence base highlights the need for more research to understand the characteristics of children and families supported through Child in Need, guidance for social workers and other professionals, as well as what support and services are being provided. Research investigating what support is currently provided, as the current research aims to do, is important to inform future attempts to more systematically track provision locally and nationally.

The present research, commissioned by the Independent Review of Children's Social Care in England, is one of the first to consider in-depth the support offered to families and children who are subject to a Child in Need plan under Section 17 of the Children Act, and how this might be improved. Due to the gaps in available data which we have already highlighted, this investigation uses a range of qualitative and quantitative methods to consider the characteristics of families and support provided in four LAs in England. This is a small exploratory study which aims to enable more in-depth future research which builds on its findings.

METHODS

Research aims

This research described the support offered to a snapshot of children who have a Child in Need plan and their families across four local authorities. A summary of our method is below. More detail can be found in our protocol.

The four research questions we sought to address are as follows:

1. What are the characteristics of children and families of children who are on Child in Need plans?
2. What are the reasons children and young people are on Child in Need plans?
3. What support and activities are families of children who are on Child in Need plans receiving?
4. Does the support provided match the needs of families of children who are on Child in Need plans?

Research question one is concerned with demographic characteristics, whilst research question two considers contextual characteristics (such as domestic violence or mental health difficulties) which are reasons families might be referred to children's services or why a Child in Need plan may be recommended. Findings under research question four consider both whether the support meets the needs as well as what are the areas in which there are gaps.

Selected local authorities

Due to time constraints, we approached local authorities who had either expressed interest in supporting the Independent Review of Children's Social Care, or with whom WWCSC had an existing relationship through other projects. We aimed to select four local authorities which represented a range of regions, Ofsted ratings, rates of Children in Need, deprivation and diversity. The characteristics of the four LAs who agreed to take part are presented at the start of our finding section of this report. As the purpose of the review is not to comment on practice in any one LA , and to ensure confidentiality for any children families discussed in this report, we have chosen not to name the LAs involved in this report.

Data collection

In four selected LAs, the data we were able to collect was as follows.

Table 1. Data collection completed

Activity	Target	LA1	LA2	LA3	LA4	Total
Staff focus group (Social Workers and Managers)	4 (24 staff)	4 (12 staff)	1 (5 staff)	1 (7 staff)	1 (5 staff)	7 (29 staff)
Parent interviews	12	2	3	3	3	11
Review of case files	100	18 (7 files + 11 cases discussed in focus groups)[4]	25	25	25	93 (82 files + 11 cases discussed in focus groups)
Administrative data	4	1	1	1	1	4

This research focused on children who had a Child in Need plan, not just children who were recorded in national data to be Children in Need, which represents a much larger group including for example children on a Child Protection Plan or Children in Care. Staff and case files were identified by project leads within the local authorities (LAs). LAs were asked for case files which covered a range of characteristics across teams and case characteristics. For example, we asked for case files provided to include children which were open for a range of different referral reasons, including those who are on Child in Need plans because they are children with disabilities, to include children that had been on Child in Need plans for shorter and longer durations, and with varying history of children's social care involvement, such as previous involvement of Early Help or Child Protection intervention. Further to this, parents (of children whose case files were selected for review) were given the opportunity to opt out of their child's case file being reviewed. Parents were also asked if they would be happy to take part in an interview.

Within the participating LAs, focus groups were carried out with social workers[5] and managers from a range of teams who worked with children receiving support under a Child

3. Due to only being able to access a small number of case files in this LA, we undertook three additional small focus groups with staff to ask more in-depth questions about individual cases they supported.
4. As we did not ask social workers describing case files to provide their identification numbers, we cannot be certain whether or not there is overlap between the set of seven files and the set of eleven cases discussed.
5. And a family support worker in one LA

in Need plan. These were 90-minute meetings undertaken virtually via Teams.[6] Interviews were carried out over the phone with parents of children on Child in Need plans.[7]

We requested aggregate administrative data from all four LAs, and which covers all children within the local authority who are subject to a Child in Need plan or are currently undergoing assessment under section 17. We requested data as a snapshot of all open cases on 31 October 2021.[8] The data requested was based on the information we knew LAs would have available based on the DfE's Children in Need census. This data covered the number of children, their age and ethnicity, the number of children with a disability, the duration of Child in Need plans, primary need codes recorded at referral and the factors identified at the end of assessment.

Information to answer the pre-specified research questions was extracted from up to 25 case files per LA into a pseudonymised spreadsheet. Broadly, this covered demographic information about the child and family (such as age, ethnicity, disability, prior involvement of children's social care, immigration status), and reasons for being on a Child in Need plan (the primary areas of need, factors at the end of the assessment, reasons why the child is considered to meet the threshold for a Child in Need plan). We also extracted information on any support and assessments provided by the Social Worker whilst the child was on a Child in Need plan (direct work with the child and parent, referrals to other agencies, frequency of visits, meetings, reviews and supervision), as well as support and assessments by other professionals within the LA, and from outside of children's social care (who provided the intervention, what it was for, and which family member, and level of engagement). The full data extraction sheet is provided in Appendix 3.

The project was also informed by four roundtables to which we invited staff from LAs other than the ones who were included in the research. Attendees were invited by reaching out to the Principal Social Worker networks.

- Before starting data collection we held two one-hour roundtables, led by social workers in the WWCSC Practice Team. One of these was with social workers and team managers, and the other with principal social workers and senior leaders. Attendees were from 12 LAs from four different regions, with Ofsted ratings ranging from Inadequate to Outstanding. These aimed to inform the research design and questions asked.

6 In focus groups we asked about common reasons children and young people were on Child in Need plans, what support social workers and other internal and external services provided whilst families were on a Child in Need plan, information about the local practice model, and how support has changed since the COVID-19 pandemic. We also asked how support varies depending on the different needs families have, whether there are any areas where the support doesn't match needs, how satisfied and engaged families are with the support provided, why some children remain on Child in Need plans for longer periods of time or what the reasons are where Child in Need plans can be escalated to a higher level of intervention. We also asked for recommendations for how the support can be improved.

7. In interviews we asked parents about any support they had received from their social worker, or other internal or external services, as part of their Child in Need plan. We asked about their experiences of using these services, what they had found useful and what they thought could be improved. We asked if there were any services they hadn't received which they would have found helpful.

8. Due to availability, for one local authority data was provided for 26/08/2021, and another for 04/11/2021

- After completing the data collection and analysis we held two further one-hour roundtables, led by a social worker in our Practice Team. One of these was with social workers and team managers, and the other with principal social workers and senior leaders. Attendees were from ten LAs from six different regions, with Ofsted ratings ranging from Requires Improvement to be Good to Outstanding. These aimed to help us understand and interpret our research findings so far,[9] think about their implications and how consistent they were with experiences in a wider range of LAs.

This project was reviewed and approved by the WWCSC research ethics committee. More detail on the methodology is available in the research protocol.

How we analysed the data

Administrative data about characteristics of families on Child in Need plans were analysed descriptively for each LA individually and used to answer research question one. Rate per 10,000 children is an estimate calculated using the most recent Office for National Statistics (ONS) mid-year population estimates (2020) along with data from 2021 reported by the LAs as part of this project.

Findings across cases from the case file review were integrated to provide summary findings for each LA. Findings for each LA are compared where appropriate to draw conclusions about variation across LAs, or integrated where appropriate to draw overarching conclusions.

Transcribed focus groups and interviews were analysed using a deductive approach to thematic analysis based on a pre-prepared coding frame, to identify patterns (i.e. themes or topics that recur across the data) to answer the pre-specified research questions.

Findings from case file review, and analysis of focus groups and interviews, were triangulated together to answer research questions two to four, as well as the family characteristics indicator of research question one. Triangulation of findings across the different data collection methods involved collating findings together which answered each question, including consideration of where findings from the different methods agreed, disagreed or provided complementary information to provide a broader picture.

More detail on the analysis undertaken is available in the research protocol.

Supplementary in-depth review

In addition to the methods above set out in our protocol, we undertook a supplementary in-depth review to further understand some of the features of the case files we had reviewed for this project, and questions which emerged as we progressed the analysis. For this in-depth review, we purposefully selected nine cases for in-depth review which reflect the range of need, risk, and complexity we observed from the review of 82 Child in Need case files. We included two case files for LAs 1, 2 and 4 and three case files for LA3 where we had recorded a greater level of detail relevant to the in-depth review when reviewing the 25 case files for this LA. In this report, reference to the 'in-depth review' refers to our in depth review of nine case files (two to three per LA). Reference to the 'case file review' refers to our main, planned analysis of 25 case files per LA. Further detail on this review methodology is provided in Appendix 2.

9. Due to the timing of the roundtable, we were unable to present our final findings and conclusions, but presented interim findings

Strengths and limitations

As has been set out in the introduction to this report, this is one of the first research studies to look at the type of support provided to children and families of children on a Child in Need plan in England. Understanding of this is so far absent from research and nationally collected data. The report provides an in-depth look at these questions in four LAs in England.

Because much of what we were interested to find out is not collected and recorded in a systematic way, this study took a primarily qualitative approach, supplemented by some high-level LA data where available. As such, when considering the findings of this report, a number of limitations should be taken into account which mean that the findings of this report cannot be used to attribute how prevalent support provided - or gaps in support are. The findings are intended to be used to inform an initial understanding of the type and range of support received by families of children on a Child in Need plan, and starting to map some of the challenges and gaps that should be further explored in future work. This is intended to act as a basis to inform larger scale surveys or comparative studies across LAs in future. However, due to the nature of the current study, the present findings are not intended to be generalised to other LAs.

More specifically, the limitations include:

- These findings are based on the LAs in which they are conducted. The selection process and characteristics of these LAs should be taken into consideration when interpreting the findings from this research. We use findings from our roundtables with attendees from other LAs in the discussion section of this report to help consider how applicable the findings are outside of the LAs involved in this study. However, limitations of these are that they still only represent a small proportion of LAs in England, and there was limited opportunity to get into depth in these one hour discussions. further research is needed to understand more comprehensively whether the findings about Children in Need support in these LAs are similar to or different to those in other LAs.
- Though we aimed to capture as wide a range of characteristics as possible, the case file review, interviews and focus groups are based on a small sample and where staff and parents agreed to speak to us or have their file reviewed. Importantly, though we asked for a random selection, the LAs selected the cases and staff and parent participants themselves, and further to this, only those where parents gave permission were included. As such, the findings are not necessarily representative of all cases or experiences of staff and parents in the LAs of interest. For example, families considered 'harder to reach' may not have been easy for the social worker to contact or may not have been asked to participate due to worries about damaging the social worker relationship. Further, staff who had particularly positive (or particularly negative) experiences may have been more likely to have been asked or more likely to have agreed to take part. This means that a positive bias may be present in the findings presented in this report (i.e. we may have been more likely to hear from parents and staff who had positive experiences of services than those who were dissatisfied with services), though it should be emphasised that the aim of this study was to start to understand the range and nature of, rather than prevalence of, different experiences.

- Due to time limitations, we focused only on 'recent' case history, which may limit our ability to draw conclusions about the support provided in the longer term to cases open for longer periods of time. For one LA, we received access to certain files rather than the whole case file system, meaning that not all the detail we had been able to access in the other authorities was available to us.
- It is also important to note that what we were able to record and use in the research is dependent on the comprehensiveness and quality of case recording, and not necessarily representative of what practice looks like in person. In particular, there may be practice which is not recorded meaning that we may under-estimate the amount of support provided by relying solely on what is recorded in case files. Triangulating with staff and parent reports helps to mitigate this to some extent but this is likely to be a significant limitation of our study.
- Further to this, it should be noted that the in-depth review of nine case files was based on a very small and purposively selected set of case files, and cannot be taken to be representative of practice across the LAs.
- This study is based on cross-sectional aggregate data from the administrative systems, rather than longitudinal individual level data, so is not able to consider trajectories of children or clustering or timing of relevant problems or services.
- We are unable to draw comparisons with national data which does not report separate statistics for children on a Child in Need plan.
- Our research aimed to describe a snapshot of work being done in and by local authorities for children and families with a Child in Need plan. It is not an evaluation of the services provided and cannot speak to whether plans meet the needs of children and families or not.

FINDINGS

The characteristics of the four LAs participating in this study are reported below. The characteristics below are presented as a summary, rather than by LA, in order to maintain anonymity of the LAs.

Table 2. Characteristics of included local authorities

Characteristics	
Region	The LAs came from four different regions in England
Ofsted	2x Requires Improvement, 1x Good, 1x Outstanding
Urban/Rural	1x Major Urban, 1x Other Urban, 2x Significant Rural
Rate of children in need at 31 March 2021 per 10000 children aged under 18 years (National is 321.2)	Two below the national average, two above the national average
Ethnic diversity percentiles[10]	Ranging between 0-20 and 60-80%
Deprivation percentiles[11]	Ranging between 0-20 and 80-100%
Modelled prevalence of children in households where parent is suffering a severe mental health problem[12]	Below the national average (LA2) Higher than the national average (LA1, LA3, LA4)
Modelled prevalence of children in households where parent is suffering domestic abuse[13]	Below the national average (LA2, LA3) Higher than the national average (LA1, LA4)
Children under 16 living in absolute poverty (before housing costs)[14]	Below the national average (LA2) Higher than the national average (LA1, LA3, LA4)

10 www.ons.gov.uk/census/2011census

11 www.gov.uk/government/statistics/english-indices-of-deprivation-2015

12 www.childrenscommissioner.gov.uk/chldrn/

13 www.childrenscommissioner.gov.uk/chldrn/

14 www.childrenscommissioner.gov.uk/chldrn/

1. What are the characteristics of children and families of children who are on Child in Need plans?

Number of children who are on Child in Need plans

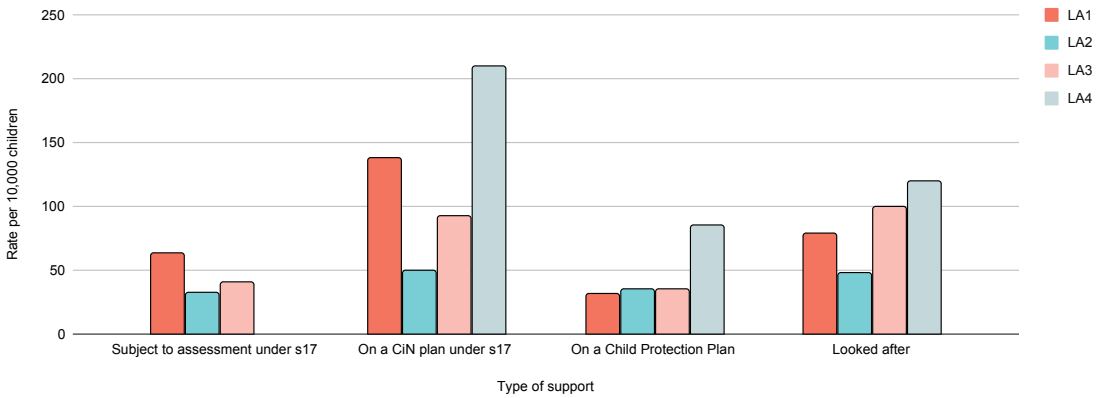
The following section is based on whole-local authority data for all four LAss. Findings show that there is significant variation between LAs in the rates and duration of Child in Need plans.

Based on whole LA data provided, the number of children on a Child in Need plan in the four LAs ranged between 358 and 2,345 children. The rate per 10,000 children on a Child in Need plan ranged between 50 and 210[15] (seen in Figure 1). Further to this, the number of children subject to assessment under section 17 in the four LAs ranged from 156 to 1,079 children, and the rate per 10,000 children subject to assessment ranged from 32 to 63 (not available for LA4).

Figure 1 shows that the LA with the highest rate of Child in Need plans (LA4) also has the highest rate of children on a Child Protection plan and who are in care, suggesting some LA smay have higher or lower intervention rates overall than others (i.e. higher use of all types of statutory involvement). However, findings also show different relative uses of different types of statutory status. In some instances (e.g. LA1 and LA4), there are higher relative uses of Child in Need plans and lower relative uses of Child Protection plans, a smaller proportion of children in care, or both. On the other hand (e.g. LA2 and LA3) there are lower relative uses of Child in Need plans, and higher relative uses of Child Protection plans, a greater proportion of children in care, or both.

We also considered the Child in Need plan data in relation to centrally reported data on Children in Need for each authority (DfE, 2021), removing the rate of children in care and children on a Child Protection plan to estimate a roughly equivalent group. Even when factoring in the different time of year of reporting, the figures we collected show that the rate per 10,000 children on a Child in Need plan which we collected is substantially below the rate of Children in Need per 10,000 that is reported in national data.[16] This further highlights that the national data comprises a group much larger than just children on a

Figure 1: Rate per 10,000 children receiving different types of statutory support (whole local authority data)[17]



15 Using ONS mid-year population estimates for 2020 as used in the DfE's Children in Need Statistics (DfE, 2021).

16 To maintain confidentiality of the LAs, we do not report this data here

17 Number subject to assessment not available for LA4

Child in Need plan,[18] and that children on a Child in Need plan make up only a part of the population currently reported as Children in Need in the national statistics. This further emphasises the lack of data currently available for this specific group of children at a national level.

Duration of Child in Need plans

Based on whole LA data provided, across the four LAs, the average (mean) length of time currently open Child in Need plans had been open for (at the time of reporting) varied between LAs. This ranged from 17 weeks since the referral was accepted in LA4, 50 and 51 weeks in LA1 and LA2, to 91[19] weeks in LA3, though there was a wide range from 0 weeks to 1139 weeks (almost 22 years) depending on the LA.[20] These were for Child in Need plans which were currently open. Reasons some cases remain open for longer than others based on social worker focus groups are considered later under research question four.

Guidance on how long Child in Need cases should remain open seemed to vary. In one local authority, a social worker in the focus group reported a focus on undertaking Child in Need work within twelve weeks where possible (after handover from the assessment team). In another local authority, a social worker mentioned that Child in Need plans weren't expected to be open for longer than twelve months without a good rationale. In a third local authority, staff within a Restorative Early Support Team aimed to work with families for no longer than six months where possible, however no specific time frame was mentioned by staff in the area safeguarding teams. In the final local authority, a social worker noted that the length of plans were not restricted, as it would depend on the complexity of specific cases. Some social workers mentioned an approach of not wanting plans remaining open for longer than they needed to be:

> *"We don't want to remain involved. We want to get them in and get them the help that they need, and then get out of their lives so that they can do it themselves." [Social worker].*

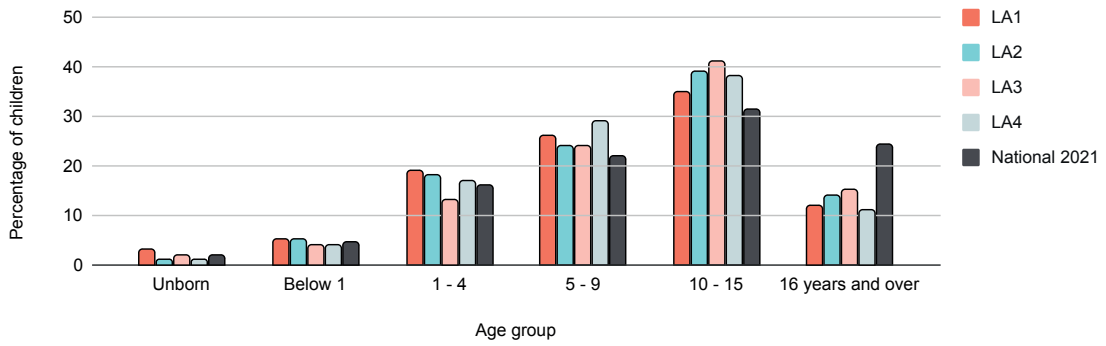
Reasons why some cases might stay open for longer than this guidance specifies, such as where children are receiving long term support for a disability, are considered later in the report, under research question 4.

18 The statistics state that 'this group includes children subject to Child in Need Plans, Child Protection plans, children in care, young carers, and disabled children. Children in need include young people aged 18 or over who continue to receive care, accommodation or support from children's services and unborn children.' (DfE, 2021)

19 As we do not have the underlying data, only summary data from LAs, we are unable to calculate means with outliers excluded.

20 The LA from whom this very long Child in Need plan was reported stated that long Child in Need plans could be for a range of reasons, including supporting a child with a long term disability up to age 25, or a care leaver who has been supported on short breaks or intermittent care, or cases left open to receive finance or on a legal order if appropriate, there could also be instances where cases were not closed properly. It was noted that there were only a small number of cases which were open for long periods such as this, suggesting it is not a systemic issue of cases not being closed.

Figure 2: Age of children on Child in Need plans



Characteristics of children who are on Child in Need plans

The following section is based on whole data for all four LAs.

Age

Across the four LAs, children undergoing assessment under section 17 Children Act 1989 were between 0-18 years of age, and those on Child in Need plans were between 0-25 years of age.[21]

Ethnicity

Data collected from each LA shows that there was considerable variation between LAs, with some falling below and some falling above the national average for Children in Need for each ethnic group. Further to this, findings show over and under-representation of certain ethnic groups amongst children on a Child in Need plan relative to the school aged population in each area.

Figure 3 and Table 3 (see Appendix 4) presents a comparison of ethnicity data we collected from each LA with publicly available data about the demographics in the four LAs (DfE 2021a, DfE 2021b).[22] This table and figure show that, consistent with national data, and findings for children in care, there is variation in rates of children on a Child in Need plan by ethnicity in each LA relative to their prevalence in the general population within the LA. For example, children who are Asian or Asian British are consistently under-represented amongst children on a Child in Need plan in these four LAs, relative to school aged children. On the other hand, children who are Black African, Black Caribbean or Black British, appear to be overrepresented amongst children on a Child in Need plan in these LAs. At times the patterns of over or under-representation of different ethnicities differs from what is seen for children in care in these same LAs (for example in LA1 children who are Black African, Black Caribbean or Black British appear to be overrepresented amongst children on a Child in Need plan but under-represented amongst children who are in case).

The local variation in over and under-representation of different ethnic groups as well as differences from national data on the broader definition of Child in Need, as well as local data for children who are in case identified in this report suggest that further exploration into the national and local patterns for different ethnicities for children on a Child in Need plan is warranted.

21 This age range includes cases held by children with disabilities teams

22 Data on Children in Need (the broader categorisation of children with a social worker including Children in Need, Child Protection, Children in Care and other groups) is not available by LA in the public data (DfE, 2021) for comparison

Figure 3: Percentage of each ethnicity recorded for children on a Child in Need plan, and school age children

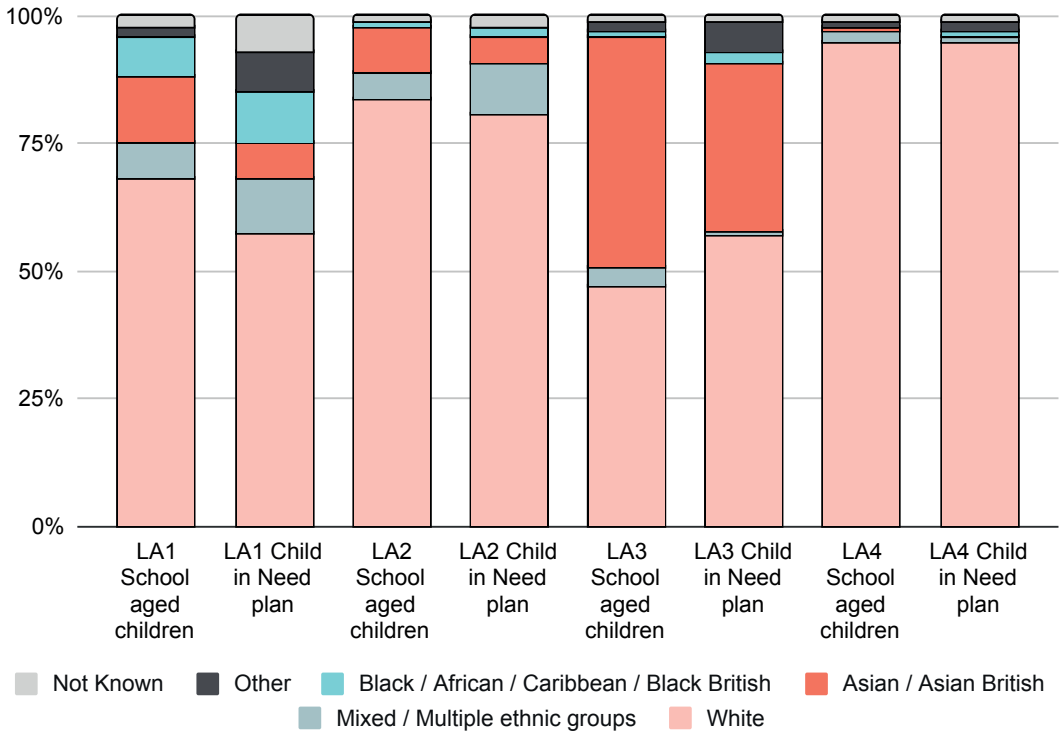
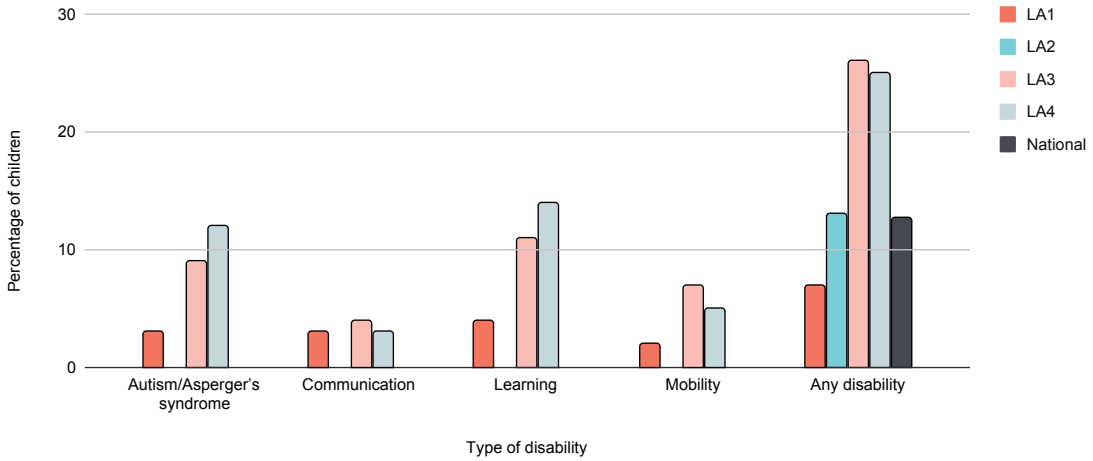


Figure 4: Recorded disability of children on a Child in Need plan under section 17 (whole LA data)[23]



Disability

Based on whole LA data we collected, across the four LAs, 7%-26% of children on a Child in Need plan were recorded as having any disability. The most common type of disability recorded (based on three LAs[24]) was 'learning' in all three LAs (4%-14% of all children on a Child in Need plan), followed by 'Autism/ Aspergers' (3%-12%), 'communication' (3%-4%) and 'mobility' (2%-7%).

This was consistent with national figures for 2021 (DfE, 2021), where 13% of Children in Need had a disability recorded, with the most common type of disability as learning (41.5% of those with a disability), followed by autism/ Asperger syndrome (36.5%).

We are unable to state whether the primary reason these children were on a Child in Need plan was because they had a disability, or whether they were supported by the children with disabilities team, as we did not seek to collect this information.

Characteristics of families who are on Child in Need plans

Findings below on parent and sibling care experience and history with children's social care are based on the subsample of up to 25 case files we reviewed for each LA, but may not be representative of all children on a Child in Need plan within these LAs. We found in around one in ten cases that it was recorded that the child had a parent who was care experienced, and similarly around one in ten cases had a sibling who was care experienced. We also found that financial difficulties, or material or financial support provided through the Child in Need plan, was often noted in case files, although there were gaps in recording of this type of information in some LAs.

Parents' care experience

Across the four LAs, the proportion of children where it was mentioned in their case file that they had parents who were care experienced was 12% (10 of 82 case files reviewed), ranging between 8%-16%

23 National data is only presented visually for 'any disability' as national data for each type of disability is presented as a proportion of children with a disability, rather than a proportion of all children on a Child in Need plan, and is therefore not comparable. Disability type is missing for LA2.

24 Data missing for LA2

depending on the LA. This information was most often recorded about the mother (in nine case files), and very infrequently about the father (in two case files). Some files also referenced adverse childhood experiences for parents and it was sometimes unclear, unknown or not recorded whether or not they had formal care experience. For example, in one instance the social worker recorded that:

> *"Mother states that she herself first became known to Children's Social Care at the age of two and this was because she had endured physical and sexual abuse". [Case file review]*

Whether or not a parent had experienced any adverse childhood experiences (ACEs) was not initially part of our data extraction template, therefore this information was not systematically recorded across all participating LAs and thus calculating a percentage would be misrepresentative. Additionally, we noticed important information about childhood experiences for many parents within case files was not recorded or was unknown.

Siblings care experience

Across the four LAs, the proportion of case files reviewed or discussed, where it was recorded that the child had a sibling either currently or previously in care, or who had been removed from either parent's care, was 9 of 93 (10%). The pattern was relatively similar across LAs.

As these case files were not representatively sampled, these findings cannot be used to indicate how prevalent these characteristics are amongst Children in Need in the four selected LAs.

Socioeconomic status

Findings suggest that recording of families' socioeconomic status was inconsistent. Socioeconomic background of families was largely not available for the 25 files reviewed from LA2, and was not recorded in 44% of Child and Family (C&F) assessments in the 25 files reviewed in LA4.

Based on the data that was available, families were in receipt of benefits (including families who were in receipt of child benefit, carers or disability living allowance) in 21 of 25 case files reviewed in LA3, and 11 of 15 of case files reviewed (where this information was available) for LA4. Five of seven cases reviewed in LA1[25] were in receipt of benefits. Further, it was recorded that the family reported struggling financially in 7 of 25 case files reviewed in LA3, and 6 of 12 case files reviewed (where data was available) in LA4.[26] No financial hardship was noted in the seven files reviewed for LA1. Financial factors (not including housing) were identified as reasons the Child in Need plan was in place in 2 of 25 case files reviewed in LA3, and in one of the 25 case files reviewed for LA4. Financial support was provided through the Child in Need plan (including help accessing benefits, and support accessing material goods or food) in 9 of 25 case files reviewed in LA3, and 12 of the 25 cases reviewed in LA4.

25 The socioeconomic background of families is only available for the seven case files reviewed manually for LA, and was not collected in the individual discussions of 11 case files

26 Some families in LA4 described increased financial pressures due to having to take time off work or having to give up their job entirely as a result of the issues that have brought them to the attention of social care.

2. Why are children and young people are on Child in Need plans?

Primary referral reasons

Based on the whole LA administrative data we received from the four LAs:

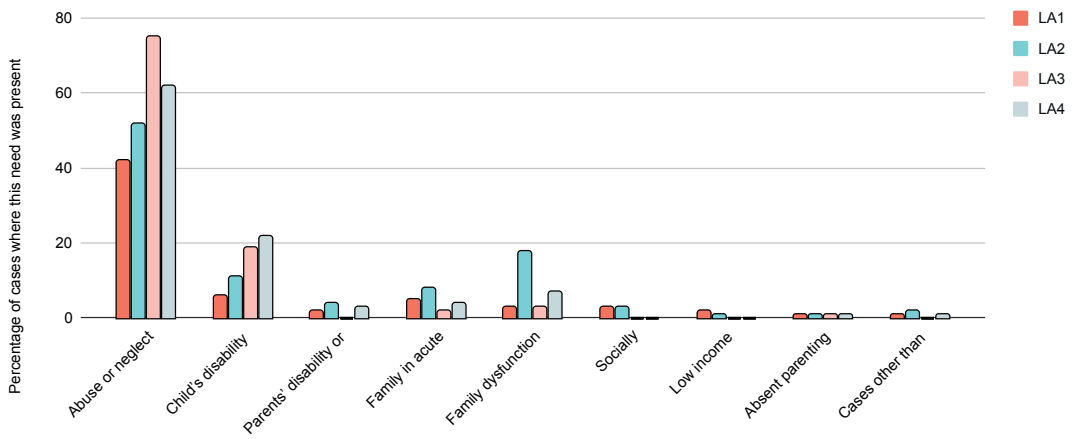
- The most common primary need code for children on a Child in Need plan under section 17 was 'abuse or neglect' (this was recorded for 42%-75% of children depending on the local authority)
- The next most common need code varied between the LAs. In three LAs it was 'child's disability' (6%-22%) whilst in one it was 'family dysfunction' (18%)
- This was consistent with national data (DfE, 2021), the most common primary need was also abuse and neglect (56%), followed by family dysfunction (14%), family in acute stress (9%) and child's disability or illness (8%).

Factors identified at the end of assessment

Based on the whole LA administrative data we received from the four LAs, the most common factor at the end of assessments for children on a Child in Need plan varied between LAs. Factors identified at the end of assessment are defined as 'all factors that are known about at the end of the assessment which compromise the ability to parent, or are potential risk factors to the child.'[27]

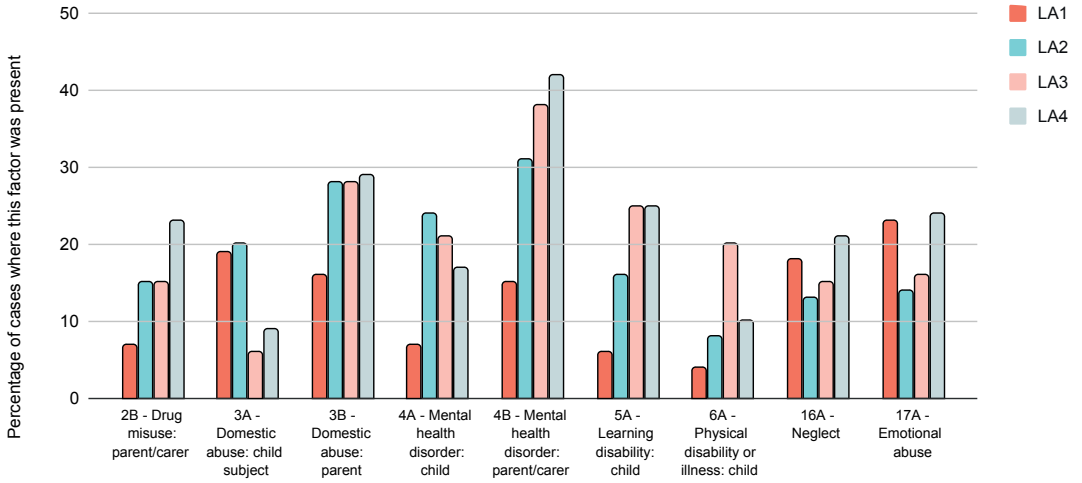
- In three LAs the most common factor was 'mental health disorder: parent/carer (31%-42% of cases had this as a factor), whilst in one LA the most common factor was 'emotional abuse' (23% of cases had this as a factor)
- Other common factors across LAs were domestic abuse, child mental health, child learning disability, child physical disability or illness, neglect, and parent or carer drug misuse. Details on the prevalence of each can be seen in the figure overleaf

Figure 5: Primary referral reasons for children on a Child in Need plan (whole LA data)



27 Children in Need census, 2021, p.15

Figure 6: Most prevalent factors identified at the end of assessment for children on a Child in Need plan (whole LA data)



This varied slightly from national figures, where domestic violence was the most common factor in 2021 (DfE, 2021), followed by parent or carer mental health, then emotional abuse. Differences may be to do with regional variation, inconsistent recording across LAs, or because the national Children in Need data includes more than just children on a Child in Need plan.

Using a review of case files, as well as focus groups and interviews with staff and families, we were able to build on the findings about referral reasons and factors at the end of assessment, to understand more about how decisions are made around whether to recommend a Child in Need plan. We found that there was variation in the type and severity of need or risk present in families of children on a Child in Need plan. As a result, families were on Child in Need plans to receive a range of support, from accessing entitlements to support a child with a disability, addressing parental abuse and neglect, and supporting parenting, to addressing extra-familial risk factors such as exploitation. Decision making considered the history of concern, ongoing risk factors, and protective factors including parental engagement with support.

Range in the type and severity of need or risk present

In the case file review we found a breadth of needs and different levels of risk of abuse or neglect for children and young people who have a Child in Need plan. In some instances, Child in Need plans were in place for families where a high level of risk was identified. In other cases reviewed there was no risk of abuse or neglect highlighted, however areas of need were identified.

For example, in the in-depth review we found one child had a severe disability, and their needs were considered by the social worker to be complex:

> *'It is unfortunate that due to her not being dependant on an air nebuliser means that she doesn't meet criteria for complex care needs however clearly, [child's] needs are complex and the family are in need of support, to ensure they can continue to also meet the need of their other child [sibling].' [Social Worker]*

Other children had Child in Need plans because they were considered to have complex needs as a result of being

unaccompanied asylum-seeking children (UASC) or because they had no recourse to public funds (NRPF).

We also reviewed files for adolescents at high risk of Child Criminal or Sexual Exploitation (CCE or CSE). For example, one adolescent was described as 'one of the most high risk cases', due to her serious suicide attempts and significant self harm, highlighting the level of risk sometimes held under a Child in Need plan.

Some staff in focus groups also mentioned that there was some variation in the type of need between areas even within LAs. When asked about what made cases high risk or high complexity, staff in focus groups generally viewed these two things as closely linked, with higher risk cases often being those with higher complexity. Issues that staff perceived made a case more complex included:

- Neglect, particularly intergenerational neglect
- Exploitation and risk taking behaviours, including where families struggled to cope with certain behaviours
- Co-occurring risks for parents or carers such as domestic abuse, substance misuse and mental health
- Where there were insufficient services available to address a need, or where there was difficulty identifying the presence of suspected sexual or emotional abuse
- Complex health needs for children with disabilities.

Areas of support

Building on our findings about what risk factors were present for families, our findings from the case file review as well as focus groups and interviews, across all four LAs, suggested that children and young people had a Child in Need plan to receive support or interventions for the following range of reasons:

- To support parents or caregivers to access entitlements or specialist services for their families, including providing support for a child's disability or where families have NRPF
- To allow for multi-agency input or to allow for a specific intervention to take place e.g. a Family Group Conference (FGC)
- To support or reduce current risk factors e.g. non-parental abuse or grooming, child exploitation, substance misuse, offending, and missing episodes
- To support families, for a given length of time, following the conclusion of proceedings e.g. under a supervision order or a special guardianship order
- To prevent family or adoption breakdown
- To provide parenting support e.g. with managing behaviour and supporting routines
- To address physical, emotional and sexual abuse and neglect
- To continue to support families who were stepping down from Child Protection.

Factors contributing to decision-making around whether a Child in Need plan is used

Our findings from the case file review suggested several factors which appeared important in the decision-making process around whether a Child in Need plan was appropriate:

- Family characteristics including history of concern or involvement of children's social care, age of the child, and mother's characteristics such as whether they were care-experienced, an unaccompanied asylum seeking child, or a first time mother
- Protective factors, particularly parental or caregiver engagement, including adherence to safety plans, or willingness to accept support offered. The number and quality of protective factors or protective people and having a support network, having another parent willing or able to care for the child (such as if one parent requires hospitalisation), and demonstration of positive change such as abstinence or improved home conditions
- Risk factors such as ongoing risk from a perpetrator or an abusive relationship, presence of multiple concerns or multiple contacts with children's social care, or the level of risk as determined by the multi-agency scaling of danger statements and overall safety scale in authorities that use the Signs of Safety[28] approach.

3. What support and activities are families of children who are on Child in Need plans receiving?

This section answering research question three focuses on the types of support that were identified in the case file review, focus groups with staff, and interviews with parents. Where possible, we highlight how prevalent these different types of support were i.e. how commonly they were reported in the files we reviewed. Firstly, we discuss support provided internally by the social worker, then by other professionals internally, and finally we present the range of available external support for children and families on a Child in Need plan. We also discuss whether support provided appears to differ depending on different needs families have. This section focuses primarily on mapping the range of types of support provided, rather than the sufficiency of that support. In a later section addressing research question four, we separately consider whether there are any gaps in service provision and how far support appears to be meeting families' needs.

However, due to the nature of the data, this response to research question three is only a snapshot of support provided, and is unable to draw strong conclusions about how prevalent these different activities were across the LA, or present an exhaustive list of all different services available. Our reporting of higher and lower use of services recorded in the case files does not take into account whether there was a higher or lower need for these services in the LAs we reviewed (i.e. lower use may be due to lower need or lower availability, or both).

28 The Signs of Safety® approach is a relationship-grounded, safety-organised approach to child protection practice.

Assessments and support provided by social workers

We found that the range of support provided by social workers included home visiting, direct work, and administrative and practical support. We also include information about assessments undertaken by social workers and use of panels to identify services when working with children on a Child in Need plan.

Assessments by social workers

From the case file review and focus groups, we found a range of assessments being used by social workers e.g. child and family (C&F) assessments, pre-birth assessments, parenting assessments, and risk assessments. Some case files also included a graded care profile (for families where there were concerns around neglect). In a small number of cases, social workers had used the domestic abuse, stalking, and honour-based violence (DASH) assessment and also a drug and alcohol screening tool. Social workers in focus groups who worked with children and young people with disabilities also reported making ongoing assessments of their needs. In LA1, social workers completed child sexual or criminal exploitation assessments too.

Use of panels to identify services

Social workers in focus groups in three local authorities mentioned using panels to help identify services to support children and families. In the case file analysis, two LAs presented cases at different panels to request resources in complex cases. Family resource panels and multi-agency panels were frequently used across LA3 and LA4, as well as specialist panels to approve support such as respite for children with disabilities and adolescents. As these panels were not the focus of our case file review, we do not have information on how frequently these panels were used, or how much support they were able to identify for families. A roundtable attendee however highlighted that panels could be useful for reducing Child in Need drift and delay as attending a panel could ensure more timely identification of appropriate support than in instances where a panel was not used.

Support for children and young people with a disability

Support for children and young people who had a Child in Need plan because of a disability often involved:

- Organising respite and short breaks for parents and carers
- Supporting parents or carers with their child's behaviour
- Supporting stimulation for the child (e.g. through attending clubs or within the home)
- Implementing domiciliary or support packages
- Arranging financial support for the family in the form of direct payments.

Some social workers highlighted that the process and some of the support accessed for children with disabilities (CwD) was similar to provision for children without disabilities, but that different tools or approaches might be needed to accommodate different learning and communication needs. In the case file review, for some CwD cases Child in Need planning was used as a means of delivering an ongoing support package, such as short breaks or one-to-one care and support. As such, cases tended to be open for a longer period of time. In these circumstances, Child in Need reviews, case supervision, and Child in Need visits happened less frequently.

However, when CwD cases present with additional safeguarding concerns such as neglect or parental substance misuse, the frequency of home visits and intensity of support aligns more with what we have found in cases open to assessment and safeguarding teams.

Home visiting

The majority of children and young people whose case files we reviewed were visited monthly. Consistent with this, where it was mentioned in interviews and focus groups, guidance for social worker visits was reported to be a minimum of four weekly for three LAs. In LA3, social workers reported that guidance for visits was six weekly for children with complex needs, and three monthly for less complex cases.

However, case files showed that some children were visited more or less often, with visit frequency ranging from weekly (or even more than this in some instances) to every 12 weeks. Staff in focus groups suggested this variation depended on the individual needs of the child or family. Across case files in all four LAs, a higher visit frequency was recorded for children where there appeared to be a higher level of need or risk present. When asked about individual cases they worked with, social workers from LA1 also stated that the frequency of home visits would change during periods of crisis, or increased need, as well as with what other support they were being offered.

One parent interviewed mentioned that support had begun to reduce as they came towards the end of the plan and concerns from their social worker had reduced. Another parent mentioned that they saw their social worker monthly because they saw a family support worker more often (weekly). In addition, a social worker who worked with only Child in Need cases reported being able to contact and visit families more often:

> *"Because we're not kind of dealing with child protection daily [and receiving] referrals in through the duty teams, and we're there to work with families at that level, and being allowed to spend that much time with each family. So we're having a weekly contact with them, reviewing weekly how the plan is going." [Social worker]*

In case files reviewed for LA3 and LA4, some children and young people who had a Child in Need plan held by the CwD team (e.g. for respite or domiciliary care), and where there were no safeguarding concerns, were visited less frequently. This was consistent with what was reported by social workers in focus groups. In LA3, visits were sometimes conducted by a child support officer and not a social worker in the CwD team. In LA2 cases open to the CwD team were visited four weekly, or four to six weekly in one instance. This was consistent with what was reported in the focus group, where staff noted that in the CwD team visits had recently moved to four weekly, from six weekly previously, though six weekly visits were still used where it was agreed the child's needs were sufficiently low.

> *"...in the Children's Disabled Service, we were taking six weekly visits, but I think that is being changed now to four weekly....Except in exceptional circumstances where it has been agreed that a child's needs are low enough to accept the six weekly visits to comply with the policies". [Social worker]*

Across LA3 and LA4, home visits recorded in case files were most often focused on monitoring families through general check-

ins as opposed to conducting direct work with families. Less regularly, social workers provided practical support in home visits such as delivering hampers or food parcels. In these two LAs, case recordings of home visits were regularly used to document the lived experience and voice of families. In some cases, case recordings included analysis and hypotheses to aid their assessment and decision making.

A theme among some of the social workers from LA1 was the view that more meaningful direct work that they did with children took place with children in a school setting. This aligns with findings from LA4 where we found only one example of a planned direct work session (out of seven case files we reviewed), which took place between the social worker and the child in a school setting. Consistent with this social workers and parents in focus groups and interviews, also mentioned that direct work between social workers and children took place in school in some instances, or pre COVID-19 might involve trips out of the house with the social worker.

More detail on the content of these visits is covered in the following sections, 'direct work with children' and 'direct work with parents.'

Direct work with children and young people

There is no standardised definition of direct work with children and young people in social work, and it is not defined in guidance such as 'Working Together' (DfE, 2018). For the purposes of this report, we include a broad definition of direct work. From the case file review, anywhere the social worker has referenced the 'child's voice' or 'lived experience' or 'direct work' explicitly we include this as direct work. The 'child's voice' includes the child's views, thoughts, and feelings, and their 'lived experience' includes understanding about what daily life is like for them. This might be recorded during observations of the child or young person within their family home and conversations with them. It might also include use of physical resources such as art materials, worksheets, toys, digital games, or books. It can also include occasions when the social worker may take the young person out for a drive or go and do an activity together, or direct work can be facilitated in the child or young person's school. From our review of case files, we found there was a spectrum of direct work that showed various degrees of purposefulness i.e. from planned, structured, direct work sessions to monitoring visits that included interaction between the social worker and the child.

We found variation in case-recording about direct work with children and young people across the four LAs. We noted variation in the frequency of direct work, the approach taken to direct work (i.e. active vs more passive forms), variation in the use of tools and resources used to facilitate direct work, and also in how this is recorded on children's case files. One LA in particular [LA1] appeared established in child-focused case-recording e.g. by writing directly to the child. C&F assessments in this LA included sections such as the child's story / their lived experience, their worries and the best things in their life, and what they want to happen. There is also space for the child's 'contribution' (a place where visual representations of direct work can be shown or a picture of the child). Similarly, LA3 were beginning to introduce Child in Need visits written by the social worker directly to the child.

Social workers, in LA1 in particular, often described what direct work was used for (e.g. exploring views and experiences and understanding children's routines), but did not tend to specify exactly what their direct work entailed. In two LAs social workers shared that they facilitated direct work in relation to

sexual abuse and exploitation. In LA1 this was mentioned as 'preliminary' direct work where there was a wait for specialist services.

We also found variation in social workers' approaches to direct work. We found some examples of more active forms of direct work, where this appeared to be creative, or tailored to the individual, and also where direct work appeared to be intentional and consistent. For example, consistency in direct work was demonstrated when a social worker regularly called the young person to check-in and ask about their day. A creative example of direct work was demonstrated when a social worker arranged a gym membership for a child and took them to the gym. Further, when a child did not want to engage in the specific activities (e.g 'three houses' activity), the social worker instead played a video game with them to try to engage them in conversation.

Direct work tools largely consisted of feelings worksheets, safety plans, or Signs of Safety (a LA practice model) related resources. We also found many examples of direct work that appeared unplanned; these largely involved observations of the child at home and reflections on their lived experience. In LA4 for example, direct work was often described as 'free-flowing conversation' rather than planned structured sessions.

Direct work with parents and carers

Across the LAs, direct work with parents or carers involved understanding more about the family's experiences, addressing particular needs within the family, bringing together support for the family and creating a safety plan.

Social workers often spent time exploring parenting, relationships, identifying any unmet needs, seeking parents' views, and understanding the impact of parental behaviours. Some social workers provided ongoing support to develop parenting skills e.g. on issues such as children's behaviour, boundaries, and routines. Other forms of direct work with parents included creating safety plans and having family network meetings. Also, some examples of direct work were focused on the particular needs within the family e.g. drug use, harmful sexual behaviour, emotional wellbeing, and contact arrangements. However, similar to what we found with direct work with children and young people, whilst the broad areas for direct work are documented, mode of delivery or frequency of this work, and any resources or tools used were not described. There was more emphasis on use of safety planning in some LA's than others, for example, safety plans were widely used in LA4 and LA2. In LA1, one social worker reported in the focus group that their team had been recently trained in a programme to support separated parents where there is conflict.

Most parents we spoke to in interviews described that a key component of the social worker's support included providing advice, support and guidance. This included helping keep parents on track with making the change that was needed, signposting services and training and groups they could access. For a small number of parents, this was the main type of support they described receiving from their social worker. One parent also mentioned that having the Child in Need plan in place provided useful guidance about what they needed to do to keep their children safe. Most parents however also described other types of support from the social worker. This varied widely, and included talking to and listening to their child's experiences and feelings (at home, in school or on trips out), helping children make sense of their experiences, supporting communication between the parent and child, helping with strategies to support their child, creating

safety plans, liaising with partner agencies, facilitating short breaks and helping with access to food and household items.

Administrative and practical support

Across the four LAs, case files reviewed showed that social workers offered a range of administrative and practical support outside of S17 financial assistance (covered later in this report), and in LA3 there was a particularly high offer of this type of support recorded in the case files we reviewed.

Support identified in case files, and reported by staff and / or parents included:

- Liaising with relevant agencies and services (e.g police, housing, solicitors, doctors and schools)
- Organising and attending multi-agency meetings
- Supporting parents to contact agencies and make referrals
- Arranging transport (e.g. to hospital, school or parenting courses)
- Supporting various applications (e.g funding for therapy, reimbursement claims, housing applications, asylum claims, accessing benefits entitlements including disability living allowance, and disabled facilities grant)
- Delivering or coordinating food parcels to families in need
- Signposting and referring to other agencies
- Sourcing or providing games and activities for families
- Sourcing or providing food, furniture or essential baby items

Involving families in the development of Child in Need Plans

Involving families in developing and agreeing their own Child in Need plans and goals was noted by social workers in focus groups in all four LAs. Practice described included holding family meetings (i.e. between the social worker and family), recording the views of children and parents, and in some instances writing plans and notes from the perspective of the child. However, when we spoke to parents, their understanding of and sense of involvement in goals was mixed, suggesting there isn't consistency in parent involvement, or that this may vary by area. Four parents/ carers we spoke to reported that the goals had been developed together with the family, while the other seven reported either not being aware of the goals, or that they were decided by professionals. For example, when asked whether there were any specific goals being worked towards with their social worker, one parent responded:

> *"Not that I'm aware of no [laughs]. It's very much they say he's on a Child in Need Plan. I know I went through it previously with… our previous Social Worker. I never had a copy of the Child in Need Plan and that was done last June and July. I don't even have a copy of it, and I've told them I don't have a copy of it. So I'm not too sure." [Parent Interview]*

Another parent, who was asked how the goals of their Child in Need plan were decided, responded:

> *"They decided it and just let me know" [Parent Interview]*

Of those who were aware of their goals, parents generally agreed with these goals or felt that these were the right goals to be working on. The case files reviewed also frequently acknowledged the involvement of professionals outside of the local authority in developing and reviewing Child in Need plans.

Child in Need Reviews

According to staff in focus groups, multi-agency Child in Need reviews took place four weekly to six monthly, depending again on the LA team, case complexity and length of time the plan had been in place for (in some cases being more frequent in the early stages then less frequent over time). One social worker in a focus group commented that the local guidance suggested Child in Need review meetings should be three monthly, but that staff tended to set these up more regularly, such as every six to eight weeks, to avoid drift and delay.

In the case file review, for LAs 1 to 3, Child in Need reviews were reported to take place six weekly to six monthly, and this appeared to be dependent upon the team, case complexity, and length of time the plan had been in place for. More specifically, the frequency of Child in Need reviews in three LA's was consistent, with the majority of cases being reviewed monthly or six weekly, apart from CwD cases, which were reviewed less frequently (three or six monthly). In contrast, the case file analysis found that in LA4, the frequency of Child in Need review meetings were recorded inconsistently, with many cases missing the review paperwork in the past six months. In many cases, it was unclear whether a review had been completed as paperwork was not stored in one consistent place on the system.

Social workers in focus groups mentioned that Child in Need review meetings provided an opportunity to assess whether the right level of support was being offered, with one social worker highlighting the benefits of review meetings to hold not just family members to account but also social workers to hold themselves and other professionals to account. One parent noted that a Child in Need plan helped hold other services, such as Child and Adolescent Mental Health Services (CAMHS), to account:

> *"... Because obviously as soon as a child's on a Child in Need plan, people start to be a bit more deliberate and take a bit more of a note of what they need to do and need to do it by. But yeah like I say, for [my child] it was the CAMHS input." [Parent]*

Staff also reported that cases were reviewed in supervision and through audits. Social workers in two LAs mentioned that reflective discussions took place in supervision and with service managers to assess whether the right level of support is being received and at the right time and keep things on track.

Assessments and support provided by other professionals within the local authority

The case file review and focus groups showed that there was a range of internal services that provided support in the majority of case files we reviewed across all four LAs. Findings from the focus groups and interviews were consistent with the findings in the case file review.

Family support workers were used across all four LAs. Exploitation and Adolescent Teams were also commonly used in three of the LAs. Other resources varied between LAs, with some offering internal support for parent

or child mental health, parent substance misuse, or domestic abuse, though less use of these services may relate to the capacity of internal teams. Family group conferences were available in three LAs although it was only recorded as having been used in a small number of case files reviewed. All four LA's offered some support to families of children on a Child in Need plan through their Early Help offer, although the nature of this support varied. More detail on each of these areas is provided below.

Family support workers

Case file review and focus groups identified that family support workers[29] or family intervention workers provided support in all four LAs. Family support worker involvement was higher in LAs 3 and 4 (e.g. 40% of cases had a FSW in LA3) and lower in LAs 1 and 2. Case file review and focus groups identified that family support workers in all four LA's provided support for parenting or family relationships. Other support included budgeting or accessing benefits, and arranging access to food parcels and other household essentials. In LA1 and LA2 the focus groups and case file review identified that family support workers also supported young people with mental health, anger management, healthy relationships and risk-taking behaviours.

Early Help

Case file review and focus groups identified that in all four LAs, support for families on Child in Need plans was also provided through Early Help services either by early help workers, or by family support workers who were situated within early help services. In LA3, the family support workers mentioned above were located in an Early Help and Support team which was primarily working with children's social care cases (unlike the other local authorities where family support workers were situated within children's social care teams). In LA2, parents of children on Child in Need plans accessed parenting programmes such as Triple P or other parenting programmes through the Early Help service. Support through Early Help for families of children on a Child in Need plan in LA2 also included support for domestic abuse, Special Educational Needs and Disability (SEND) and child exploitation, as well as parent mental health and wellbeing. In LA1, mental health as well as alcohol and substance abuse practitioners from the Early Help service provided support to parents of children on a Child in Need plan. In LA4 some parenting support was accessed through Early Help, and parenting support was also provided through an edge of care service.[30]

Family Group Conference

Family Group Conferencing was available for families of children on a Child in Need plan in LA1, LA3 and LA4. Staff in the focus groups reported that referral to the Family Group Conference service was encouraged for all cases in LA1, although we were not able to review enough files to draw a strong conclusion about whether this was happening. Family Group Conference was reported in 32% of case files reviewed in LA3 and was offered to 4% in LA4. This was offered both as a means of conflict resolution and to identify more sources of support for parents. However, some families declined or did not engage with this support in LA3 and LA4. In LA2, staff in the focus group reported that family group conference was more commonly used at later stages such as in pre-proceedings, rather than for families of children on a Child in Need plan.

29 Also referred to as family workers and parenting support workers

30 This team was part of children's services, and parenting or other support was recorded for 24% of 25 families whose case files were reviewed in LA4

Services for adolescents and contextual safeguarding

Specialist services for adolescents such as youth services and child criminal and/or sexual exploitation teams were present in three LAs in the case files we reviewed (LA1, LA2 and LA3). LA1 and LA3 delivered this through dedicated teams for 17% and 28% of the subsample respectively, whilst support for child exploitation and youth services was included in the Early Help offer in LA2. Youth services in LA1 were delivered to families in the subsample by various teams such as the Antisocial Behaviour Team, Young Carers Service and Youth Offending Service.

LA3 delivered a particularly comprehensive and intensive package of support for contextual safeguarding. This included parental support delivered by a Parents Against Child Exploitation (PACE) worker and a short breaks and outreach service for adolescents considered vulnerable, as well as 1:1 direct work sessions for the child. Staff in the focus group reported that the exploitation service in LA3 was multi-agency, with co-located health practitioners and police. Staff also referred to multi-agency adolescent panels for information sharing, risk management and requesting support, and mentioned that the youth justice service in LA3 had an in-house mental health practitioner. Additionally, the case file review identified a Targeted Youth Service (TYS) that offered individualised one-to-one and group support to 12% of families in the subsample in LA3, which included direct work and engaging young people in recreational activities.

Use of exploitation or adolescent services was not mentioned in the focus groups or case files we reviewed for LA4, despite exploitation being an issue in the area mentioned in focus groups. LA4 did have an edge of care team, but this was mainly mentioned in relation to parenting support as described above.

Mental health and therapeutic support for children

Some children and young people in LA3 whose case files we reviewed received support from an internal mental health team that included a clinical psychologist. Staff in the focus group for LA1 also mentioned an in house therapeutic social work team. Staff in the focus group for LA2 also mentioned that there was a therapeutic social worker internally who might offer support for issues such as harmful sexual behaviour. The number of children and young people reported to be receiving this type of report was generally small, which may relate to the size and capacity of these services.

Domestic abuse

Staff in all focus groups for four local authorities referred to internal support for domestic abuse. This varied from specialist staff (Early Help domestic violence coordinators), internal or commissioned services supporting perpetrators of domestic violence (e.g. 'Caring Dads'), or survivors of domestic violence (e.g. the Freedom Programme), and groups for children who have experienced domestic violence. These were sometimes provided to families of children on a Child in Need plan through the local authority's Early Help function. Use of these services was recorded infrequently, in only one or two case files we reviewed per local authority, however some local authorities referred to external services to provide similar support.

Parental mental health and substance misuse

Focus groups and case files identified that two local authorities had some internal resources for parental mental health, and one had coordinators for drug and alcohol use (within Early Help hubs). In one local authority, a complex cases team coordinated

multi-agency support for families affected by domestic abuse, substance misuse and mental health. In the case file review, we found that support for parental mental health and substance misuse, where recorded, was more often provided externally, which may highlight the limited capacity of these internal services.

Practical and financial assistance provided under section 17

In LA3, 16% of the 25 case files from the subsample had received financial assistance provided under Section (S) 17. This rose to 24% in LA4. For LA1, there was very little information or detail on support given under S17 in case files, although some financial support was mentioned in focus groups. One case file in the review of 25 files mentioned it, where it was used to support electricity payments. Information on financial assistance under S17 was not provided or explicit in the documentation we received for LA2 but was mentioned in focus groups.

Funds noted in case file review and focus groups were used for the following:

- To purchase essential items such as furniture or nappies, furniture
- Taxi fares for hospital appointments or school attendance
- A gym membership for a young person
- Two weeks basic allowance for a young person moving into supported accommodation.
- Payment of bills (e.g. phone, utilities, gas)
- Funding for children with disabilities, including funding for short breaks and in-home support or access to services
- Supporting nursery provision costs in certain circumstances.
- Assessments and support which families are referred to outside of the local authority

The review of the children's case files, focus groups and interviews across the four local authorities revealed a number of areas of assessment and support provided by external agencies and services. However, it is important to note that external involvement was not always recorded in detail in the case files reviewed. Social workers in two of the local authorities highlighted that resources and agencies could vary depending on which district or locality of the local authority you were working in. A few of the parents we spoke to also noted the support they and their children receive from their friends and family networks.

Mental health and therapeutic support is largely external to CSC

Support appeared to be more likely to be provided externally for mental health needs. Two LAs provided some internal resources for mental health and wellbeing, however mental health support for adults and children was primarily delivered by NHS services (such as CAMHS and IAPT) and charitable organisations. LAs often sought specialist therapeutic provisions from the charity sector, although LA2 provided a therapeutic social worker who offered support for issues such as harmful sexual behaviour.

Child wellbeing and mental health

The use of CAMHS was noted in case files reviewed in all four local authorities, as well as in focus groups for all four local authorities. CAMHS was referenced in 44% of cases in LA1, and 40% of cases in LA4. This service provided support including

various assessments (e.g. to assess whether a child has a learning disability), behavioural interventions, crisis support, medication monitoring, and in a small number of cases some therapeutic interventions. In LA4, 40% of those who received CAMHS support received specialist services from Learning Disability CAMHS, and these cases were usually open the longest. CAMHS support was less frequent in LA2 (32%) and lowest in LA3 (16%) from the case files we reviewed. Engagement with CAMHS was found to be low in these two local authorities, and there was little recorded about the frequency and duration of support.

Three local authorities recorded support provided by charities and other services to promote child mental, emotional and social wellbeing. Some alternative mental health provisions were also offered to families. For example, in LA1, extracurricular activities such as drama groups and organised day trips were used as alternative forms of support to promote healthy community engagement and emotional wellbeing. Dance classes to promote mental wellbeing were provided to a small number of children whose case files we reviewed in LA2.

Counselling for bereavement and wellbeing was offered to a small number of children in LA2 and LA4. A small number of children and young people in LA4 received, or were on a waiting list for, specialist therapeutic provisions e.g. for sexual abuse, young carer responsibilities, and family psychotherapy (such as Dyadic Developmental Psychotherapy in one case). In all four local authorities, networks or charities for ADHD or Autism were also mentioned in focus groups with staff or interviews with parents. Other types of external services accessed, which may support child wellbeing and mental health, include targeted youth support and young carers' support.

Parental wellbeing and mental health

Improving Access to Psychological Therapies (IAPT) provision was noted in three local authorities. However, this was infrequent with only a small number of case files reviewed receiving this service in LAs 2, 3, and 4. The Perinatal Mental Health Team provided mental health support and monitoring for mothers in a small number of case files reviewed in LAs 3 and 4. Further to this, in LA4 a small number of parents were encouraged to seek mental health support from two local mental health charities, and a small number of parents received community mental health support from the Intensive Home Treatment team.

Parental and child physical health

A range of primary and specialist NHS services were provided to families in all four local authorities. Primary services included support from health visitors and midwives. A high number of case files in LA4 (40%) received support from a health visitor. Specialist NHS services were provided to children with disabilities which were specific to their health needs. In LA3 and LA4, support was commonly provided by consultant paediatricians and paediatric learning disability nursing teams. A small number of children received occupational therapy from external agencies.

Other health involvement mentioned in focus groups and interviews included school nurses, and speech and language therapy. In one local authority, health professionals were required to be a part of Child in Need plans and a health assessment was requested for every Child in Need plan (although we did not gather data on which health professionals this needed to be). In a small number of cases, other types of health support was provided by charities including a parent support group, a sleep service, and support to access health appointments.

Other external support for children with disabilities

Other external support provided for children with disabilities was also described across all four local authorities. This included residential schooling, outreach, respite and short break services and in-home care.

Education

In the case file review and focus groups we found that support and interventions from schools was noted in all four local authorities. Support included assessment of learning needs, emotional wellbeing support, self-esteem programmes, and support for improving educational achievement. Further, Special Educational Needs Coordinators (SENCOs), pastoral teams, Education and Health Care Plans (EHCPs), and support for the transition between primary and secondary school was also mentioned.

In a small number of cases reviewed, support was specific and tailored to the child. For example, the provision of Emotional Support Literacy Assistants (ELSA) in LA2 to provide daily support in schools, a NEET (Not in Education, Employment or Training) worker in LA4 who worked one-to-one with children, and Educational Psychologists who provided psychological support in schools in LA3 and LA4.

Substance misuse

While findings above show that provision of substance misuse support internally was limited, external substance misuse support seemed more common across all four local authorities. Some use of external substance misuse services was recorded across all four local authorities in the case file review and mentioned in focus groups. We noted referral to or use of external substance misuse services in 15 of 93 case files reviewed or discussed (16%). The majority of times this support was for a parent, though in three local authorities an instance of support was recorded as being provided for a young person. Information on the nature and intensity of support was provided in case notes for one of the local authorities, but was not well recorded in three of the local authorities' case files we reviewed.

Domestic abuse

In one local authority the domestic abuse provision we recorded was provided through internal or services commissioned by the LA[31] (for both survivors and perpetrators of domestic abuse). Referral to external domestic abuse services was recorded in three local authorities in the case files we reviewed. For two of these local authorities, who also offered internal support for survivors of domestic abuse through the Freedom Programme,[32] we also saw one or two instances of use of external domestic abuse services through local charities (survivors and perpetrators support). In the third local authority, who offered the Caring Dads[33] programme internally, seven (28%)

31 We distinguish between external services and commissioned services where commissioned services are those purchased by a local authority and external services are those run independently of the local authority.

32 A programme for victims of Domestic Abuse. The aim is to help them to make sense of and understand what has happened to them, and consider impacts on children. The programme usually lasts 11 to 12 weeks.

33 Caring Dads is an internationally-implemented perpetrator-based program aiming to help keep women and children safer by holding the dads accountable. The intention of the program is to work towards preventing recurrence of domestic violence and child maltreatment.

of 25 case files reviewed received external support for domestic abuse, which included support programmes for both survivors and perpetrators of abuse (six mothers, one father and one child). These findings suggest no consistent pattern for whether there are internally or externally provided services for domestic abuse survivors or perpetrators, as it varied between areas, but that only a small proportion of families appeared to be accessing any type of domestic abuse support, whether internal or external.

Practical support

In a small number of case files, focus groups and interviews, use of charities providing food, clothes and household items was noted. This was usually facilitated by the social worker or family support worker, and is covered in more detail in the earlier sections.

Partner agency engagement

Social workers reported some examples of good engagement from partner agencies, particularly schools, and that partners would often send written updates if they weren't able to attend meetings in person. In one local authority, a team manager highlighted the multi-agency nature of plans:

> *"So we do try not to just have everything focused solely on the social worker. It is a multiagency plan." [Team manager].*

However, staff in three local authorities highlighted challenges getting partner agencies to engage at times. Two local authorities mentioned difficulties getting information from police at times, and social workers in one of these local authorities highlighted it could be more difficult to engage partners such as school or police under Child in Need, rather than Child Protection. In both of these, it was noted that children's social care could end up doing the majority of the work at times, with other professionals sometimes becoming over reliant on social workers to lead the plan rather than becoming an active part of the process:

> *"We do a majority of the work. It feels like that, but sometimes there's other agencies as well that are part of that Child in Need plan, and the families." [Team manager].*

In the third local authority, social workers talked about the need to work closely with partners to manage risk and prevent cases from escalating to Child Protection. Managing partners to do this was challenging at times, although it was noted that this had recently been seen to improve.

How does the support provided vary between LAs or different models or frameworks of practice?

The following section summarises our findings in relation to support provided and case recording, based on the case file review, as well as findings from staff focus groups about the different practice models and service structures which were in use across the local authorities.

Practice models

Staff in focus groups provided details about the different practice models within their authorities. This was supplemented with information from the case file review.

One local authority used Restorative Practice, which involved a high support, high challenge approach to working with families. This was reported to be helpful when working with families of children on Child in Need plans, given the voluntary nature of the intervention.

This local authority also used formulation as a way of thinking about the presenting problem and actions to take with the family to achieve change. This process involves consideration of the presenting issues or problems, precipitating factors which might have led to difficulties occurring, predisposing factors which might be areas of potential vulnerability, and perpetuating factors which might lead to a problem continuing. This local authority also used geographical clusters to link together services, including schools and social care.

Staff in two local authorities reported using Signs of Safety (SoS) as their practice model. Key features described by staff included looking at harm, complicating factors, strengths and safety, a danger statement and a safety goal. In the case file review, the SoS approach was reflected in assessment, case recordings and use of direct work tools (such as three houses and words and pictures). However, there were observed differences in how it was used between the two local authorities. In LA2, direct work was well recorded and tools were frequently used. Their C&F assessments emphasised the voice and lived experience of the child through its child contribution section (where the child was directly addressed) and the inclusion of the 'child's story' section. In contrast, whilst the SoS approach was evident in LA4's assessments and direct work tools used, they were used less frequently and assessments were less child-focused and detailed.

Staff in the final local authority reported working Systemic teams and using a model which helps to support practitioners in understanding how underlying and high risk factors may be identified. In this local authority, C&F assessments and case recordings were child-centred, although direct work by social workers was rarely recorded and use of direct work tools was not documented. In contrast to the local authorities using signs of safety, direct work was usually undertaken by other practitioners within the local authority, such as family support workers, youth workers and exploitation team workers. We did not collect any information as to why this was.

Which teams hold Child in Need cases

Staff in focus groups also shared details about which social work teams held Child in Need cases. In two local authorities, the cases of children on Child in Need plans were held by area or locality based safeguarding teams. One of these local authorities also had restorative early support teams with social workers who held cases which were both Early Help and Children in Need. In all four local authorities Child in Need cases could also be held by children's disability teams. In two of the four local authorities, social workers would hold cases from the point of referral through to the end of care proceedings, rather than transferring from a front door team (this was a recent change in one of these). In the other two, the assessment and initial plan for Child in Need cases were undertaken by a front door team, (called assessment team, or first response and duty team). In one of these, the case would be handed over to be held by locality safeguarding teams following the initial Child in Need meeting, in the other it would be transferred to be held by safeguarding teams after nine weeks.

Case recording

The information available through case files and the quality of case recording varied between the local authorities. One local authority (LA2) was particularly child-focused in their case-recording. For example, we observed that case notes were detailed and written to the child. Also, assessments

begin with a chronology and the experiences of children and families. They include sections such as the child's story/their lived experience, their worries and best things in their life, and what they want to happen. There is also space for their 'contribution' (a place where visual representations of

direct work can be shown or a picture of the child). The assessment then details the parent's experiences, key family members' experiences, before coming to professional views. There is also detailed managerial oversight, also written directly to the child, and 'recommendations and actions'. In a different local authority, we noticed there was limited depth at times in case-recording. This was particularly in respect to assessments, with minimal information recorded and a lack of recording about managerial oversight or comment on assessments. It is also important to note that some social workers shared, in a focus group, that their practice is not always captured in case-recording (constraints of the focus group meant we were not able to explore the reasons for this).

Has support changed since the COVID-19 pandemic?

Findings from the staff focus groups suggested a range of ways in which support had been affected by the COVID-19 pandemic, although they also commented that some of these changes were beginning to return to normal.

Non-statutory services had often been reduced or moved online, or affected by staff shortages or sickness. This had led to gaps in services or waiting lists and affected progression on plans. The impacts for children with disabilities was noted to have been of particular concern.

> *"Lots of our families and parents rely on overnight short breaks, in order to function and keep going. That's the area during the pandemic that's been really hit." [Team Manager].*

Ongoing police investigations were also affecting progression on plans at times.

Social workers and family support workers had also needed to do more to fill gaps in support, particularly where they were often the only professional seeing families in person. Staff were also responding to increased levels of need as a result of the pandemic, such as mental health and domestic abuse.

Social workers had to work creatively to overcome barriers to home visits when families were isolating, and the barriers of wearing personal protective equipment (PPE) during the Covid-19 pandemic. Video calls could be difficult with children who had communication difficulties, although worked well with some teenagers who were used to video calls and texting. Some families found virtual meetings with professionals made it harder to take in what was being said and understand who was who, particularly as parents often joined by phone rather than video. However, some staff said a virtual approach could feel less formal for some families. Some staff reported that other professionals' attendance decreased for virtual meetings, whilst others noted that professionals who might not have time to travel would be more likely to attend virtually.

4. Does the support provided match the needs of families of children who are on Child in Need plans?

The previous section presented findings on the type and range of support identified in case file review, focus groups and interviews. The previous section was focused on understanding the nature of support, rather than its sufficiency. The presence of a service doesn't tell us how sufficient that service is, or whether it meets the needs of families. In this next section we consider how well the support meets the needs of families and children, where there are gaps in support and how support might be improved.

How does the support provided vary depending on different needs families have?

We found some differences in the support provided to children, young people, and their families depending on the needs they have. Some services, such as short breaks, were offered only where needs or risk were high. The in-depth review found that some children and young people require practical, administrative, financial, and emotional support to enable parents or carers to meet the basic needs of their child/ren rather than an intervention or programme to help reduce risk and increase safety.

Use of short breaks in high need or high risk Child in Need cases

Many Child in Need cases we reviewed involved use of a short breaks service and this type of service was offered when needs or risk appeared to be high. For example, in cases where young people may be considered to be on the edge of care or edging towards care, where there was a risk of family breakdown, and in cases involving exploitation. We found children with a disability were often also offered short breaks e.g. when parents were needing respite. Case files did not specify what the short breaks entailed (e.g. where they went or what they did).

Some Child in Need cases open for monitoring purposes

In two cases reviewed in-depth, there did not seem to be current, active involvement from children's social care. In one case, the child had a Child in Need plan with a CwD team, and the social worker's role appeared to consist of monitoring use of direct payments, and liaising with relevant agencies. In another case with an extensive CSC history, where the Child in Need plan was recommended by the court following a Child Arrangement Order (CAO), the purpose of Child in Need visits was to drop food off, see how the family are, monitor progress on the plan, and to spend time with the child. These cases demonstrate how some Child in Need cases can be open for monitoring purposes, needing less frequent contact or active input from a social worker.

Differences in support for children open to CwD

We found differences in the support provided under Child in Need planning by CwD teams in comparison to assessment or safeguarding teams. In some CwD cases, Child in Need planning was used as a means of delivering an ongoing support package (such as short breaks or one-to-one care and support). As such, cases tended to be open for a longer period of time. In these circumstances, Child in Need reviews, case supervision, and Child in Need visits happened less frequently. However, when CwD cases present with additional safeguarding concerns (such as neglect or parental substance misuse), the frequency of home visits and intensity of support aligns more with what we have found in cases open to assessment and

safeguarding teams. In these cases, home visits are more frequent (four-six weekly) as well as review meetings and case supervisions.

Importance of relationship-based practice

In one case included in the in-depth review, there was not a high level of services involved, but the trusting relationships built between the social worker, health visitor, and mother and father appeared important in the positive outcome of the case. Therefore, in addition to providing services, support for families can also be inclusive of having a quality relationship with their social worker and other involved key professionals.

Are there any gaps in service provision?

All staff focus groups and most parent interviews identified ways in which support provided had met some of families' needs, however there appear to be some gaps in responding to the needs of children, young people and their families. In particular, whilst there were usually services available for most types of needs, getting access to those services could be challenging due to capacity, waiting lists, or thresholds.

Waiting lists and capacity for internally and externally provided services meant families were unable to access much needed support. This issue was highlighted by professionals in all four local authorities. Areas of concern varied between local authorities, but usually included access to CAMHS, as well as other services such as internal Child Exploitation Teams, and specialist therapeutic support through external charities (e.g. sexual abuse support through Barnardos, or local outreach services for autism). It was noted that social workers often had to fill gaps in support while families were on waiting lists, although social worker capacity to undertake direct work was often limited. Some parents also referenced that they did not receive any support or that support received wasn't sufficient to resolve the issues it aimed to address. For example, one parent highlighted that support to manage a child with complex needs had not been sufficient, and that they would have found it helpful to have more respite, less cancellation, as well as support with transport to the respite that was in place:

> *"When you actually break it down and look at it in more depth, in the grand scheme of things no, it doesn't actually help a great deal if I'm honest." [Parent]*

It is important to consider the quality of provision and the capacity of external services when thinking about whether support meets needs for families of children with a Child in Need plan. This is because children's social care relies heavily on external support to meet families' needs. In addition, where there is a lack of high quality mental health provision or delays assessments of needs, this can mean that cases may remain open longer than intended or risk being escalated to Child Protection.

Insufficient mental health provision

In particular, staff in focus groups in all four local authorities highlighted challenges accessing support for child and adolescent mental health, such as long waiting lists and issues of eligibility, meaning vulnerable young people are left without support. One social worker stated that it could be easier to get CAMHS support when a case was under Child Protection than when children had a Child in Need plan. Similarly, the in-depth case file review highlighted that if there are very high mental health needs for a child e.g. the young person is making serious attempts to end their life, then there is a range of external mental health provision or crisis

support. However, some families explained that support from community CAMHS teams was insufficient and they were grateful for other forms of support. While there were also staff and parents who reported that CAMHS support was good quality when it was actually received, participants reported experiences of CAMHS support. Overall, there appears to be insufficient mental health provision for children and young people on a Child in Need plan. This is concerning given child mental health was a common factor identified at the end of the assessment across the four local authorities included in this study.

Gaps and waiting lists for parental mental health support were also noted in focus groups in two local authorities. This is particularly concerning given that in three local authorities included in this study the most common factor identified at the end of the assessment was 'mental health disorder: parent/carer.' For example, in one case in LA2, there was support in place for a mother's mental health, however a lack of progress and the social workers' case-recording indicate that it may have been insufficient. The social worker reported that there had been minimal input from the Community Psychiatric Nurse (CPN). In correspondence, the social worker wrote:

> *"You are the key agency currently working with [Mother] as all issues stem from her mental health and I've had no communication from any of the mental health team since prior to her discharge from the crisis house 11 days ago now." [Social worker]*

As a result, the case remained open to CSC despite there being not many actions for the social worker. In essence, we found that case-recording suggests that sometimes there is support in place for a child or parent's mental health, however this support is not always sufficient.

Therapeutic intervention is not readily available or offered in CSC

In two of the case files from LA3 included in the in-depth review, there was an absence of therapeutic support, e.g. psychological services, which may have been beneficial to the young person. On one occasion, the young person was an asylum seeker who had lost both parents and no support was being offered directly around this trauma. On another occasion, the young person was described as having experienced significant trauma, yet the interventions being offered were addressing current risk rather than offering therapeutic support to address needs arising from past trauma. This implies that important therapeutic support is not available for children who need it, potentially increasing the need for statutory intervention in the long term.

Other gaps in support

As well as the aforementioned issues, which appeared prevalent across a number of sites, a range of other gaps in support were also highlighted which appeared to vary between local authorities:

- **Delay from external agencies in assessing needs:** In LA1, an adolescent experienced significant delay with accessing various assessments of his needs including mental health, learning needs, and assessment for autism. The lack of assessment from external services in this case resulted in escalating needs and became the primary reason for intervention from CSC. Therefore, delays for families in accessing assessment of their needs are detrimental and can contribute to needs escalating into risk, resulting in a higher level of intervention from CSC (Children in Need rather than Early Help for example).

- **Providing recommended support after specialist assessment:** For example, in one local authority, following a Parent Assessment Manual (PAMS assessment)[34] conducted by an independent social worker, there were challenges in providing the follow-up support due to the level of resource and practitioner expertise necessary to implement the recommendations.
- **Education welfare provision:** In one local authority it was noted that the resources to provide parenting, wellbeing or therapeutic support varied between schools, and that there had been cuts to services like youth centres. A social worker in another local authority commented on reductions in the school nurse offer.
- **Domestic abuse support for perpetrators:** Staff members in two local authorities highlighted a lack of support (including waiting lists or a lack of programmes) for domestic abuse perpetrators. This was raised even where sites had either internal or external domestic abuse provision in place, suggesting it was an issue of capacity in these services that was the key issue.
- **Children with Disabilities provision:** In the case file review for LA4, we found that some families felt that there was a lack of suitable service provision for children with disabilities. In two cases, families reported that the support offered through direct payments was insufficient in meeting their child's needs. Sufficiency in services to meet the needs of children and young people with disabilities or complex needs was also highlighted by staff in one local authority (who stated it was a national issue) and by a parent in another local authority. This parent also highlighted that vacancies and staff changes were difficult for children who needed routine and stability:

"So when I'm getting to the point where I'm exhausted and sleep deprived, and saying I'm struggling, all I get told is 'well your package is really big.' And you know, there isn't really anything else that they can be offering." [Parent].

Satisfaction

Social workers and parent interviews indicated that family satisfaction with services was mixed. Social workers reported receiving compliments and families feeling happy with the support they had received and the way it had helped them make change, but also receiving complaints from families or reported some families feeling unhappy that they could not be offered more support or frustrated at waiting times for services.

The majority of parents (seven of eleven) we spoke to expressed mixed experiences with their social worker or other support provided. A small number (three) expressed mainly positive experiences, and one parent expressed mainly negative experiences. Positive experiences of the support received (reported by those with positive or mixed experiences) included satisfaction with the amount of support received, feeling listened to in review meetings, or satisfied with support received through partner agencies such as CAMHS or school.

"I do feel that I'm glad they [social services] were involved. I were glad how everything happened the way it did, you know, because all the processes come out the correct way for safely having the kids and everything." [Parent interview].

34 The Parent Assessment Manual (PAM) is a comprehensive assessment tool for use with vulnerable families, including parents with learning disabilities.

Of parent feedback which was negative, one parent mentioned they did not feel the social worker was sufficiently responsive to their needs. Another parent reported feeling judged and that their social worker didn't understand their child's complex needs, and was also dissatisfied with the response from health services. Another parent had been dissatisfied at the speed at which it took to allocate a social worker, which was said to have been due to staff shortages. One parent reported that their social worker was approachable and they had everything they needed, but at times reported feeling dictated to or told what to do. Having multiple changes of social worker, and starting over and building new relationships with themselves and their child each time, was highlighted as difficult for a few parents.

Across the board, minimal detail on the satisfaction of children and families with the support provided was recorded in the case files. The level of engagement with services was far more commonly reported than families' satisfaction with services. In the small number of instances where satisfaction was mentioned, it was more commonly in relation to a negative perspective or dissatisfaction from the families, and at times including feelings of dissatisfaction with reference to mental health services.

Engagement

Social workers reported that because being placed on a Child in Need plan was voluntary, consent was key, and highlighted the importance of transparency and building strong, trusting relationships with families early on to facilitate engagement. Social workers reported that most families consented to Child in Need support, and that some families engaged well because this type of support was seen as less punitive than child protection. A couple of parents reported that their preconceptions or distrust of social workers had been overcome:

> *"You know, and if people said to me before I had a social worker, the social worker's going to be on your case, I would be worried. But now if someone said to me, a social worker's on your case, I wouldn't be worried because I've dealt with it. You know, it's not what people make it out to be. It's right for the kids" [Parent].*

It was noted that though families gave consent in most cases, some families agreed to a Child in Need plan because they felt they had to, or were still not aligned with the goals of the plan, or even that one parent may engage while the other did not. Perceived barriers to engagement included negative previous experiences, as well as long waiting lists to internal and external services which left families feeling unsupported. Comments in case files also suggested that in some cases a high level of support with multiple agencies involved sometimes felt overwhelming to families and this appeared to influence their engagement. Where families didn't consent to being placed on a Child in Need plan, we saw that sometimes the LA needed to consider whether the concerns should be escalated to a s47 investigation.

Social workers also reported that family relationships with partner agencies and families' engagement with services provided by partners, such as schools, were mixed. Some staff and parents commented that families had particularly good relationships with professionals they saw regularly, such as family support workers or intensive specialist services such as Multi Systemic Therapies (MST) and CAMHS. Some parents commented on how well social workers and other services such as CAMHS had been able to engage young people who were hard to engage. Most parents we spoke to had declined some elements of support they had been offered. It was not possible to identify a consistent type of support declined; it seemed that this varied between families and what their individual needs were. Examples

referred to included 'counselling' for their child, support from the local authority's adolescent support unit, family therapy, support from a domestic abuse service for the parent, or parenting support.

Families who had declined elements of support had usually accepted other types of support, but just felt this particular element of support was not right for them or at that time. Support was declined for a range of reasons, such as where they felt things were already getting better, they were receiving enough support already, had their own social support, didn't have time to engage or didn't want too many professionals involved. One social worker highlighted challenges with non-statutory services not being as persistent as social care might be, when trying to engage families in support, for example closing after a missed appointment.

There was some recording of level of engagement in case files, though this recording was inconsistent. We noted instances where difficulty engaging parents in external services was recorded, such as substance misuse services, or where social workers had difficulty engaging children, but are unable to comment on the prevalence of this. In LA3 we noted that often the onus appears to be placed onto family members to engage with services, rather than the onus being on the intervention or programme to engage the family member e.g. 'Mother superficially engages' and 'Dad declined to engage - case closed to FGC after several attempts.'

Where some children remain on Child in Need plans for long periods of time or escalate to a higher level of intervention e.g. child protection, what are the reasons for this?

Social workers reported in focus groups that in some cases, a Child in Need episode could be closed quite quickly where a Child in Need meeting led to a plan for a lead professional such as a representative within school to continue supporting the family. Cases which stayed open for longer included those who had no recourse to public funds or those receiving funding under section 17, as well as those receiving long term support for disabilities such as short breaks. Some cases had to remain open for ongoing police investigations, whilst assessments or intervention were delivered, or due to waiting lists for support. The examples given in focus groups referred to internal assessments and support or external waiting lists, but this list is unlikely to be exhaustive. One social worker also mentioned that a case may remain open longer where new concerns were uncovered over time. Families and even other professionals becoming dependent on social work support could also be a challenge when trying to close cases.

Social workers in focus groups reported a range of reasons why there could be a lack of progress in plans. It is not possible to conclude how prevalent each reason is, but we have included detail on how commonly each issue was raised. All four local authorities identified difficulty accessing the support that was needed as a reason for lack of progress; this included mental health support through CAMHS, as well as parent mental health support. Some social workers also noted that families with complex health needs, requiring specialist equipment, resources or services could also take time to progress. Other reasons identified included failure to

successfully engage the family or failure to have regular reviews. One social worker noted that staff pressures, workloads and sickness could also lead to drift in some Child in Need cases. Another challenge raised by one social worker was where safety plans were compromised by a continued relationship with a perpetrator of domestic abuse.

Social workers in focus groups mentioned that reasons for case escalation might include:

- Difficulty getting parental engagement or lack of progress on the Child in Need plan
- High levels of risk such as child exploitation, parent drug and alcohol misuse, disclosure of a domestic violence incident, or repeated missing episodes.

Practitioners' and parents' recommendations for how the support can be improved

The recommendations in this section are based on what social workers and parents told us in focus groups and interviews were challenges they experienced in Child in Need support, or things which might improve support for children and families of children on Child in Need plans. These are supplemented with findings from our roundtables with social workers from other local authorities.

Social workers across all four local authorities, as well as attendees at our roundtables from other local authorities, highlighted that the statutory requirements, for example having a high number of statutory visits to complete, completing paperwork, as well as child protection and court work could limit the amount of time social workers had to undertake direct work with children and families of children on a Child in Need plan. For example, staff in three local authorities highlighted the demand of case recording, with lots of paperwork and duplication. However, roundtable attendees noted that issues of social worker capacity were not the case across the board in all local authorities, with some local authorities in roundtables highlighting that social workers in their area did have enough capacity to deliver sufficient direct work. Findings in focus groups and roundtables suggested that improvements to social worker capacity through reducing some of these competing demands might enable social workers in areas where this was an issue to work more effectively and plans to end more quickly. One roundtable attendee highlighted that they believed the social worker's job should not just be about referral, but that social workers, especially more newly qualified social workers who might be more likely to hold Child in Need cases, should receive sufficient support to deliver support and intervention themselves, where appropriate.

- Social workers in our focus groups also highlighted that increased capacity in external services could improve support for children with a Child in Need plan, avoid plans needing to remain open unnecessarily whilst waiting for services, and reduce the likelihood of escalation of risk. Cuts to services and pressure during the pandemic were issues affecting this which were raised in one of the roundtables. One roundtable attendee highlighted that earlier mental health support could reduce the need for more intensive therapeutic support later down the line, and an attendee in another roundtable reported that wellbeing practitioners in their local authority had tackled some of the early signs of mental health in children which they perceived had lessened the need for referrals to CAMHS. Another roundtable attendee suggested that reducing timescales for police investigation would also be of benefit to improving longer term outcomes.

- Social workers in our focus groups and at our roundtables also discussed challenges in the quality of case recording, but also examples of good practice or ways in which this had been improved in some areas. Accuracy of case recording was noted in one local authority in particular, where staff noted that it was difficult to record in a way that accurately captured the quality of direct work that was being undertaken. The quality of case recording may affect support provided by affecting how easily what is being provided can be reviewed and quality assured. In one roundtable it was mentioned that in local authorities with a lower Ofsted rating social workers may have anxiety about what should be recorded, prioritising recording things in great detail over recording about direct work undertaken. Examples of case recording staff felt worked well included having clear formats for recording case notes and plans. For example, outlining all agencies involved and capturing their views at Child in Need reviews. Instances of child-focused case recording and recording the child's voice clearly was praised in focus groups and in the roundtables. In another local authority, staff described a recent move away from use of a Word document towards an embedded process with drop down boxes to enable review of the plan and actions completed more easily.
- Some staff in focus groups also mentioned that plans could improve by being more targeted. A roundtable attendee suggested that plans should look at desired outcomes and behaviours for families, rather than just having attending a certain service as the goal.
- The image of social care, and parents' understanding of the system were also highlighted by some staff and parents. A number of social workers mentioned that some families had negative views of social workers, and that it was important to be clear and transparent with families. One social worker also commented that positive messaging to improve the image of social services could help improve engagement. Consistent with this, one parent didn't feel that the Child in Need process was explained well enough to them, and another highlighted the importance of families understanding the consent-based nature of the services and their rights as a parent. Another parent reported that their own professional familiarity with the system helped them demand the support they needed, but expected that other families who didn't have this experience may find it more difficult.
- Attendees at our roundtables also highlighted the importance of increasing partner agencies' confidence in safeguarding children, to facilitate stepping cases down from Child in Need support.

WHAT ARE OUR CONCLUSIONS?

Strengths and limitations

The findings of this study provide an understanding of the range of support provided, and identify key gaps in support. This study aims to inform further exploration of these issues in a larger number of local authorities in future. Our findings are not intended to provide accurate information about the prevalence of practice within these local authorities or draw conclusions about practice in other local authorities in which the research has not been conducted. More detail on the limitations of this study are set out at the beginning of the report.

Conclusions

Our findings highlight that understanding of the characteristics of children on a Child in Need plan as a distinct group is limited. One reason for this is that the national data on Children in Need (e.g. DfE, 2021) is based on a much broader group than only the children on a Child in Need plan. Further to this, key information about family history or socio-economic factors, or details of direct work undertaken, are not always systematically recorded, or easy to extract from the data at an aggregate level, and there may also be limitations in the accuracy of recording. Better recording about children on a Child in Need plan is likely to be an important way to improve our understanding of Child in Need support and whether it meets needs. This is not the first time this recommendation has been made. Bywaters et al. (2020) highlight that professional practice often fails to address families' material circumstances in assessment, planning and intervention. These authors call for case management and data collection systems to be reviewed to ensure that data on parental demography and socio-economic circumstances are available.

There appears to be considerable variation in the reasons for using Child in Need plans, and consequently considerable variation in their length and the types and sources of support provided. Child in Need plans are used to address a wide range of family and contextual needs and risks, including in instances where there is no risk of abuse or neglect such as where support is being provided because of a child's disability, or to offer financial support where a child is an unaccompanied asylum seeking child or the family has no recourse to public funds. We also noted that the rate of children on a Child in Need plan varies considerably between local authorities, suggesting they may be being used differently in different areas.

Factors important in decision making to recommend a Child in Need plan included the engagement of parents with children's social care, whether or not there is a history of concerns, the availability of family support, and whether or not there was any ongoing risk. Roundtable attendees agreed that these factors were seen in decision making in their own local authorities as well, and expanded on our findings by highlighting that risk and impact on the child were the particularly key factors.

Consistent with the wide range of reasons for using a Child in Need plan, we noted a wide range of support provided by social workers, family support workers, specialist teams within the local authority, and external services to which families were referred. Consistent with guidance in the DfE's 'Working Together to Safeguard Children', plans often included multi-agency support. Our findings also highlight that a large part of the social worker's role when supporting children on a Child in Need plan is providing advice or guidance to parents, and coordinating the multi-agency support provided. Use of direct work with parents and children is variable, with variation in the frequency of direct work, approach taken, and use of tools and resources to facilitate, as well as how this is recorded in case files. Often the social worker's direct work appears to focus on capturing the child's voice, while other specialist services are commissioned to provide more targeted interventions.

Despite a range of support offered internally and externally, there are gaps in services and support available, which does not always fully meet families' needs. In particular, we noted limited internal provision to support child and parent mental health, and difficulties accessing timely external mental health support. We also noted that there can be significant delay for some families in accessing assessment of needs including for autism, learning needs, and mental health. This can mean CSC needs to become involved as needs escalate. Roundtable attendees agreed that there was insufficient mental health support for children as well as in domestic abuse services. Roundtable attendees also agreed with the challenge of needing to keep cases open while on a waiting list for specialist support. In agreement with our findings about the effects of competing demands of paperwork as well as Child Protection and court work, some attendees of our roundtables observed that staff may benefit from more specialist training and time to deliver high quality direct work to parents and children. However, others disagreed and highlighted that lots of good direct work was already being completed in their areas. Roundtable attendees also agreed with our finding that there would be a benefit of more multi-agency capacity where specialist input is needed, to overcome drift and delay or case escalation that may result from waiting lists or high thresholds for services. Further to this, roundtable attendees highlighted the importance of increasing partner agencies' confidence in safeguarding children to facilitate stepping cases down from Child in Need support.

We also noted that despite Child in Need provision being voluntary, and a heavy emphasis on parent and child's voices in the social worker's accounts of their work, and observed in case files, **the parents we spoke to didn't always feel involved in developing their plans, and some weren't aware of what the goals on their child's Child in Need plan were**. Despite this, in instances where parents did know what the goals were, they did tend to agree with them, even if they had not felt involved in deciding them. In roundtables, it was highlighted that using approaches like Signs of Safety was one way to support social workers to formulate a Child in Need plan alongside families, and if done correctly, families and children should understand the plan. From our focused review, it seemed that this family understanding of the goals did not always happen even where signs of safety was the practice model being used. Findings suggest the importance of conceptualising support stretching beyond providing services to thinking about the quality of relationship between the family and professionals.

Recommendations for policy and practice

- **More consistent use of Child in Need plans** may be warranted. Every child's Child in Need plan should have a clear statement of purpose, and how this is going to be achieved. Our findings also suggest that there may be differences in decision making around thresholds between areas.
- **Social workers should collaborate with parents, carers and children to develop goals for their child's Child in Need plan.** This includes parents and carers setting goals, understanding the plan and having a record in an accessible format. This is important given the voluntary nature of Child in Need support.
- **Create consistency across LAs in the availability and quality of services provided for the most common areas of need.** Our findings suggest there is variation in the support available from local authorities. There should be sufficient funding to allow a more consistent or equivalent offer of support, regardless of where a family lives.
- **Improve access to external support provided by multi-agency partners,** for services including mental health and domestic abuse. This would help reduce time on a plan or delay in progress for families.
- **Local areas should consider increasing multi-agency partnerships.** Partners should agree on roles and responsibilities, and consider how the professional network can best support children and families.
- **Ensure Social Workers and Family Support Workers have sufficient time and training to undertake direct work** with children and their parents or carers.
- There should be a **better understanding of what direct work is happening with children and families and consideration for how this is captured to ensure case recording is helpful to social workers families.**
- **More and better quality data should be collected and recorded about children, families and their Child in Need plans.** This should include socio-economic factors, parent characteristics, parental engagement and what support and interventions are provided by social workers and external agencies. Critically, outcomes of plans must also be captured. In addition, children with a Child in Need plan should be identified as a distinct group in administrative data.

Recommendations for future research

Future research should:

- **Evaluate whether support provided to children with a Child in Need plan is effective** in meeting the needs of children and families.
- Describe and explain **regional variation in the use of Child in Need plans.**
- **Capture the views and experiences of children, young people and families who have a Child in Need plan.**

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APPENDIX 1

Supplementary in-depth review methodology

In undertaking the in-depth review, we examined the services offered and assessed whether or not support provided appeared to be meeting needs. We made this assessment by reviewing the risk(s) and/or need(s) present within the case files, and then reviewing whether there was any indication of the quality of support being provided and whether this directly related to the specific need(s) or risk(s) present within the case file. To protect children, young people and families from potentially being identified, we chose to exclude potentially identifying information such as age, and any specific details of concerns, and instead we gave some indication of the child's age and a high level picture of the need and/or risk.

We extracted detail on family history and functioning, which includes whether parents or siblings have had previous care experience, information on socioeconomic status (any reported financial struggle), and a description of previous Children's Social Care (CSC) involvement. We also included information on the severity and complexity of need and risk in these cases, and included any factors which appear to contribute to decision-making around whether to initiate a Child in Need plan. We extracted information on the support provided, and any information around the quality of support or interventions. Finally, we made an assessment on whether support appears to be meeting needs and if there were any gaps in service provision. The case files were analysed individually, by extracting information relevant to the aforementioned key areas, and then findings collated to make reflections across the four local authorities.

Within the in-depth review, two out of nine parents had previous care experience themselves, and one had a history of being on a child protection plan under the category of neglect. Some parents also had significant histories, despite no care experience, e.g. previous suicide attempts, domestic abuse, or involvement with the police. Six out of the nine parents reported to be struggling financially, and one parent was from a Traveller background.

In-depth review - Nine case files

The in-depth review consisted of nine cases which reflect the range of need, risk and complexity we have seen from the case file review of 82 Child in Need cases in England. This consisted of two to three cases per local authority. We considered the services offered and assess whether or not support provided appears to be meeting needs. Cases with the following high level concerns have been selected for in-depth review:

- An adolescent who is at high risk CSE.
- An adolescent with UASC/ NRPF status, both parents deceased, and a sibling with complex health needs.
- A child who has a Mother experiencing significant mental ill health, requiring hospitalisation and their Father is deceased.
- A child with a severe disability where there was no need for ongoing, frequent contact from the SW (after arranging direct payments).
- A child with extensive CSC involvement whose Child in Need plan was court recommended following a CAO.
- An adolescent with multiple needs assessments outstanding (autism, learning, mental health), who was being physically harmed (due to needing to be restrained) and harming others in the house.
- An adolescent who is at medium risk of CCE.
- An adolescent who has significant mental ill health, requiring a high level of external mental health support.
- A child who has had four siblings removed from his Mother's care previously, due to previous domestic abuse and neglect.

APPENDIX 2

Focus group and interview schedule

1. Within LA Social Worker Focus Group Before Case File Review

- One Focus Group per Local Authority.
- Should include approximately: Social Workers, 1 Senior Practitioner, 1 Team Manager.
- Focus Group should be approximately 90 minutes

Welcome: Researcher(s) introduce themselves and asks if they've read information sheet

Background: This focus group is part of a research project to understand the support provided to children and families of children with a Child in Need plan, and whether that support meets their needs. This has been commissioned by the independent review of children's social care, to inform their review. As well as this focus group, we are also speaking to parents, and reviewing case files. We are also working with three other local authorities to answer this question.

This Focus Group:

- We'd like to ask you some questions about the support you and other professionals provide to children and families of children on child in need plans.
- Please be as honest as you can: We are interested in positive and negative views.
- The focus group is expected to last approximately 90 minutes; we can take a short break at any point.
- We will publish a report on our website. The findings we report will be anonymous. You won't be able to be identified in the report from anything you share today. The only time we may need to share information is if we have any concerns about practice, or if there was a risk of harm to yourself or someone else.
- Taking part in this research is completely voluntary; you do not have to participate, you can leave the focus group at any point, and you can change your mind after you have taken part, up until we write our report. You do not need to give a reason.
- Please can we ask that you do not share anything discussed by colleagues outside of this focus group, without their permission

Ask

- Do you have any questions or is there anything you are not clear about?
- Are you ok with the focus group being audio recorded?
- [In person] Ask them to sign a consent form
- [Virtual] Should have received consent forms back already, if not can record consent

Process

- I will begin the recording by saying my name, the time and date, and the identifying code we have assigned to this focus group.
- [If needed] I will then read out some statements to record your consent/ agreement to take part.
- Is it ok for me to start recording now?

BEGIN RECORDING

- Researcher's name
- Date and time
- The focus group identifying code

Consent [If needed - don't ask if collecting written consent]

- I am going to start by asking a few questions to record your consent to take part in this focus group.
- Have you had the research explained to you?
- Have you asked all the questions you'd like to ask (and are happy with the answers)?
- Do you understand that taking part is your choice - you can choose not to without giving a reason?
- Do you agree to take part in this study?

(If participant(s) say no to any questions, try to address issue, and only proceed once they can say yes)

Introductions (5m)

1. Could you each introduce your role and which team you work in?
2. Which teams within your local authority work with families of children on child in need plans? What are the criteria for cases to be held by each of these teams / At what points do cases transfer between teams (e.g. after referral or assessment?)? What about for children who may transfer to the Children's Disability team?
3. Does your local authority follow a certain practice model, and can you tell me briefly about it?

Reasons CYP are on Child in Need plans (10m)

4. What are some of the key areas of need that families receive support for under Child in Need in your local authority?

a. We're interested in understanding more about the cases you might identify as high need, or high complexity. What areas of need do you tend to see in cases you would class as higher need and higher complexity, and are these the same cases?

What support families receive (20-30m)

5. Is there any guidance in your local authority for Child in Need plans and what does it say (e.g. frequency of child in need visits and reviews, and for how long Child in Need plans should go on for, as well as what should be in child in need plans / how they should be recorded)? (Might this differ for children with a disability?)
6. Could you tell me about the support provided for families who have children on a Child in Need plan in your local authority?

Prompts if needed:

a. In what ways are children and young people supported?

b. In what ways are parents supported?

c. What support is provided by Social Workers (both direct work, administrative and practical support, and referrals to other agencies)?

d. What support is often provided by other professionals or teams within the local authority?

e. Would you hold family group conferences or family network meetings?

f. What support is provided by external services parents or children are referred to?

7. If not covered in the last question, ask about what type of support is provided for different needs families might have, e.g. neglect, parent/carer or young person mental health, substance misuse, domestic abuse, disabilities, risks in the community, parenting, edge of care?

8. Does recording in case files accurately reflect the services that are provided? (Prompt: How is support recorded in case files? Could case recording around interventions or services provided be improved in any way?)

9. In what ways has support changed since the COVID-19 pandemic?

Does support meet needs? (20-30m)

10. Do you think families on Child in Need plans are getting the right support to meet their needs, or not? Why is this?

    (Prompts: Are there any areas of need where there are gaps or long waiting lists in the support available, and why is this? What are the reasons cases might be re-referred to Children's Social Care after a Child in Need plan is closed? What are the reasons some Child in Need plans escalate for example to a section 47 investigation?)

11. Does the length of Child in Need plans tend to vary according to different needs, and why is this?

    (Prompts: What are the reasons why some Child in Need plans remain open for longer periods of time than others do? Are there some instances where Child in Need plans are more likely to be subject to drift and delay, and why is this? What review process do you have in place to monitor whether cases are open for the right amount of time?)

12. What challenges do you encounter when supporting families of children on a Child in Need plan? How well do partner agencies engage with Child in Need plans? Do you see more engagement from some partner agencies than others?

13. How satisfied are families with children on a Child in Need plan with the support provided by CSC and partner agencies? How does your local authority gather feedback from families?

14. How well are children's services able to engage families with children on a Child in Need plan? How do you or your local authority measure the engagement of families? Is this framed, for example, as Mum/ Dad have not engaged in X intervention, or as: X intervention has not engaged Mum/ Dad?

15. Do you see some partner agencies being able to engage families more so than others? Can you tell me more about this?

16. In what ways might support for families with children on a Child in Need plan be improved?

Closing

17. s there anything you'd like to add?

APPENDIX 3

Information extracted from the case file review

A. Case Details

- Case ID
- Local Authority
- Which team is the case open to?
- Additional notes

B. Background

- Child Age at point of case file review
- Child Ethnicity
- Number of siblings (age, whether they are open to CSC, what type of plan they are on, whether they are in care, what type of placement they are in, if known)
- Who the child lives with (and what is known about them: relation to child, age, gender, ethnicity, disability, etc.)
- Is the child recorded as having a disability?
- Type of disability
- Date of referral to CSC
- Date Child in Need plan started
- Date Child in Need plan ended
- Any previous contacts to CSC? (and how many)
- Number of previous assessments by CSC
- Details of previous episodes of support from CSC (the type and length of involvement, number of episodes of involvement)
- Has Early Help been offered previously (Include detail on involvement if known)

- Mother age at point of case file review
- Father age at point of case file review
- Caregiver age at point of case file review (if not mother or father)
- Mother ethnicity
- Father ethnicity
- Caregiver ethnicity (If not mother or father)
- SES information
- Does mother have previous care experience?
- Does father have previous care experience?
- Does caregiver have previous care experience (If not mother or father)
- Is the child an unaccompanied asylum seeker (UASC)
- Child immigration status (if applicable)
- Mother/Father/Caregiver immigration and no recourse to public funds (NRPF) status, if applicable

C. Reasons for Child in Need plan

- Primary Areas of Need (Child in Need census categories)
- Factors identified at the end of assessment (Child in Need census categories)
- Nature and severity of factors identified at the end of assessment (how serious the need / risk is)
- At the end of the most recent single assessment what was the recommendation? 1). Case closure w/ no further action, 2). Step down to Early Help, 3). Progress to Child in Need plan, 4). Initiate a S47 investigation.
- Reasons why the child is considered to meet the threshold for a Child in Need plan (i.e. why Child in Need plan was identified rather than case closure / step down to early help or initiating S47 investigation)?

D. Support and Assessments SW provide whilst families are on a Child in Need plan

- SW direct work with parent / carer or other adult family member (give details of nature, frequency and duration if known)
- SW direct work with child (give details of nature, frequency and duration if known)

- SW administrative support (e.g. has the social worker helped the family completing forms or applications for services such as housing or benefits, supported the family with contacting services or booking or attending appointments, or followed up with services directly on behalf of the family)
- SW offering practical support e.g. food packages, sourcing furniture
- What, if any, financial assistance is provided for the family under S17?
- SW making referrals to other agencies for support and assessment
- Any delay experienced with accessing services after referrals have been made?
- Referrals made by the SW to internal or external services, but which were not accepted (which service was referred to, reasons not accepted if known)
- Assessments undertaken by the SW (and type of assessment e.g. risk assessment, parenting assessment)
- Frequency of SW visits over the past three months (and if possible what type of visits these are and proportion which include direct work)
- Changes in SW since start of current Child in Need episode
- Frequency of Child in Need review meetings
- Frequency of case supervision
- Details of any other case review e.g. attendance at Child in Need review panels if these are used

E. Support / Interventions / Direct work provided by other professionals in the local authority

- What is the intervention / piece of work?
- Who (i.e. which team and which role) is delivering the support or intervention?
- What is the intervention for?
- For which family member(s) is the support or intervention provided?
- Duration of intervention
- Number of sessions
- Frequency of sessions?
- Length of sessions?

- How well does the intervention provided engage the family member(s) it is supporting?

F. Assessments undertaken by other professionals in the local authority

- What is the assessment for (i.e. what is being assessed)?
- Who (which role) undertook / is undertaking this assessment?
- What is the outcome and recommendation from the assessment?
- G. Support provided by organisations outside of CSC
- What is the intervention?
- Who (i.e. which organisation and which role) is delivering the support or intervention?
- What is the intervention for?
- For which family member(s) is the support or intervention provided?
- Duration of intervention
- Number of sessions
- Frequency of sessions?
- Length of sessions?
- How well does the intervention provided engage the family member(s) it is supporting?
- Any evidence of whether the external agency / multi-agency safeguarding partner who is delivering this intervention is engaging with the child's Child in Need plan e.g. do they attend Child in Need meetings, contribute to assessments, have actions on the plan etc?

H. Assessments undertaken by organisations from outside CSC

- What is the assessment for (i.e. what is being assessed)?
- Who (which organisation and which role) undertook / is undertaking this assessment?
- What is the outcome and recommendation from the assessment?

I. Any other support or equipment provided (which has not already been recorded)

APPENDIX 4

Table 3 Percentage of each ethnicity recorded for children on a Child in Need plan, children in care, and school age children

	White	Mixed / Multiple ethnic groups	Asian / Asian British	Black / African / Caribbean / Black British	Other	Not Known
National Data						
Children in Need in England in March 2021 (DfE, 2021)*	68%	9%	8%	8%	3%	4%
Children in care in England (2021a)	75%	10%	4%	7%	3%	1%
School aged children in England (DfE 2021b)	72%	6%	12%	6%	2%	2%
LA1						
On a Child in Need plan under section 17 (whole local authority data from this study)	58%	11%	7%	10%	8%	7%
Children in care (DfE 2021a)	72%	15%	3%	6%	*	*
School aged children (DfE 2021b)	69%	7%	13%	8%	2%	2%

* This information is not directly comparable to the data collected in this study, however, as national data for Children in Need does not capture children on a Child in Need plan alone, only in combination with other categories of children with a social worker.

Table 3 Percentage of each ethnicity recorded for children on a Child in Need plan, children in care, and school age children (continued)

	White	Mixed / Multiple ethnic groups	Asian / Asian British	Black / African / Caribbean / Black British	Other	Not Known
LA2						
On a Child in Need plan under section 17 (whole local authority data from this study)	81%	10%	5%	2%	0%	2%
Children in care (DfE 2021a)	87%	7%	2%	*	3%	*
School aged children (DfE 2021b)	83%	5%	9%	1%	0%	1%
LA3						
On a Child in Need plan under section 17(whole local authority data from this study)	57%	1%	33%	2%	6%	1%
Children in care (DfE 2021a)	79%	5%	11%	*	*	*
School aged children (DfE 2021b)	47%	4%	45%	1%	2%	1%

* Withheld due to small numbers

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