OSCB Annual Report 2015 - 2016

Oxfordshire Safeguarding Children Board
Annual report 2015-16

Contents

Annual Report Introduction

By Paul Burnett
Interim Chair

I am pleased to introduce the Annual Report for Oxfordshire Safeguarding Children Board 2015/16. The role of the OSCB is to make sure improvements continue to be made in protecting all children from harm across Oxfordshire. Safeguarding standards have been tested through the Stocktake Report on child sexual exploitation in 2015 and the Joint Targeted Area inspection in 2016. The findings from these reviews as well as our local knowledge have given Board members a clear view of how well child protection work is being managed but also clearer understanding of the pressures on the system due to the increased activity at the front door.

It is pleasing to see the commitment of colleagues across the safeguarding partnership, which has led to improvements in the transportation of vulnerable children, the services to our most vulnerable children who have been or are at risk of child sexual exploitation and progress made over the last year on work to support adolescents, which has included an increase of older children on child protection plans. It has also been invaluable to involve parents and victims in county wide learning events.

OSCB partners are mindful of ensuring that the needs of both younger and older children are met. Our quality assurance work highlights that we must address long term issues of neglect and protect children in families where domestic abuse, substance misuse and mental illness are prevalent. Going forward we need to keep a tight grip across the partnership on what is working well and where challenges are emerging and ensure organisations set clear baselines and targets for improvement.

Challenges lie ahead with the forthcoming Children and Social Work Bill 16/17. A new statutory safeguarding framework will be introduced, which will set out clear requirements, but give local partners the freedom to decide how they operate to improve outcomes for children. I believe that we are in a sound position as a Board to meet these requirements, provide scrutiny and give assurance that safeguarding children in Oxfordshire is at the forefront for all organisations.

Chapter 1: Local Safeguarding Context

Oxfordshire Demographics

There are 141,200 young people aged under 18 in Oxfordshire. This population has grown by 6% in the last ten years – mainly in urban areas where the majority of new housing has been developed. An estimated 14% of under18s are from minority ethnic backgrounds, with considerable differences across the districts, the figure rising to 35% in Oxford City.

Based on the IDACI (income deprivation affecting children) rankings, Oxfordshire is relatively prosperous and is the 14th least deprived upper tier local authority area (out of 152 in the country). There are areas of deprivation in the urban centres of Oxford and Banbury, with further pockets in Abingdon and Didcot.

Oxfordshire performs above both national and statistical neighbour averages for the proportion of both primary and secondary schools judged as good or outstanding. Despite this the proportion of outstanding schools in Oxfordshire continues to be lower than the national average. Persistent absence rates, permanent exclusions and fixed term exclusions in secondary schools continue to be a concern.

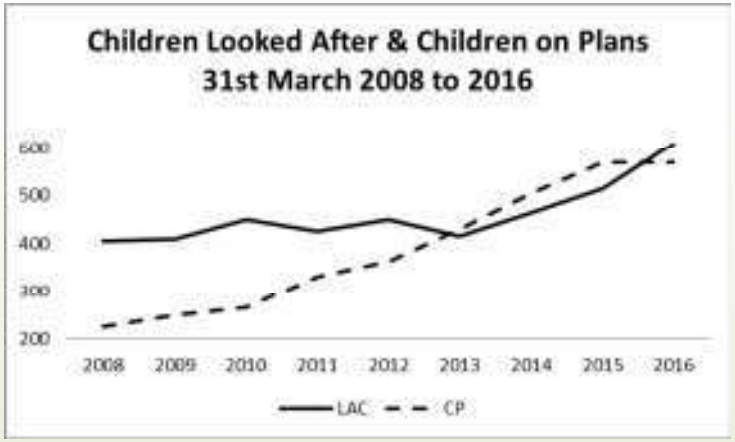
Early Help

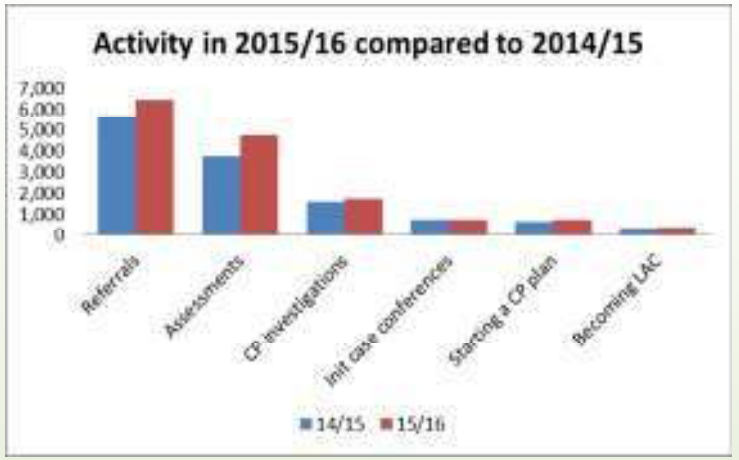
Early help assessments (CAFs) are completed and families are then supported by regular 'team around the child' (TACs) meetings to monitor progress. Support includes help for children where parents or carers misuse substances and help for those families when social care intervention ends. Last year early help work increased. There were 957 recorded CAFs and 912 recorded TACs; with schools predominantly taking the lead in this work. The number of under 5s reached in Oxfordshire i.e. seen at least once at an event or activity at any Oxfordshire children's centre in the financial year 2015-16 was 18,251 or 43.8% of the population of under 5s.

The Troubled Families initiative is working with the most vulnerable families. The initiative has identified 2,000 families with 925 having a named worker from a County Council service. Ofsted reported; '*It is intensive, well organised and cost effective and has led to clear improvement in the lives of particular families*.'
A longer term piece of work is underway to integrate early help and statutory work to support vulnerable children and families. The focus is on services for 'children in need' i.e. for those who meet the statutory thresholds for services but are not deemed to be at the level of significant harm which would warrant a child protection plan. The intention is to develop more robust early help and reduce the numbers of children who are escalated to children's social care.

Children with a child protection plan

Children who have a child protection plan are considered to be in need of protection from either neglect, physical, sexual or emotional abuse; or a combination of two or more of these. The plan details the main areas of concern, what action will be taken to reduce those concerns and by whom, and how we will know when progress is being made. At the end of March 2016 there were 569 children subject to a plan. This was the same figure as 12 months previously and the first time in over 10 years that the figure did not rise. However this masks a considerable increase in activity. The graph below shows the increase in activity last year, which varies from 3 to 26%.





Activity levels are generally slightly below the national average, but above those of statistical neighbours and higher than we would expect for an authority which is the 14th least deprived in regard to children in the country. The OSCB has developed a 'report card' on the relatively high levels of activity within the system and a subsequent 'impact assessment' to consider what impact reduced budgets will have on the system.

20% of the child protection plans ended in the year because the child became looked after. The proportion of plans which did not end successfully (i.e. within 18 months and with the child remaining at home) has dropped in each of the last 3 quarters. So far this year 58% of children who become looked after have previously been subject to child protection planning looked after, 49% of them within the last 12 months.

The number of looked after children rose by 18% in the year. For comparison the national growth over the last 5 years has been 3% per annum.

Improvements that are made when a child is the subject of a child protection plan need to be sustained once the plan ceases. Understanding what happens once a child stops being the subject of a plan and ensuring improvements are sustained will be an area of focus in the coming year.

Children in care

Children in care are those looked after by the local authority. This rose by 15% in the year from 514 to 592. For comparison the national growth over the last 5 years has been 3% per annum. Despite this growth numbers remain comparatively low, the average for our statistical neighbours (the authorities that are most demographically similar to Oxfordshire) would by 600. 61% of all children becoming looked after had previously been the subject of a child protection plan - 49% within 12 months of their looked after episode beginning. 11% of children becoming looked after had been previously looked after. Understanding what happens once a child stops being the subject of a plan and ensuring improvements are sustained will be an area of focus in the coming year.

We want to ensure that where people are looked after, we keep our riskiest closest to home. We have managed to do this over the year. The number of children looked after and not placed in neighbouring authorities rose slightly (74 to 77). The biggest increase has been in children placed in foster care or with family and friends

Children leaving care

In Oxfordshire 346 care leavers (aged 17-21) are supported. 170 are in education, employment or training (49%). This is an improvement on last year and in line with the national average. Over a third of care leavers are in independent living, 14% with parents or relatives and 12% are in accommodation linked to their employment or training. None are in bed and breakfast or emergency accommodation.

Children who are privately fostered

The county council worked with a total of 140 private fostering arrangements. This is an increase from the previous year. International students make up the majority of referrals. There has been a decrease in the number of vulnerable children living with friends and distant relatives this has decreased from 28% last year to 23% this year. However, the county service remains focused on this group this year to ensure that the most vulnerable children are identified and supported. At the end of March 2016 the local authority were aware of 43 children living in a privately arranged foster placement, similar to last year (44) but up from 34 the end of March 2014.

Disabled Children

At the end of March 2015 there were 14 disabled children with a Child Protection Plan; this is in line with previous years

Children who offend

The children who are involved with Oxfordshire Youth Justice Service (YJS) often present with complex needs requiring significant support both in and out of custody. The YJS has the same amount of work as last year, 246 children received a substantive outcome (a caution or above) in 2014-15 and in 2015-16. The figures for the year 2015/16 (April to March) show “that the performance is satisfactory” and that we are “still better than both the regional and national rates”. There were 12 custodial episodes within the last year period. This is measured against the rate of young people per 1000 in the population. The custodial episodes arise out of serious episodes of offending/ repeat serious episodes of offending.

Children who are at risk of sexual exploitation

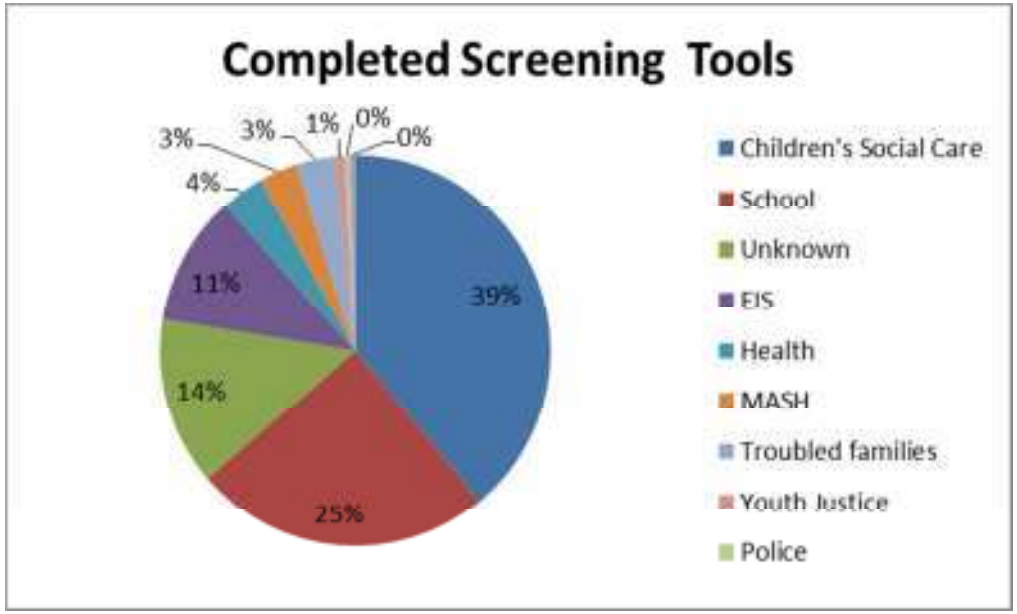
There are currently 280 children open to social care at the risk of CSE. 88 new assessments in 2015/16 identified a risk of CSE for a child in Oxfordshire. This reflected 2.5% of all social care assessments completed and was slightly below the national average of 3%. There was a 25% increase in CSE screening tools in the year (increasing from 178 to 223 There were 119 CSE crimes and a further 133 incidents which were not crimes (to the end of February). There were 13 arrests and 6 people charged. 11 child abduction warning notices were issued. The number of children open to social care at risk of CSE at the end of the year (280) was similar to the end of September (278). However within this the number on children in need plans has halved with a consequent increase in children not on any plan. This may reflect the increase in assessment activity (26% in the last year).

23 children had risk assessments (for sexual abuse or exploitation for sexually active young people and vulnerable adults) requiring referrals to a safeguarding organisation in the first 9 months of the year. 108 people in the first 9 months have accessed drug and alcohol services; 35 at tier 2 and 73 at tier 3. 22 children are currently at risk of CSE and not in full-time education. 40 children in 2015/16 accessed a school nurse. All sexually active young people and vulnerable adults accessing GUM and contraceptive services have had a risk assessment for sexual abuse or exploitation performed at each presentation as a new case. The Joint Targeted Area inspection praised this work in particular.

My support worker from the kingfisher team has helped me become the person I am today".

"I have grown enormously since the start of this. I've grown into a woman who is now confident in my abilities to move forward in life".

"I can now see what my future holds"



Children who are at risk of sexual exploitation going missing

This year 817 children have gone missing; this includes 115 children for whom a CSE screening tool has been completed (14%) and 100 looked after children (out of 864 children looked after at some point in the year in the year) - i.e. 12% of the looked after population.

Children who are at risk of sexual exploitation and known the to the youth justice service

Every young person known to the youth justice service is screened for CSE as a matter of good practice.17 young people, known to the youth justice service have been convicted for a sexual offence on the year out of the 38 young people convicted for a sexual offence last year.

Children who are at risk of poor mental health

Oxford Health NHS Foundation Trust Child and Adolescent Mental Health Services (CAMHS) continues to receive significant increases in referrals, this increase follows the national trend. During 2015/16 the Oxford CAMHS received 6,214 referrals of which 5,724 were accepted as appropriate referrals (92%) and 3,990 young people were assessed by CAMHS during this period. The numbers open to CAMHS continue to increase with a noted intensification in the complexity and presentation of children and young people.

Although CAMHS meet the target of seeing children who need to be seen urgently or as an emergency they are working very hard to reduce the waiting times for those children who are referred for a routine or non-urgent assessment and have plans in place to help reduce the waiting time for routine referrals. Following the DH report “Future in Mind”, the partnership review of CAMHS, and in line with the NHS England 5 year Transformation Plan, local services are undergoing transformation to move to a new service model which has been developed in partnership commencing April 2017.

There are strong relationships and developing partnerships between CAMHS and other agencies in respect of working together to safeguard children and young people from harm, to develop easier access to services including targeted and specialist mental health services, to increase resilience and self-help and to reduce waiting times to ensure access as quickly as possible and to the most appropriate intervention.

Children missing from home

The number of children who have gone missing from home has risen from last year (817 children compared with 694 last year). The number who went missing three or more times rose from 132 to 149 meaning the proportion of children who repeatedly went missing remained at 19%.

In summary: what does the data tell us?

- There have been more CAFs but the numbers of children under 5 reached by children's centres have gone down
- Increasing levels of activity across child protection plans; neglect being the most common reason for a child protection plan
- Lower levels of children becoming subject to a second or subsequent plan
- Increasing numbers of children in care; the highest level for many years.
- Half of the children becoming looked after had been on a child protection plan within the previous 12 months
- Increasing numbers of children missing from home
- Children at risk of sexual exploitation are being identified at the same rate and there is a higher use of the screening tool
- Children who offend: fall in numbers involved with youth justice service...however…increased custody rates
- CAMHS meet the target of seeing children who need to be seen urgently or as an emergency but they are working very hard to reduce the waiting times for those children who are referred for a routine or non-urgent assessment
- The implications of increased workloads on ensuring children are kept safe: the system is under pressure.

Chapter 2: Governance and accountability arrangements

About the OSCB

We are a partnership set up to ensure that local agencies co-operate and work well to safeguard and promote the welfare of children. We are responsible, collectively as a Board, for the strategic oversight of child protection arrangements across Oxfordshire. This means that we lead, co- ordinate, develop, challenge and monitor the delivery of effective safeguarding practice by all agencies. The impact should be evidenced in front line practice.

The Wood Report released in May 2016 will impact on the arrangements for safeguarding boards in the coming year. Changes to safeguarding boards are being outlined within the Children and Social Work Bill 2016-17. Presently the Board's remit is set out in the government guidance, Working Together 2015 and is to co-ordinate and ensure the effectiveness of what is done by each agency on the Board for the purposes of safeguarding and promoting the welfare of children in Oxfordshire. We aim to do this in two ways:

Co-ordinating local work by:

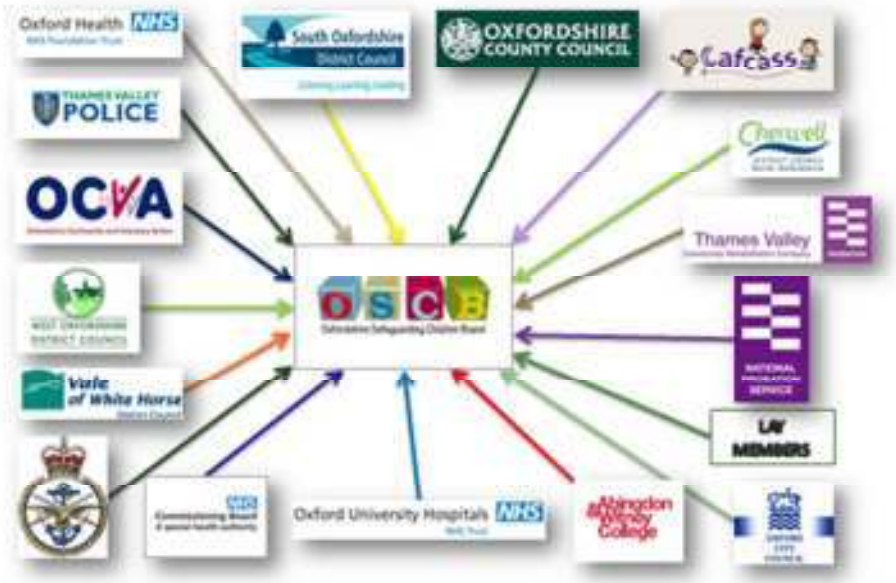
- Developing robust policies and procedures.
- Participating in the planning of services for children in Oxfordshire.
- Communicating the need to safeguard and promote the welfare of children and explaining how this can be done.

Ensuring that local work is effective by:

- Monitoring what is done by partner agencies to safeguard and promote the welfare of children.
- Undertaking Serious Case Reviews and other multi-agency case reviews and sharing learning opportunities.
- Collecting and analysing information about child deaths.
- Publishing an annual report on the effectiveness of local arrangements to safeguard and promote the welfare of children in Oxfordshire.

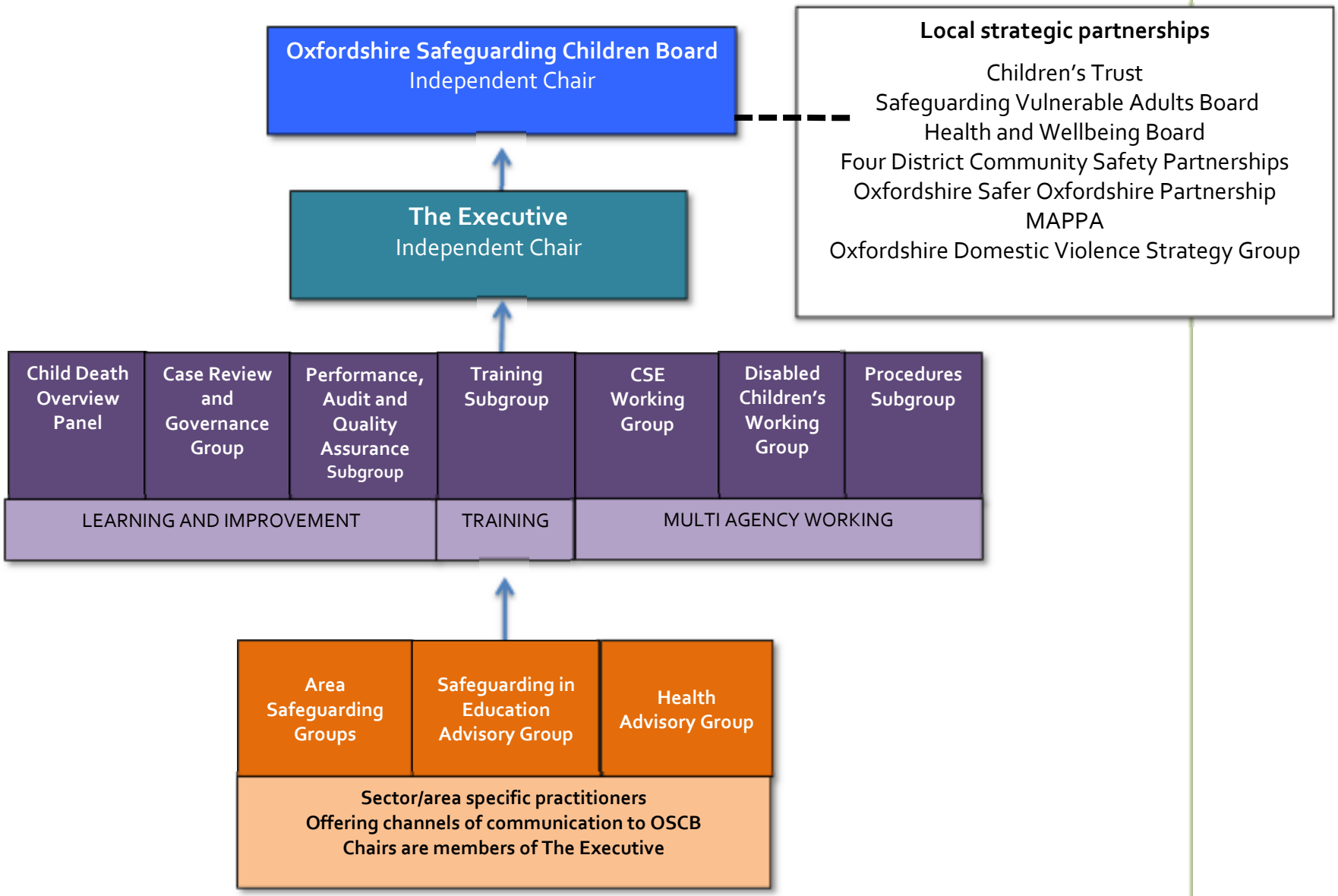
Board membership

Independent Chair	Thames Valley Police
Oxfordshire County Council: children's services, youth justice services, adult services, fire and rescue services	Children and Family Courts Advisory and Support Service
Oxford University Hospitals Foundation Trust	Community Rehabilitation Company
Oxfordshire Clinical Commissioning Group	National Probation Service
Oxford Health NHS Foundation Trust	Lay Members
NHS England Area Team	Representation from schools and colleges
Cherwell District Council	Representation from the voluntary sector
Oxford City Council	Representation from the military
South Oxfordshire and Vale of White Horse District Council	
West Oxfordshire District Council	



Structure

The main Board is supported by a range of sub-groups and other panels that enable its functioning:



How the Board works

Statutory body
We are a partnership set up under the Children Act 2004 to co-operate with each other in order to safeguard children and promote their welfare. The Board's job is to make sure services are delivered, in the right way, at the right time, so that children are safe and we make a positive difference to the lives of them and their family. We are not responsible or accountable, as a Board for delivering child protection services. That is the responsibility of each of our agencies separately and collectively but we do need to know whether the system is working.

Local Authority
Oxfordshire County Council is responsible for establishing an LSCB in their area and ensuring that it is run effectively. The Lead Member for Children's Services is the Councillor elected locally with responsibility for making sure that the local authority fulfils its legal responsibilities to safeguard children and children. The Lead Member contributes to OSCB as a participating observer and is not part of the decision-making process. During this period Councillor Tilley fulfilled this role.

Independence
As an independent Board we hold each other and our respective governance bodies to account for how they are working together. The Board's Independent Chair is directly accountable to the County Director at the County Council and works very closely with the Director of Children's Services.

The Independent Chair also liaises regularly with Thames Valley Police and the Police and Crime Commissioner, the Council's executive member for children's services and the Chair of the Health and Wellbeing Board in driving forward improvement in practice. Moreover, the Independent Chair maintains a close relationship with the Oxfordshire Clinical Commissioning Group and NHS Trusts. The OSCB is pleased to have strengthened representation from the voluntary and community sector during 2015/16.

Individual partners
Member agencies retain their own lines of accountability for safeguarding practice. Members of the Board hold a strategic role within their organisation and are able to speak for their organisation with authority and commit their organisation on policy and practice matters. On the Board we share responsibility collectively for the whole system, not just for our own agency. These governance and accountability arrangements are set out in a constitution.

Key Relationships

The Board is part of a set of strategic partnerships in Oxfordshire which provide oversight of the planning, commissioning and delivery of services to children. The Board has the specific oversight of safeguarding children within this partnership structure.

Protocols are in place to maintain healthy working relationships with the Children's Trust; the Safeguarding Adults Board; the Safer Oxfordshire Partnership and the districts' Community Safety Partnerships in particular. The newly created 'Strategic Partnerships' post within the Business Unit has developed these working relationships through formal protocols and operating frameworks for key safeguarding issues such as taxi licensing and the transport of vulnerable children, which need a wide ranging and strategic approach.

Oxfordshire Children's Trust
The OSCB has a strong relationship with the Oxfordshire Children's Trust, which is responsible for developing and promoting integrated frontline delivery of services which serve to safeguard children. The Chair of OSCB is a member of the Children's Trust and the Chair of the Children's Trust sits on OSCB. The Children's Trust has produced a Children and Young People's Plan which sets out its priorities, including a focus upon early help, and how these will be achieved. The Children's Trust and the OSCB share performance monitoring arrangements to ensure a cohesive approach and collective oversight.

The OSCB is formally consulted as part of any commissioning proposals regarding safeguarding children made by the Children's Trust. OSCB presents its annual report to the Children's Trust outlining key safeguarding challenges and any action required from the Children's Trust.

The Health and Wellbeing Board (HWB)
The Health and Wellbeing Board brings together leaders from the County Council, NHS and District Councils to develop a shared understanding of local needs, priorities and service developments. The OSCB is formally consulted as part of any commissioning proposals regarding safeguarding children made by the Health and Wellbeing Board. OSCB reports annually to the Health and Wellbeing Board and will hold it to account to ensure that it too tackles the key safeguarding issues for children in Oxfordshire.

Police and Crime Commissioner
The Police and Crime Commissioner (PCC) is an elected official charged with securing efficient and effective policing in the area. OSCB presents its annual report to the PCC outlining key safeguarding challenges and any action required of policing in the area. During 2015/16 the Police and Crime Commissioner actively supported the multi-agency work focussing on vulnerable adolescents at the OSCB annual conference.

Safer Oxfordshire Partnership
The Safer Oxfordshire Partnership aims to reduce crime and create safer communities in Oxfordshire. It has a co-ordination function. It is supported in this task by the district level Community Safety Partnership (CSPs), which develop local community safety plans for their areas and are accountable for delivery.

A core part of the role of Safer Oxfordshire is to distribute funding from the Police and Crime Commissioner to support our community safety priorities: training for domestic abuse champions across the county; raising awareness of Child Sexual Exploitation and Female Genital Mutilation with local practitioners; activities to engage young people and prevent them from engaging in Anti-Social Behaviour and from entering the criminal justice system; education and training opportunities for ex-offenders with drug and alcohol problems; and training on preventing extremism for frontline staff.

Priorities for 2016-17 are to reduce: anti-social behaviour; levels of re-offending, especially young people; the harm caused by alcohol and drugs misuse; the risk of extremism and hate crime; violence and serious organised crime and to protect those at risk of abuse and exploitation.

Health Economy
Oxfordshire's Clinical Commissioning Group (OCCG) is an important contributor to the OSCB. The OCCG and local health provider's work together to lead a health advisory group to engage health professionals in the safeguarding work of the board. The local area team (NHS England) supports this. The Oxford University Hospitals Foundation Trust and Oxford Health NHS Foundation Trust are key partners on the Board and important providers within the Oxfordshire safeguarding system.

Community safety partnerships
The community safety partnerships deliver projects that aim to cut crime and the fear of crime. Based in each district or city council area partners from the local authority, police, probation services, housing, fire and rescues services, the environment agency, the health sector and voluntary sector jointly tackle crime and safety issues. The OSCB partners have worked hard this year to align our safeguarding work. District colleagues are integral to the safeguarding work on child sexual exploitation; engagement with the community and voluntary sector and safer transport. Arrangements have been made for better representation on the Board of these key partners.

Oxfordshire Safeguarding Adults Board
The Board leads on arrangements for safeguarding adults across Oxfordshire. It oversees and coordinates the effectiveness of the safeguarding work of its member and partner agencies. As a strategic forum it has three core duties: to develop a strategic plan; publish an annual report and commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these. Partners include adult social care, trading standards, the Police, probation services, fire and rescue services, health commissioners and providers, the voluntary sector and Bullingdon Prison.

OSCB voluntary and community sector members

We are the VCS (voluntary and charity sector) representatives on the Oxfordshire Children's Safeguarding Board (OSCB).

Clive Peters

Former Headteacher of an Oxfordshire Special School and Head of the Oxfordshire Physical Disability Service, he retired in 2007. He is presently a governor of two Oxfordshire schools, where he is the governor link for Safeguarding issues.

Clive is also a Trustee of the Oxfordshire Outdoor Learning Trust (OOLT) (www.oolt.org.uk) and of the Borien Educational Foundation for South Africa (BEFSA) (www.befsa.org)

Simon Brown

Simon Brown is CEO of The FASD Trust, an Oxford based charity, which he founded with his wife.(www.fasdtrust.co.uk) It has grown from humble roots in Witney to be the UK's leading charity in this field, supporting thousands of individuals and families affected by FASD (foetal alcohol spectrum disorders) not only in the UK, but increasingly overseas.

Simon is also one of the Directors of The Oxford Foundation for FASD, (www.oxfordfoundation-fasd.com) a project of The FASD Trust, engaging with professionals and encouraging research in the field of FASD. Simon has experience from engaging at Governmental level (see www.appg-fasd.org.uk) to on a personal level being a "service user" as dad of a child with special needs. Simon and Julia have 3 children, two of whom they originally fostered.

Romy Briant

Romy Briant has worked across the statutory and voluntary sectors. She qualified and worked as a social worker in child protection in South London, and subsequently worked as a volunteer in Oxford developing community projects and resources with a focus on special needs and inclusion. More recently she has been director of Relate Oxfordshire, Chair of Home-Start Oxford and founder trustee of Reducing the Risk of Domestic Abuse www.reducingtherisk.org.uk which she currently chairs. She has represented the voluntary sector in Oxfordshire on various Partnerships including OSCB.

She now deputises for Clive and Simon – and is voluntary sector representative to PAQA and to the Safer Oxfordshire Partnership Oversight Committee and the Oxfordshire Partnership.

Our collective role on OSCB is to ensure:

- The VCS' voice is heard
- The sector's local knowledge and expertise helps enable the Board to meet its and our safeguarding responsibilities
- Decisions being made draw on the cumulative expertise of the sector and take into account the unique and, in these times of austerity, increasingly valuable role that the sector plays in the provision of services to some of the most vulnerable members of our society.

We are mandated to bring our own voluntary sector perspectives to the Board and, where possible, to consult on substantial issues with the wider VCS. This is undertaken through on-line communication and regular meetings of OCVA's Children and Young People's Forum which is facilitated by Gillian Warson (gillian.warson@ocva.org.uk). Reciprocally we act as a channel of communication from the Board to the sector.

Lay Members

Working Together 2015 sets out a requirement for all LSCBs to have at least two Lay Members on their Board, operating as full members of the LSCB, participating as appropriate on the Board itself and on relevant committees. In 2015/16, the OSCB has been fortunate to have had two Lay Members representing the local community: Clare Periton and Modupe Adefala.

Clare and Modupe have continuously demonstrated their commitment to improving safeguarding outcomes for children and young people and have challenged (sometimes easier said than done) the views and assumptions of partners round the table. They have provided a public voice on the board, bringing diverse perspectives and local concerns to discussions.

Modupe Adefala has left the OSCB during this year but played an important role in board meetings often offering the voices of reason, challenge and calm. We thank her for the contribution that she has made. The post will be recruited to in 2016/17.

Clare Periton

Throughout my career I have been committed to contributing to safeguarding vulnerable people, and am grateful to be able to extend this commitment as a Lay Member on Oxfordshire's Safeguarding children Board. As a Lay Member, I am in a positon which is independent from any of the organisations that attend, it is therefore imperative that I exercise my right to ask questions and to make suggestions. I have been a board member for over 4 years and whilst I always attend with constructive, sometimes critical observations, I have always left impressed by the joint ambition of all agencies around the table to work and learn together to promote the welfare of children and young people and to do their upmost to protect them.

	Projection as at July 2015	Actuals as at July 2016
Funding streams	£	£
OCC Early Years funding	-14,465.00	-19,250.00
Public Health Risky behaviours	-31,625.00	-31,625.00
Contributions		
OCC Children, Education & Families	-196,610.00	-196,610.00
OCC Dedicated schools grant	-64,000.00	-64,000.00
Oxfordshire OCCG	-60,000.00	-60,000.00
Thames Valley Police	-21,000.00	-21,000.00
National Probation Service	-2,500.00	-2,500.00
CRC	-2,500.00	-2,500.00
Oxford City Council	-10,000.00	-10,000.00
Cherwell DC	-5,000.00	-5,000.00
South Oxfordshire DC	-5,000.00	-5,000.00
West Oxfordshire DC	-5,000.00	-5,000.00
Vale of White Horse DC	-5,000.00	-5,000.00
Cafcass	-500.00	-500.00
Public Health	0.00	0.00
Total income	**-423,200.00**	**-427,985.00**
Expenditure		
Independent Chair	36,000.00	40,715.00
CRAG chair	1,100.00	1,650.00
Business unit	270,000.00	255,000.00
Comms	10,000.00	10,000.00
Training & learning	50,000.00	53,000.00
Subgroups	10,000.00	12,366.00
All case reviews	75,000.00	65,000.00
Total expenditure	**452,100.00**	**437,731.00**
Use of reserves:	**28,900.00**	**9,746.00**

Financial arrangements

Board partners contribute to the OSCB's joint budget as well as providing resources in kind. The original funding for 2015/16 was projected to be £423,200 – the actual was £427,985. This increased a small amount due to extra funds to cover early years training. This figure does not include the funding of the Oxfordshire Child Death Overview Panel which is funded through Oxfordshire Clinical Commissioning Group. The Board has agreed to carry forward the low level of reserves from 2015/16 to the 2016/17 budget and is revising its forward plan.

Chapter 3: Progress made in 2015 /16

The OSCB child protection partnership in Oxfordshire is active and committed to ensure the wellbeing of the most vulnerable children. This section provides an account of progress made against priorities in the last year and assessment of where there is need for further work.

Aim 1: to provide leadership and governance

Priorities: partnership arrangements, community engagement and involving parents and carers

Why these priorities?

The OSCB is a transparent and effective partnership. It has an important role to challenge the Children's Trust to ensure that the Trust delivers effective services against a backdrop of reduced resources. The 'impact assessment' carried out by Board agencies in 2015/16 enabled services to fully consider the impact of cuts on the delivery of a range of services. This was a helpful assessment of the local provision. The Trust now has the responsibility to manage increased demand, reduced resources and remodelling of services.

The board extended its reach to secure robust safeguarding arrangements; fair representation; working protocols and clearly understood priorities. It placed a priority on increasing engagement with the voluntary, community and faith sector to promote key safeguarding messages through training and to increase representation on the board and its subgroups. OSCB partners also wanted to ensure that the voice of children, parents and carers remains central to safeguarding work.

Progress includes the new protocol for partnership arrangements working to support children across the county; new voluntary sector representatives on the Board and Subgroups; focus group with faith and community groups on raising awareness of child sexual exploitation; involving parents and victims in the OSCB's county wide learning events following serious case reviews and ensuring that the voice of children and parents is in the revision of the OSCB child sexual exploitation training materials, new community engagement framework across children and adult services.

What young people have told us

Sexting – views of young

Focus groups about sexting were carried out which highlighted that this is a concern for most young people. Many have seen explicit images and are aware of the risks involved, in terms of personal reputation, future prospects and also personal impact e.g. bullying, self-harm, low self-esteem. Knowledge of the law is inaccurate. There are gender differences with girls feeling in a 'no win' situation. Both boys and girls are affected by peer pressure, expectations and this is sometimes coercive. Young people felt current education isn't effective and isn't changing their behaviour. Recommendations included confidential, single-sex, relationships education delivered by those other than school staff.

HBT bullying including supporting Trans children and young people – views of young people

Last year's online bullying survey indicated that LGBT children and young people are the most vulnerable group in terms of bullying and feeling unsafe (young people identifying as LGBT are almost 12 times more likely to feel unsafe in the classroom). Anecdotal evidence from young people is that if their school openly acknowledges same-sex relationships and provides information about being transgender, this has a huge positive impact.
Young people (consulted at Oxford Pride) spoke about SRE being delivered without any discussion of same sex relationships. They described a lack of information meaning that they had to educate themselves by looking on the internet. Some young people described bullying and abuse as a result of their sexuality or gender. Several said they didn't feel safe to 'come out' at school. When asked what would help, inclusive SRE was mentioned several times – to have their gender or sexuality acknowledged would help them feel accepted and able to be themselves.

Over the last year there have been a number of sounding boards; workshops and the OXME.info website. Here is a short summary of views:
Young people want more confidential, single-sex, relationships education delivered by those other than school staff. They want it to better address single sex relationships and provide information on being transgender. They want more information so that they don't need to rely on the internet.

"*You know everything about me; I know nothing about you*." Young people, in particular those in care, want to know the professionals who know them. This builds trust.

Issues such as sexting, bullying, care plans and reviews as well as sexual health issues such as access to condoms, consent, safer sex have been raised by children in care

Concern that services for young people are being cut and having somewhere to go and 'hang out' that is "*warm and safe*"

Being able to air views – on line, face to face or in forums is important. They would value an Oxfordshire-wide forum for sharing views

Aim 2: to drive forward practice improvement

Priorities: working to address neglect, working to safeguard adolescents and monitoring the effectiveness of training.

Why these priorities?

Neglect is the most common reason for a child to be subject to a child protection plan; board members and practitioners are signed up to this as an area for improvement. Safeguarding adolescents is a priority due to issues arising through case reviews. Practitioners have identified the need for better sharing of information, more training and resources on these 'high risk' issues. Finally the OSCB is determined to improve the effectiveness and impact of training.

Neglect: what progress has been made?

Five work streams were identified;

- **Strengthening core groups** as part of the child protection planning process: simple things such as ensuring meetings take place as planned by arranging a 'deputy' to cover in a social worker's absence; ensuring that there is consistent, good quality administration so that all parties know what has been agreed.
- **The use of tool kits**: professionals are developing better 'tools' to support assessment, analysis and intervention across children's services. The scope of this work also includes a review of 'CAF/TAC' and how partner agencies are supported when working with families.
- **Transition and transfer**: The neglect pilot developed a 'transition's meeting' which is a forum where all cases requiring additional resources and services and cases moving in/out of the service through partner agencies or moving between social care teams are discussed. This good practice is to be rolled out.
- **Early identification of neglect**: Oxford Health NHS FT, Childrens Centres, Children's Social Care and Oxford University Hospitals are working together to improve identification of neglect as it has become clear that the current 'neglect tool' is not widely used across partner agencies.
- **Training** is being developed to support this new work.

Neglect pilot: working to support better outcomes for children on Child Protection Plans for neglect – what families told us…

'The North Pilot' ran in the north of Oxfordshire for 6 months in 2015. It sought to establish more effective ways of working to support better outcomes for children on Child Protection Plans for neglect. Interviews were conducted with six families that were involved in the pilot. Some of the key findings from **talking to families** are that: their engagement is the critical factor in enabling change; ensuring there is capacity for practitioners to deliver intensive support to support, and test a family's capacity for change is vital to instigating positive change in complex families and that planning for the needs of the whole family is vital to achieving better outcomes.

A day in the life of an Independent Reviewing Officer… a typical day full of many emotions.

Its 7.45am. Time to start. I have two hours before my first meeting of the day. There is an email to tell me the child protection plan from yesterday's conference is ready for me to approve. I review the tasks, the actions and the outcomes, which takes just under an hour.
I have two social work reports for today's second review of two children in care. The two young children currently have separate placements, which is better for them. Having given full consideration to other options the long term care plan is for them to become adopted although that decision will rest with the courts. A lot of work has been done with Mum. She has had a lot of support to improve her parenting but is not able to do this – it is a sad case as I have known the family for some time. I read the report thoroughly, thinking if any further questions need to be addressed and if any matters are unresolved.

After checking travel details I set off. I am seeing each child separately followed by mum. The first meeting is attended by the foster carer, her worker, the child's social worker and me. We also have a report from the nursery and the health visitor so can take on board many views. The child is at nursery today which enables the foster carer to concentrate on the meeting – I will of course be seeing them as part of this process. We talk through the care plan and the social worker confirms that the plan is for adoption.

It's now 12.30, a quick lunch before heading off to see the younger sibling, who is some 40 minutes away. Once I am inside and introductions are completed we begin. Both children have the same social worker which is as it should be; the child clearly knows who she is and gives a big smile. The child plays happily – laughing and chuckling throughout the meeting. I leave this meeting feeling that there are undoubtedly unresolved issues but they are happy and settled living in a well-structured, safe, stimulating environment.

The final part of this review is the meeting with mum at 3.30pm. I arrive back at the office with time to review the day so far. As I study my notes and the local authority's care plan I fully consider the decisions we are making. I am clear that Adoption is the best way to provide stability and security for the children. The social worker comes for a discussion prior to mum arriving. We are aware that we have distressing information to convey. We agree the best way to talk through the children's progress and the proposed care plan for them – we know that this will be hard news to hear.

Mum arrives in good time. Once in the meeting room we chat and she tells us about her plans for the day. I update her on the children's progress talking in detail about each child one by one. We then move onto the care plan. I begin by explaining the court process. I then tell her that assessments had been completed and that the local authority was recommending to the courts that the children are adopted. I make it clear that the decision rests with the courts. Mum says that she had seen this information - the social work report was ready some ten days ago. It is difficult for her and she becomes tearful but is controlled. I ask her if she feels able to support the plan. She says that she does as long as she has face to face contact with the children. The social worker lets her know the date that they were meeting in court and that this would all be discussed further. Once Mum has left the social worker and I discuss the meeting. We are both subdued as it is difficult news for Mum but we feel that our conversation went as well as it could. The decisions have not been taken lightly but they were in the best interest of the children.

I am now in the office; it's just after 4.30pm. I return to my emails and do some case notes. At 5.35pm I sign off for the day. It has been a typical day - full of many emotions.

Improving mental health services for young people

The OSCB Stocktake Report on child sexual exploitation in July 2015 recommended that there should be better access to therapeutic services for survivors of child sexual exploitation. **The Horizon service** was launched early 2016; this is a service for young people and their families who are experiencing distress as a result of sexual harm and works with partner agencies to provide a comprehensive and consistent service for those children who have experience sexual abuse and exploitation. This mental health service works alongside Safe!, a voluntary sector group, funded by the Police and Crime Commissioner and provides a range of services to young people in need. It is already proving to be a valuable part of the service provision in Oxfordshire. Adult Social Care are funding a new service to support vulnerable adult survivors to access therapeutic and other services.

Over the last year the Trust has further developed services for high-risk young people, offering several closely-coordinated services for young people who present with high-risk behaviours, or who come into contact with the youth justice system. The services include: **Forensic CAMHS** for young people who show a range of risky behaviours towards others; **Child & Adolescent Harmful Behaviour Service** (CAHBS) for concerns in relation to sexualised or sexually-harmful behaviour; **Criminal Justice & Liaison Service** for concerns in relation to mental health or neuro-developmental difficulty at the first point of contact with the youth justice system; **Horizon** which aims to restore sense of safeness and well-being for those experiencing distress as a result of sexual harm.

Other developments over the last 12 months include the offer from CAMHS to secondary schools to increase mental health professional input and resource within all Oxfordshire mainstream secondary schools. In partnership with OUH colleagues CAMHS have been piloting an Autism Diagnostic Clinic. The aims are to streamline the referral, assessment, diagnosis and maximise the health outcomes of children and young people through direct engagement with the specialist multidisciplinary professionals working within the CAMHS team, in collaboration with other disciplines within specialist paediatric neuro-disability services and children's community therapies.

The service is launching a new model specialist CAMHS **Eating Disorder Service** summer 2016 which aims to see and begin treating children in two weeks of referral.

Making sure that children in care and care leavers are safe, securely attached and in education

The county council has increased local capacity to respond to the most risky and vulnerable. The increase in the county's own pool of foster carers, particularly for the hard to place, is the most critical part of placement strategy. Over fifty new carers were recruited. The county developed a "Mockingbird" model of support for them, which enables a hub co-ordinator to support six to eight other carers. In addition a 'residential pathway' is being set up so that the County Council has the capacity to move young people around when the group dynamics are not working.

Ensuring that supported housing is offered to the most vulnerable is essential to a young person's safety. The county council and its partners have developed a robust "supported lodging scheme" for those young people who still want family links. The intention is to further develop this by training supported lodging hosts to deal with CSE risks. Part of this includes helping young people help themselves when they are in a particularly destructive cycle e.g. enabling them to be away from Oxfordshire.

The workforce is responsive and able to step in to prevent family or placement breakdown. The 'residential edge of care service' has at least 8 staff on every weekend providing support in the community which is due to double in 2016/17. They are able to work up to 10pm on weekday evenings. Similarly there is increasing support to foster carers in out of office hours.

The 'residential edge of care service' is now working with 270 families. They work with schools, especially for those who are persistently absent or have been permanently excluded, to keep children on the school roll and to develop alternative education across the county.

Making sure that children in care and care leavers are safe, securely attached and in education

Oxfordshire maintains a significant investment in specialist therapeutic and counselling services for looked after children recognising the importance of placement stability for securing good long term outcomes. There is an embedded understanding that placement breakdowns are both traumatic to our children and can put extreme pressure on budgets. For example adoption placement breakdowns can lead to children being placed in residential settings. The cost of one of these placements for one year is comparable to the full cost of the ATTACH service. The REoC service has now been set up to offer the same level of support to children on the edge of care to safeguard them, improve their outcomes and avoid significant placement costs.

There is a need for tighter evaluation of the impact and outcomes of all looked after children therapeutic provision moving forward. Partners will be developing a therapeutic model across the whole of corporate parenting which will measure the impact of interventions on initial, mid and long term outcomes. This will enable partners to assess whether interventions are having a sustainable impact. Partners are continuing to develop the tracking and monitoring of Strength and Difficulty Scores, and using outcomes stars so that children and families are feeding back whether interventions are making a difference.

Development of transgender work and work to combat HBT bullying

The county council's HBT toolkit has been updated to include guidance on supporting transgender students in school. The county council is currently working with Stonewall and with other local authorities to provide a national trans toolkit for schools which is due for publication in September. Local case studies are being written to supplement the national guidance which will also include a local pathway for support via CAMHS. A workshop on supporting trans children and young people was provided at the Managing Bullying Effectively workshop. Inclusive SRE training for schools and school health nurses has been provided to 7 primary and 18 secondary schools (including training delivered to 20 school health nurses). Training and insets on HBT bullying have been provided both centrally and to individual schools including a specialised inset on supporting transgender children. Other work includes the development of a drama piece by young people to raise awareness about HBT bullying; work with a local LGBT youth group to develop a film resource; work to develop inclusive SRE resources.

Understanding the impact that sexting has and how to support young people

National guidance on sexting to support schools with managing an incident has been promoted via the Safeguarding and Anti-Bullying networks. The Anti-Bullying Co-ordinator and Thames Valley Police have worked together to run the sexting project, involving 4 Oxfordshire schools. Recommendations include development of a resource pack, a survey and supporting schools to review their provision of Sex and Relationships Education to include education on sexting in the context of healthy relationships. Work is ongoing to develop resources and TVP are reviewing their procedures.

Ensuring the safe transportation of vulnerable children: Joint Operating Framework for Transporting Children/Adults with Care and Support Needs and Taxi Licensing in Oxfordshire

The Joint Operating Framework provides a single set of minimum standards for agencies with responsibilities for transporting children/adults with care and support needs in Oxfordshire, including addressing vetting, training, awareness raising, information sharing, policy alignment, enforcement activity and quality assurance and monitoring. The framework is shared by the county and district councils and Thames Valley Police.

It has been developed as a result of the learning from the Bullfinch investigation into historical child sexual exploitation in Oxford, the subsequent Serious Case Review into child sexual exploitation of Children A-F (published in March 2015) and the findings of the Stocktake Report set up to review Oxfordshire's current approach to tackling child sexual exploitation (published in July 2015).

Improving conversations on consent

Work has been done to understand the level of health practitioner 'knowledge and attitude' to consent. It was initiated as a result of the serious case review into child sexual exploitation and covered a wide range of professionals, including GPs. It considered how effectively consent is discussed with young people seeking sexual health advice. The findings were positive: the majority of health professionals have a good understanding of consent but some areas of improvement were identified. This has led to training for a range of professionals including independent school nurses and pharmacies who provide hormonal contraception; the development of resources for practitioners and improved access to safeguarding advice for Pharmacists through GPs and nurses. Sexual health professionals have worked on and now co-deliver the OSCB course on sexual health awareness and consent.

A day in the life of a Sexual Health Outreach Nurse.

My work is with young women, who are at risk of unplanned pregnancy, have the potential for poor sexual health and frequently have intimate relationship difficulties. They are all vulnerable in some way. Many could be described as "hard to reach" as they do not always recognise the risks they are exposed to. Most of the clients are under 18 but sometimes I work with young women who are under 24. They tend to be people who find it hard to access services due to where they live or though lack of confidence or mental health problems. Some are teenage parents; others may be in care or have left care; they may be receiving support from the youth justice service or there could be concerns that they are at risk of or experiencing sexual exploitation or abuse.

Referrals come from school health nurses, midwives and family nurses, health visitors, social workers, specialist nurses, the Kingfisher Team, and sometimes from colleagues within the Sexual Health Service in Oxfordshire.

My work takes place in a range of locations including schools and Pupil Referral Units (providing Governing bodies have agreed to my service in their school), client's homes, Early Intervention Hubs and Children's centres, GP surgeries and health premises. An acceptable location is negotiated with the client; most arrangements are made by text message. A typical consultation can take over an hour. During this time the reason for the referral is explored and information gathered about medical history, sexual history, social circumstances, family structures, friendships and support mechanisms noted. The aim of this first visit is to establish a good rapport and trust between client and practitioner. It is important to give the client a sense of self determination and choices in their care, whilst trying to give accurate and relevant advice, and maintaining professional curiosity. A risk assessment (Spotting the Signs) is always done for under 16s, and if indicated for under 18s, to explore any possible pressure or coercion in their relationships or other possible abuse. Supporting clients to manage the pressures experienced via the internet and social media is a growing part of my role. The concept of consent or agreement to sex is discussed fully. Domestic abuse within the relationship is also assessed using appropriate assessment tools, and referring on as required. The limits of confidentiality must be made clear from the outset as I will need to share information with other professionals if issues of concern arise in consultations.

The consultations can include advice about contraception methods, teaching clients how to use and issuing contraception (all methods apart from Intra Uterine Contraceptive Devices IUCDs), Chlamydia Screening tests, and arranging follow up visits as needed. Many of these young people have difficult lives and challenging circumstances, so being able to provide a listening ear is a very important part of the role. Suggesting other professionals who may be able to help and making referrals is part of my role. The ability to network, and understand the different priorities and agendas of different organisations/ services is an essential part of this role. At the end of each day I then have to document all of my appointments, including analysing what I have assessed, and planning future interventions. Documentation via electronic systems is invaluable, as this enables all professionals who come into contact with the client within the service to have up to date information.

Sometimes I only need to see a person once, but often I will work with them over a period of time to ensure they are safe, supported and can access other services before I discharge them. Some clients are referred but then decline to see me. When this happens I will inform the referrer that I have been unable to follow up the client – this is vital to ensure no child gets "lost" in a system, without the necessary interventions. It is rewarding when a young person can be helped to take some control and feel healthy and safe in their relationships.

Improving practice through safeguarding messages

Promoting awareness of child sexual exploitation

Say Something If You See Something and Hotel Watch are both national programmes to raise awareness of child sexual exploitation amongst key industries including taxis, hotels, guest houses and bed and breakfast providers and licensed premises and to ensure they know how to recognise signs of child sexual exploitation and when and how to report concerns. There is a county-wide roll out of both programmes which is being successfully led by the City Council and district councils and local police areas.

Promoting awareness of staying safe

The NSPCC's 'Speak Out Stay Safe' programme visits primary schools across Oxfordshire to give children the knowledge and understanding they need to stay safe from abuse. Delivered by volunteers it educates children about all forms of abuse and how to speak out about it safely. The programme has visited over 150 primary schools and reached 9,910 children across Oxfordshire. Children have said that the programme is: "*A fun way of learning*", "*It deepened my understanding about what ChildLine does and how it helps people*", "*It was good for learning about things you may not have known*"

One of the volunteers, Philippa Radford, is based in Oxfordshire and says:

"The Schools Service assemblies and workshops give children a chance to understand what is right and wrong. It teaches them that they have a choice and that they can get help if they need it. The programme protects children from harm by giving them all an opportunity in their school environment to listen, watch and discuss issues of abuse.
Volunteering is rewarding on many levels. I have especially enjoyed being part of a team, gaining new skills and knowledge. It is a wonderful opportunity to work with children to help prevent abuse. The primary schools and teachers are always welcoming and enthusiastic about our service."

Raising awareness of self-harm: 'Under My Skin' by the Pegasus Theatre

This is a Public Health funded pilot project to raise awareness of self-harm and support services for young people using a theatre based intervention provided by Pegasus Theatre. The play was performed in a total of 28 schools (including 1 special school) and reached a total of 5,049 young people in Years 8 and 9 in Oxfordshire. 50% reported the play increased their knowledge of self-harm a lot. 71% of young people knew how to access support after seeing the play

Learning and improvement work

Resources for practitioners:

- ✓ Child development tool for assessing and tracking neglect
- ✓ Updated child sexual exploitation screening tool
- ✓ Medical advice for parents considering male circumcision
- ✓ Updated screening tool for female genital mutilation
- ✓ Revised self-harm guidelines
- ✓ New referral pathway for young people at risk of domestic abuse
- ✓ Mental health learning summary
- ✓ Homosexual, Bi-sexual and Transgender toolkit updated to include guidance on supporting transgender students in school
- ✓ National guidance on sexting to support schools with managing an incident
- ✓ Schools and settings prevent checklist

OSCB Training

The OSCB delivers over **150** free safeguarding training and learning events plus online learning each year. The training is overseen by a multi-agency subgroup. In 2015/16 the training reached over **9000** members of the Oxfordshire workforce.

Over 85% of delegates report that they have found the training good or excellent.

Most of the training is delivered by a volunteer training pool comprising members of the children's workforce and is free to the practitioner.

'Thank you to Oxfordshire's volunteer trainers!'

Learning events were run for over 1,000 practitioners

Child sexual exploitation: powerful presentation by a mother and (now adult) child on being a victim of child sexual exploitation. Practitioners received a summary of the review and were made aware of a training pack on the views of families which was put together following another review in to child sexual exploitation.

Adolescents and risk: learning from recent serious case reviews - this included a play from the Producers of Chelsea's choice about sofa-surfing, which vividly highlighted the risks that adolescents are exposed to. Professor Ray Jones set the context and Jenny Pearce highlighted the issue of consent and coercive behaviours.

Young people at risk of domestic abuse: learning from a serious case review / domestic homicide review launch of the new referral pathway for young people at risk of domestic abuse.

Aim 3: to quality assure and scrutinise the effectiveness of practice

Priorities: to test if the learning is embedded across the child protection partnership and to scrutinise how well partner agencies' arrangements can show improvements

Why these priorities?

The OSCB evaluates the effectiveness of the local safeguarding system to ensure that children and young people are kept as safe as possible. Over the last few years a significant amount of learning has been achieved. The OSCB is using its local framework to test this. The current priority is to scrutinise procedures for escalating safeguarding concerns; supervision of workers supporting vulnerable young people as well as the recording and reporting of multi-agency meetings.

What progress has been made?

OSCB Child sexual exploitation stocktake and report to the Department for Education;

The child protection partnership was jointly assessed this year on how effectively it responds to child sexual exploitation in Oxfordshire. In March 2015 the OSCB published the A-F Serious Case Review which identified a considerable amount of learning, which was communicated through two multiagency events. Following this the OSCB Independent Chair was asked by the Children's Minister and Ministers from the Home Office and Department of Health to provide an update on the impact of services to tackle CSE across Oxfordshire. This 'Stocktake report into progress made in tackling child sexual exploitation in Oxfordshire', which was supported by an Independent commentary by Sophie Humphreys, a government adviser, was published in July 2015.

The 'Stocktake' demonstrated that the partnership in Oxfordshire had moved a long way to address the problem of child sexual exploitation, identify collective solutions and produce some tangible evidence of impact. The independent government adviser commented, '*the key noticeable difference that was shared by all was that that the partnership is reflecting a more curious approach in its safeguarding arrangements*'.

In March 2015 following the successful Operation Reportage Investigation and criminal trial the OSCB commissioned a review of practice to identify any further learning. This review was signed off by the OSCB in October 2015. The review, like the Stocktake, listened to children and parents. It involved two multi-agency events for professionals and led to a learning summary for professionals, which was published January 2016.The review was able to demonstrate tangible progress in Oxfordshire and as one child said *'It wasn't just a job to them. They were in it for us.'*

Operation Reportage and the Learning Review to test Oxfordshire's approach to child sexual exploitation

Operation Reportage was the first major investigation following the establishment of the Kingfisher Team in Oxfordshire and led to successful prosecutions of a number of men involved in grooming and abuse of a number of children. The OSCB commissioned a learning review which identified significant improvements in how all the partner agencies were working and evidence of learning from the A- F Serious Case Review. Children were positive about the support they received from the Kingfisher Team. The process of the learning review included practitioner sessions which were in themselves important learning opportunities.

Children's voices and parents' voices were central to the learning review and their messages have been used in the development of the refreshed CSE strategy and action plan. A Children's voices training and development tool has been produced and published on the OSCB website.

Checking the effectiveness of joint working through audit

The three multi-agency audits domestic abuse, child sexual exploitation and 'Education, health and Care Plans' for children and young people with learning difficulties or disabilities (aged 0 to 25) highlighted some positive practice in safeguarding arrangements:

- ✓ Good child, young person and family involvement. It is recognised that parents and carers of the children are key partners in keeping them safe and that the needs of other children should also be taken in to account;
- ✓ Children are listened to, believed and drive planning; in particular health partners demonstrated strong evidence of the voice of the child through a persistent approach;
- ✓ Strong partnership between agencies. Good evidence of assessment; communication; information sharing;
- ✓ Dynamic meetings taking place behind plans and some examples of good immediate action.

The audits also highlighted a number of areas for learning and improvement, including:

- Management oversight; whilst the section 11 showed that there are supervision processes in place an audit of records has highlighted that managers need to help assess risk and look at the bigger picture;
- Using practice tools for risk assessment can support the work of practitioners, for example the neglect tool, CSE screening tool or working with drug using parents but they often don't get used or used inconsistently;
- Information sharing whilst there is significant evidence of good practice there are still some gaps – this includes being more vigilant as to when children and young people are subject to a child protection plan or identified as children in need;
- Points of transition between services; evidence suggests that there is room for improvement.

Scrutinising OSCB agencies' safeguarding practice

Each year the OSCB runs a safeguarding self-assessment for all statutory partners. This year the returns demonstrated good compliance and regard to safeguarding practice as well as positive direction of travel. A peer review was held with all partners to ensure that they had the evidence to back-up their self-assessments. Key multi-agency messages can be summarised as follows:

Escalation – the OSCB can be assured that agencies can reference their internal escalation process and/or adhere to the OSCB multi-agency escalation process. However, agencies struggled to quantify how much escalation goes on due to a lack of recording or the use of informal escalation pathways.

Supervision – the OSCB can be assured that agencies have supervision arrangements in place and most ensure that safeguarding issues form a standing item on their supervision.

Transport – relevant agencies are showing progress in improving arrangements to transport vulnerable children and intend to report more closely against the Oxfordshire's Joint Operating Framework for transporting children and adults with care and support needs in 2016.

Assurance of practice in Commissioned Services – there are mechanisms in place to check safeguarding practice within commissioned services. Areas for improvement (for providers, which by and large are from the voluntary and community sector) were noted as the need to:

- create ways of involving children & young people and their families in the development of policies and practices;
- better understand the PREVENT agenda and how to incorporate this into internal safeguarding policies and training;
- better understand the multi-disciplinary tools available and the participation in safeguarding processes, in particular, the Common Assessment Framework (CAF).

In 2016/17 the OSCB and the Oxfordshire Safeguarding Adults Board will undertake a single assessment of safeguarding practice for both vulnerable children and adults.

The Joint Targeted Area Inspection

The child protection partnership was jointly assessed this year on how effectively it responds to abuse and neglect in Oxfordshire. The headline judgement was that Oxfordshire now has '*a highly developed and well-functioning approach to tackling exploitation'* provides an important external judgement on an area of work that has been a key priority for the Oxfordshire Safeguarding Children Board in recent years. This builds on Ofsted's judgement in their last major inspection of children's services in 2014 that the OSCB was 'Good'. The report identified a wide range of key strengths and importantly recognised that key agencies have learned lessons from recent investigations into child sexual exploitation and have acted effectively to improve performance. Critically it confirmed that agencies in Oxfordshire understand the needs of children and young people and help them keep safe.

Key strengths identified by inspectors included:

- Strategic leadership from individuals, agencies and the Oxfordshire Safeguarding Children Board (OSCB);
- The Kingfisher Team which provides specialist multi-agency responses to children at risk of exploitation and its links to MASH – the multi-agency safeguarding hub;
- The responsiveness of local authority, police and health services;
- A high standard of inter-agency working with sexually exploited children and a clear commitment to safeguarding children at risk.

The report identifies 16 areas of key strength which include praise for:

- Significant investment from the local authority, police and health agencies;
- Effective leadership and commitment from senior leaders of all agencies led by the Director of Children's Services, the Council's Head of Paid Service and senior politicians;
- Strong collaboration between health providers
- The success of the OSCB in leading the development of robust multi-agency services to exploited children;
- Good oversight of practice by professionals across all agencies;
- Post-abuse therapeutic work
- Clear and coherent disruption activity to identify and tackle perpetrators;
- Work with hotels, taxi drivers and the wider community to identify and report signs of child sexual exploitation;
- Work with young people who repeatedly go missing.

Strengths outweighed areas for improvement. Critically areas for development matched those identified by partners in their own self-assessment of performance and action plans to address these matters are already well-developed. The key focus moving forward will be to translate success with CSE into consistently good standards of practice across all services. Most importantly there is a drive to further develop the 'front-door' into services and to secure consistently good standards of practice across all children's services. OSCB is playing a role in ensuring that the changes to MASH to make it a co-located and virtual partnership with the primary aim being to identify hidden harm will make it better. Attention will be paid to ensuring that the 'front-door' to services works well – that they are timely and offer feedback.

Chapter 4: What happens when a child dies in Oxfordshire

The Child Death Overview Panel (CDOP)

CDOP is a sub-group of the OSCB. It enables the LSCB to carry out its statutory functions relating to child deaths. It carries out a systematic review of all child deaths to help understand why children have died. Child deaths are very distressing for parents, carers, siblings and clinical staff. By focusing on the unexpected deaths in children, the panel can recommend interventions to help improve child safety and welfare to prevent future deaths. The findings are used to inform local strategic planning on how best to safeguard and promote the welfare of the children.

In 2015/16, 79 child deaths were reported to the Oxfordshire CDOP and were discussed with the Designated Doctor for child deaths. 35 of the child deaths reported were of children normally resident in Oxfordshire and 44 of the deaths were of children normally resident in other counties.

In 2015/16 the Oxfordshire CDOP reviewed the deaths of 39 children who usually reside in Oxfordshire. These reviews included 22 deaths that occurred in the year 2015-16 and 17 reviews that occurred before 2015-16 but had been carried over due to alternative processes and investigations that prevented completion of the CDOP process any earlier. The outcomes of panel meetings are twofold firstly to identify the classification of death and modifiable factors. Of the deaths reviewed in 2015/2016, 6 were identified as having modifiable factors.

Preventable child deaths can be defined as “those in which modifiable factors may have contributed to the death. These factors are defined as those which by means of nationally or locally achievable interventions could be modified to reduce the risk of future child deaths. http://www.workingtogetheronline.co.uk/chapters/chapter_five.html

The panel considers all the available information and makes a decision as to whether there were any modifiable factors in each case. These include factors in the family, environment, parenting capacity and service provision. Consideration should be made as to what action could be taken at a regional and or national level to prevent future deaths and improve service provision to children, families and the wider community. When considering modifiable factors the panel is required to make a decision on whether the factors contributed to or caused the death.

In the year 2015-2016 the CDOP panel concluded that in the 39 cases reviewed 6 modifiable factors were identified that contributed to or caused the death.

Modifiable factors identified were co sleeping; consanguinity; smoking and alcohol; suicide; home safety; drowning. As a result of the identified modifiable factors the following specific recommendations were made by the CDOP:

- Maternity Services to audit the advice given to mothers after the birth of their baby, until discharge, re safe sleeping
- Suicide cluster information should be sent to all agency representatives to share within their agencies. CDOP to be kept informed by the Lead Nurse Suicide prevention (Oxford Health) re developments in the service
- Anonymised details re blind cord deaths to share with ROSPA as part of a national data collection and child safety campaign
- Schools and community policing should review the advice they give re swimming and water safety

The Rapid Response Service

CDOP is advised of all child deaths and monitors the response when this involves a rapid response process. In Oxfordshire, the rapid response service, coordinated by a team in the Oxford University Hospitals NHS Foundation Trust commissioned by OCCG, is well established and assists in gathering as much information as possible in a timely, systematic and sensitive manner to inform understanding of why the child has died. In addition its primary role is to ensure bereavement support for the family is initiated and that processes are initiated where there may be other vulnerable children within the family. The rapid response coordination (RRC) team has an on-call rota to cover the service 24 hours a day 7 days a week including bank holidays. The RRC Team provides a safe, consistent and sensitive response to unexpected child deaths up to the age of 18, where the child dies in or is brought to hospital immediately after their death. This culturally sensitive approach provides support to the bereaved parents and family.

In collaboration with the Designated Doctor for Child Deaths (in working hours) the rapid response coordination team ensure families are provided with support in the event of a sudden and unexpected child death. They work collaboratively with other organisations including the Coroner's office, Schools, Youth Projects, Social Care, South Central Ambulance Service, Thames Valley Police, Oxford University Hospitals NHS Trust, Oxford Health NHS Foundation Trust, Helen and Douglas House Hospice and the child bereavement charity SEE SAW, in order to enhance the quality of care provided to all those whose work brings them into contact with bereaved families.

The process ensures that the rapid response team makes a vital contribution not only to the CDOP review but to the immediate response provided in the event of an unexpected child death. This difficult and sensitive work provides robust support for families and professionals in the tragic circumstances surrounding a child death.

In every case in which the death of an Oxfordshire child is unexpected the CDOP officers arrange a professionals meeting. The Designated Doctor for child deaths chairs these rapid response meetings ensuring that the principles underlying the rapid response process are considered throughout by all agencies. These are set out by the DfE:

1. The family must be at the centre of the process, fully informed at all times, and treated with care and respect.
2. Joint agency working draws on the skills and particular responsibilities of each professional group.
3. A thorough systematic yet sensitive approach will help clarify the cause of death and any contributory factors.
4. The "Golden Hour" principle applies equally to family support and the investigation of the death.

Currently families do not attend the Rapid Response meeting however the role of the coroner is to keep them fully informed throughout the process. To this end the notes and actions of the Rapid response meeting are shared with the Coroner and a Coroners officer attends the meeting. In 2015/16, a total of 23 unexpected deaths were reported to the Oxfordshire CDOP and rapid response coordination team. Of these 10 were of children normally resident within Oxfordshire.

Update on recommendations from 2014/15

The CDOP considered issues arising from its review of all the deaths of Oxfordshire children in the year 2014/15. The outcomes of the recommendations by the panel are:

Schools to ensure that road safety education is provided to all pupils:

Road safety advice is provided in schools through a programme called 'footsteps' in Key Stage 1 and the 'Next Steps' in Key Stage 2.

OSCB to advertise training to health professionals re: the issues around young people and substance misuse:

The OSCB have held a learning event covering Substance misuse, this was a multi-agency event and was well attended with good representation across agencies.

Maternity staff to ensure mothers have information on safe sleep guidance and safe nappy sack storage.

The NSPCC leaflet is to be given to all new mothers for information and guidance. An audit on post-natal care and co-sleeping advice reported to the November 2015 CDOP showed that co-sleeping has been discussed with new mothers in 100% of cases, with 88% having been instructed on each contact. The audit tool will be altered in June 2016 to remove the measure for discussion 'at every contact' as this is felt to be unrealistic.

Guidance for schools dealing with suicide clusters to be produced:
Guidance has been produced. There is ongoing work around suicide reduction and development of suicide prevention work led by public health who will continue to inform CDOP of its work.

The importance of taking folic acid in pregnancy needs to be highlighted to new mothers:
Public Health Oxfordshire ran a 'Healthy Mother and Baby' campaign in the financial year 2015/16.

Review of serious cases

A serious case is one where:

(a) abuse or neglect of a child is known or suspected; and
(b) either (i) the child has died;
or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Serious case reviews (SCR)

LSCBs must always undertake a review of cases that meet the criteria for a SCR. The purpose of a SCR is to establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children. OSCB has also been committed to undertaking smaller scale partnership reviews for instances where the case does not meet the criteria for a serious case review but it is considered that there are lessons for multi-agency working to be learnt.

There has been an exceptionally high volume of work on serious case reviews. During 2014-15 three serious case reviews were completed and one was amended and re-published. Seven new cases were brought to the attention of the OSCB for consideration; of these two serious case reviews were commissioned, one was subject to a learning review with partners and the remainder led to no further action by the OSCB. The OSCB has another two on-going serious case reviews: one which is waiting for a criminal investigation to complete and one which has been delayed due to an Independent Police Complaints Commission investigation which is now complete. All **case reviews** and **learning from reviews** can be found on the OSCB website.

The OSCB generates learning about how we can work better together. It takes seriously its responsibilities to ensure that lessons learned from case reviews are disseminated and embedded into frontline practice and used to support improvements across agencies. Themes from reviews this year that are in common with other serious case reviews are:

- Challenges in dealing with inconsistent and neglectful parenting;
- Professionals' lack of challenge or curiosity in relation to self-reported explanations of harm to the child/ren;
- Loss of continuity of service (and records) when families move across boundaries;
- Effective risk management supported by systematic planning across the multi-agency partnership;
- The capacity of adolescents to protect themselves can be overestimated and a tendency to view teenagers as adults rather than children can mean that proactive steps to protect them are not always taken;
- Young people can 'slip through the net' by not meeting criteria for a number of services leaving them in need of help but without support.

Learning points for working together

- Agencies should feedback to Children's Social Care when they do not receive minutes of formal meetings (CP Conferences and Core Groups, and Strategy Meetings) within the required time;.
- Where there are agreed reasons to hold a professionals meeting without a parent, any professional from any agency should be able to request this;
- Effective multi-agency work requires careful joint planning, so that services do not overwhelm the family.

Story of Child J (serious case review / domestic homicide review published in March 2016)

Context

17 year old Child J was killed by her ex-partner in December 2013. A wide range of agencies had been involved with Child J and her family at various times. Child J's mother had quite serious problems of her own and Children's Social Care became involved with the family for two periods of time, alongside several other agencies who also attempted to provide help and support, but with limited long term success. She was for a period identified as a 'Child in Need' and at a later date subject to a 'common assessment framework'. Child J became more and more unsettled, her needs were not being met at home, she was missing school and it is apparent that she was very vulnerable with episodes of self-harm.

Child J became involved in a relationship with a young man (Adult L) who himself had a very damaging early life. Adult L was known to services and had a history of violence, including in intimate relationships. His relationship with Child J was highly controlling, emotionally and physically abusive. Many of the services were aware of the level of risk Adult L posed and her case was reviewed at the local 'Multi-agency risk assessment conference' meeting but attempts to help Child J to leave him were unsuccessful. There were often times when she was homeless or sleeping rough and would contact key professionals hungry and in distress. In the last few weeks of her life Child J was placed in supported housing. Despite attempts by staff to persuade her not to, she arranged to meet Adult L when she discovered she was pregnant. She was killed that night. Although she was reported missing it was several days before the seriousness of the risk to her was properly recognised by the statutory agencies.
Although some individuals worked very hard to help Child J, statutory assessments of her needs were inconsistent and individual work was not supported by a clear multi-agency plan either with Child J or in relation to Adult L.

Responding to the findings

The review highlighted two key findings: the continuing need for services to respond effectively to older children in need of protection and the importance of understanding the impact of domestic abuse within adolescent relationships. However, the review concludes that whatever the actions of agencies, there could be no guarantee that Adult L could have been prevented from killing Child J or any other young woman – either at that time or in the future.

Recommendations for individual agencies have been made as part of the review and these are listed in Annex C of the report. In addition, there are seven multi-agency recommendations for all local organisations with child protection responsibilities. The report highlights the importance of all statutory agencies and voluntary organisations, including housing providers, having a clear understanding of the risks facing older children who are the direct victims of domestic abuse within adolescent relationships.

There are also recommendations for strengthening agencies' approaches towards young people who pose a serious risk of harm to others and that it is vital that these are acted upon by law enforcement and child protection services. Thames Valley Police, Oxfordshire County Council and other agencies have already put in place changes to address the issues. A progress report can be found on the OSCB website

Chapter 5: Challenges and messages for the local child protection partnership

National drivers

- Implementation of the Wood Report;
- Implications of the Children and Social Work Bill 2016-17;
- Implications of reduced resources at a national level.

For the board

- Strengthen partnership arrangements as the Children's Trust function is reviewed;
- Continue to better engage with the voluntary and community sector;
- Continue work to check the impact of reduced resources and increased workloads on services to the most vulnerable;
- Test if learning is embedded from the serious case reviews which have been published in recent years.

For local multi-agency work

- Promote continuity and reduce risk. leaders in Local Authorities, Police and Health should initiate and lead the streamlining and refocusing of functions to provide local assurance, scrutiny and challenge of multi- agency safeguarding arrangements;
- Implement the new Children's services delivery model at a local level;
- Ensure good understanding of thresholds and use resources to understand and work with them;
- Be vigilant to emerging pressure points and concerns: breast ironing; cyber bullying; suicide clusters; safeguarding travelling families; transgender young people.

Key priorities

- Ensure that local partnership arrangements are understood and that the 'front door' for safeguarding concerns for children provides a swift and robust response to all children;
- Protecting younger children from the harm of neglect and parental risk factors;
- Protecting older children from harm;
- Testing if learning is embedded across the child protection partnership

Chapter 6: What next for child protection in Oxfordshire

Children's workforce: We know that the volumes of work in the system are high and that you feel that you are dealing with more complex cases than ever before. We are making service providers aware of this through an assessment of impact of reduced resources.

- Take time to go on training; to check out what we have learnt through case reviews already;
- Use your board representative to escalate concerns;
- Make sure you understand the changing 'front-door' to children's services;
- Keep up to date with emerging issues e.g. breast ironing; honour based abuse; child on child abuse and transgender issues.

Children: we value what you have to say. We understand that LGBT is something that you want to talk more about; that we need to find better ways to talk about healthy relationships, consent and sex; that what we understand as 'sexting' is something we need to be better at dealing with. We know that you want more opportunities to be heard and we will support 'Oxfordshire Youth Voice' to do that.

Key Messages to:

The community, faith and voluntary sector: we know that you want more training; better understanding of how to get early help and better understanding of how to work in partnership to provide early help through a CAF;

Our local community: safeguarding is a shared responsibility. Report a concern if you are worried.

Heads and Governors of schools:

- Take advantage of local safeguarding initiatives: the NSPCC Childline assemblies are still being rolled out in Oxfordshire;
- Check your pupil attendance and take action – we know that Oxfordshire schools could do better on this – know pupils' 'whereabouts';
- Get informed. Know how to deal with concerns like sexting; self-harm; radicalisation; transgender pupils; honour based abuse;
- Use the termly e-bulletin to stay up-to-date on safeguarding issues – this comes directly from the safeguarding in education subgroup of the OSCB and ties you in to current issues in the safeguarding system.

Glossary

CAF	Common Assessment Framework
CDOP	Child Death Overview Panel
CiCC	Children in care council
CRC	Community Rehabilitation Company
EIS	Early Intervention Service
FE	Further Education
HBT	Homosexual, bi-sexual and transgender
LAC	Looked After Children
LGBT	Lesbian, gay, bi-sexual, transgender
LIQA	Learning, Improvement and Quality Assurance (framework)
MAPPA	Multi-agency Public Protection Arrangements
NPS	National Probation Service
OCC	Oxfordshire County Council
OH NHS FT	Oxford Health NHS Foundation Trust
OSCB	Oxfordshire Safeguarding Children Board
OUH NHS FT	Oxford University Hospitals NHS Foundation Trust
PAQA	Performance, Audit and Quality Assurance
PPU	Public Protection Unit within the National Probation Service
QA	Quality Assurance
QAA	Quality Assurance and Audit (subgroup)
SCR	Serious Case Review
SRE	Sex and relationships education
TVP	Thames Valley Police
VCS	Voluntary and Community Sector