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Notice of a Meeting

Performance Scrutiny Committee
Thursday, 8 November 2018 at 10.00 am
Rooms 1&2 - County Hall, New Road, Oxford OX1 1ND

Membership

Chairman Councillor Liz Brighouse OBE
Deputy Chairman - Councillor Jenny Hannaby

Councillors:	Nick Carter	Liz Leffman	Emily Smith
	Mike Fox-Davies	Charles Mathew	Michael Waine
	Tony Ilott	Glynis Phillips	Liam Walker

Notes: ***A pre-meeting briefing*** *will take place in the Members' Board Room at 9.30am on the day of the meeting.*
Date of next meeting: *13 December 2018*

What does this Committee review or scrutinise?

- The performance of the Council and to provide a focused review of:
  - Corporate performance and directorate performance and financial reporting
  - Budget scrutiny
- the performance of the Council by means of effective key performance indicators, review of key action plans and obligations and through direct access to service managers, Cabinet Members and partners;
- through call-in, the reconsideration of decisions made but not yet implemented by or on behalf of the Cabinet;
- queries or issues of concern that may occur over decisions being taken in relation to adult social care;
- the Council's scrutiny responsibilities under the Crime and Justice Act 2006.

How can I have my say?

We welcome the views of the community on any issues in relation to the responsibilities of this Committee. Members of the public may ask to speak on any item on the agenda or may suggest matters which they would like the Committee to look at. **Requests to speak must be submitted to the Committee Officer below no later than 9 am on the working day before the date of the meeting.**

For more information about this Committee please contact:

Chairman	-	Councillor Liz Brighouse E.Mail: liz.brighouse@oxfordshire.gov.uk
Policy & Performance Officer	-	Katie Read, Senior Policy Officer 07584 909530 katie.read@oxfordshire.gov.uk
Committee Officer	-	*Colm Ó Caomhánaigh, Tel 07393 001096* *colm.ocaomhanaigh@oxfordshire.gov.uk*

Yvonne Rees
Chief Executive

October 2018

About the County Council

The Oxfordshire County Council is made up of 63 councillors who are democratically elected every four years. The Council provides a range of services to Oxfordshire's 678,000 residents. These include:

schools	social & health care	libraries and museums
the fire service	roads	trading standards
land use	transport planning	waste management

Each year the Council manages £0.9 billion of public money in providing these services. Most decisions are taken by a Cabinet of 9 Councillors, which makes decisions about service priorities and spending. Some decisions will now be delegated to individual members of the Cabinet.

About Scrutiny

Scrutiny is about:

- Providing a challenge to the Cabinet
- Examining how well the Cabinet and the Authority are performing
- Influencing the Cabinet on decisions that affect local people
- Helping the Cabinet to develop Council policies
- Representing the community in Council decision making
- Promoting joined up working across the authority's work and with partners

Scrutiny is NOT about:

- Making day to day service decisions
- Investigating individual complaints.

What does this Committee do?

The Committee meets up to 6 times a year or more. It develops a work programme, which lists the issues it plans to investigate. These investigations can include whole committee investigations undertaken during the meeting, or reviews by a panel of members doing research and talking to lots of people outside of the meeting. Once an investigation is completed the Committee provides its advice to the Cabinet, the full Council or other scrutiny committees. Meetings are open to the public and all reports are available to the public unless exempt or confidential, when the items would be considered in closed session.

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, giving as much notice as possible before the meeting

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

2. Declarations of Interest - Guidance note on back page of the agenda

3. Minutes (Pages 1 - 8)

To approve the minutes of the meeting held on 6 September 2018 and to receive information arising from them.

4. Petitions and Public Address

5. Establishing a Joint Sub-Committee for the Fit For The Future Programme (Pages 9 - 14)

10.05

In October 2018, Cabinet agreed an implementation strategy for the Council's new Operating Model that had itself been previously endorsed at the September Cabinet meeting.

The Performance Scrutiny and Audit and Governance Committees have taken an active role in the development of the Fit for the Future programme as the programme's implementation and the functionality of the new Operating Model will have significant implications across the areas of responsibilities of both committees. Both committees are therefore expected to continue their roles of monitoring and of challenging performance, delivery, reporting and control. The October Cabinet report noted that the Committees may wish to consider how they are organised through the life-time of the programme, including the potential establishment of individual or joint sub-committees as the business of the Committees demands.

This report considers the requirements for new arrangements and proposes the establishment of a Joint Sub-Committee. This same report is being considered by the Performance Scrutiny on 8 November and Audit and Governance Committee on 14 November.

The Committee is RECOMMENDED to:

a) Agree to the establishment of a joint Sub-Committee of the Performance Scrutiny and Audit & Governance Committees as set out in paragraphs 18-20.

b) Agree to the terms of reference set out in Annex 1.

6. Commissioning Mental Health Social Work Services

10.20

The Committee will receive a verbal update on the new partnership arrangements with the provider of mental health assessments.

7. Community Safety and Risk Management (Pages 15 - 30)

10.30

The Fire and Rescue Services Act 2004 requires the Secretary of State to prepare a Fire and Rescue National Framework to which Fire Authorities must have regard when discharging their functions. The 2018 Framework requires each Fire and Rescue Authority to produce a publicly available Intergrated Risk Management Plan (IRMP). Within Oxfordshire Fire and Rescue Service (OFRS) we have called this our Community Risk Management Plan (CRMP) to make it more meaningful to the public. This report proposes a number of projects to be included within the Fire Authority's CRMP for the fiscal year 2019-20.

The Committee is RECOMMENDED to approve the CRMP action plan.

8. Safeguarding Adults (Pages 31 - 46)

11.00

The Oxfordshire Safeguarding Adults Board is required to report annually on the work of the Board and of its partners, assessing the position of the partnerships in relation to the safeguarding adults at risk within Oxfordshire.

The Committee is RECOMMENDED to

a) Note that the adult safeguarding partnership is working across Oxfordshire and that work undertaken by the Board and its partners has resulted in a 9% decrease in safeguarding concerns being referred into the Local Authority, reversing a six-year trend of an annual 30% increase in concerns year-on-year; and

b) Note the priorities for 2018-19.

9. Safeguarding Children - Annual Reports (Pages 47 - 134)

11.30

Local Safeguarding Children Boards were set up under the Children Act 2004 to co-operate with each other in order to safeguard children and promote their welfare. The Oxfordshire Board is led by an independent chair and includes representation from all six local authorities in Oxfordshire, as well as the National Probation service, the Community Rehabilitation Company, Police, Oxfordshire Clinical Commissioning Group, Oxford University Hospitals NHS Trust, Oxford Health NHS Foundation Trust, schools and Further Education colleges, the military, the voluntary sector and lay members.

This paper highlights findings from the Board's annual report on the effectiveness of local arrangements to safeguard and promote the welfare of children in Oxfordshire. It also includes themes from two of the Board's multi-agency subgroups: the the Case Review and Governance subgroup and The Performance, Audit and Quality Assurance subgroup.

The OSCB annual report will be considered at Cabinet, the Health and Wellbeing Board

and the full Council.

The Committee is RECOMMENDED to note these annual reports and provide any comments.

10. Children Missing from Home or Care in Oxfordshire (Pages 135 - 144)

To be taken with Item 9.

This report provides a strategic update on the number of children reported as missing from home, care and school in Oxfordshire, including children looked after by Oxfordshire County Council. It covers the period between 01st January 2018 and 31st June 2018.

The report focuses on the main patterns, trends and concerns across the county which will be of note to the strategic leads. It covers best practice in line with the agreed 'joint protocol' and current risks or shortfalls and how these are being managed to ensure compliance with the relevant guidance issued by the Department for Education (DfE) and the College of Policing.

The Committee is RECOMMENDED to note the report.

11. Cabinet Response to the Young Carers Deep Dive recommendations

12.45

Cabinet reviewed the recommendations from the young carers scrutiny deep dive on 16 October and deferred a decision on these, pending further work by the Committee and a further report back to Cabinet. In particular, Cabinet was keen for the deep dive group to gather the views of young carers and ensure these are reflected in the report.

The Chairman of the deep dive group will outline the proposed next steps for this work.

12. Committee work programme (Pages 145 - 148)

12.55

To agree the committee's work programme for future meetings based on key priorities and discussion in the meeting.

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?.
The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *"You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself"* or *"You must not place yourself in situations where your honesty and integrity may be questioned…..".*

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:
Employment (includes"*any employment, office, trade, profession or vocation carried on for profit or gain*".), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Glenn Watson on **07776 997946** or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

PERFORMANCE SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 6 September 2018 commencing at 10.00 am and finishing at 1.15 pm

Present:

Voting Members:	Councillor Liz Brighouse OBE – in the Chair
	Councillor Jenny Hannaby (Deputy Chairman) Councillor Nick Carter Councillor Mike Fox-Davies Councillor Tony Ilott Councillor Liz Leffman Councillor Charles Mathew Councillor Glynis Phillips Councillor Michael Waine Councillor Liam Walker Councillor John Howson (In place of Councillor Emily Smith)
By Invitation:	Ben Pykett, PwC (Item 5) Chief Constable Francis Habgood (Items 7 and 8)
Officers:	
Whole of meeting	Katie Read, Senior Policy Officer; Colm Ó Caomhánaigh, Committee Officer

Part of meeting

Agenda Item	**Officer Attending**
5	Peter Clark, Chief Executive; Bev Hindle, Strategic Director for Communities; Jonathan McWilliam, Strategic Director for People; Lorna Baxter, Director for Finance
6	Ian Dyson, Assistant Chief Finance Officer (Assurance); Steven Jones, Corporate Performance and Risk Manager
9	Simon Furlong, Director for Community Safety; Paul Bremble, Strategic Risk & Assurance Manager

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting and agreed as set out below. Copies of the agenda and reports are attached to the signed Minutes.

46/18 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

Apologies were received from Councillor Emily Smith (Councillor John Howson substituting).

47/18 DECLARATIONS OF INTEREST - GUIDANCE NOTE ON BACK PAGE OF THE AGENDA

(Agenda No. 2)

There were no declarations of interest.

48/18 MINUTES

(Agenda No. 3)

The minutes of the meeting on 5 July 2018 were approved and signed as a correct record.

49/18 IMPLEMENTING A NEW OPERATING MODEL FOR OXFORDSHIRE COUNTY COUNCIL

(Agenda No. 5)

Peter Clark introduced the report. The proposed operating model describes how the Council will reorganise to work more efficiently and enhance services. It complies fully with the priorities in the Corporate Plan. Officers worked with PwC in developing this model.

Members raised various issues and the following are the responses from officers and Ben Pykett of PwC:

- 'Plan B' would be the Council reverting to making cuts in services or agreeing some hybrid of these proposals and cuts.
- Members of the public will see improvements in the provision of information online and through facilities such as 'chat boxes' so that they will have less need to make direct contact to find information. Many such systems are tried and tested elsewhere.
- Members and the public will be consulted at the design phase because it is essential that the systems work for them. Staff training will be another critical element.
- It is expected that there will be a Members' committee/reference group overseeing the process to give them ownership.
- Recruitment is an example of an area that takes up too much time for managers and could be handled more efficiently.
- Staff have seen big changes over the last 3 to 5 years and there is a risk of this plan being seen as more of the same. However there has been widespread staff consultation on this programme including staff conferences, workshops and activity analyses. Staff see the sense in reducing bureaucracy and freeing time for direct provision of services.

- If you design a system that is 90% digital it frees up time to deal with the other 10%. The implementation plan will include how to identify and respond to those who don't want to or can't access services online.
- The Council's collection of data from residents is at multiple points at the moment and a lot more could be achieved by using common systems.
- Reorganisation can change the way people think. The changes already made in senior management have encouraged people to think across the organisation and not in their own departments.
- Officers are confident that the lower range of savings can be made and then it depends on how far the Council wants to go to achieve the higher level of savings. The reduction in staff numbers is predicted to be between 650 and 900. Around 650 leave each year anyway. The Council has a strong record on redeployment. Any redundancy costs would be one-off whereas savings will be recurring.
- If the Council makes good use of business intelligence then it will help transformation and service improvement.

Members were agreed that the operating model should be accepted and the Chairman concluded by asking for more engagement with Members who are good collectors of business intelligence for the Council. Members will have more confidence in the programme if they are more engaged in it.

50/18 POLICE AND CRIME COMMISSIONER

(Agenda No. 7)

Police and Crime Commissioner Anthony Stansfeld was unable to attend the meeting due to serious traffic congestion. His presentation had been circulated with the agenda. It was agreed to take Agenda Items 7 and 8 together. Chief Constable Francis Habgood made a presentation and responded as follows to questions on both items:

- Although the crime rate last year increased, numbers are still relatively low and the overall trend is down. Changes to reporting rules account for some increases.
- It is noticeable that the increase in knife crime appears to mirror the reduction in the number of 'stop and search'es.
- There are definitely capacity issues with the 101 service. It was originally meant to be cross-agency. People are being encouraged to report suspicions which has increased demand for the service. Reporting online works better for a lot of people.
- Decriminalising parking offences would reduce pressure on police and much of that could be handled online.
- The biggest increases are in violent crime. Some of it can be attributed to now having to record harassment and assault separately even if arising from the same incident.
- Most engagements with schools are not logged as the police are reluctant to become involved when it can be better for the school to deal with the matter.
- While the number of S136 Mental Health Detentions is down there is still an issue finding beds as required by new legislation.

- The protocol on unauthorised encampments is helpful but police cannot use Section 62 of the Criminal Justice and Public Order Act as there are no transit sites available.
- The police have expressed their concern at the closure of Banbury Magistrates' Court. This leaves only one in the county and the concerns surround both capacity and travel.
- Neighbourhood teams will get the necessary IT by the end of the year and an increase in the number of 4x4s with aging vehicles being replaced when appropriate.
- The statistics in the Chief Constable's presentation all relate specifically to Oxfordshire. The share of the Community Safety Fund for Oxfordshire has not changed.
- In cases of domestic abuse, it is not always in the public interest to press charges. If the risk has been appropriately managed then that is a positive outcome. Some pilot schemes have indicated that restorative justice can be effective.

The Chairman thanked the Chief Constable for taking both items and hoped that more time could be given to discussing the reports and presentations next year.

51/18 THAMES VALLEY POLICE DELIVERY PLAN 2018-19

(Agenda No. 8)

Taken with Agenda Item 7.

52/18 BUSINESS MANAGEMENT AND MONITORING REPORT QUARTER 1 2018-19

(Agenda No. 6)

Ian Dyson and Steven Jones responded to Members' questions as follows:

- There have been delays in settling compensation claims relating to pot holes due to the volume of claims this year following the harsher winter. The target time period is 12 weeks. Officers will circulate data on the number of claims, size of payments and comparisons to previous years.
- The number of Looked After Children (LACs) has increased but is within expectations. It has brought Oxfordshire into line with the national average. There have been improvements in practice and management oversight for LACs.
- The figures for school reserves in Local Authority schools will be circulated to Members after the meeting.
- Officers will consider how young carers could be brought into the measurements.
- The Grant Thornton report that includes their "Vibrant Economy Index" will be circulated to Members so that they can see the rationale for the index and perhaps understand why Cherwell and West Oxfordshire District Councils have a lower rank than other Oxon councils.
- Although the number of home care hours purchased is slightly off target the outlook is positive.
- The one indicator that shows a negative outlook relates to LACs. It was noted though that the indicator could be said to confuse performance with demand.

53/18 COMMUNITY SAFETY SERVICES ANNUAL REPORT 2017-18

(Agenda No. 9)

Simon Furlong introduced the report. The period of the report included the Manchester Arena bombing and the Grenfell fire both of which impacted on the service's resources. When the inspectorate visits shortly they will ask what the Chief Fire Officer is most proud of and his answer will be his staff who support, advise, sometimes enforce but most of all are there when needed.

Members raised points on the report and Simon Furlong responded as follows:

- "Key" stations are all the full-time stations and a plan has been devised to ensure basic cover when individual vehicles are unavailable.
- The service is engaged with the property team working on a strategy which should be completed in October.
- The service is involved in many council and community activities including adult services, smoking and alcohol campaigns, highways and the coroner. There may be a risk related to the coming inspection which will focus only on the core fire service activities.
- The Berkshire fire service responds to many incidents in South Oxfordshire which explains why Response Standards in South Oxfordshire are so high despite a lower On Call Availability.
- The memorandum of understanding on unauthorised encampments is very welcome. It has been difficult to get court time this year so the closure of Banbury Magistrates' Court is of concern. Transit sites – currently the subject of a government consultation – may not be the answer for Oxfordshire as they would not be big enough to deal with the incidents here.
- The service tries to educate HGV drivers on weight restrictions but will prosecute in cases of more than three incidents. This takes a lot of time and it would be helpful if local communities could help with this work.

54/18 RECOMMENDATIONS OF THE YOUNG CARERS DEEP DIVE

(Agenda No. 10)

Councillor Nick Carter introduced the report and thanked Katie Read, Senior Policy Officer, for her work in bringing it together.

The Chairman put the report's recommendations individually to the Committee:

Recommendations a) to e): agreed.

Recommendation f): it was agreed to write to the Schools' Forum and the Governors' Forum instead of the Regional Schools Commissioner

Recommendations g) to l): agreed

Councillor Glynis Phillips stated that the group never got to talk to young carers themselves but that they are committed to doing that.

RESOLVED: to

a) Ask the Cabinet to explore ways of funding the unique support to young carers provided by Be Free Young Carers.

b) Support the development of good quality, evidence-based targeted group therapeutic work for young carers within the Young Carers Service.

c) Review the impact of moving the Young Carers Service into the Family Solutions Service in 12 months' time.

d) Ask the Cabinet to review and improve the timescales for completing statutory young carers' assessments and delivering support.

e) There are examples of good in identifying and supporting young carers practice in some schools, e.g. opportunities for young carers to complete homework on school premises. This good practice needs to be recognised, captured and shared.

f) Invite the Schools' Forum and Governors' Forum to make it a requirement for schools to their staff to identify where a child may be undertaking a caring role, the impact of that responsibility, and to understand what support is available to minimise the impact.

g) Ask the Education Scrutiny Committee to review the measures used by Ofsted to assess the standard of support delivered to young carers as vulnerable learners, and to scrutinise the effectiveness of this regulatory oversight.

h) Ask the Education Scrutiny Committee the scrutinise the range, quality and impact of pastoral care across Oxfordshire schools and colleges, particularly in relation to young carers.

i) Ask the Education Scrutiny Committee working group focused on rates of school attendance to give specific attention to young carers, as a cohort at particular risk.

j) Ensure Oxfordshire's health and social care system specifically considers the impact of its drive to deliver more community-based care on young carers and ask the Joint Health Overview and Scrutiny Committee to review this as part of its scrutiny of transformational change across the system.

k) Ask the Council to establish a Young Carers Councillor Champion to help people understand the needs of young carers and promote the identification and support of young carers.

l) Review progress against these recommendations in 12 months' time.

55/18 WORK PROGRAMME

(Agenda No. 11)

The following was agreed:

- move the item on Adult Social Care Contributions Policy from the January meeting to March 2019.
- remove the item Impact of Carillion liquidation as the Audit & Governance Committee is monitoring that.
- add a follow-up item on Recycling to the March 2019 meeting.
- add a follow-up item on Young Carers for next year.

56/18 FOR INFORMATION: CABINET RESPONSE TO RECYCLING DEEP DIVE
(Agenda No. 12)

57/18 FOR INFORMATION: HIGHWAYS DEEP DIVE - DRAFT SCOPE
(Agenda No. 13)

Councillor Jenny Hannaby invited Members to email her with any thoughts on this issue.

..... in the Chair

Date of signing 20

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Division(s): All

PERFORMANCE SCRUTINY COMMITTEE – 8 NOVEMBER 2018

Establishing A Joint Sub-Committee For The Fit For The Future Programme

Report by the Director of Law and Governance

Introduction

1. In October 2018, Cabinet agreed an implementation strategy for the Council's new Operating Model that had itself been previously endorsed at the September Cabinet meeting.

2. During development and agreement of both the September and October Cabinet reports, elected members emphasised the importance of member engagement and effective scrutiny throughout the process of transformation to:

   - Ensure the most effective use of resources
   - Monitor and challenge timescales and the delivery of benefits
   - Challenge and improve business cases
   - Review performance and delivery
   - Monitor management of risk and systems of control and performance management
   - Ensure robust programme governance arrangements are in place
   - Ensure member intelligence informs implementation

3. The Performance Scrutiny and Audit and Governance Committees have taken an active role in the development of the Fit for the Future programme as the programme's implementation and the functionality of the new Operating Model will have significant implications across the areas of responsibilities of both committees. Both committees are therefore expected to continue their roles of monitoring and of challenging performance, delivery, reporting and control. The October Cabinet report noted that the Committees may wish to consider how they are organised through the life-time of the programme, including the potential establishment of individual or joint sub-committees as the business of the Committees demands.

4. This report considers the requirements for new arrangements and proposes the establishment of a Joint Sub-Committee. This same report is being considered by the Performance Scrutiny on 8 November and Audit and Governance Committee on 14 November.

The requirement for joint sub-committee arrangements

5. The October Cabinet report noted that with respect to the Fit for the Future Programme, the Performance Scrutiny Committee would be expected to consider issues including:

    - Impact of the programme on outcomes for residents, i.e. Corporate Plan priorities;
    - Impact of the programme on service performance;
    - Impact of changes on staff;
    - Predicted costs and savings as compared to actual costs and realised savings.

6. The report went on to note that the Audit and Governance Committee would be expected to consider issues including:

    - Risks identified and mitigations proposed and actioned;
    - Systems of internal control, to include assurance that a robust performance framework is in place;
    - Governance of the project.

7. The Cabinet report described the scale and scope of the implementation of the Fit for the Future programme, noting that it will have implications across all Council services, over a prolonged period.

8. Across this very broad scope, members will need to exercise their oversight functions over two distinct areas:

9. Firstly, members will need to exercise oversight of *the delivery of the programme itself* – considering all of the issues of delivery of benefits, costs, impact on business as usual, staff and residents, risk, control and governance listed above. This will be required during design, implementation and through to the period of transition to business as usual.

10. Secondly, and distinctly, members will need to exercise oversight of *the design of the new Council Operating Model itself* – assessing, challenging and assuring the robustness of the design of new ways of working with respect to the areas of attention of the two committees, before they are implemented.

11. Taken together, this activity is expected to generate a considerable volume of work for the committees both of which already have full agendas. Establishing a sub-committee arrangement therefore has the benefit of increasing the capacity of the committees and providing for focussed and timely review of the complex issues expected to be generated through the programme.

12. While the two main committees have distinct areas of focus as set out above, with respect to the Fit for the Future programme, their considerations are very likely to be interconnected and overlapping. For example, while looking at potential impact on residents and staff, it would make sense to do this while

also considering the arrangements for risk management and appropriate mitigating measures.

13. To avoid duplication and to ensure that all matters are covered in the context of the full-picture, it is proposed that a 'Joint Sub-Committee' is established.

Clarity of roles – Joint Sub-Committee and Cabinet Advisory Group

14. The October Cabinet report agreed to establish a Cabinet Advisory Group (CAG) on the Fit for the Future Programme to support and advise Cabinet and a recommendation was agreed.

15. Ensuring that the roles and responsibilities of the respective bodies involved in member oversight are district, understood and transparent from the outset of the programme will be critical to ensuring:

- That there are clear lines of accountability with the responsibility for scrutinising, challenging and supporting each aspect of the programme understood and adhered to;
- That reporting is efficient – avoiding the same issues being dealt with in multiple forums;
- That there is the opportunity space for creative and open engagement with members on policy development and problem solving, separate from formal challenge and scrutiny processes;
- That conflicts of interest are avoided – in particular that those involved in the development and implementation of policy are not involved in the scrutiny of that policy.

16. While it is likely that there will be cross-over of issues to be considered by the Joint Sub-Committee and the CAG from different perspectives, it will be productive for the lead officers with the chairs and deputy chairs of both groups to liaise on agendas and work programmes to ensure that matters are being considered in the most appropriate forum in a timely manner.

17. The October reports outlined these roles as follows:

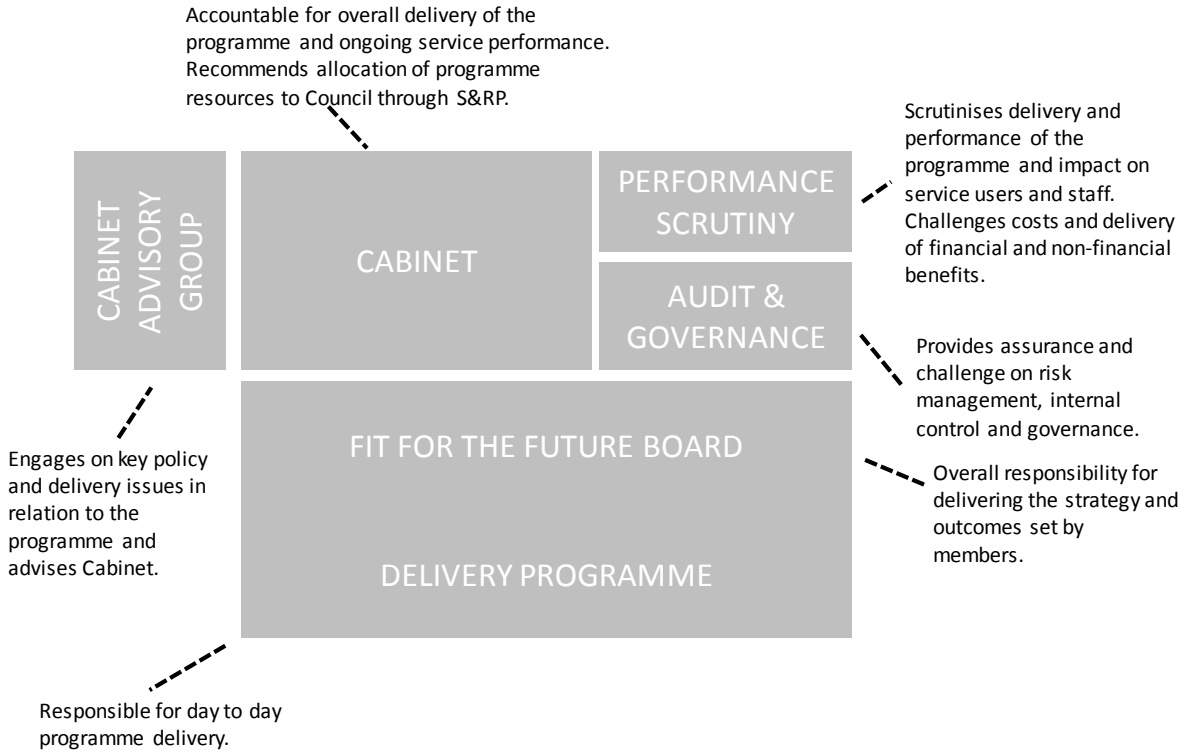

Fig. 1: Member over-sight arrangements and officer-led delivery functions

Establishing the Joint Sub-Committee

18. It is suggested that the Sub-Committee be called the Fit for the Future Joint Sub-Committee.

19. The Sub-Committee will be established by decisions of both the Performance Scrutiny and Audit & Governance committees.

20. Proposed Terms of Reference for the Joint Sub-Committee are set out in Annex 1.

RECOMMENDATION

21. **The Committee is RECOMMENDED to:**

a) Agree to the establishment of a joint Sub-Committee of the Performance Scrutiny and Audit & Governance Committees as set out in paragraphs 18-20.

b) Agree to the terms of reference set out in Annex 1.

NICK GRAHAM
Director of Law and Governance

Contact Officer: Robin Rogers, Strategy Manager
November 2018

Annex 1 – Terms of Reference

ANNEX 1

TERMS OF REFERENCE FOR THE JOINT SUB-COMMITTEE FOR THE FIT FOR THE FUTURE PROGRAMME

The Joint Committee will bring to bear the perspectives of their parent committees with regard to the governance and performance of the Fit for the Future Programme in terms of its management and its implementation.

In particular, in terms of *performance* the Sub-Committee will review the:

- Delivery and performance of the programme
- Impact of the programme on outcomes for residents, i.e. Corporate Plan priorities;
- Impact of the programme on service performance;
- Impact of changes on staff;
- Predicted costs and savings as compared to actual costs and realised savings
- Predicted non-financial benefits.

In terms of *governance, accountability and internal control*, the Sub-Committee will consider:

- Risks identified and mitigations proposed and actioned;
- Systems of internal control, to include assurance that a robust framework is in place;
- Governance of the project
- Any ethical governance implications

Frequency of meeting
The Sub-Committee will determine its own meeting cycle. Notwithstanding this, it is anticipated that the Sub-Committee will meet at least quarterly.

Membership and Quorum
The membership will be 8 Councillors to include equal numbers from both main committees. The quorum will be 4 of the Sub-Committee's membership.

NB. Given that the Sub-Committee will be undertaking certain overview and scrutiny functions, no member of the Audit and Governance Committee who may, from time to time, also be a member of the Cabinet will be eligible for membership of the Sub-Committee

Chairman and deputy chairman
The Sub-Committee shall appoint a Chairman and a Deputy Chairman – one of whom will be from the membership of the Audit and Governance Committee and one from the Performance Scrutiny Committee as the Sub-Committee may determine. These roles to rotate at successive meetings where possible.

Procedure Rules
The Sub-Committee will operate in accordance with the Scrutiny Procedure Rules under the Council's Constitution.

Division(s): N/A

Performance Scrutiny Committee – 8 November 2018

Community Risk Management Plan Action Plan 2019-20

Report by Director for Community Safety Services

Introduction

1. The Fire and Rescue Services Act 2004 requires the Secretary of State to prepare a Fire and Rescue National Framework to which Fire Authorities must have regard when discharging their functions. The 2018 Framework requires each Fire and Rescue Authority to produce a publicly available Integrated Risk Management Plan (IRMP). Within Oxfordshire Fire and Rescue Service (OFRS) we have called this our Community Risk Management Plan (CRMP) to make it more meaningful to the public. This report proposes a number of projects to be included within the Fire Authority's CRMP for the fiscal year 2019-20

Community Risk Management Plan action plan 2019-20

2. The following projects will be included within the fire authority's CRMP for the fiscal year 2019-20

   Project 1: Risk profiling local communities
   Project 2: Prevention Review
   Project 3: On Call Retention Review
   Project 4: Proactive Role in improving standards in rented housing

Continuation of existing CRMP Projects

3. The continuation of the following projects should also be considered from existing projects in the 2018-2019 CRMP Action Plan:

   Project 1: Establishing community Safety Advocates or Wardens.
   Project 2: To increase the diversity of the Operational Workforce to reflect the community that we serve.

4. If the action plan is agreed there will be a full internal and external consultation for a period of 12 weeks. Scrutiny is therefore invited to comment on the proposed Action Plan 2019-20.

5. Our medium term financial plan and supporting business strategies underpin the proposals within our CRMP action plan

RECOMMENDATION

6. **The Committee is RECOMMENDED to approve the CRMP action plan.**

Simon Furlong

Director of Community Safety Services

Contact Officer: Paul Bremble 07880780805
October 2018

Oxfordshire County Council
Community Safety Services

365alive.co.uk

Community Risk Management Action Plan

2019-20

Securing a safer Oxfordshire

OXFORDSHIRE FIRE & RESCUE SERVICE

OXFORDSHIRE COUNTY COUNCIL

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Welcome

Councillor
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Chief Fire Officer
Simon Furlong

Director of Community Safety Services

'We are very pleased to present our Community Risk Management Action Plan for 2019/20. This details the key projects we are proposing to undertake during this period, which will lead to a safer Oxfordshire and contribute to Oxfordshire County Council's 'Thriving Oxfordshire' vision. These projects will sit within the Council's Fit for the Future programme, which is designed to put the residents of our county at the heart of everything that we do. They are designed to address the current and future risks that were identified in our overarching CRMP 2017-2022.

The organisation is committed to delivering a high performing service that provides excellent value for money to tax payers. Our integration within the wider county council and collaboration with partners enables us to ensure that we are joined up in delivering solutions to the key issues affecting our communities. We will maintain our focus during this period on our prevention activity to ensure that the public remain safe and aware of how they can keep themselves out of harm and able to seek the opportunities to thrive.

We are extremely proud of Oxfordshire County Council Community Safety Services and of our achievements during recent years - keeping people who live, travel and work in our county safe. We have seen the number of fires reduce and greater engagement with the most vulnerable in our communities to continue to support this downward trend.

Our CRMP recognises the changes within our population and this Community Risk Management Action Plan will assist our service to meet the challenges ahead and strive to improve the services we deliver to the residents and visitors to Oxfordshire.'

Introduction

The Fire and Rescue Services Act 2004 requires the Secretary of State to prepare a Fire and Rescue National Framework to which fire authorities must have regard when discharging their functions.

The 2018 National framework document for England states that each fire and rescue authority is required to produce an Integrated Risk Management Plan colloquially known as an IRMP. In Oxfordshire, where our service incorporates the wider, Community Safety Services*, our plan has been renamed as our Community Risk Management Plan or CRMP.

Each plan must:

- Reflect up to date risk analyses including an assessment of all foreseeable fire and rescue related risks that could affect the area of the authority;
- Demonstrate how prevention, protection and response activities will best be used to prevent fires and other incidents and mitigate the impact of identified risks on its communities, through authorities working either individually or collectively, in a way that makes best use of available resources;
- Outline required service delivery outcomes including the allocation of resources for the mitigation of risks;
- Set out its management strategy and risk-based programme for enforcing the provisions of the Regulatory Reform (Fire Safety) Order 2005 in accordance with the principles of better regulation set out in the Statutory Code of Compliance for Regulators, and the Enforcement Concordat;
- Cover at least a three-year time span and be reviewed and revised as often as it is necessary to ensure that the authority is able to deliver the requirements set out in this Framework;
- Reflect effective consultation throughout its development and at all review stages with the community, its workforce and representative bodies and partners; and
- Be easily accessible and publicly available.

** Community Safety Services includes Emergency Planning, Trading Standards, Gypsy and Travellers and Fire and Rescue.*

Our Vision

365alive is Oxfordshire Fire and Rescue Service's vision to ensure that we are working every day to save and improve the lives of people across Oxfordshire. The vision is supported by Road Safety, Trading Standards, Emergency Planning and Gypsy and Traveller's Services.

The vision will run for 6 years from 2016 to 2022; over this time, we would like to achieve:

PREVENTION, PROTECTION & EMERGENCY RESPONSE	EDUCATION	VULNERABLE / LOOKED AFTER CHILDREN & ADULTS	BUSINESSES
6,000 more people alive as a result of our prevention, protection and emergency response activities.	85,000 children and young adults (to include looked after children) to be better educated to lead safer and healthier lives.	37,500 vulnerable children and adults helped to lead more secure and independent lives supported by safe and well-being visits.	20,000 businesses given advice and support to grow.

1.6 Million Safety Messages

Our Vision supports Oxfordshire County Council's strategic direction, values and principles that guide our work; "Thriving communities for everyone in Oxfordshire"

We strive to give every child a good start in life, and protect everyone from abuse and neglect

We enable older and disabled people to live independently. We care for those in greatest need

We help people live safe, healthy lives and play an active part in their community

We provide services that enhance the quality of life in our communities, and protect the local environment

We support a thriving local economy by improving transport links to create jobs and homes for the future

More information on our Vision can be found at www.365alive.co.uk

Oxfordshire County Council's vision can be read in more detail in the 2018-21 Corporate Plan.

Visit www.oxfordshire.gov.uk and search for 'corporate plan' for more details.

5-year CRMP (2017-2022) annual update

This section summarises any key strategic changes or changes in emphasis from our 5-year CRMP. We are working on the implications and creating action plans associated with the emerging issues listed below.

- The new national framework document:

The national framework sets out the government's priorities and objectives for fire and rescue authorities and was republished this year following a period of consultation.

- The Kerslake Report:

An independent review of the events and aftermath of the Manchester Arena Terrorist Attack, commissioned by the Mayor of Greater Manchester Andy Burnham.

- Independent Review of Building Regulations and Fire Safety: interim report:

Interim report which was commissioned by government following the Grenfell Tower fire to make recommendations on the future regulatory system.

- The creation of the PESTELO

PESTELO is an acronym which describes the way we, as a service, prepare for future threats. The Community Safety Leadership Team consists of senior managers within Community Safety Services, who use their experience and knowledge to understand current and future issues which could have an impact on our service. The themes of focus are

Political,
Economic,
Social,
Technological,
Environmental
Legal and
Organisational.

The outcome of this analysis helps shape future CRMP projects.

Projects

Project 1 - Risk profiling local communities
AM Heycock

What it is?
We are planning to use our risk profiling model at a local level to identify the impact of changes in the local environment in order to understand what resources are needed to ensure we can effectively and efficiently deliver our response, protection and prevention activities.

Why it is needed?
The future plans for Oxfordshire see significant development in housing, infrastructure and commercial properties across the county. We need to ensure that our resources are matched to any future risk to ensure the safety of our residents. Our current profile is based on the whole county and this project will ensure that we are able to understand risk at a local level and the impact on local communities.

What will it look like?
The project will:

- Identify areas of planned expansion
- Prioritise the localities based on type of development and implementation timeframes
- Model the current and future risk for a locality
- Identify any gaps in Response, Prevention or Protection
- Provide recommendations to address any gaps

Throughout the process we will engage with the local authorities and other partners to ensure a single view of risk for the locality.
The final outcome will be a comprehensive report on those localities that were identified through the project.
This information will be available in a tabular format and presented on a map of the county.

What difference will it make?
We will understand the impact of future developments on our local communities, our resources and our activities.
This will ensure that these local risks and their impact have been considered, and are then used to inform our wider Community Risk Management Plan.

Project 2 Prevention Review

AM Crapper

What it is?
Prevention is made up of many different activities aimed at reducing the incidence and impact of fires and other emergencies. These activities include educating the public across a number of age groups as well as conducting Safe and Well visits in people's homes. This project will review these Prevention activities to identify opportunities for improvement.

Why it is needed?
During the last decade, the amount of Prevention activity undertaken by ourselves has expanded greatly. There is therefore a need to ensure that those Prevention activities provided by us:

- have clear outcomes which are achieved
- are properly co-ordinated and co-designed with our partners
- deliver maximum value with the limited resources at our disposal
- those delivering the activities have the requisite skills and ability.

What will it look like?
This project will evaluate our existing Prevention activities and identify opportunities to adapt or stop doing them. Additionally, this review will aim to identify new Prevention activities that can be co-designed and delivered with our partners. The project will culminate in a full report with recommendations for change.

What difference will it make?
This project will ensure that Prevention interventions are focused on those with the greatest need and thus support the County's vision of supporting people to thrive. As such, this project will ultimately aim to ensure that people in Oxfordshire are helped to lead safer lives.

Project 3 On-Call retention review
AM Adcock

What it is?
A review of retention of On-Call firefighters in the service. This review will seek to understand the drivers behind the reasons our staff stay, and what we can do to keep our staff longer.

Why it is needed?
We have noticed that there has been an increase in the turnover of On-Call firefighters and want to understand the reasons for this, identify what we could do to reduce this trend and improve the retention of these valuable professionals. By increasing how long our staff stay with us we will ensure we maximise their

experience, reduce the need to recruit, and in the longer term improve fire engine availability

What will it look like?
We will gain a better understanding of why people leave the service by completing the following activities:

- We will consult our firefighters currently working the On-Call duty system
- We will consult members of the community who want to be On-Call firefighters to understand what their expectations are when joining the service
- We will look at similar careers such as the military reserve forces to identify areas of good practice
- We will produce a list of the recommendations that will be identified within the report
- We will set out the performance indicators to measure On-Call firefighter retention

What difference will it make?
If we improve the retention of people working as On-Call firefighters, we would see an improved availability of On-Call fire engines and response to the communities throughout the County. We would also keep our experienced professionals for longer thus reducing the impact on recruitment and training.

Project 4 Proactive Role in improving standards in rented housing
Jody Kerman

What it is?
This project seeks to protect tenants and prospective tenants from both physical harm and financial loss when renting a residential property.

Why it is needed?
Oxfordshire has some of the highest rental costs in the country, compounded by areas of high demand and short supply. These factors can lead to significant levels of consumer detriment and an imbalance of power between tenants and landlords and/or letting agents. The Government's Tenants Fee Bill is one example that highlights the need to make renting fairer and to protect consumers from rogue landlords and agents.

What will it look like?
The project will have a number of areas of work. We will undertake work to better understand the issues affecting consumers within Oxfordshire, as well as investigating the regulatory options that already exist. Work will be conducted to assess compliance with relevant legislation, to improve advice to businesses and to

help ensure that consumers are able to make informed choices. An enforcement approach will be devised to target those businesses who fail to comply with the law and this is likely to include making use of civil penalty arrangements, where appropriate.

What difference will it make?
The project will seek to protect consumers from financial and physical harm, improving their health and wellbeing. Levels of compliance with relevant legislation will increase; raising consumer confidence in rental decisions.
Responsible businesses and landlords will be protected from those who seek an unfair competitive advantage through unscrupulous practice, damaging the reputation of landlord and letting agents in Oxfordshire. Oxfordshire will be a safe place to live and thrive.

Continuation of existing CRMP Projects

The following projects were part of the CRMP Action Plan for 2018-2019, the service recognises that due to the nature of these projects, they will continue in to the 2019-20 action plan:

Project 5 Establishing Community Safety Advocates or Wardens
ACO Mitchell

What it is?
We aim to attract people who would like to be a part of us and what we do, but not necessarily by fighting fires. Our Prevention teams coordinate and conduct our prevention activity delivered through our Safe and Well programme.
These visits make our residents and communities safer, using information, education and technology such as smoke alarms.

Why it is needed?
We have a desire to increase our Safe and Well visits and to assist in coordinating community resilience. Community Wardens will be a well-trained and professionally supported volunteer group, and in larger towns we will look to provide a volunteer coordinator.

What difference will it make?
We are planning to complete many more Safe and Well visits, and have the local knowledge that we need to provide the right service at the right time.

Project 6 To increase the diversity of the Operational Workforce to reflect the community that we serve
AM Heycock

What it is?
Over 2017-18 the service has been looking at ways to encourage applicants from underrepresented groups into operational roles within the service This work will continue over 2019-20.

Why it is needed?
We acknowledge that the modern fire service can be perceived as non-representative. We recognise that to better help the people we serve, we need to reflect the community we serve. We also recognise that a more diverse workforce has great benefits to the way in which the service works.

What will it look like?
We use data to understand where our diverse communities are and ensure that we build strong community relationships, further breaking down barriers. Opportunities will be advertised in more accessible places. We conduct 'taster' days, where interested individuals can experience what it takes to be a firefighter and ask questions of those already in service.

What difference will it make?
Inclusive environments encourage people to reach their full potential. Increasing the diversity in our workforce will not only make us more representative but will allow us to attract and retain the best and brightest individuals from all communities.

Consultation

Have your say

You are now invited to comment on our projects. Our consultation for these projects runs from **8th November 2018** to **1st February 2019**. You can get involved by responding:

On-line: oxfordshire.gov.uk/consult.ti/consultations/CRMP/consultationhome

Email: CRMP@oxfordshire.gov.uk

Or in writing: CRMP 2019-2020
Oxfordshire Fire and Rescue HQ
Sterling Road
Kidlington
Oxon
OX5 2DU

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Division(s): N/A

Performance Scrutiny – 8th November 2018

Oxfordshire Safeguarding Adults Board - Annual Report 2017-18

Report by Director for Adult Services

Introduction

1. The OSAB is required to report annually on the work of the Board and of its partners, assessing the position of the partnerships in relation to the safeguarding adults at risk within Oxfordshire.

2. The Oxfordshire Safeguarding Adults Board has made great strides in the last year in bringing together partners to better protect adults in Oxfordshire.

Key Findings

3. There were 6,639 safeguarding concerns raised by organisations in 2017-18. This is a decrease in concerns as compared to 2016-17 (7,201 concerns). This also represents the first time in 6 years that concerns have not increased by 25% or more.

4. This change in numbers is thought to be the result of several pieces of work undertaken by the Board and its partners, outlined below.

5. Firstly, the Board is offering face-to-face training for professionals. Over 1,200 professionals undertook training in 2017-18 from across nearly all partner agencies. Those that did not send workers were able to satisfy the Board that their staff had been adequately trained in Safeguarding using internal training resources.

6. Secondly, the Board pulled together a large group of service providers to review and update the thresholds document. This document is used to describe the situations in which an issue should be reported to the Local Authority, who ultimately have safeguarding responsibility under the Care Act 2014. The coproduction of the document has received very positive feedback from service providers and has led to three other Safeguarding Boards requesting to use our thresholds document, as well as the Care Quality Commission using it as a good practice example across the region.

7. Thirdly, the Local Authority set up a consultation service, which is heavily promoted by the Safeguarding Board in all its communications and training. This allows people to discuss a concern before raising it via the website so they can seek assurance that the issue does meet the thresholds criteria mentioned above.

8. Training for Councillors covering both Children's and Adults Safeguarding was delivered on 11th October 2018. An updated briefing for Councillors (County, Parish, etc) is being produced to ensure the message is continuing to get out to the general public.

RECOMMENDATION

9. **The Committee is RECOMMENDED to**

   a) **Note that the adult safeguarding partnership is working across Oxfordshire and that work undertaken by the Board and its partners has resulted in a 9% decrease in safeguarding concerns being referred into the Local Authority, reversing a six-year trend of an annual 30% increase in concerns year-on-year; and**

   b) **Note the priorities for 2018-19.**

Melanie Pearce
Service Manager - Safeguarding

October 2018

OSAB

Oxfordshire Safeguarding Adults Board

2017-18 Annual Report

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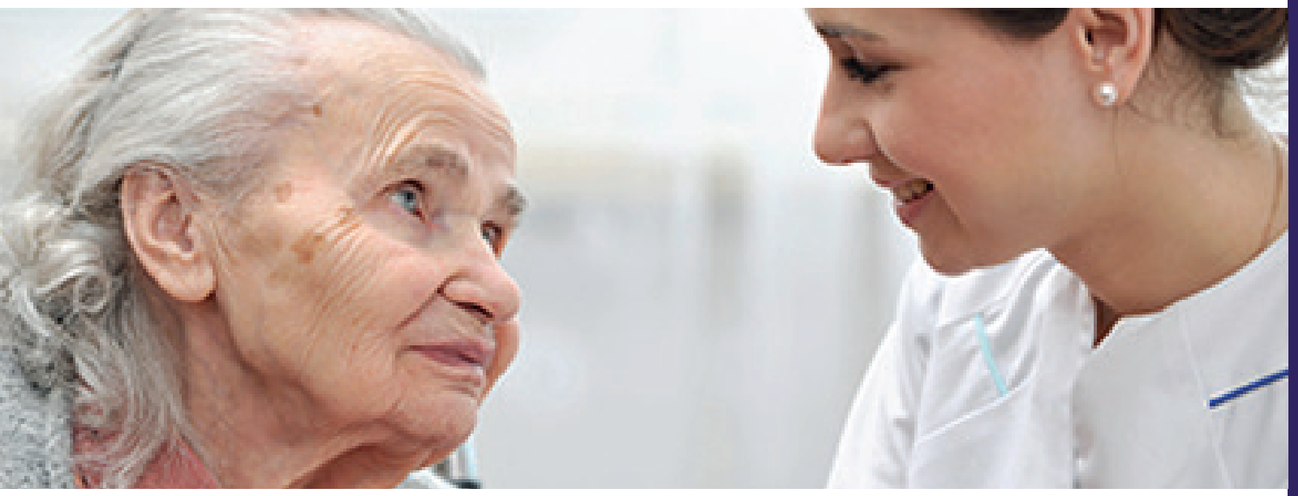

FOREWORD

I am pleased to present the fifth annual report of the Oxfordshire Safeguarding Adults Board. This report outlines the role, function and purpose of the Board as prescribed by the Care Act 2014 and lists the organisations represented. It highlights the risks faced by the most vulnerable and most importantly what local agencies both statutory and voluntary are doing to safeguard them.

The report contains examples of the collaborative work undertaken by partners to show through case studies the effectiveness of our work to empower and protect the most vulnerable adults in our community. I am however mindful of the risk of complacency, as for many the arrangements for their care are made either through their own or their family's private arrangements and the volume of other settings stretches the capacity of organisations such as CQC to effectively monitor all of these arrangements.

We have been looking at the patterns in safeguarding activity to inform our priorities for improvement going forward. We are particularly proud of our data around Making Safeguarding Personal, which has improved throughout the year and demonstrates our joint commitment to ensuring the person is at the centre of all decision-making and safeguarding activity. The statistics also include contextual data showing the size of the eligible adult population and the estimated number of those adults who have care and support needs as well as the overall numbers of concerns and enquiries, giving an idea of the activity across the partnership relating to safeguarding work.

Work will also continue on increasing practitioners' confidence in applying the Mental Capacity Act 2005 to decision-making. Other themes are to ensure that prevention and early intervention work is better understood across the partnership; that the key issues identified by partners (mental ill-health, domestic abuse, substance abuse, exploitation, and housing) are monitored and progress is challenged where appropriate, and that service users and community groups are better engaged with the work of the Board and its partners.

The Board continues to work closely with the Oxfordshire Safeguarding Children's Board to ensure that we all "Think Family', make progress on our joint priorities and importantly we learn together and from each other.

Through discussions and reports received at the Board and through our annual impact assessment, I am very mindful of the pressures on partners in terms of their contribution of people, funds and other resources. I continue to be very grateful to all partners for their contributions and the considerable time and effort they put into the Board. The partnership has continued to grow and develop, as reflected in this annual report.

Pamela Marsden
Independent Chair of the Oxfordshire Safeguarding Adults Board

WHAT IS THE OXFORDSHIRE SAFEGUARDING ADULTS BOARD?

The Care Act 2014 says that Local Authorities must have a Safeguarding Adults Board in place from 1st April 2015.

The Oxfordshire Safeguarding Adults Board has provided leadership for adult safeguarding across the county since 2009. The Board is a partnership of organisations working together to promote the right to live in safety, free from abuse or neglect.

Its purpose is to both prevent abuse and neglect, and where someone experiences abuse or neglect, to respond in a way that supports their choices and promotes their well-being.

The Care Act says key members of the Board must be the Local Authority; the Clinical Commissioning Groups; and the Chief Officer of Police.

The three key members on the Oxfordshire Safeguarding Adults Board are:

- The Director of Adult Social Care, Oxfordshire County Council
- The Director of Quality, Oxfordshire Clinical Commissioning Group
- The Detective Chief Inspector, Protecting Vulnerable People, Thames Valley Police

The Care Act says these key members must appoint a chairperson who has the required skills and experience. Pamela Marsden is the Independent Chair of the Oxfordshire Safeguarding Adults Board. She has many years' experience as a Director within Adult Social Services and has held the Chair position since November 2016.

The Care Act 2014 states that the Board can appoint other members it considers appropriate with the right skills and experience.

There are senior representatives on the Board, from the following organisations:

NHS Oxford University Hospitals NHS Foundation Trust

NHS Oxford Health NHS Foundation Trust

NHS South Central Ambulance Service NHS Foundation Trust

NHS England

Public Health England

Community Protection Services (Fire & Rescue, Trading Standards & Community Safety)

National Probation Service

Abingdon & Witney College

OCHA Oxford Citizens Housing Association

healthwatch Oxfordshire

Oxfordshire age UK

OACP Oxfordshire Association of Care Providers

HM PRISON SERVICE

CareQuality Commission

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Board Members are the senior people in each of the organisations with responsibility for safeguarding. Their role on the Board is to bring their organisations adult safeguarding issues to the attention of the Board, promote the agreed priorities and work to embed learning throughout their own organisation.

The Board meets four times each year and alternate meetings include a joint meeting with the OSCB (Oxfordshire Safeguarding Children's Board) where our joint priorities can be progressed.

THE ADULT SAFEGUARDING STRATEGY 2017-18

In March 2017, the Board consulted with organisations working with people who have care and support needs, to develop the Board's strategic plan. From what organisations told us was important to the people they work with, we created the OSAB Strategic Plan 2017-18 and vision.

Our Vision for Oxfordshire

"Oxfordshire is a place where safeguarding is everyone's responsibility, where the OSAB partners work together to recognise and prevent abuse so that adults at risk from harm feel safe and empowered to make their own life decisions."

Principles and Values

PREVENTION
All organisations will have the necessary culture and structures in place to prevent abuse from occurring; which takes all concerns seriously, transparently and enabling swift proportionate interventions at an early stage. There is active engagement with all sections of the local community so that everyone is well informed about safeguarding and related issues.

PROPORTIONALITY
All staff and volunteers in whatever setting have a key role in preventing abuse or neglect occurring and in taking prompt, proportional action when concerns arise. All staff and volunteers also have the appropriate level of skills, knowledge and training to safeguard adults from abuse.

EMPOWERMENT
Any intervention and support provided is person centred and focused on the outcomes identified by the individual. People must be supported with dignity and respect and be in control of decision making as much as possible; enabling individuals to safeguard themselves from harm and to be able to report any concerns that they have.

GOVERNANCE
There is a robust outcome focused process and performance framework so that everyone undergoing safeguarding procedures will receive a consistent high-quality service which is underpinned by multi-agency cooperation and continuous learning. The Board and its partners are accountable for what agencies do and learn from local experience and national policy.

WHAT HAS THE BOARD BEEN DOING?

Prevention

"It is better to take action before harm occurs"

The Executive Group

The group has overseen the development of a strategy around prevention. As the Board members have again highlighted prevention and early intervention as priorities for 2018-19, the strategy will be reviewed and how it works in practice will be monitored.

The group has also improved its engagement with other local organisations, particularly the University of Oxford, through joint working on case reviews.

Policy & Procedures Group

The group have developed and reviewed a number of strategies contributing towards preventative work. These include:

- Working with people who don't engage
- Hoarding & Self-neglect
- Modern Slavery/Exploitation
- Thresholds for accessing safeguarding services

The group has also reviewed the multi-agency safeguarding policy, working closely with colleagues in the Buckinghamshire Safeguarding Adults Board to produce a policy covering both counties.

Training

2017-18 was the first full year of the Board running Frontline Worker training. This has led to over 600 delegates receiving face-to-face training from the Safeguarding Board, delivered by a Safeguarding Social Worker and a Health professional. Feedback on the training has been excellent, with a 98.5% satisfaction rating.

We have also started delivering Safeguarding Training for Managers/ Leaders, delivering our first course in February 2018.

Vulnerable Adults Mortality Group

The group is in the process of producing its first annual report, highlighting themes and trends across the cases that have been reviewed this year and cascading this learning through the Board Members to partner agencies and via the OSAB training to ensure practitioners are alerted to the specific issues for this cohort of service users.

Performance, Information & Quality Assurance Group

The group receives a wide range of data, which is placed under themes, including prevention. Each theme contains data relevant to that area, so as an example, prevention includes data from the Fire & Rescue service on fire safety (safe and well) checks carried out. For adults with mobility issues this is a vital piece of preventative work, with over 2,000 visits being conducted in 2017-18.

Proportionality

"Proportionate and least intrusive response"

Policy & Procedures Group

The group has increased its membership from care providers, both at the group and at its temporary working groups that complete specific tasks. This has led to policy and procedures being much more user-friendly from the perspective of care providers and other professionals.

The best example of this is the review of the thresholds document, which was significantly rewritten as a result of the feedback from frontline professionals.

Training Group

The training overseen by the group has been well received, with over 600 delegates across 60 agencies having attended either the level 2 course for frontline workers or the level 3 course for managers and team leaders. Feedback has given a 98.5% satisfaction rating for the training. The training promotes the person-centred approach to work, ensuring the adult with care and support needs is empowered to protect themselves where they have declined a response from partner agencies. It also aims to improve professional understanding of the roles and responsibilities of partners, informally through networking at the sessions and directly through content of the course.

Safeguarding Adult Review Group

The group have reviewed 7 cases in 2017-18 from a variety of partner agencies. One met the criteria for a Safeguarding Adults Review and the findings are outlined later on.

The other cases were subject to internal serious incident processes, the outcomes of which were reported to the group to ensure any learning could be shared across the partnership.

Empowerment

"Presumption of person led decisions and informed consent"

Full Board
During 2017-18, the Board commissioned Healthwatch to meet with those who had been through a safeguarding process to establish their views on the service they had experienced. All service users are asked at the point the safeguarding enquiry is concluded whether they would be willing to share their views on the experience with a third party.

The project began in January 2018 so its findings have yet to come to the Board for discussion. This work will be completed in 2018-19.

Vulnerable Adults Mortality Group
This group has a lay member who comes from a local community group supporting adults with learning disabilities. The Board is rolling out this good practice to other meetings, including the Full Board to ensure the voice of those with care and support needs is heard at Board meetings.

Performance, Information & Quality Assurance Group
The Making Safeguarding Personal data forms part of the performance dataset and has seen significant improvements in 2017-18. The proportion of adults who define the outcomes they want from a safeguarding enquiry has risen from 90% in quarter 1 to 96% in quarter 4. The proportion of people who have gone through a safeguarding enquiry and who are satisfied with the outcomes has increased from 45% in quarter 1 to 73% in quarter 4, which is a significant increase and shows the partners are working hard to keep the adult at the centre of all decision-making. The rates of both figures have continued to improve throughout the year, demonstrating that professionals are following the principles of Making Safeguarding Personal throughout their work with adults with care and support needs.

Governance

"Ensuring the Board is fit for purpose and working effectively"

Full Board
All subgroups of the Board have reviewed their Terms of Reference and the Full Board has developed a series of questions each subgroup in required to report against for each Full Board meeting.

As part of the Peer Review carried out in January 2017, the Board requested a report from Oxfordshire County Council, requesting they provide an assurance report on the changes made to the Safeguarding Service, which went live in October 2016. The report was received in Autumn 2017 and provided both qualitative and quantitative assurance that the creation of a central team had produced a positive impact on the safeguarding work undertaken by the County Council.

Executive Group
The Executive continues to review the membership and the chairing arrangements for all of the sub-groups to ensure they reflect the partnership and are as fully representative as possible. During the year it was agreed that the police would take over chairing the Safeguarding Adults Review subgroup.

The Executive also oversaw the review of Board documents, simplifying a number of documents and combining others, such as the self-assessment and impact assessment, to reduce the paperwork associated with the Board. There is now a requirement that all documents over 10 pages have an executive summary to improve accessibility.

Vulnerable Adults Mortality Group
This group was created as part of the Board' responsibilities for ensuring the deaths of those with a learning disability are reviewed and given appropriate scrutiny. The group was one of the first in the country and has provided a forum for frank discussions on the deaths of those with a learning disability within Oxfordshire. The first annual report of the group is due to be considered by the Full Board in June 2018.

Performance, Information & Quality Assurance Group
To ensure the Board is fully aware of the current safeguarding issues and is working effectively, the PIQA group have developed and improved its dataset throughout the year, resulting in a performance dashboard that partners agree shows the breadth of safeguarding work underway across partner agencies throughout Oxfordshire.

Joint Working

"working together to ensure people are safe from birth until end of life"

Transitions

Work is continuing with the co-production group 'Moving into Adulthood: Working Together', which fully involves people affected by the issues and using services, to refine proposals for a new approach to supporting young people with social care needs through transition. Conversations are being held with focus groups to test the emerging proposals with a wider group of young people, and to discuss emerging ideas with key groups of staff. The proposals, which include moving to a dedicated social care team which spans transition (from around 14 to 25), improving information, focusing on promoting independence, and following a case work model with a named social worker, are being well-received. Finer detail as to exactly which cohorts and age groups should be included in this team are still under discussion, but the intention is to focus on those with life-long disabilities and to ensure that the service is aligned well with services for other young people which extend up to 25 (care leavers, young carers and Special Educational Needs and Disabilities). The group will present its final recommendations to Directors of Adult and Children's Services in July.

The Joint Commissioning Team has recently re-aligned, bringing together commissioning for children and adults of working age into a single team. This provides a step-change in thinking about transition and the way services are planned and commissioned, providing opportunities to improve continuity between children's and adult services. The Strategic Commissioning Group is also in the process of radically reviewing the decision-making structures that relate to young people and adults with disabilities, with a view to bringing together decisions which have traditionally been fragmented into a cohesive life-time model.

Housing

A successful workshop was held in June 2017 for housing providers led by the two safeguarding boards for the following purpose.

- To create a better understanding of safeguarding challenges in the housing sector and identify what could be done to help promote effectiveness
- To share learning from Serious Case Reviews relevant to the housing sector
- To provide information on the new locality structures in children's services and adult social care
- To consider how we can strengthen working together in the new structures

The workshop recognised that a number of actions would need a more strategic response and would be complex and challenging to address on a multi-agency basis. These include concerns about the overall gap in support between front line housing services and statutory provision since the services provided through the Supporting People Programme are no longer available, and issues relating to supply of housing not meeting demand. The first two actions below would enable those more strategic safeguarding issues to be addressed. The other actions are practical responses to operational concerns raised.

There is now have a housing representative on each safeguarding board, from Sovereign Housing (Adults Board) and Response (Children's Board).

The new adults' protocol on 'Working with people who do not engage with services/ or are deemed ineligible to receive services' has been launched across housing providers and to test out how it works in practice.

A network for Housing Provider Safeguarding Leads is being established to improve communication about issues such as :

- referral routes;
- ensuring all housing providers keep up to date with best practice in safeguarding;
- raising awareness of key issues on a two-way basis;
- promoting safeguarding training opportunities.

Domestic Abuse

The Domestic Abuse Operational Board is now working effectively, meeting quarterly, with good participation from a broad range of relevant local services. There is now also service user attendance on the Board and this is being developed to enable service users to have a voice at the Strategic Board. The Operational Board works on a thematic basis and most recently has developed the Young People's Pathway Action Plan which follows on from the recently completed YP DA Safeguarding Pathway Audit. The Pathway has been revised and due to be relaunched in June 2018.

The Strategic Domestic Abuse Board is overseeing the delivery of the co-commissioned domestic abuse services. The commissioning process identified a winning bidder to deliver the new domestic abuse service model and we had been working towards implementation from 4 June for the new service -. Unfortunately, at the beginning of May the preferred bidder withdrew due to unforeseen implications from the transfer of undertakings regulations which meant they felt unable to continue. We have now awarded the contract to the second highest bidder and are working with them to deliver the new service model with a revised timetable for some aspects of the service.

A sub-group of the Strategic Board is working on a training strategy, developing a framework for a range of multi-agency and single agency training which sets expectations for specific organisation types, in terms of the types of training their staff should have. This framework is likely to include Champions training, Designated Multi Agency Risk Assessment Conference (MARAC) Officer Training, Basic multi-agency domestic abuse training, Risk Assessing, and Young People and Domestic Abuse, and other training with specialist focus. The sub-group is also considering the funding options for such training.

SAFEGUARDING ADULT REVIEWS

In 2017-18 one Safeguarding Adults Review was completed.

Adult C

Adult C was a man in his 40s living alone in Oxford. He had no partner or children. He had historic unspecified mental health issues. While living in Oxford, Adult C was involved in a number of disputes with a neighbour about noise, and was arrested on several occasions for aggressive and threatening behaviour.

In February 2017, Police were called to his home as there were concerns about his behaviour and mental health. A Mental Health Act assessment was convened, but Adult C had calmed down and the outcome was that he did not require admission to hospital. Community follow-up was arranged with the Step-Up Team, and Adult C had face-to-face and telephone contact with staff over the next two days.

Less than a week later, there was an explosion at the block of flats where Adult C lived, resulting in a large fire and total demolition of the two-storey structure. The body of Adult C was later found in the rubble. There were no other casualties. An Inquest concluded that "the explosion is likely to be accidental in nature but he was heard to say he was going to cause an explosion about five days before and it cannot be ruled out that it was caused deliberately."

Overall Conclusion

The Safeguarding Review Report concludes, having examined all of the information and spoken to a range of professionals, that if the fire was accidental then it could not have been reasonably predicted or prevented. It also concluded that if the fire was deliberate, then there was still no clear evidence that it was predictable or preventable. The Review found that the mental health services were of good professional standard, and the system for convening and undertaking an emergency Mental Health Act assessment worked well in this case. Police Officers attended the address within a few minutes of the initial calls, and restrained Adult C before calling an Ambulance. The assessment appears to have been thorough and to have resulted in a unanimous and reasonable conclusion based on the evidence available.

While the Review found that the death of Adult C was neither predictable nor preventable, there is always something for agencies to learn from the detailed analysis of incidents like this, as shown below:

Recommendations

The NHS 'Root Cause' investigation report makes the following recommendations:

- A full review of the inputting and removal of information onto the Step-Up FACT board
- Any change to a pre-existing Step-Up plan must be documented

The Thames Valley Police (TVP) report makes the following recommendations:

- To review current practices and agree a standardised Safeguarding Referral process with Fire and Rescue Services across the TVP area and communicate this to staff and officers. This should include referrals being made both ways.
- The Contact Management Call handling Procedure should be updated to reflect the importance of attaching the correct address to a URN (i.e. the address for officers to attend). Contact management staff should be advised of the change to the policy.

A2Dominion (the housing provider) have identified the following actions:

- All residents who live in homes who are on the cautionary contact list (CCL) will be visited and each of them assessed to understand their circumstances and individual needs, involving relevant agencies where necessary.
- Where there is a known Anti-Social Behaviour case involving a resident on the CCL, A2Dominion will visit the alleged victim & perpetrator in their own homes rather than calling them to the office.

HOW WE KNOW WE ARE MAKING A DIFFERENCE

Here are five examples of how the work of the Safeguarding Adults Board is making a difference to the residents of Oxfordshire.

CALL BLOCKERS PROJECT

As part of partnership work to tackle the harm caused by nuisance and scam telephone calls, the Trading Standards Service provides call blockers to people who may be vulnerable to telephone scams.

Call-blockers are devices that are fitted to telephones to restrict unwanted calls. They can be set to block all calls except those from pre-programmed numbers or to block calls from specific numbers.

Cold-calls can be harmful in many ways. A cold-call is often the start of a fraud, whereby vulnerable people are identified and systematically targeted with different misleading phone calls to elicit payments for non-existent goods or services. For some they are the start of systematic financial abuse. For people with mobility problems they can also lead to higher risk of falls as they repeatedly answer the phone at all hours of day or night.

Working from referrals about vulnerable people from the Police, Fire Service, Social Care or the National Trading Standards Scams team, Oxfordshire Trading Standards will offer to fit call blockers where a person may be vulnerable to telephone scams. Since May 2015, they have installed 69 call-blocking units, free of charge.

In total, by the end of February 2018 these units had blocked 40,235 nuisance calls. On average those using the equipment had been receiving 50 nuisance calls per month (the average across the UK is 18 per month). One household had been receiving 448 nuisance calls per month.

Research commissioned on the effectiveness of call-blockers concluded that the call-blockers fitted in Oxfordshire in 2017 alone blocked 4,196 scam calls, prevented 23 scams being committed and provided total savings to the individuals affected as well as to the health and social care services of over £59,000.

IDENTIFYING RISK AND ENGAGEMENT FOR A BETTER OUTCOME

Mrs Brown*

Mrs Brown, aged 59 and living alone, was known to have alcohol problems. Concerns regarding her wellbeing were raised by Thames Valley Police following a small fire in the area around a chair she used in her kitchen. In response to this safeguarding concern, Oxfordshire Fire and Rescue services arranged a joint visit to meet with Mrs Brown with colleagues from Environmental Health, Adult Social Care and the Police..

At the joint visit, the kitchen area was heavily cluttered with combustible material, rotten food and alcohol bottles, some of which were broken, leaving shards of glass across the floor. On inspection of the fire debris, it appeared that material possibly from clothing or a tea towel had become ignited, spreading to some food packaging and the bottom of a curtain. There was evidence of careless disposal of cigarette ends around her chair, around the settee in the living room and around her broken bed in her bedroom.

All present agreed a multi-agency approach was required to ensure the safety of Mrs Brown and her neighbours.

At the time of the joint visit two temporary smoke alarms were fitted to the kitchen area and the living room area near to her settee.

A GOOD OUTCOME

With Mrs Brown's consent, arrangements were made for the District Nurse to visit her as she did not want to attend the surgery and there were concerns for her health. A mental health assessment was also carried out. Environmental Health arranged with Mrs Brown for a blitz clean in the property to make the home environment less of a health risk. Food deliveries were arranged and a Care Agency was also employed. The Fire & Rescue Service had managed to build a positive relationship with Mrs Brown and so they continued to visit her.

Mrs Brown subsequently agreed for Extreme Heat Sensors, a Falls Alarm and a Key Safe to be installed and her care has been increased to support her with maintenance of the home.

*all names have been changed to protect to identity of those involved

ESCAPING A COERCIVE RELATIONSHIP

Mrs Vine*

Mrs Vine was living with her husband in their family home along with another woman who was said to be Mr Vine's girlfriend. A safeguarding concern was raised as it was suspected that Mrs Vine's husband had slowly isolated her and was preventing her from attending the day centre and even health appointments. There was previous evidence that Mrs Vine had been living in an abusive and controlling relationship for a long time.

A Social Worker and an Occupational Therapist visited Mrs Vine and tried to encourage her to discuss her home situation but she would not speak openly.

Mrs Vine was admitted to hospital shortly after this meeting, so the Social Worker and the Occupational Therapist took the opportunity to address again the concerns that had been so difficult to discuss candidly whilst in the family home. Mrs Vine disclosed that she did not want to go home and that she was not happy with her home life.

A GOOD OUTCOME

Working together to support Mrs Vine led to a proposal for her to move from her family home to an Extra Care housing facility locally at her request.

To facilitate this sensitively involved a lot of close joint working with other agencies: colleagues from Adult Social care, the Safeguarding service, the housing and care providers, and the acute hospital staff.

Mrs Vine was supported emotionally and practically as there needed to be conversations with her husband about the move. There were complexities with her tenancy and starting a new one in her own name, as well as finances/benefits to sort. Mrs Vine required furniture and adaptations for her new property and the care agency staff needed special training to support Mrs Vine's health care needs.

Several months on Mrs Vine is settled in her new home and she is reportedly much happier.

PROVIDING PROTECTION FOR VULNERABLE ADULTS

Mr Benn*

At the time the Housing officer referred Mr Benn to the safeguarding team, he was an extremely vulnerable man. He had suffered a stroke a few months before and needed regular hospital appointments.. When Mr Benn was at a previous address his grandson brought lots of unwanted visitors involved in drugs and drug dealing to his home . The situation had gotten so bad that the Housing provider had had to move Mr Benn to another property for his own safety.

More recently, following a term in prison Mr Benn agreed for his grandson to live with him and for Mr Benn's home to be his grandson's bail address. The situation rapidly deteriorated, his grandson's visitors causing problems as before and bailiffs coming to take Mr Benn's goods due to his grandson's debts and unpaid fines. Mr Benn was also forced by his grandson to give him money and to hand over his bank card.

There was a risk that if his grandson caused any more trouble at the property, Mr Benn could lose his home and tenancy.

A GOOD OUTCOME

The Housing officer carried out regular welfare visits to Mr Benn jointly with the Police. Mr Benn told the Housing officer he did not want his grandson living with him any more.

Mr Benn's grandson was again remanded in custody and a multi-disciplinary meeting was held to discuss the risks posed to Mr Benn should his grandson be released and bailed back to his address.

Through this joint working the decision was confirmed by the Probation service that they would not approve the release from prison to Mr Benn's address. Notification was shared on the planned date of release so that any additional security measures needed could be arranged. Sadly, Mr Benn passed away during this time.

*all names have been changed to protect to identity of those involved

WORKING TOGETHER TO PROVIDE MATERNITY CARE AND PLANNING FOR THE FUTURE

Miss Kay*
Miss Kay is rehabilitating and is expecting her third child, her oldest children live at home.

Miss Kay has the mental capacity to consent to care and treatment, and surrounding the birth of her baby however the team were concerned that she doesn't have capacity surrounding her rehabilitation and discharge home, this prompted a safeguarding concern to be raised.

WORKING TOWARDS A GOOD OUTCOME

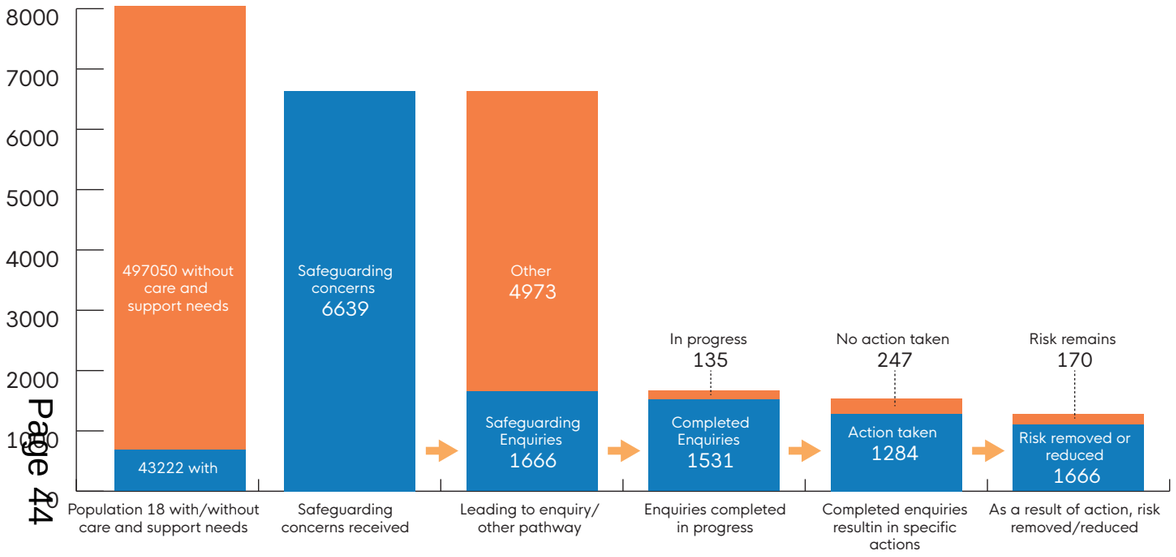
The teams involved with Miss Kay are the children's and adults health and social care safeguarding teams.

Miss Kay now has an advocate to enable her 'voice' to be heard whilst pregnant and planning for the baby's care once born; and plans are in place between her clinical team and the maternity services for the safe delivery of her baby.

*all names have been changed to protect to identity of those involved

WHAT ARE THE NUMBERS TELLING US

The safeguarding journey - from raising of safeguarding concern to outcome of safeguarding enquiry 2017-18



RAISING OF SAFEGUARDING CONCERNS

- Safeguarding includes a whole range of activities that are designed to "protect an adult's right to live in safety, free from abuse and neglect". First and foremost, it is about prevention – stopping abuse and neglect before it happens.
- However, when abuse does occur Oxfordshire has robust procedures to ensure that people receive the support they want to live a safer life.
- Safeguarding procedures support people who are at greatest risk, those of us who rely on others (staff, family and neighbours) for their care and support.
- In Oxfordshire this is about 43,222 people.
- Most people in Oxfordshire say their needs are well met and they feel safe
- Anybody can notify the county council if they have concerns about someone with care and support needs – but if you can talk to the person you're worried about first and ask them what they want, that's better.
- In 2017-18, Oxfordshire County Council were contacted 6639 times about concerns that a person with care and support needs was experiencing abuse or neglect.

RESULTING SAFEGUARDING ENQUIRY PROCESS

- A quarter of the concerns received last year were assessed as requiring further enquiries
- This is because the people involved were:
  (a) Experiencing, or being at risk of, harm or abuse; and
  (b) Having care and support needs which prevented them from protecting themselves
- Those concerns (4973) which did not result in a safeguarding enquiry were followed up in other ways:
  - Providing information or advice
  - Referring on to other agencies: trading standards; domestic abuse support agencies; the police or other health or social care services

OUTCOME OF ENQUIRY PROCESS

- Of the safeguarding enquires which were completed in 2017-18, 1284 or 84% resulted in action being taken to reduce the level of risk to the person.
- Where no action is taken it is usually because the person themselves doesn't want anything to change, or at the end of the enquiry it is evident that abuse or neglect have not occurred.
- Even in these cases we are often able to support people in other ways to live safer lives.
- In a small number of cases (170), despite actions being taken, the risk to the person was judged to have remained or the outcome was unknown (we have amended our processes to ensure that the outcome is now known in all cases)
- This may occur where the actions taken are intended to protect others but the person themselves doesn't want anything to change in their own lives.
- However, in most cases, 88%, the risk of harm or abuse to the person was removed or reduced as a result of the support of all the people involved in their care and support.

WHAT WILL THE BOARD WORK ON IN 2018-19?

A business planning meeting of the OSAB in May 2018 agreed the following interim strategic priorities, which will be finalised after consultation with service users, carers, community groups and other stakeholders. The priorities detailed below are based on feedback from Board Members on those matters which are of most concern to the range of agencies working within Oxfordshire. They also include feedback from front line practitioners.

In 2018-19 the OSAB will continue to build upon its good joint working work with the OSCB, holding bi-annual joint meetings and sharing a number of priorities identified as affecting both children and adults with care and support needs.

Early Help Strategies & Initiatives

Improving Multi-agency Working

Monitoring Key Issues

Service User and Community Engagement

1. Establish an Engagement & Communications Group to:
   - Oversee a series of meetings with services users, carers, community groups and other stakeholders.
   - Investigate the development of a Phone App and a shared multi-agency safeguarding website.
   - Produce flyers/posters/promotional material/briefings to share with existing communication networks.
   - Raise awareness of safeguarding issues amongst the general public.
   - Co-ordinate a community awareness week.
2. Recruit at least one lay member to the Full Board

Early Help Strategies & Initiatives

1. Refine the annual self-assessment to understand more about the challenges around Prevention & Early Intervention
2. Monitor the enquiries made to the safeguarding consultation services operating across all partner organisations to establish the themes and range of issues.

Improving Multi-agency Working

1. Develop further multi-agency awareness of Mental Capacity Act best practice, including the issues raised by the concept of Executive Capacity.
2. Review current Making Safeguarding Personal (MSP) training sessions. Consider models of delivery in order to maximise practitioners knowledge and confidence.
3. Define and develop a multi-agency risk assessment tool.
4. Review the membership of sub-groups and the roles of vice-chair to ensure they reflect the wide range of partner organisations.
5. Review work-plans of subgroups to ensure all actions are matched to the four priorities

Monitoring Key Issues

1. Continue to monitor the thematic priorities identified by Board Members that remain at the forefront of safeguarding work:
   - Prevention and early intervention work
   - Mental health service provision
   - Domestic abuse
   - Alcohol and drug abuse
   - Exploitation
   - Housing

Specific work is already underway to address these key issues. The governance of them falls to other strategic groups to manage so our role is to scrutinise and challenge these arrangements to ensure that safeguarding is kept at the forefront of any new developments.

With regards to domestic abuse, the development of a Multi-Agency Tasking and Coordination (MATAC) strategy is currently being trialled in Oxford City with a view to expanding this to address needs across the county.

Public Health are already reviewing pathways for children to access Children and Young People Services, especially for drug and alcohol abuse, as some who are eligible are not accessing this support.

Further development of the 'Think Family' approach to address inter-related safeguarding issues, including domestic abuse and exploitation, is also welcomed.

Prevention has become a focus for the Health Improvement Board and Housing is now a joint priority for both safeguarding boards.

GLOSSARY OF TERMS

Safeguarding
Safeguarding means protecting our right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and reduce the risk of abuse and neglect. When people have experienced abuse or neglect, safeguarding is about taking actions that are informed by the person's views, wishes, feelings and beliefs.

Making Safeguarding Personal
Making Safeguarding Personal starts with the principle that we are experts in our own life. Things other than safety may be as, or more, important to us; for example, our relationship with our family, or our decisions about how we manage our money. So, our staff are being encouraged to always ask 'What is important to you?' and 'What would you like to happen next?'

An Outcome
An Outcome is what you hope to get out of the conversations we have, and the work we do with you. Measuring outcomes helps the Board to answer the question "what difference did we make?" rather than "what did we do?"

Deprivation of Liberty Safeguards (DoLS)
Deprivation of Liberty Safeguards apply when a person in a care, or nursing home, or hospital, is subject to continuous supervision and control from staff, and is not free to leave; under the Supreme Court judgement known as 'Cheshire West', they are deprived of their liberty. Once identified, a deprivation of liberty must be authorised either by the Court of Protection order; or under the Deprivation of Liberty Safeguards in the Mental Capacity Act 2005; or under the Mental Health Act 1983. If it is not authorised, under the law, it is an illegal detention.

Self-neglect
Self-neglect covers a wide range of behaviour including neglecting to care for one's personal hygiene, health, or surroundings, and behaviour such as hoarding. The term itself can be a barrier as some people do not identify with this term or description of their situation. It is important that practitioners find common ground and understand the person's own description of their lifestyle rather than making assumptions about how it can be defined.

Hoarding
Hoarding behaviour was previously seen as a symptom of Obsessive Compulsive Disorder but it has now received a separate clinical definition of 'hoarding disorder' and is defined as: 'A psychiatric disorder characterised by persistent difficulty discarding or parting with possessions, regardless of their actual value resulting in significant clutter that obstructs the person's living environment and produces considerable functional impairment.' (Greater Manchester Fire and Rescue Service: Hoarding, Prevention, and Protection).

Clutter Image Rating
Clutter Image Rating a series of pictures of rooms in various stages of clutter – from completely clutter-free to very severely cluttered. People can just pick out the picture in each sequence comes closest to the clutter in their own living room, kitchen, and bedroom. When clutter reaches the level of picture number four, or higher it begins to impact on people's lives and we would encourage the person to get help for their hoarding problem.

Safeguarding Adult Review
A Safeguarding Adults Review must be conducted where an adult with care and support needs has died as a result of abuse or neglect and there are concerns about how agencies worked together to safeguard the adult.

A Safeguarding Adults Review should also be conducted where an adult with care and support needs has experienced serious abuse or neglect as a result of abuse or neglect and there are concerns about how agencies worked together to safeguard the adult. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

Boards can also choose to arrange a review into any other case of an adult in its area with care and support needs.

Division(s): N/A

PERFORMANCE SCRUTINY COMMITTEE - 8 November 2018

Safeguarding Children – Annual Reports

Report by Director for Children's Services

Introduction

1. Richard Simpson (OSCB Independent Chair), Lara Patel (Deputy Director, Safeguarding, Children, Education and Families) and Tan Lea (Strategic Safeguarding Partnerships Manager, Children, Education and Families) will present a paper on **three** annual reports from the Oxfordshire Safeguarding Children Board. The reports concern an overview of safeguarding work; serious case reviews and quality assurance.

   The Performance Scrutiny Committee is requested to note these annual reports and provide any comments.

Background

2. Local Safeguarding Children Boards were set up under the Children Act 2004 to co-operate with each other in order to safeguard children and promote their welfare.
3. The Oxfordshire Safeguarding Children Board (OCSB) is led by an independent chair and includes representation from all six local authorities in Oxfordshire, as well as the National Probation service, the Community Rehabilitation Company, Police, Oxfordshire Clinical Commissioning Group, Oxford University Hospitals NHS Trust, Oxford Health NHS Foundation Trust, schools and Further Education colleges, the military, the voluntary sector and lay members.
4. The Board is funded through a partnership arrangement and meets 4 times per year. The Board is supported by a Business Unit located within Oxfordshire County Council. The board has two joint meetings with the Safeguarding Adults board per year. There are three area groups to ensure good communication lines to frontline practitioners.
5. The Board has a series of multi-agency subgroups, each of which produce an annual report. This paper includes annual reports produced by two the subgroups working on learning and improvement in safeguarding practice: the Case Review and Governance subgroup and The Performance, Audit and Quality Assurance subgroup.

OSCB Annual Report

6. The key purpose of the **OSCB Annual Report** is to assess the impact of the Board's work in 2017/18 on:
   - service quality and effectiveness

- safeguarding outcomes for children and young people in Oxfordshire.

7. The report evaluates performance against the priorities that are set out in the Business Plan for the year and against other statutory functions that the LSCB must undertake.

8. The report highlights lots of good examples of safeguarding work within the partnership. This included the successful conviction of a predatory offender through the actions of a taxi driver, who had undertaken local safeguarding training; the successful prosecution of a perpetrator of historical abuse through the use of multi-agency guidance for responding to non-recent (historic) abuse (example from OH NHS FT); identified improved attendance at Core Groups and timely responses to requests for information from the Multi Agency Safeguarding hub (example from Community Rehabilitation Company); increased recording of children's information when attending domestic abuse incident by Thames Valley Police; increased involvement of the hospital's young people's group (Yippee) in decision making meetings; new material and video to promote the work on neglect (Children's Social Care); self-assessment in 'Excellence when working with boys on CSE (Kingfisher) as well as the development of a new exploitation group to address broader issues of child exploitation (all OSCB partners).

9. In 2017/18 the OSCB delivered over 150 free safeguarding training and learning events plus online learning. The training reached over 9000 members of the Oxfordshire workforce:
   - ✓ 2040 multi-agency practitioners trained core safeguarding
   - ✓ 417 multi-agency practitioners trained on early help assessments
   - ✓ 451 multi-agency practitioners trained on mental health, child sexual exploitation, working with men and boys, drugs and alcohol and sexual abuse
   - ✓ 38 multi-agency practitioners trained on female genital mutilation
   - ✓ 697 early years multi-agency practitioners trained on safeguarding
   - ✓ 3854 multi-agency practitioners trained on abuse and neglect; safeguarding and think family

10. The OSCB delivered termly newsletters to over 4000 members of the workforce and e-bulletins to educational settings across the county. Learning and improvement events for approximately 150 delegates each time have covered:

    - ➢ Ten learning points from Oxfordshire case reviews
    - ➢ Fathers and male care givers
    - ➢ Working with neglect

Performance, Audit and Quality Assurance Annual Report

11. The Performance Audit and Quality Assurance subgroup scrutinises the effectiveness of safeguarding practice. This annual report summarises the common themes for learning and improvement to support vulnerable children.

They are drawn from safeguarding self-assessments, school audits, single and multi-agency audits, participation work with children and young people, annual reports and serious case reviews practitioner feedback, performance data.

12. The quantitative data shows that levels of activity continue to increase across the safeguarding system. The child protection partnership has three key pressures on its system: rising demand, diminishing resources and staffing shortfalls as well as difficulties with staff recruitment and retention. This is accompanied by an increasingly complex set of issues for vulnerable young people ranging from self-harm, to peer abuse to social media pressures. The OSCB sees evidence for better understanding of thresholds and improved safeguarding front-door effectiveness as well as the need for better co-ordination of the routes for referral and assessment between early help and the multi-agency safeguarding hub.

13. Qualitative evidence highlights the complexity of cases not only within the children's safeguarding arena but also in relation to adults in those children's lives; the need for stable, appropriate and secure housing and the benefit of supporting vulnerable adolescents to develop protective behaviours. Quality assurance work has raised concerns locally about the pathway of support for young people suffering domestic abuse; the response and provision for young people exploited in crime-related activity as well as concerns about mental health and self-harm amongst young people.

14. Practitioners and Board members have told the OSCB that they are concerned about availability of hospital beds for children with acute mental health needs; placements for children in the care of the local authority; the quality of provision in the Secure Estate and the limited access that the local authority has to support children who are in Elective Home Education. These matters, along with the pressures on the system, are being escalated.

15. Parents and children have given three simple messages (1) '*communication, communication, communication*' (2) don't leave help until we are at crisis point, *"make a difference as early as possible*". (3) please co-ordinate your efforts and share information appropriately. Children also said to show you care, "*get to know me as a person not just a case or a set of problems*". They want to be informed and involved "listen to me".

Case Review and Governance Annual Report

16. The purpose of the group is to support the OSCB in fulfilling its statutory duty to undertake reviews of cases both where the criteria[1] are met and where they are not met in order provide valuable information on joint working and areas for improvement. The group comprises members drawn from Thames Valley Police, the County Council's children's services and legal services, the OCCG Designated Doctor and Designated Nurse and a Head teacher representative.

[1] Working Together to Safeguard Children 2015

17. Over the last year the OSCB has worked on four different serious case reviews which have concerned five children. One of the serious case reviews is associated with a Mental Health Homicide Review. No reviews have been published this year.

18. The themes covered by case reviews have been: the long-lasting impact of neglect; physical abuse; self-harm; child and parental emotional wellbeing; engagement and attendance in education. The issue of neglect is a repeated theme in terms of the risks it presents to young children and the impact it continues to have as they grow up. In Oxfordshire neglect is the most common reason for a child to be subject to a child protection plan. The OSCB has a Task and Finish Group to co-ordinate work to address neglect.

19. The ten most frequently recurring learning points have been:

1) **Curiosity:** being curious about the family's past history, relationships and current circumstances in a way that moves beyond reliance on self-reported information
2) **Responding to physical abuse:** professionals identifying it, listening to children and following safeguarding processes thoroughly; children may sometimes be too afraid to speak or unable to verbalise what they are going through
3) **The role of schools in keeping children safe:**
   - effective management of records and sharing them when children transfer schools; effective escalation of concerns.
   - children are safest in full time education. Oxfordshire serious case reviews indicate that children on part time time-tables, children absent from school and children educated at home are at increased risk. School attendance is a critical factor to support opportunity, well-being and safety
4) **Professional understanding of the implications of elective home education:** actively knowing which agencies are in touch with the family and to what effect
5) **Taking a cumulative view when working with children**: not seeing events in a linear way but weighing up risks over time and keeping previous events in mind (using chronologies)
6) **Parental wellbeing:** mental health, substance misuse and domestic abuse are recurring themes. With respect to mental health colleagues need to recognise the risks and impact on the safety of the child; don't minimise 'older' information
7) **Fragmented management of health needs:** ensuring effective communication across services for co-ordinated and consistent management of care
8) **Children's emotional wellbeing:** increasing evidence of self-harm by children aged 10 years & above
9) **Children's limited capacity to protect themselves:** as they move into adolescence after experiencing a lack of consistent, supportive parenting in their early years (long lasting impact of neglect)
10) **Rethinking 'did not attend' to 'was not brought'**

Financial and Staff Implications

20. None noted

Equalities Implications

21. None noted

RECOMMENDATION

22. The Committee is RECOMMENDED to note these annual reports and provide any comments.

Deputy Director for Safeguarding, Lara Patel

Background papers:

Contact Officer:
Tan Lea
October 2018

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Annual Report & Accounts 2017-18

Oxfordshire Safeguarding Children Board

Contents

Introduction from the Independent Chair, Paul Burnett

I am delighted to present the Oxfordshire Safeguarding Children Board's Annual Report for 2017/18 – the last time I will be doing so as Independent Chair in the county.

The report evaluates the impact of the work we have undertaken in 2017/18 focusing on service quality and effectiveness and on safeguarding outcomes for the children and young people of Oxfordshire. Specifically it evaluates performance against the priorities that we set in our Business Plan for the year and other statutory functions that the LSCB must undertake.

There is much to celebrate in terms of improvement and achievement:

- Strong challenge at national and local level in relation to issues presenting safeguarding risks including: exploitation; domestic abuse; support to transgender children; elective home education; school attendance and exclusions; specialist residential placement for children in care and; availability of beds for children with acute mental health needs
- Stronger links and collaboration with the Adult Safeguarding Board and Voluntary and Community Sector
- An online practitioner portal for Neglect that has received 8000 hits
- Over 2000 staff attending learning events across the county
- Stronger engagement with young people including VOXY
- Examples of community impact on safeguarding, such as apprehening a perpetrator of CSE as a result of an alert from a taxi driver who had received the mandatory safeguarding training for drivers three months earlier.

A further success was a commendation received by the OSCB Training Pool from in the NSPCC/BASPCAN awards.

Our robust quality assurance and performance management has identified priorities for action as we move into 2018/19. These feature in our refreshed Business Plan.

They include:

Providing strong leadership and governance – increasing the effectiveness of the Board, partnership working with the Oxfordshire Safeguarding Adults Board and Community Engagement;

Driving forward practice improvement – working to address neglect and working to safeguard adolescents;

Quality assuring and scrutinising the effectiveness of practice – taking robust action following learning, to secure improvement and to assess risk and capacity across the partnership

A key piece of legislation will impact on our work next year. The Children & Social Work Act 2017 creates a new framework for local safeguarding arrangements as well as revised procedures for local and national practice learning reviews (which replace Serious Case Reviews) and the reform of CDOP arrangements.

Revised local arrangements have to be in place by April 2019. In Oxfordshire we are not planning any radical change to existing arrangements. We intend to retain a Board with the current constitution and membership. We also intend to retain an Independent Chair though this may be provided through a different route to our current arrangement. Responsibility for local arrangements and their effectiveness will now rest with three organisations: the County Council, Thames Valley Police and the Oxfordshire CCG. The precise nature of this leadership does need to be agreed once the final version of the revised Working Together is published by the Department for Education.

In Oxfordshire there is a strong belief that we must retain an inclusive Board which enables all partners to have a voice in our overall safeguarding arrangements and direction of travel.

I retire from my post at the end of June 2018. I would like to take this opportunity to thank all Board members and those who have participated in Subgroups for their continued commitment in 2017/18 and throughout my time in post. In addition I would like to thank staff from across our partnerships for their motivation, enthusiasm and continued contribution to keeping the children and young people of Oxfordshire safe.

Safeguarding is everyone's business. The achievements set out in this Annual Report have been achieved not just by the Safeguarding Board but by staff working in the agencies that form the partnership. The further improvements we seek to achieve in 2018/19 will require continued commitment from all to ensure that children and young people in Oxfordshire are safe.

I commend this report to all our partner agencies.

Independent Chair, Oxfordshire Safeguarding Children Board

Oxfordshire Safeguarding Children Board

Introduction

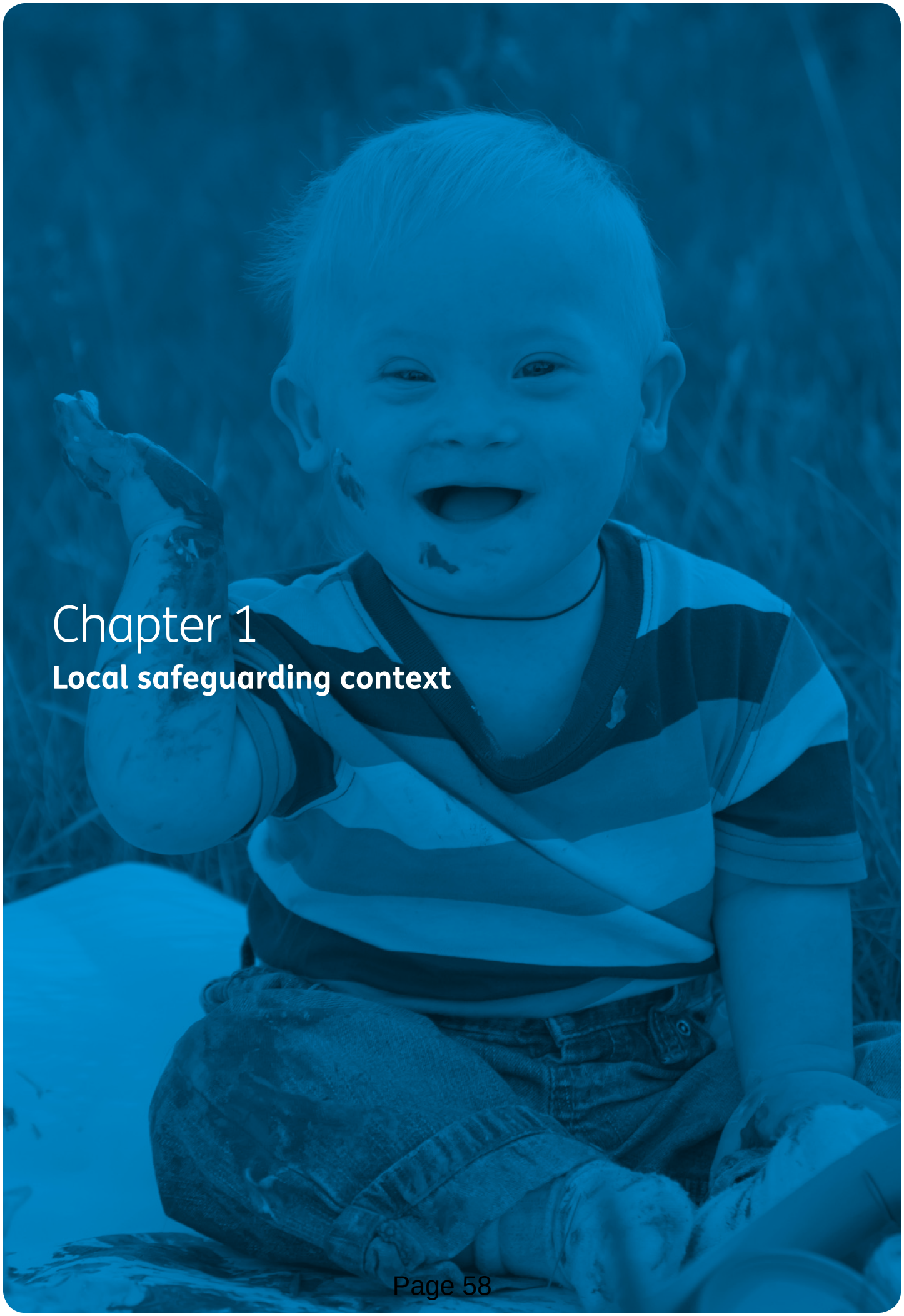
The reason for this report

The key purpose of the OSCB Annual Report is to assess the impact of the Board's work in 2017/18 on:

- service quality and effectiveness
- safeguarding outcomes for children and young people in Oxfordshire.

It evaluates our performance against the priorities that we set in our Business Plan for the year and against other statutory functions that the LSCB must undertake. See appendix A for these details.

It celebrates a number of areas of success and achievement but also identifies areas that present continuing challenge in safeguarding children and young people in Oxfordshire, challenges which form the basis of priorities for improvement in the Business Plan for 2018/19.



Chapter 1
Local safeguarding context

The Local Safeguarding Children Board is a partnership set up under the Children Act 2004. The agencies in this partnership co-operate with each other to safeguard children and promote their welfare.

The local safeguarding profile of the child population is our business. This is what we know about 2017/18.

The child population of Oxfordshire has grown by 6% in the last ten years and is estimated to stand at 141,800 young people aged under-18. Alongside this growth there has been increased demand for services particularly towards the high end of the continuum of need.

Key data presented shows that the local context is one of continued increasing demand on services and higher rates of escalation into child protection and care. This remains a concern for the OSCB but it was reassuring to see that the recent Ofsted judgement of children services stated that this context was being managed well locally.

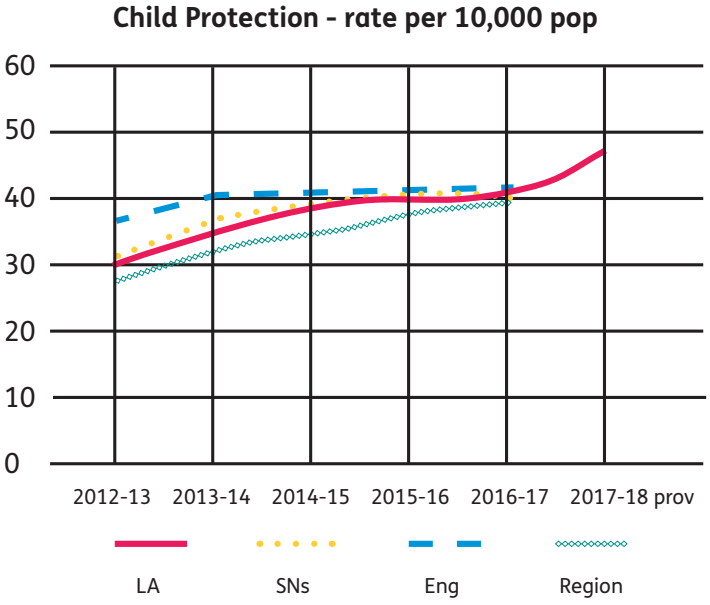
Help at the earliest point for families increases the chance of good outcomes for children. Early help assessments are the means for doing this. They have increased significantly from 458 recorded early help assessments last year to 1255 by end of year in 2017/18. This is commendable as Board partners know that not all agencies have found the early help assessments easy to complete and activity is underway to make it easier to do so. The number of troubled families worked with rose from 1549 last year to 2398. This increase is positive and would indicate that the work is on track.

Those families in need of immediate help and safeguarding support should be referred to the Multi-Agency Safeguarding Hub (MASH) which has been in place since 2013. This multi-agency team can assess need and ensure that the right kind of support is provided. The timeliness of enquiries managed by the Multi-Agency Safeguarding Hub are monitored closely. They show how quickly families are receiving help and have been a key indicator used by OSCB to gauge how well MASH is working.

The recent Ofsted inspection was positive about improvements made to the MASH so it is hoped that the improvements will soon be felt in the timeliness of services as at year end was below the target of 75% at 45%. This needs to be improved as does feedback to the referrers.

The number of children on a child protection plan rose from 569 last year to 730 at the end of March 2018 (higher than national average). Neglect is the most common reason for children to be subject to child protection plans (65%). This is higher than the national average where the proportion of children subject to child protection plans for reason of neglect is 48% (SFR 2016/17). Neglect is not however the most common reason for children to be subject to an early help assessment. This has raised questions to OSCB partners about how we identify, name and tackle neglect earlier in the child's journey. The recent Ofsted inspection agreed with this assessment.

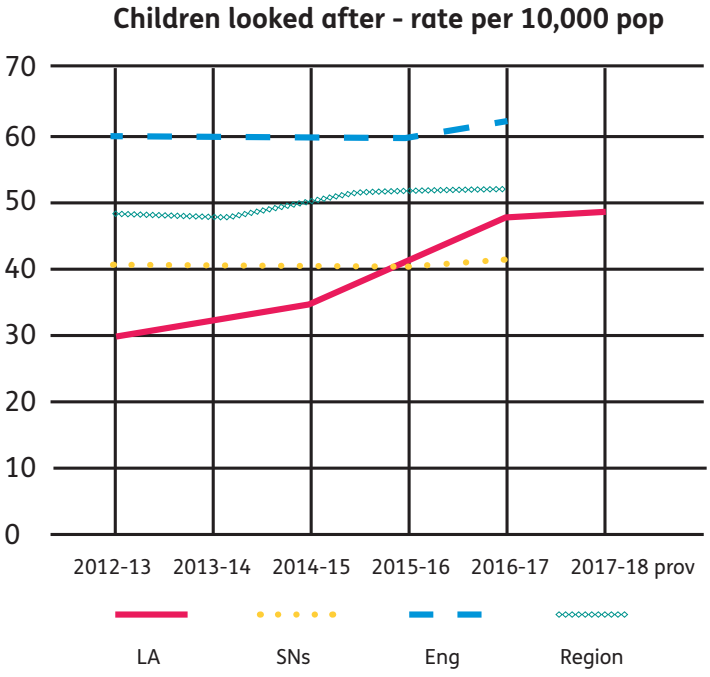
A close look at the management of child protection plans indicates that only 50% of fathers are attending children protection conferences regarding their children. 'Working with fathers' has been a focus for learning in 2017/18 and should remain one for now.



Graph 1: child protection

The number of children looked after by the local authority rose by 6% from 667 last year to 691 at the end of March 2018 (lower than national average). This is an increasing trend. The biggest increase has been in adolescent children, who are presenting with increasingly complex needs and elevated risk profiles particularly autism, mental health issues and risk of exploitation.

The OSCB closely monitors information on vulnerable children. Whilst the number of children who have gone missing from home has fallen from 798 to 773 the number who went missing 3 or more times was 149 or 19.3%. This needs further enquiry and consideration by the child exploitation subgroup.



Graph 2: looked after children

The numbers of child victims of crime rose from 2189 in 16/17 to 2268 in 17/18 – a rise of 3.6%. The numbers of domestic crime involving children rose from 1780 in 16/17 to 1804 in 17/18 – a rise of 1.3%

From national and local (children A-F and child J) case reviews the OSCB has evidence of links between safeguarding risk and safeguarding in education issues: attendance, exclusions, elective home education, attainment and achievement of pupils with special educational needs and disabilities. In 2017/18 499 children were recorded as receiving elective home education in Oxfordshire. At the end of 2017-18 the county council were aware of 378 pupils who were on a reduced timetable; 6 pupils who were currently on a fixed term exclusion and of 34 pupils who were permanently excluded from their school. Permanent exclusions of children with Special Education Needs have increased. The OSCB is very concerned about this vulnerable group of children and has made a priority to secure improvement. Data is showing us that children with additional needs make up at least 70% of the children worked with by the Kingfisher team, which specialises in supporting those children most at risk of child sexual exploitation. We know that this type of vulnerability often overlaps with drug exploitation. Data also shows that the proportion of Oxfordshire's disadvantaged pupils aged 10-11 achieving the expected standard was below the England average at Key Stage 2 in 2017.

The percentage of children referrals to Child and Adolescent Mental Health Services who are seen within 12 weeks continues to be a cause for concern. At the end of the year this was only 56% compared with a target of 75%. The service continues to face high levels of demand: in 2017/18 there were 6794 referrals into CAMHS, 11% higher than the previous year when there were 6128 referrals. An action plan has been put in place by the provider (Oxford Health NHS FT) which is routinely reviewed in contract meetings with the commissioner (CCG). Detailed updates are provided to both the Children's Trust and its Performance Audit and Quality Assurance sub group. Alongside this there has been a rise of 22% of children aged 12-17 who have attended A&E for self-harm of (542 in 2016-17 to 660 in 2017-18).

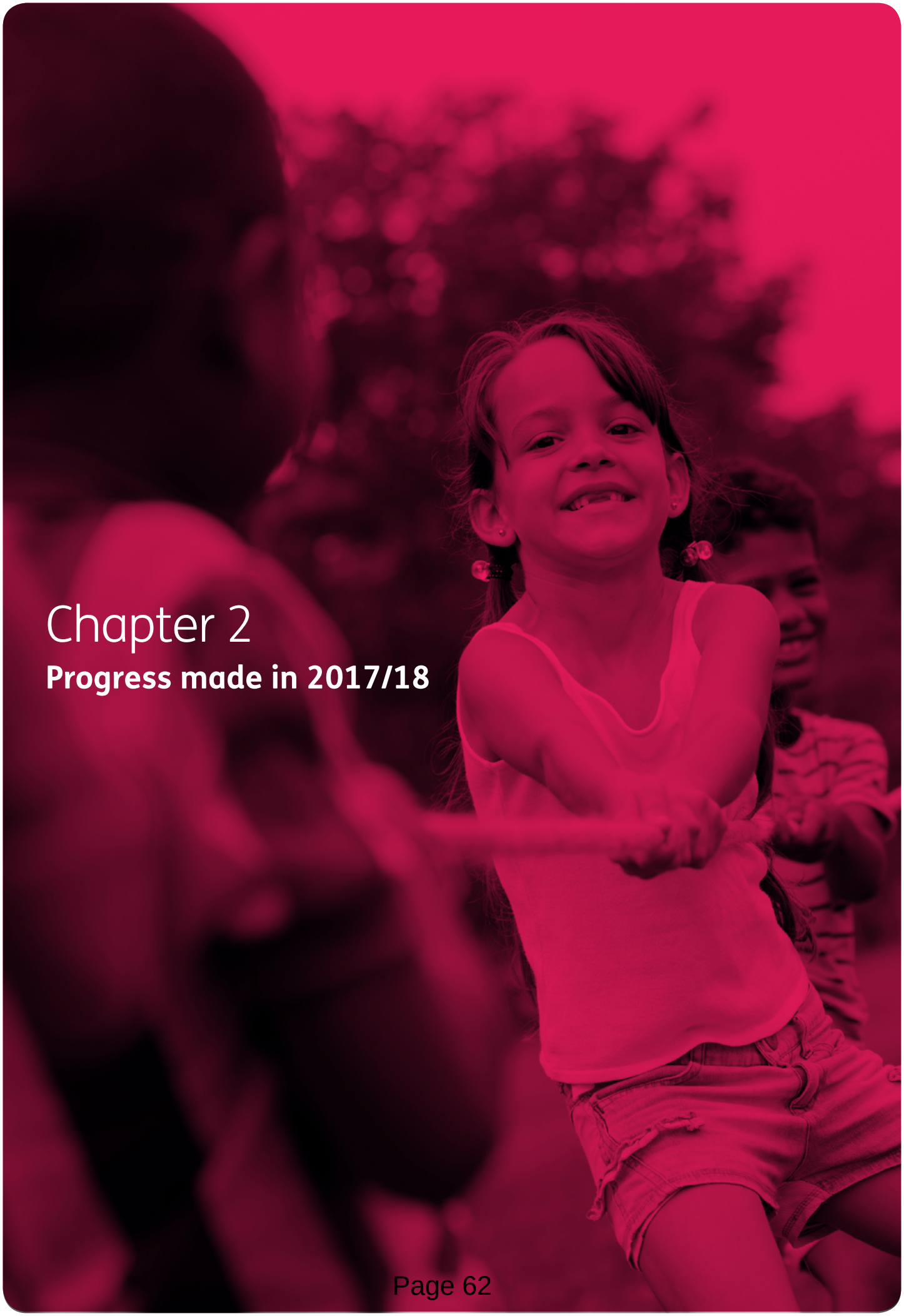
Health providers have also escalated the concern that there is a lack of provision for children with acute mental health needs, which had meant that it has not been possible to discharge them from hospital care to receive more appropriate support.

There are a higher than average numbers of young people remaining in their placement after 16 (84%) and high percentage of 19-21-year olds in suitable accommodate (88%). The county council maintains contact with 94% 19-21 year old care leavers. This is commendable as is the fact that 88% of the cohort are currently in employment, education or training.

What does this mean for the OSCB's priorities in 2018/19?

The local context is one of a system under pressure. There has been a long period of rising demand for services against a background of cuts. This pressure will be felt at the frontline in the hours and effort that colleagues put in every day. OSCB partners should:

- ensure that the early help process is improved and that partners in the safeguarding system understand thresholds, early help and their role in it. The aim is to reduce the number of families that are escalated for help through child protection planning of the care system
- ensure that partners know how to see and name neglect earlier and understand the value of a multi-agency chronology when working with children
- improve multi-agency responses to safeguarding vulnerable adolescents from criminal exploitation, in particular those children with special educational needs
- maintain an emphasis on risks identified through 'safeguarding in education': attendance, exclusions, elective home education, attainment and achievement of pupils with special educational needs and disabilities
- scrutinise pressure points until improvement is seen e.g. Early Help Assessments (EHA) completion rate, MASH timeliness, CAMHS waiting times
- escalate risks which sit outside of the local partnership e.g. lack of provision for looked after children and for children with acute mental health needs, elective home education
- ensure that the workforce is thinking family and thinking dads
- ensure that the workforce is capable and able to deal with:
  - parental issues such as substance misuse, mental health problems and domestic abuse are addressed as part of this problem
  - adolescent issues of substance misuse, mental health, healthy relationships as well as online well-being.



Chapter 2

Progress made in 2017/18

The Annual Report evaluates performance against the 3 aims of the OSCB as set out in the Business Plan 2017/18:

1. **To provide leadership and governance**
2. **To drive forward practice improvement**
3. **To scrutinise and quality assure**

Aim 1

To provide leadership and governance

Priorities have been to increase the effectiveness of the board, partnership working with Oxfordshire Safeguarding Adults Board and community engagement

Progress includes	
Increasing the effectiveness of the board	✓ Partnerships protocol updated and simplified (see appendix X) ✓ Annual impact assessment on the effect of efficiency savings and transformation of services across the child protection partnership ✓ Six monthly reports on key aspects of the system e.g. the Multi-Agency Safeguarding Hub and CAMHs waiting times ✓ Systematic challenge and escalation of safeguarding risks which have emerged in addition to the board's ongoing business
Challenge made	**Escalation by the OSCB**
Safeguarding of children in secure estates	✓ To the HMIP, the CRC and the AILC. The outcome is that a national level task group is now reviewing this serious concern. We are yet to see if this will lead to change at a national level.
Safeguarding risks for children in elective home education	✓ To the government via the association of independent. Government is consulting on this in 2018 and OSCB has submitted evidence from a recent case review. The outcome of this work will become clear in 2018/19.

Challenge made	Escalation by the OSCB
Specialist residential provision for looked after children	To the regional association of directors for children's service. The outcome has been that this has been escalated onward to the government to inform them of the problems with and lack of provision as well as particular concern for children with acute mental health needs. We are yet to see if this will lead to change at a national level.
Exploitation of children in the form of drug exploitation	To local partners. The outcome has been to set up an OSCB child exploitation group which is developing outputs such as a screening tool, referral routes and provision to be used by safeguarding partners across the county. The next annual report will comment on what difference these safeguarding arrangements are making to children.
Uptake of the police's 'Encompass' system	To schools. They have been made aware of this domestic abuse notification via OSCB. The outcome has been improved uptake from 16% to 48% (May 2018 data). This is still not sufficient and remains a concern.
Pathway for support for LGBTQ children	To the Children's Trust. Outcomes have been that the health advisory group is developing a 'referral' pathway for children asking for help; school health nurses have done awareness training to better support children; OSCB training is coming online in 2018 for professionals who want to improve their practice when working with children.

Partnership working with Oxfordshire Safeguarding Adults Board	Community engagement
Joint work on transitions ✓ Co-production group 'Moving into Adulthood: Working Together' set up to develop a new approach to supporting young people with social care needs through transition. ✓ Draft proposals to develop a social care team which spans transition (from around 14ys to 25ys), improving information, promoting independence and providing a named social worker. ✓ The Joint Commissioning Team re-aligned, bringing together commissioning for children and adults of working age into a single team. ***Joint work on housing*** ✓ New housing representative on each safeguarding board ✓ New adults' protocol has been launched on 'Working with people who do not engage with services/or are deemed ineligible to receive services' across housing providers and test out how it works in practice. ✓ New network for Housing Provider Safeguarding Leads is being established to improve communication about issues and concerns e.g. referral routes; access to information; good communication and training ***Joint work on domestic abuse*** ✓ Audit on the 'referral pathway' for young people ✓ The 'referral pathway' for young people subject to domestic abuse has been revised and will be launched in 2018 ✓ New domestic abuse service model commissioned to start in 2018 ✓ Work on training strategy for domestic abuse to deliver in 2018 ***Joint work on training*** ✓ Joint oversight of shared thematic training ✓ 'Think Family' online course developed for adults and children	✓ VCS representation on all key subgroups and board with a plan for action in 2018 ✓ VCS partners joined the training pool ✓ OSCB safeguarding training to specialist groups ✓ OSCB regular input in to Children, Young People's Forum ✓ Self-assessment of safeguarding for local partners completed ✓ Template Safeguarding policy for local partners ✓ Safeguarding checklist for local partners ✓ 4 meetings with the Voice of Oxfordshire Youth group ✓ Children in Care Council and Voice of Oxfordshire Youth group part of OSCB recruitment processes ✓ Voice of Oxfordshire Youth group presented their main safeguarding concerns ✓ Voice of Oxfordshire Youth group asked OSCB to look at how well safeguarding partners work with perpetrators of sexual harm to prevent further abuse – this audit will be reported in 2018 ✓ 200 survey responses received from children in care aged 5 to 18 yrs – analysis processed in 2018

OSCB view of progress made in terms of leadership and governance

Points of progress:

OSCB partners have challenged one another robustly and escalated issues from the board to the Children's Trust, local partners as well as to national government – it has played an active role in the safeguarding system. There has been regular scrutiny of MASH and the early help system which is showing improvement as the data indicates. OSCB and OSAB have made good joint progress on common issues leading to better outcomes for children transitioning as well as improved safeguarding connectivity with housing providers. Good progress has been made with voluntary sector partners ensuring that safeguarding concerns such as 'managing increased risk' are understood as a real pressure for local partners.

Points for improvement:

OSCB and OSAB should keep a tight focus on the domestic abuse work, in particular training as well as a watching brief on modern slavery too in order to assess prevalence in Oxfordshire. The OSCB partners should continue to review the system and ensure responses to local safeguarding risks e.g. exploitation, domestic abuse multi agency training, referral pathway for transgender children. Partners should also escalate issues where the solution lies beyond the partnership e.g. children in elective home education, specialist residential children for children in care.

OSCB should continue the positive work together with the voluntary and community sector developing representation, increasing training opportunities and improving communication.

Aim 2. Priority 1.

To drive forward practice improvement

The priority to address neglect has been focused on increasing support to families at an early point. This means seeing it and naming it before it impacts on children. Currently 65% of children protection plans are due to neglect. The aim is to reduce this.

Progress on practice improvement	
Working in partnership Neglect portal on the OSCB website	✓ Guidance on identifying and naming neglect – knowing what it looks like and feels like for a child ✓ Development of neglect pathways ✓ Safeguarding tools and interventions for identifying and working with neglect including Childcare Development Checklist, 3 houses, Signs of Safety, Safety House and Wizards and Fairies ✓ Information so that all practitioners understand a child protection core group and what role they play ✓ Provision of named link workers within adult services to provide consultation and advice ✓ Online resources to help practitioners

Progress on practice improvement	
Seeing and naming neglect	✓ Multi-agency chronology template to help partners track and record working with families ✓ 'Community impact Zones' initiated in Oxford and Banbury to target higher risk areas ✓ 'Community around the school' pilot targeted at risk hot spots ✓ 2304 'no names' consultations from partners and schools to social care have been dealt with ✓ Development of multi-agency neglect training video to provide common approaches for identifying neglect, tips on how to identify and name neglect, approaches to working with neglect and development of common, shared language. ✓ Development of 2-day multi-agency neglect training programme
Improving practice	✓ Multi-agency Neglect Strategy Group led by senior managers across partners ✓ Multi-agency Neglect Operational Group to deliver Neglect Action Plan ✓ Over 1000 multi-agency practitioners trained on the early help process: thresholds and referral forms ✓ Over 200 multi-agency practitioners at OSCB neglect conference ✓ Over 150 multi-agency practitioners at OSCB learning event on case reviews where early help and neglect was key ✓ OSCB 'Think Family' online course launched ✓ OSCB awareness of abuse and neglect online course launched – 791 trained ✓ Multi-agency audit on how well we work on cases of neglect ✓ More than 8,000 hits on neglect portal within first 9 months of launch ✓ Development of multi-agency Neglect Practitioner Forum to share best practice, identify issues of concern and drive forward practice improvement across services

Progress on practice improvement	
Measuring change in practice	✓ Local 'dashboard' on neglect which, for example, measures the proportion of early help assessments compare to referrals to social care for neglect ✓ A peer review of Oxfordshire practice is set up for 2018/19

OSCB view of progress made in terms of leadership and governance

Points of progress:

OSCB partners have driven forward the work on neglect setting up a strategy group, operational group as well as a practitioner forum to promote this work. The development of an online practitioner portal with over 8000 hits, the different learning events reaching over 2000 delegates as well as a performance framework to measure change in practice is commendable. The pilot on the multi-agency chronology work should further support this. It is really encouraging to see a major increasing in the number of early help assessments.

Points for improvement:

However, neglect is still the most common reason for children to be subject to child protection plans. At 65% this is higher than the national average. The groups working on neglect are clear there is more work to be done – a position which this has been endorsed by Ofsted report on children's services. The OSCB would like to see an increase in the number of early help assessments relating to neglect.

Neglect must remain a priority for the OSCB. It must be seen and named. Multi agency chronologies should be kept up-to-date and shared.

Aim 2. Priority 2.

To drive forward practice improvement

The priority to keep adolescents safe is wide ranging due to the complex needs of the most vulnerable. The aim has been to better understand concerns, train the work-force and work more effectively together.

Progress on practice improvement	
Working in partnership	✓ Kingfisher is a nationally recognised multi agency service that manages the riskiest sexual exploitation cases. It has worked with 554 children since 2014 ✓ Kingfisher has linked with voluntary agencies to ensure that children we are concerned about can get help quickly e.g. Donnington Doorstep's Step out project, Horizons, Safe!, Elmore, Oxford sexual abuse and rape crisis centre ✓ Two children's assessment homes and two 'move-on' homes opened in 2017 to ensure that children at most risk are kept closer to home ✓ The OSCB child sexual exploitation group has been expanded to consider wider exploitation issues ✓ Partners work on disability and education subgroups have made this work a priority ✓ Locality and Community managers chair multi-agency self-harm networks using risk assessments to screen high risk children and work out support ✓ Multi-agency complex case panel of senior officers and clinicians meeting to consider how best to support and 'unstick' complex cases ✓ Multi-agency entry to care panel to ensure that decisions are joined up and support is appropriate ✓ Horizons services within the Oxford Health NHS FT service have worked with local partners such as 'Safe!' ✓ Multi-agency work on suicide prevention strategy ✓ Multi-agency networks to assess and support most serious self-harm cases

Progress on practice improvement	
Protective actions	✓ Thames Valley Police issued 45 Child Abduction Warning Notices in 2017 ✓ Children who go missing are reviewed on a weekly basis and return interviews are monitored. There was a 93.8% completion rate at the end of Dec 2017 ✓ Thames Valley Police commended a local taxi driver for raising a safeguarding concern regarding a child that he was transporting which led to the eventual prosecution of the perpetrator ✓ Oxford Health NHS FT school health nursing team and the county council have worked together to raise awareness of LGBTQ inclusion ✓ South Oxfordshire and Vale of White Horse DC ran 'Chelsea's choice' for local schools ✓ Multi-agency audit initiated on how well we work with perpetrators to prevent harm ✓ Protective behaviours work with schools driven forward by Kingfisher Team for development in 2018 ✓ Year 3 & 4: safer together programme commissioned by Kingfisher. Pilot to run in 2018 ✓ Year 5: youth ambassador programme developed by Donnington Doorsteps Step Out project ✓ Year 7 & 8: pack being developed through schools, CAMHs, Kingfisher
Identifying exploitation	✓ Child sexual exploitation champions within services supporting colleagues ✓ Work to better identify male victims including a checklist on 'how you work with boys' ✓ Work to better safeguard disabled children and identify them as potential victims ✓ New locality panels being set up to identify those children going missing and at increased risk ✓ Child exploitation screening tool drafted ✓ Task group to design 'referral pathway for help' ✓ co-ordinate effective provision for exploited children and young people

Progress on practice improvement	
Improving practice	✓ Over 60 hotel workers at 'Say something if you see something conference' organised by TVP, Hotel Watch and Oxford City Council (3 conferences to date) ✓ Thames Valley Police and district council 'test purchasing' at hotels led to further safeguarding training and OSVDC OSCB training reviewed to ensure it is up-to-date ✓ 94% of taxi drivers completed safeguarding training and an increase in LADO and MASH reporting from this workforce ✓ Updated 'joint operating framework' for taxi licensing agreed across county partners for safer transport of vulnerable children ✓ 'Mind of my own' this new app has enabled 98 children to engage with workers on their care ✓ Multi-agency audit on how well we work with victims of domestic abuse ✓ Multi-agency audit on how well we work with children with disabilities who are vulnerable to exploitation
Keeping children safe in full time education	✓ Collation of data on attendance, exclusions, elective home education, attainment and achievement of pupils with special educational needs and disabilities ✓ Headteacher breakfast briefings to drive forward strategic change ✓ Keeping 'Safeguarding Children in Banbury' was funded by Cherwell DC and led by TVP in conjunction with the Banbury Headteachers group ✓ Development of multi-agency 'Team around the school' ✓ Local authority officer termly briefings with schools safeguarding leads ✓ Development of learning from case reviews for schools ✓ Two new posts within the county council to work with schools and help with school attendance

OSCB view of progress made in terms of practice improvement: Safeguarding adolescents

Points of progress

The concerns regarding older children are reflected in the data that we have on our safeguarding system. We know that their needs are placing a pressure on the system.

It is reassuring to see the many examples of work by OSCB partners in terms of strategic leadership and co-ordination, resource allocation and work to improve practice. They range from the strategic focus on keeping children safe in schools as an important step forward to suicide prevention strategies to safeguarding training for all taxi drivers e.g. 94% of Oxfordshire taxi drivers have been trained in safeguarding. In 2017 a local taxi driver, who had undertaken this training, was commended by Thames Valley Police for his actions in safeguarding a child who was at risk of significant harm from a dangerous individual. His actions ensured the child was kept safe and proved vital in ensuring the conviction of a predatory offender. This is a positive outcome for the safeguarding network in Oxfordshire, demonstrates increased awareness and reinforces the role of tax drivers in the safeguarding intelligence network.

Oxfordshire headteachers have regularly met with the county council, senior police colleagues and health colleagues to take action on keeping children safe in full time education – reducing exclusions and improving attendance. The 'Community around the school' approach has been initiated as a means to better work together.

Points for improvement

However, the safeguarding concerns presented by vulnerable adolescents are a serious challenge the local issue of child drug exploitation is a serious concern for the partnership. Serious case reviews and data re-enforce this message. The OSCB partners must keep the work to protect older children from harm as a priority with a clear focus on criminal exploitation and schools.

Aim 3:

To scrutinise and quality assure

Priorities have been to challenge improvements, take robust action following learning and to assess risk and capacity across the partnership

Progress on practice improvement:
The OSCB has a learning and improvement framework which sets out the ability to deliver the above priorities. It includes serious case review, audit work, self-assessment, impact assessment, learning events and training. This section summarises what partners have done and learnt.

Challenge improvements through serious case reviews:

Serious Case Reviews (SCRs) are undertaken when a child has died or been seriously harmed and due to abuse or neglect and there has been interagency involvement. They are commissioned by the Chair of the LSCB. They seek to draw out learning for agencies on how to work better together.
Over the last five years the OSCB has run 12 serious case reviews and 3 learning reviews which have involved 19 children. There are two main age groups; pre-school and secondary school aged children – just over 50% are older children aged between 13 and 18ys (this figure is influenced by the serious case review on child sexual exploitation). However, 7 of these cases concern children who are pre-school or just in the first year at school. Analysis shows that either the child, their siblings or parents have previously been known to children's services, either current at time of incident or historic.
Over the last year the OSCB has worked on four serious case reviews. Some of the emerging, repeated themes have been:

1. **Curiosity:** being curious about the family's past history, relationships and current circumstances in a way that moves beyond reliance on self-reported information
2. **Responding to physical abuse:** professionals identifying it, listening to children and following procedures to properly investigate
3. **The role of schools in keeping children safe:** understanding that school attendance is a critical factor to support opportunity, well-being and safety
4. **Professional understanding of the implications of elective home education:** actively knowing which agencies are in touch with the family and to what effect
5. **Taking a cumulative view when working with children:** not seeing events in a linear way but weighing up risks over time and keeping previous events in mind (using chronologies)
6. **Parental wellbeing:** mental health, substance misuse and domestic abuse are recurring themes
7. **Fragmented management of health needs:** ensuring effective communication across services for co-ordinated and consistent management of care
8. **Children's emotional wellbeing:** increasing evidence of self-harm by children aged 10 years & above
9. **Children's limited capacity to protect themselves** as they move into adolescence after experiencing a lack of consistent, supportive parenting in their early years (long lasting impact of neglect)
10. **Rethinking 'did not attend'** to **'was not brought'**

Challenge improvements through audits

Multi agency audits and single agency audits were reported every two months to highlight safeguarding themes, good practice and learning points. Four multi agency audits covered at least 20 cases from the perspective of all agencies involved. All this year's themes are reflected above in the learning points from case reviews. Additional food for thought for the workforce from audit work is:

- Think Family.
- Use safeguarding tools earlier (look on OSCB practitioner portal)
- Engage children and families in statutory safeguarding processes – with a focus on fathers and male care givers and capturing the voice of the child
- Use chronologies to support joined up work: keep them up to date and shared
- Reassess safeguarding risk when there is a concern about neglect and children are not being brought to appointments e.g. dentist, doctor, health visitor
- Develop your understanding of online and social media abuse and your ability to talk about what constitutes abuse, healthy relationships and consent

The joint audit on disabilities confirmed some of the vulnerabilities seen in data and case reviews, such as children not being brought to appointments. It also highlighted that professionals can be concerned about raising concerns regarding neglect because they are worried about spoiling their relationship with the family. It emphasised the importance of direct communication with the child.

The joint audit on domestic abuse confirmed some of the risks raised through case reviews and in addition it highlighted that professionals need more support to talk about and deal with consent and abuse, explicit images online and what constitutes a healthy relationship.

Some of the simplest but most important messages from audits come from families and children:

Parents and carers

1. *"Communication, communication, communication!"*
2. *"Don't leave help and support until crisis point"*
3. *We want "Good sharing and co-ordination of info between agencies"*

Children and young people's views on services

1. *Get in early "make a difference as early as possible".*
2. *Relationships have got to work to build trust and progress "click and connect"*
3. *Children and young people want to be informed and involved "listen to me" – increase views being reflected in plans and decisions*

Children and young people's challenges to the board

Issues of concern have been raised by the 'Voice of Oxfordshire Youth' group:

- Lack of mental health support for young people
- Lack of youth clubs – seen as an important source of advice and guidance
- Need for more awareness for teens about drugs and alcohol
- Need for more action on bullying in schools; it is a big deal
- Fabricated and induced illnesses is an emerging concern

These messages have informed OSCB business planning.

Robust action following learning: multi agency events

OSCB partners delivered a programme of multi agency learning events to over 400 local practitioners. Board members and local professionals planned the days, delivered presentations and led round table discussions. For example, the conference on neglect was attended by 156 delegates, with an additional 34 colleagues involved in delivering the conference, e.g. speaking, facilitating group discussions, manning information stands and/or assisting the OSCB business unit with setting up/ signing in on the day. The 3 events have challenged thinking and practice and opened up conversations and covered key themes for improvement.

This is what practitioners fed back to the OSCB:

1. Working with fathers: learning from the Child Q, Children A-F serious case reviews

"Excellent speakers who made me reflect and think about my practice".

"Absolutely brilliant. Today has been a conversation which is long overdue and we need more conferences like this more frequently to raise awareness and change practice".

2. Dealing with neglect: learning from the Child Q, Children A-F serious case reviews

"Understanding the impact of neglect on how a young person perceives themselves, how they may see the world and their value, will immensely influence my practice".

"Reminding all professionals to focus firmly on the child....., the importance of keeping explanations of concerns and expectations of parents simple and unambiguous and emphasising again the importance of multi-agency information sharing".

3. Ten most frequent learning points from case reviews, Children A-F, Child J, Child Q, Baby L, Child A and Child B serious case reviews

"I'm going to talk to my manager about how we might be able to share information better within different services, e.g. housing, benefits, this was a great learning opportunity – multi-agency chronologies are a great idea if used correctly – I will be taking to team meetings".

"it is important to communicate with other professionals, don't assume other agencies have it in hand, talk to my school team and put into practice at that level, the importance of linking in with other professionals"

Robust action following learning: OSCB multi agency safeguarding training

- 2040 multi-agency practitioners trained core safeguarding
- 417 multi-agency practitioners trained on early help assessments
- 451 multi-agency practitioners trained on mental health, child sexual exploitation, working with men and boys, drugs and alcohol and sexual abuse
- 38 multi-agency practitioners trained on female genital mutilation
- 697 early years multi-agency practitioners trained on safeguarding
- 3854 multi-agency practitioners trained on abuse and neglect; safeguarding and think family

The OSCB team of volunteer trainers was awarded a Certificate of Commendation from the NSPCC and BASPCAN this year. Here are five reasons why:

1. All trainers are local frontline local practitioners who deal with safeguarding issues in Oxfordshire on a daily basis and take time out of their day to deliver training e.g. from Thames Valley Police, the local hospital or early years settings.

2. The trainers are co-producers of the training – bringing their expert knowledge and responding to local concerns. They can bring real case studies and subject knowledge to the table.

3. The trainers co-deliver our core courses, which means that there will be trainers from two different agencies within the safeguarding partnership; this strengthens our local safeguarding network.

4. The trainers are an invaluable ear to the safeguarding network meeting the workforce over 100 times each year. They talk to the OSCB after training and we listen to their comments at the three development days.

5. Passion and commitment to training. Our training team is a positive and committed group of volunteers who are good at what they do. This feedback sums it up well,

"I have gained a better understanding of how safeguarding works in Oxfordshire and how to report concerns, trainers were brilliant – best safeguarding training I have ever attended, the training enabled me to understand my role in inter-agency working brilliantly and it was clear who I should contact around safeguarding issues in other agencies, trainers worked well as a team"

Assessing risk and capacity

All OSCB partner completed a comprehensive self-assessment of their provision against standards set out in section 11 of the children's act. This provided overall reassurance that the general frameworks are in place in organisations to keep children safe.

- Senior management commitment is strong
- Information sharing is effective
- Safer Recruitment and Vetting procedures are in place and working
- The Effectiveness of the Safeguarding Boards is deemed sufficient

Partners also completed an impact assessment in the face of three key pressures on its system: rising demand, diminishing resources and staffing shortfalls as well as difficulties with staff recruitment and retention. Their impact assessment recommends

1. Further development of early help strategies and initiatives
2. Improving multi-agency working
3. Maintaining services and monitoring key issues: 5 priorities remain at the forefront of safeguarding work: mental health; domestic abuse; alcohol and drug abuse; exploitation and housing.

OSCB view of progress made in terms of scrutiny and quality assurance

Priority: Challenge improvements

The multi-agency auditing of safeguarding work is valuable in testing change. The OSCB has seen some excellent examples of improved safeguarding work through regular quality assurance of services e.g.

- The National Probation Service could demonstrate that Oxfordshire staff have a good understanding and awareness of CSE, recognised in recent visits from the National Executive Director and the Chief Executive Officer of the NPS in the past 3 months.
- Oxford Health NHS FT were able to demonstrate that colleagues were using the guidance for responding to non-recent (historic) abuse citing an example which led to the prosecution of a perpetrator of historical abuse.
- Thames Valley Police could demonstrate an increase in the recording of children's information when attending domestic abuse incidents.
- The Community Rehabilitation Company identified improved attendance at Core Groups and timely responses to requests for information from the Multi Agency Safeguarding hub.
- 97% of dental staff had an excellent knowledge of safeguarding policies, procedure and guidelines when surveyed by Oxford Health NHS FT. (57 staff audited. 60% return rate. Jul 16)

OSCB should seek to develop more assurance in 2018 on neglect, safeguarding work with housing providers as well as work to scrutinise how well we work with young perpetrators (a theme chosen by young people in Oxfordshire).

Priority: Take robust action following learning.

The work on multi-agency training has been commended nationally this year. OSCB trainers are thanked for their time and effort to deliver high quality work. The statistics delivered by this group of volunteers is impressive and includes:

- 3854 multi-agency practitioners trained on abuse and neglect; safeguarding and think family
- 2040 multi-agency practitioners trained in core safeguarding
- 697 early years multi-agency practitioners trained on safeguarding

In 2018/19 multi-agency training will be developed to include domestic abuse, neglect as well as refresher courses for professionals who have undertaken a lot of safeguarding training and would benefit from a different type of learning. These should be a priority for the partnership to deliver in 2018/19.

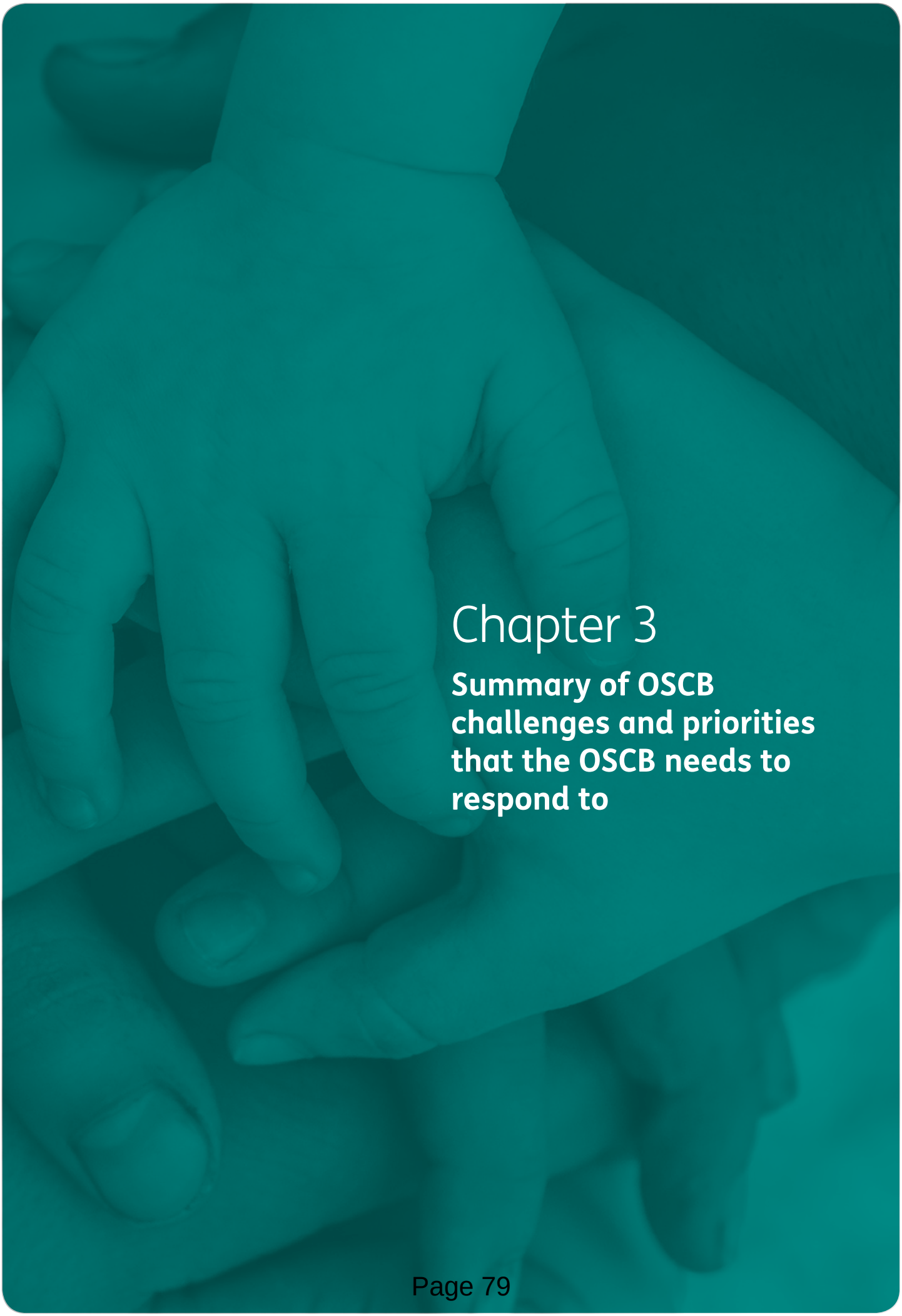
In 2018/19 multi-agency events will pick up on broader safeguarding issues for the workforce e.g. understanding criminal exploitation, multi-agency chronologies and the benefits of using them, talking about consent and healthy relationships and the additional vulnerabilities of disabled children.

Priority: Assessing risk and capacity.

The extensive work by OSCB and OSAB partners showed that they take safeguarding into account within their leadership arrangements and provision of services. Some good examples were given as to how safeguarding children is incorporated in to the daily provision of services:

- Children's Social Care developed an online portal for working with neglect
- Oxford City Council developed a Safe Haven Project for language students
- South and Vale District council put a 'Safe Place scheme' in place in Didcot and Wallingford
- West Oxfordshire District council set up safeguarding policy, procedure and specific 'Safe from Harm' pages on intranet
- Cherwell District Council introduced a safeguarding training programme for Councillors
- OUH NHST FT produced safeguarding leaflets and leaflets for parents to provide them with the information needed when a safeguarding concern has been raised
- Partnership work between the School Health Nursing Team (OH NHST FT) and Oxfordshire County Council on a number of initiatives to raise awareness of LGBTQ inclusion
- Public Health ran targeted focus groups on sexual health services, smoking cessation services and school health nursing to improve service delivery
- Thames Valley Police ran 'Hidden Harm: Open your eyes to abuse' 18-month campaign to raise awareness of hidden forms of abuse, initially focussing on Modern Slavery
- The Youth Justice Service improved work on the wider 'exploitation' of young people, e.g. focus within strategic plan, development of exploitation toolkit and educational resource
- The Fire and Rescue service in Oxfordshire is one of 6 pilot areas developing a national safe and well evaluation framework measuring the impact of safe and well in terms of positive outcomes for vulnerable people

OSCB wants to see the work on self-assessing safeguarding standards joined up with impact assessment in 2018.



Chapter 3

Summary of OSCB challenges and priorities that the OSCB needs to respond to

Oxfordshire Safeguarding Children Board

Summary of OSCB challenges and priorities that the OSCB needs to respond to

National drivers

- Implications of the new safeguarding partnership arrangements following the new Children and Social Work Act 2017
- Implications of reduced resources from Government
- Planned statutory changes to elective home education

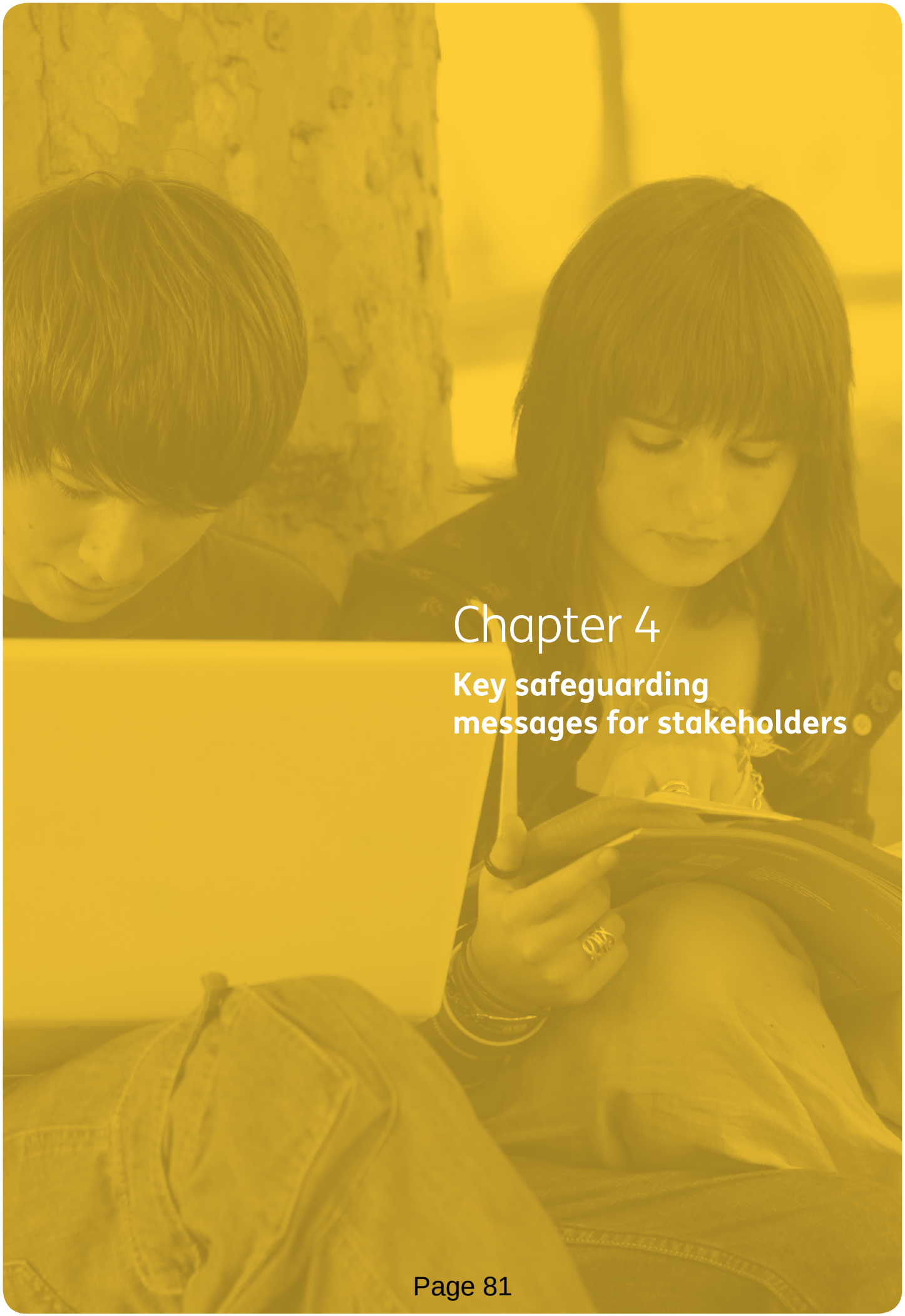
Local priorities for the OSCB and multi-agency work

- ensure that the early help process is improved and that partners in the safeguarding system understand early help, their role in it and the thresholds for statutory services
- ensure that partners know how to see and name neglect and understand the value of a multi-agency chronology when working with children
- improve multi-agency responses to safeguarding vulnerable adolescents from different forms of criminal exploitation and peer on peer abuse in particular those children with special educational needs
- maintain an emphasis on risks identified through 'safeguarding in education': attendance, exclusions, part-time timetables, elective home education, attainment and achievement of pupils with special educational needs and disabilities
- improve connections and communications with safeguarding leads in housing
- ensure that the workforce is competent, confident and capable and able to deal with:
- parental issues such as substance misuse, mental health problems and domestic abuse are addressed as part of this problem.
- adolescent issues of substance misuse, mental health, healthy relationships as well as online well-being.

Priorities for the Board business plan in 2018/19

(see annex D for detail)

1. Improving the effectiveness of the board; collaboration with Oxfordshire Safeguarding Adults Board and engagement with local community and voluntary organisations
2. Tackling neglect and safeguarding adolescents at risk of exploitation
3. Taking robust action following learning; to ensure continuous improvement and to assess risk and capacity across the partnership



Chapter 4

Key safeguarding messages for stakeholders

Our local community:

Safeguarding is your concern too. Report a concern if you are worried.

Heads and Governors of schools:

- Be informed. Know how to support pupils dealing with concerns like self-harm; radicalisation; sexting; sexual identity
- Check your pupil attendance and take action – know their 'whereabouts'. We know that children are safer in school
- Sign up for 'Encompass' the only means of receiving confidential notifications from the police about domestic abuse incidents that children have been involved in

The community, faith and voluntary sector:

- Your role in early help is important: we recognise that you are managing a lot of challenging work
- Use the new safeguarding policy template and checklist
- Carry out a safeguarding self-assessment

Children and young people:

- Thank you for telling us what you think
- 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 you are concerned about how to get help quickly to support your emotional wellbeing and that you think 'unusual health seeking behaviour' is becoming a problem.

Children's workforce:

- Well done for doing a great job under pressure.
- We love hearing this kind of feedback about you: "She is very supportive, kind, thoughtful, considerate, caring and she always puts other people first, in general she's an amazing ...worker. But most of all she just wants the best for me."
- Please consider these learning points from recent case reviews:

1. **CURIOSITY:** being curious about the family's past history, relationships and current circumstances in a way that moves beyond reliance on self-reported information
2. **RESPONDING TO PHYSICAL ABUSE:** professionals identifying it, listening to children and following procedures to properly investigate
3. **THE ROLE OF SCHOOLS IN KEEPING CHILDREN SAFE:** understanding that school attendance is a critical factor to support opportunity, well-being and safety
4. **PROFESSIONAL UNDERSTANDING OF THE IMPLICATIONS OF ELECTIVE HOME EDUCATION:** actively knowing which agencies are in touch with the family and to what effect
5. **TAKING A CUMULATIVE VIEW WHEN WORKING WITH CHILDREN:** not seeing events in a linear way but weighing up risks over time and keeping previous events in mind (using chronologies)
6. **PARENTAL WELLBEING:** mental health, substance misuse and domestic abuse are recurring themes
7. **FRAGMENTED MANAGEMENT OF HEALTH NEEDS:** ensuring effective communication across services for co-ordinated and consistent management of care
8. **CHILDREN'S EMOTIONAL WELLBEING:** increasing evidence of self-harm by children aged 10 years & above
9. **CHILDREN'S LIMITED CAPACITY TO PROTECT THEMSELVES** as they move into adolescence after experiencing a lack of consistent, supportive parenting in their early years (long lasting impact of neglect)
10. **RETHINKING 'DID NOT ATTEND' TO 'WAS NOT BROUGHT'**

Senior managers and leaders:

- Engage with our priorities and lead your organisations in support of these
- Support the OSCB to escalate risks which sit outside of the local partnership e.g. lack of provision for looked after children and for children with acute mental health needs, elective home education
- Improve the confidence and capability of the whole workforce – to work effectively with families experiencing domestic abuse, parental mental health and drug and alcohol issues

Annex A: Governance and accountability arrangements

How we work:

Throughout 2017/18 we have been a partnership set up under the Children Act 2004 to co-operate with each other to safeguard children and promote their welfare and have worked to the government guidance, Working Together 2015.

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 aim to do our job 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.

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.

Our multi-agency subgroups work to deliver the three aims of the board: effective leadership; practice improvement and checking that children are kept safe. See our business plan for details. The subgroups lead on safeguarding themes of child exploitation; disabled children, quality assurance, safeguarding procedures and safeguarding in education. We have three area-based groups which meet on a termly basis to bring together managers for updates on safeguarding work and to give feedback on any emerging safeguarding themes in their areas.

Who we work with and alongside

There are a number of other multi-agency board and partnerships in Oxfordshire that are working to improve the health and wellbeing of Oxfordshire residents and safeguard children, young people and adults with care and support needs who are vulnerable to abuse and neglect. They are:

i. **Oxfordshire Health and Wellbeing Board (HWB) and its associated partnership boards and joint management groups, one of which is the Children's Trust**

ii. **Safer Oxfordshire Partnership (SOP)**

iii. **Oxfordshire Community Safety Partnerships (CSPs)**

iv. **Oxfordshire Safeguarding Adults Board (OSAB)**

The Health and Wellbeing Board, Community Safety Partnerships and Safer Oxfordshire Partnership operate as strategic commissioning and delivery bodies. The two safeguarding boards are primarily scrutiny and challenge boards focusing specifically on safeguarding and effective partnership working to support this. These roles are distinctive but align well to provide a governance framework. The partnership protocol is on the OSCB website.

Health and wellbeing board. The Oxfordshire Health and Wellbeing Board (HWB) is a forum where key leaders from the health and care system work together to improve the health and wellbeing of the local population and reduce health inequalities. Each local authority is required to have a Health and Wellbeing Board under the Health and Social Care Act 2012.

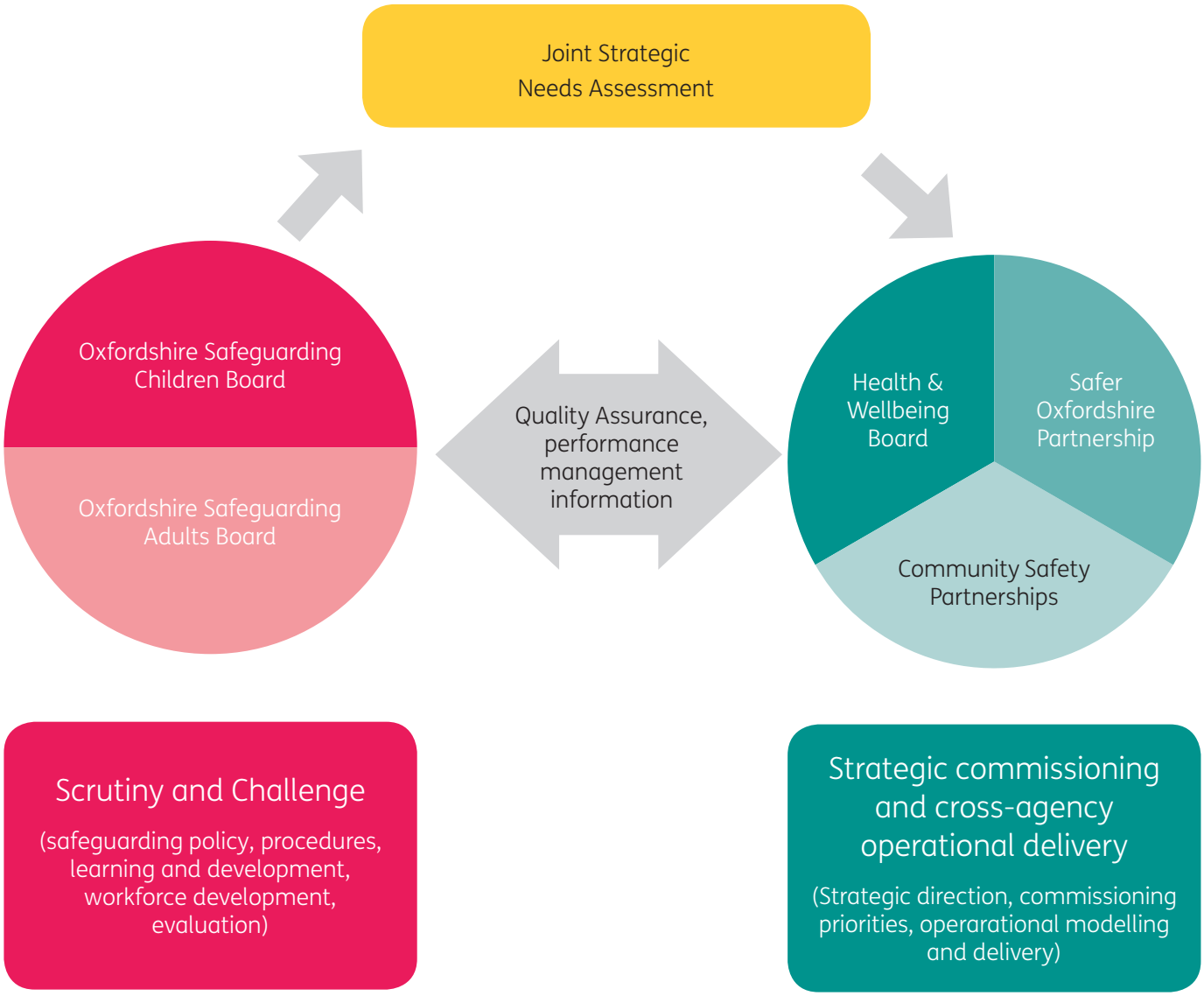
Children's Trust. The Children's Trust is responsible for developing and promoting integrated frontline delivery of services which serve to safeguard children. The partners work to plan services, find solutions and align resources as appropriate to deliver **Improvements.** The Trust produces a Children and Young People's Plan for Oxfordshire and recommends to the Health and Wellbeing Board where resources should be focused to deliver the Plan. The chairs of the Trust and Board are members of both groups.

The Safer Oxfordshire Partnership. This group aims to reduce crime and create safer communities in Oxfordshire and 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.

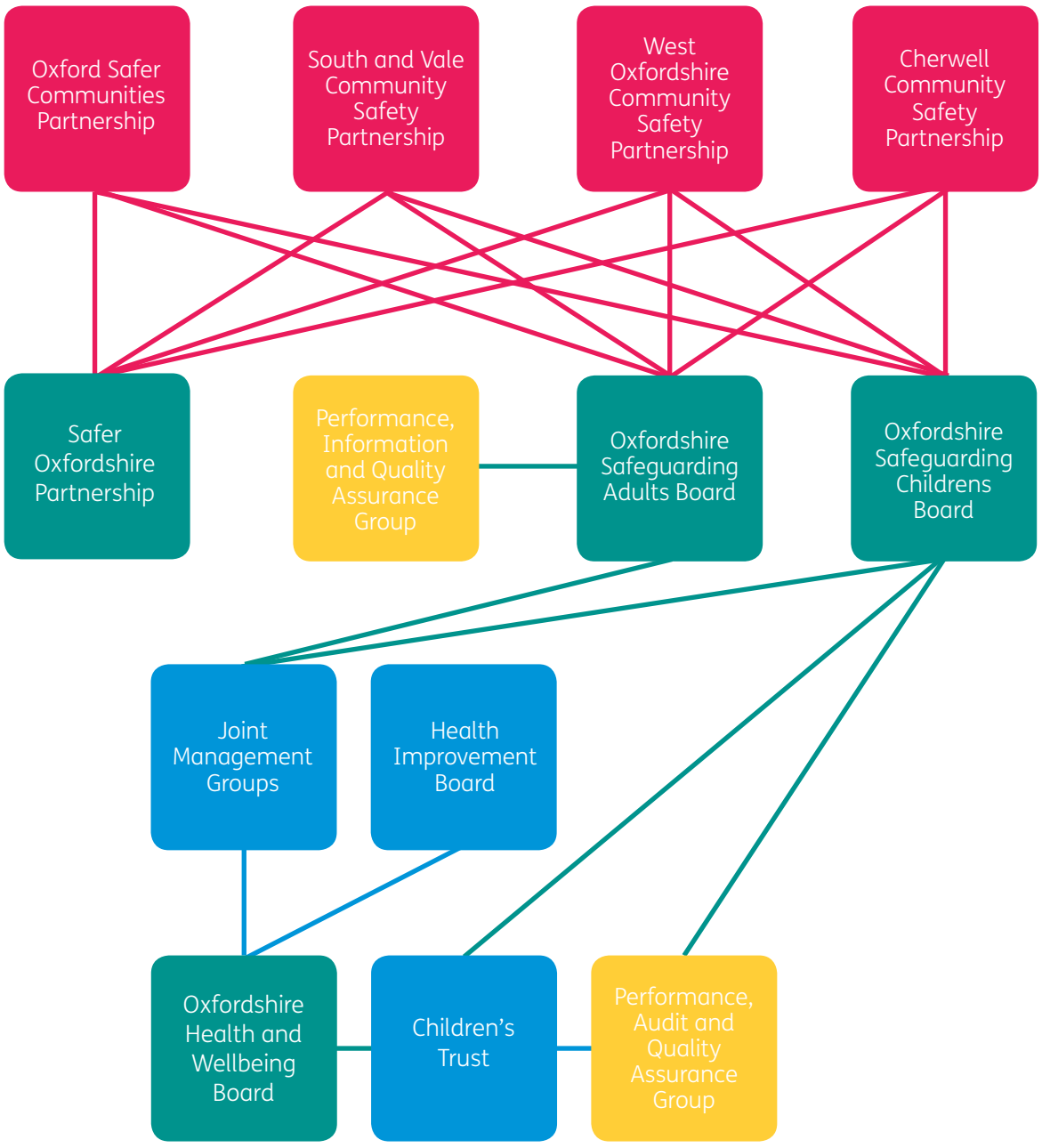
Community safety partnerships. These groups deliver projects that aim to cut crime and the fear of crime. Based in each district or city council area partners from the local authority, police, probation services, housing, fire and rescues services, the environment agency, the health sector and voluntary sector jointly tackle crime and safety issues. District colleagues are integral to the safeguarding work on child exploitation and engagement with the community and voluntary sector and safer transport.

The Oxfordshire Safeguarding Adult Board. This 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.

Oxfordshire Partnership Protocol Overview



Relationships



Annex B: OSCB Members

Who we are

The role of the County Council.
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 the period covered by this Annual Report Councillor Hibbert-Biles and Councillor Harrod have fulfilled this role.

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.

Independent.
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 Chief Executive 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 2017/18.

Health sector.
Oxfordshire's Clinical Commissioning Group (OCCG) is an important contributor to the OSCB. The OCCG and local health providers 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.

The OSCB has a designated doctor and designated nurse. This is currently a stipulated requirement of boards as set out in Working Together 2015 (page 57 and page 69 para 9). Their function is to provide the board with direct access to the expertise of designated health professionals.

OSCB member agencies

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

Annex C: What happens when a child dies in Oxfordshire

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.. Deaths in children are always very distressing for parents, carers and clinical staff. Developing an overview of the confirmed causes of childhood deaths can lead in some instances to effective action in preventing future deaths. In accordance with the statutory guidance we review deaths of all children resident in Oxfordshire, identifying themes, modifiable factors and any issues that may affect the safety and welfare of children. In particular we aim to develop a more detailed understanding of the causes of death and where appropriate take forward recommendations made by the panel to influence strategic changes and practice.

In 2017-2018, 84 child deaths were reported to the Oxfordshire CDOP and were discussed with the Designated Doctor for child deaths. 34 of the child deaths reported were of children normally resident in Oxfordshire and 50 of the deaths were of children normally resident in other counties.

In 2017-2018 the Oxfordshire CDOP reviewed the deaths of 40 children who usually reside in Oxfordshire. These reviews included deaths that occurred in the year 2017-2018 and reviews that occurred before 2017-18, but had been carried over, due to alternative investigations which prevented completion of the CDOP process earlier. The outcomes of panel meetings are twofold: to identify the classification of death and 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 2017-2018 the CDOP panel concluded that in 35% of cases reviewed there were modifiable factors. The following were identified that contributed to or caused the death.

Modifiable factors identified were:

- Co-sleeping
- Smoking
- Housing issues
- Infection guidelines/ sepsis guidelines not being followed
- Consanguinity

There are a number of established national campaigns around the issues that relate to modifiable factors, where that is the case, no specific recommendations have been made.

In 2017-2018 Oxfordshire contributed anonymised data to the following local and national campaigns:

- Co-sleeping
- Water safety
- Suicide prevention

In these areas no specific recommendations were made. Public health messages were shared, discussed and circulated. Oxfordshire also contributes anonymised data to research study requests (where appropriate) and to The Royal Society for The Prevention Of Accidents (ROSPA), so that they can collate a national picture. As a result of other identified modifiable factors, the following specific recommendations were made by the CDOP:

- When sepsis may be suspected the importance of sharing of information about baseline observations between episodes of care delivered by the out of hours service and GP services was highlighted. This has been incorporated into Sepsis training for GPs and out of hours services.
- Increased awareness of dangers of hot weather for infants – both from co-sleeping and open windows led to public health messages being circulated.

The Rapid Response Service

CDOP is advised of all child deaths and monitors the response when this involves an early response process (previously known as rapid response). In Oxfordshire, the early response service, coordinated by a team (Child Death Response 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 Child Death Team has an on-call rota to cover the service 24 hours a day, 7 days a week, including bank holidays. The 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 service is currently provided by the Chaplaincy team.

In collaboration with the Designated Doctor for Child Deaths (in working hours) and Acute Paediatricians (out of hours) the Child Death Team ensures that 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 Seesaw, in order to enhance the quality of care provided to all those whose work brings them into contact with bereaved families.

There have been several cases where there has been a delay in a family being able to view their child's body due to the complexity of processes needed at this time. This has caused distress to the family members. All relevant agencies are reviewing and updating their policies

The process ensures that the Child Death 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 Death chairs these early response meetings, ensuring that the principles underlying the early 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.

In 2017-2018 a total of 14 unexpected deaths of Oxfordshire children were reported to the Oxfordshire CDOP and Early Response Coordination team. For all Oxfordshire cases, an early response meeting was held. In all cases, the Coroner was informed of the child's death in a timely manner. A summary of the action taken by the Child Death Team have a target response time frame of two hours from the receipt of notification. This target has been reached in 100% of cases in 2017-2018.

Annex D:
OSCB priorities for 2018/19

Aim: Provide leadership for effective safeguarding practice	
PRIORITIES	**ACTIONS**
Improve board effectiveness	Develop the work of the Board to be more effective in light of the new Working Together guidance
Joint work with OSAB	Develop joint working on housing, domestic abuse, transitions and keep a watching brief on modern slavery
Engage local communities	Ensure that local voluntary and community organisations are better engaged in the partnership: training, communication and working together
Aim: drive forward practice improvement	
PRIORITIES	**ACTIONS**
Safeguard adolescents	Support multi-agency responses to safeguard vulnerable adolescents: • transitioning from children to adult services with OSAB • at risk of domestic abuse or peer abuse with OSAB • at risk of criminal exploitation • not in full time education
Address neglect	Support a co-ordinated and multi-agency response to neglect
Act following learning	Ensure the training workstream is well co-ordinated across the OSCB and OSAB and having an impact Ensure the learning and improvement comms. workstream reinforces safeguarding messages

Aim: ensure that children and young people are kept safe	
PRIORITIES	**ACTIONS**
Challenge improvements	Test how well learning is embedded in to practice through multi-agency audits which include the voices of children and families Check how well the integrated safeguarding arrangements effectively provide early help to families
Assess risk and capacity	Check the level of risk and impact on the safeguarding system through the annual partner self-assessments with OSAB

Annex E: Glossary

AILC	Association of Independent LSCB Chairs
BASPCAN	British Association for the Study and Prevention of Child Abuse and Neglect
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Service
CDOP	Child Death Overview Panel
CiCC	Children in care council
CRC	Community Rehabilitation Company
CSE	Child Sexual Exploitation
CSPs	Oxfordshire Community Safety Partnerships
EHA	Early Help Assessment
EIS	Early Intervention Service
FE	Further Education
HBT	Homosexual, bi-sexual and transgender
HMIP	Her Majesty's Inspectorate of Probation
HWB	Health and Wellbeing Partnership
LAC	Looked After Children
LADO	Local Authority Designated Officer
LCSS	Locality and Community Support Service
LGBTQ	Lesbian, gay, bi-sexual, transgender and queer
LIQA	Learning, Improvement and Quality Assurance (framework)
LSCB	Local Safeguarding Children Board
MAPPA	Multi-agency Public Protection Arrangements
MASH	Multi-Agency Safeguarding Hub
NPS	National Probation Service
NSPCC	National Society for the Prevention of Cruelty to Children
OCC	Oxfordshire County Council
OCCG	Oxfordshire Clinical Commissioning Group
OH NHS FT	Oxford Health NHS Foundation Trust
OSAB	Oxfordshire Safeguarding Adults Board
OSCB	Oxfordshire Safeguarding Children Board
OSVDC	Oxfordshire South and Vale District Councils
OUH NHS FT	Oxford University Hospitals NHS Foundation Trust
PAQA	Performance, Audit and Quality Assurance (subgroup)
PPU	Public Protection Unit within the National Probation Service
QA	Quality Assurance
SCR	Serious Case Review
SFR	Statistical First Release
SOP	Safer Oxfordshire Partnership
SRE	Sex and relationships education
TVP	Thames Valley Police
VCS	Voluntary and Community Secto
VOXY	Voice of Oxfordshire's Youth

Annex F: Finance

2017/18 OSCB accounts

	Provisional budget 2017/18	Budget as at end Mar 2018
Funding streams		
Public Health	-31,625	-31,625
Foster carer training		-2,975
Contributions		
OCC Children, Education & Families	-196,610	-197,757
OCC Dedicated schools grant	-64,000	-64,000
Oxfordshire OCCG	-60,000	-60,000
Thames Valley Police	-21,000	-21,000
National Probation Service	-2,500	-2,500
CRC	-1,410	-1,410
Oxford City Council	-10,000	-10,000
Cherwell DC	-5,000	-5,000
South Oxfordshire DC	-5,000	-5,000
West Oxfordshire DC	-5,000	-5,000
Vale of White Horse DC	-5,000	-5,000
Cafcass	-500	-500
Public Health (see above)	0	0
Total income	**-407,645**	**-411,767**
Expenditure		
Independent Chair	39,000	35,266
Business unit	253,000	258,565
Comms: learning and improvement	12,000	12,027
Training & learning	66,000	66,014
Subgroups	10,000	9,087
All case reviews	40,000	28,021
Total	**420,000**	**408,981**

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Report title:	**Case Review and Governance sub group annual report, 2017/18**
Date:	**14 06 18**
Lead Officer:	**Lara Patel**
Contact Details:	**Lara.Patel@oxfordshire.gov.uk**

Introduction:

This is an annual report from the Chair of the Case Review and Governance (CRAG) subgroup – a subgroup of the Oxfordshire Safeguarding Children Board. It covers information on cases considered, cases reviewed and action taken over the last 12 months.

1. Local context

The subgroup comprises members drawn from Thames Valley Police, the County Council's children's services and legal services, the OCCG Designated Doctor and Designated Nurse, OH NHS FT, Public Health and a Head teacher representative. The purpose of the group is to support the OSCB in fulfilling its statutory duty to undertake reviews of cases both where the criteria[1] is met and where it is not met in order provide valuable information on joint working and areas for improvement.

The OSCB has worked on four serious case reviews since the last report to the Board. Of those four reviews: two are active and two have been completed as far as possible, whilst parallel processes are underway. One of the cases affected by

[1] Working Together to Safeguard Children 2015

parallel processes was initiated in 2013. The OSCB has also instigated one management review which is currently ongoing.

2. National Context

In May 2017 the 'The Children and Social Work Act', came in to power, which includes a set of clauses that set out arrangements for a new Child Safeguarding Practice Review Panel. The national Panel will identify a number of serious or complex child safeguarding cases which raise issues of national importance and will review cases which they believe will result in learning. The intention is that the majority of SCRs will be locally-driven.

3. Cases considered for review by the subgroup

The decision making criteria for serious case reviews has changed over time to permit different types of reviews and strengthen the conditions which apply to inter-agency learning. The current Working Together (DfE 2015) guidance is attached at appendix A.

Since the last report to the Board three cases were brought to the attention of the OSCB for consideration as a serious case review. One was referred by Thames Valley Police and two were referred by Children's Social Care. Of these three referrals two serious case reviews were commissioned, one was deemed not to meet the criteria. A further case was discussed by the group. This complex case led to a request for a case summary and assurances of safeguarding practice and multi agency working.

All cases considered for a serious case review by the CRAG must be referred to the National SCR Panel. This independent expert panel of four colleagues was established through Working Together (DfE 2013). It advises LSCBs and the DfE on aspects of SCR procedure and reviews *all* decisions. The panel members will challenge LSCBs where they do not feel the criteria has been applied correctly. Of the three Oxfordshire cases submitted to the National SCR Panel in 2017/18 none were contested. However, there was one case that was contested at the end of the previous year. During 2017/18 the OSCB reviewed this decision independently and

remained of the view that it does not meet the criteria. The National SCR Panel accepted this point of view although they did not share it.

4. OSCB SCR Methodologies

Working Together (DfE 2015) gives LSCBs permission to be innovative in the range and types of reviews commissioned and proportionate with respect to the scale and complexity of the issues being reviewed.

OSCB reviews have been completed using a range of approaches. The three new cases worked on since the last report have all been 'reviewer-led'. The case initiated in 2013 was based on the Working Together (2010) style of serious case review. The CRAG has not arrived at one recommended approach but considers the best approach for each case based on the scale and complexity of issues. A set of principles were developed in 2016 which have been further strengthened in 2017/18 to include guidance for agency panel members as well as parallel processes which have had a significant influence on OSCB case review work.

5. Parallel processes

A number of case reviews completed by the Board in the last few years have run alongside parallel processes. These range from disciplinary processes, criminal proceedings, complaints proceedings or other professional proceedings such as inquests, internal investigations or other formal reviews such as domestic homicide reviews. This can impact on the terms of reference, stakeholder participation, information sharing, chronology content, review length and cost.

Attached at appendix B is guidance on how these processes are best managed to ensure they are all completed in a timely manner and where possible achieve the best safeguarding outcomes for children.

6. Family contribution

As reports are written for publication, it is essential to involve families in reviews. Family members have contributed to all reviews which has added a layer of complexity but also provided valuable learning. The OSCB has valued the support of the family liaison officers (FLOs) at Thames Valley Police, probation officers as well as social workers from the County Council all of whom have facilitated family meetings.

7. **Reviews: subject details and safeguarding themes**

The details of the cases are:

- The four different serious case reviews have concerned five children.
- One of the children was between 1-5 years. Four of the children were aged between 10-15 years.
- One was female. Four were male.
- One of these children is transgender

Over the last year the themes covered by case reviews have been: the long-lasting impact of neglect; physical abuse; self-harm; child and parental emotional wellbeing; engagement and attendance in education. The issue of neglect is a **repeated theme** in terms of the risks it presents to young children and the impact it continues to have as they grow up. In Oxfordshire neglect is the most common reason for a child to be subject to a child protection plan. The OSCB has a Task and Finish Group to co-ordinate work to address neglect.

8. Learning points from Oxfordshire case reviews

Last year the CRAG summarised the ten most frequently recurring learning points from the three most recently published case reviews. A lot work was undertaken to promote the learning including 3 learning events. Some examples of work undertaken to address those points is set out in section 13. The OSCB has not published any reviews in the last year but the themes coming through ongoing reviews are worth summarising as the consequences are so serious to children.

1. **Curiosity**: being curious about the family's past history, relationships and current circumstances in a way that moves beyond reliance on self-reported information
2. **Responding to physical abuse**: professionals identifying it, listening to children and following safeguarding processes thoroughly; children may sometimes be too afraid to speak or unable to verbalise what they are going through
3. **The role of schools in keeping children safe**
    - effective management of records and sharing them when children transfer schools; effective escalation of concerns.
    - children are safest in full time education. Oxfordshire serious case reviews indicate that children on part time time-tables, children absent from school and

children educated at home are at increased risk. School attendance is a critical factor to support opportunity, well-being and safety

4. **Professional understanding of the implications of elective home education**: actively knowing which agencies are in touch with the family and to what effect
5. **Taking a cumulative view when working with children**: not seeing events in a linear way but weighing up risks over time and keeping previous events in mind (using chronologies)
6. **Parental wellbeing**: mental health, substance misuse and domestic abuse are recurring themes. With respect to mental health colleagues need to recognise the risks and impact on the safety of the child; don't minimise 'older' information
7. **Fragmented management of health needs**: ensuring effective communication across services for co-ordinated and consistent management of care
8. **Children's emotional wellbeing**: increasing evidence of self-harm by children aged 10 years & above
9. **Children's limited capacity to protect themselves** as they move into adolescence after experiencing a lack of consistent, supportive parenting in their early years (long lasting impact of neglect)
10. **Rethinking 'did not attend'** to '**was not brought'**

The OSCB has produced a learning summary for each published review and also held learning events picking up on the key themes from the reviews. The learning events have involved: the story / learning from the SCR; the child's perspective; local resources and networking opportunities for local practitioners. In the last year they focused on staying safe online; the importance of building relationships with young people and understanding what 'identity' means as they go through adolescence.

9. Report recommendations and agency actions from case reviews

The three most recently published case reviews (Baby L, Child Q, Child A and Child B) led to 19 multi-agency recommendations. At the time of publication progress reports outlining outcomes and actions were published for two of these reports on the OSCB website. All recommendations form part of the OSCB business plan and drive the direction of work e.g. the OSCB 2018/19 priority to improve practice focuses on: working to address neglect and working to safeguard adolescents.

10.Monitoring

The recommended OSCB actions are monitored through the OSCB Executive group. A decision was taken by the Performance, Audit and Quality Assurance Group (PAQA) in 2017 that individual agency actions should be monitored internally and comments / key outcomes from them could be provided in the single agency annual report of its quality assurance work to that group.

11.Communicating the learning from reviews

In 2017/18 the OSCB held three learning events which focused on the ten learning points from serious case reviews. The CRAG Chair and members led the first event which covered each of the ten points using the case reviews as examples and involving practitioners in relaying the narrative of these cases. The second event covered the learning point regarding fathers. The third event covered the learning point regarding neglect. Health, education and social care professionals led this event which had a big impact on attendees.

12.Outcomes

The published progress reports on case reviews provide insight to work on specific recommendations but some broad headlines over the last year would be:

- *Think Family training (free online learning) has been developed and launched by the OSCB partners so that colleagues think about all family members when working to support and protect children*

- ***The involvement of fathers in CP care plans is tracked and attendance at conferences by fathers is reported. The Think Family operational group are taking this work forward in 2018/19.***

- *Guidance produced and circulated for headteachers on effective supervision for safeguarding work in schools so that school staff are better supported in their decision making when working with children*

- ***A co-ordinated and improved focus on keeping children safe in education which has included the development of an additional County***

Council post to work with education providers to ensure that children are in school

- *Development of targets for education providers to ensure that children are in full time education and are safe. This includes guidance and data on attendance, exclusions and elective home education.*

- ***Development of locality panels on children going missing which link in to the child exploitation work for better management of care and support to children***

- *A checklist has been developed by the Independent Reviewing Officers for children with complex needs and are escalated if timeframes for children's placements and 'permanency planning' are not met*

- ***Introducing the use of chronologies for children who have Child Protection plans to ensure shared understanding of how to contribute to a shared chronology***

13. Costs and timeframes

The variation in costs is down to the type of review, its complexity, duration and the level of practitioner and family involvement. Of the three published reviews the costs have ranged from approximately £10,000 for Baby L through to over £20,000 for child Q. All recently published reviews were signed off by the OSCB within a 12 - 18 month timeframe.

14. In conclusion

The OSCB is recommended to maintain a focus on the ten most common learning points from ongoing reiews and to ensure that members of the local safeguarding partnership are fully aware of the learning from the three most recently published summaries.

Appendix A

The Working Together (DfE 2015) guidance *(current at time of writing)* requires a Serious Case Review to be undertaken for every case where abuse or neglect is known or suspected[2] and either:

- a child dies; or
- a child is seriously harmed and there is cause for concern as to the way in which the local authority, LSCB partners or other relevant persons have worked together to safeguard the child.

This includes cases where a child died by suspected suicide. Where a case is being considered where the child was seriously harmed unless there is *definitive evidence that there are no concerns about interagency working*, the LSCB must commission an SCR.

Seriously harmed includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following:

a. a potentially life-threatening injury;
b. a serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred.

[2] The threshold for 'suspect' should be consistent with s47 Children Act 1989 "reasonable cause to suspect". The following question should be asked: given what we now know should this incident have led to a child protection investigation? If "yes" and the child has been seriously harmed then a Serious Case Review should take place.

Appendix B

OSCB Principals for completing safeguarding reviews

Appendix C

Links to learning summaries for each published review

Learning review for Baby L

Learning review for Child Q

Learning review for Child A and Child B

Glossary:

CRAG	Case Review and Governance Group
IMR	Individual Management Review
OCC	Oxfordshire County Council
OCCG	Oxfordshire Clinical Commissioning Group
PAQA	Performance Audit and Quality Assurance Subgroup
SCR	Serious Case Review

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Report title:	**OSCB Themes for learning and improvement 2017/18** **Report from Performance, audit and quality assurance (PAQA) subgroup**
Report Summary:	This is the learning and improvement report of the PAQA subgroup. The purpose is to highlight common themes for learning and improvement to support vulnerable children and young people in Oxfordshire. The OSCB applies the quadrant developed in the south-east region to frame its analysis: 1. Quantitative 2. Qualitative 3. Practitioner views 4. Family, children and young people's views The following sources are used: safeguarding self-assessments, school audits, single and multi-agency audits, participation work with children and young people, annual reports and serious case reviews practitioner feedback, performance data.
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Contents

Section 1: Executive summary

1. Introduction

This is the learning and improvement report of the PAQA subgroup. The purpose is to highlight common themes for learning and improvement to support vulnerable children and young people in Oxfordshire. The OSCB applies the quadrant developed in the south-east region to frame its analysis:

5. Quantitative
6. Qualitative
7. Practitioner views
8. Family, children and young people's views

The following sources are used: safeguarding self-assessments, school audits, single and multi-agency audits, participation work with children and young people, annual reports and serious case reviews practitioner feedback, performance data.

This executive summary provides a precis for each section.

2.1 Quantitative themes in summary

- The safeguarding system is (increasingly) under pressure
- Early Help assessments have increased significantly from 458 recorded last year to 1255 by end of year in 20017/18
- MASH enquires have increased. The timeliness of enquiries managed by the Multi-agency safeguarding hub (MASH) was below the target of 75% at 45% at year end
- The number of troubled families worked rose from 1549 last year to 2398 and is on track
- The number of children on a child protection plan rose from 569 last year to 730 at the end of March 2018 (higher than national average)
- Only 50% of fathers are attending children protection conferences regarding their children
- The number of children looked after by the local authority rose by 6% from 667 last year to 691 at the end of March 2018 (lower than national average)
- The number of children placed out of county and not in neighbouring authorities also continued to rise – from 118 to 155 or 17.5% to 22.5% of the looked after population.
- Whilst the number of children who have gone missing from home has fallen from 798 to 773 the number who went missing 3 or more times was 149 or 19.3%.
- The percentage of children referrals to CAMHS who are seen within 12 weeks was below the target of 75% at 56% at year end
- Attendance at A&E for self-harm of children who are 12-17 has increased from 542 in 2016-17 to 660 in 2017-18 – a rise of 22%.
- At 31 March – 499 children were recorded as receiving elective home education in Oxfordshire. There is evidence of links between safeguarding risk and safeguarding in education issues: attendance, exclusions, elective home education, attainment and achievement of pupils with SEND

2.2 What this means in terms of learning and improvement.

- Continuing to improve Early Help is a priority. The target to increase the Early Help assessments to 2,100 (an average of 175 per month) is supported
- Ensuring that Early Help assessments identify, name and tackle neglect is essential to reduce its impact on child protection plans (65% are due to neglect).
- The Think Family and Think Father message remains significant
- The poor achievement of children with SEN and other vulnerable groups should remain a priority
- The submission and collation of data from schools regarding the use of part-time tables is a priority to be able to drive change and keep children safe
- Strategic leadership and effort is required across the partnership to set and achieve targets for children missing from education i.e. exclusions, attendance, not on roll and part-time timetables. These children are at a greater safeguarding risk as they are not in school
- The use of hospital beds for children in mental health crisis because there is no suitable alternative is a regional safeguarding risk
- The cohort of children worked with by the Kingfisher Team and the Youth Justice Service demonstrate the complexity of need and wide range of vulnerabilities
- 5 priorities remain at the forefront of safeguarding work: mental health; domestic abuse; alcohol and drug abuse; exploitation and housing.

3.1 Qualitative themes in summary

Neglect is a repeated theme. Some of the issues resonate with learning from Child J, Baby L and Child Q

- Mental health, domestic abuse and substance misuse are a backdrop to neglect
- The work force needs to 'think family' and consider dads as a protective factor for children

Domestic abuse is a repeated theme due to audits covered. Some of the issues resonate with learning from Child J and Baby L and mean that further work should be done

- The circulation of indecent images of children by abusive intimate partners
- History of domestic abuse within the family home where there is peer on peer abuse
- Understanding the pathway for children and young people and the use of MARAC
- Ensuring that professionals are trained to deal with domestic abuse and discuss healthy relationships

Vulnerable adolescents and exploitation is a challenge. This resonates with Children A-F, Child J and current themes in the Kingfisher team

- The complexity involved in working across the services with children who present challenging behaviours that can be a risk to the public and themselves whilst being vulnerable
- Lack of protective behaviours: children and young people's limited ability to recognise they need help, to understand consent and what constitutes abuse
- The difficulties in finding appropriate resources for children who are at risk of exploitation in particular drug exploitation

School is pivotal in ensuring resilience. This resonates with Children A-F, Child J and current themes in the Kingfisher team

- School attendance is a critical factor to support well-being and safety of the child
- School data on attendance is critical in having a good overview of safeguarding risk
- Record-keeping is key to good information sharing and having a long view of the child
- Transitions between schools and school / college are points of vulnerability and planning should be in place for vulnerable children

Health and 'not being brought'

- Children not being brought to appointments should be identified early
- There could be greater knowledge of what a specific disability means and how this might impact on safeguarding
- Normalising and misinterpreting behaviour linked to special educational needs

3.2 What this means in terms of learning and improvement.

- Think Family.
- Use tools of the safeguarding trade earlier.
- Engage children and families in statutory safeguarding processes – with a focus on fathers and male care givers and capturing the voice of the child
- Take a cumulative view when working with children – not seeing events in a linear way but weighing up risks over time and keeping previous events in mind.
- Use chronologies to support joined up work. Keep up-to-date and shared.
- When there is a concern about neglect and children are not being brought to appointments levels of concern should be escalated
- Need for greater understanding of online and social media abuse coupled with knowing how to talk about what constitutes abuse, healthy relationships and consent

4.1 Practitioner views

There are concerns about:

- Threshold awareness by the workforce in general and in particular at the level of early help
- Safeguarding front-door effectiveness and the need for better co-ordination of the routes for referral and assessment between early help and the multi-agency safeguarding hub
- Complexity of cases not only within the children's safeguarding arena but also in relation to adults in those children's lives
- The need for stable, appropriate and secure housing
- Supporting vulnerable adolescents to develop protective behaviours
- Young people exploited in crime-related activity: response and provision
- Placement Sufficiency for children in care and children with acute mental health problems
- Young people's domestic abuse pathway: knowledge and application

- Links between safeguarding risk and safeguarding in education.
- Young people's mental health and self-harm: increasing risks and long waiting times for CAMHs

4.2 What this means in terms of learning and improvement.

Priorities should include:

- Improving the workforce's understanding of thresholds and early help
- Addressing neglect and raising awareness amongst the workforce
- Developing a strategic response to criminal exploitation and raising awareness amongst the workforce
- Developing programmes of protective behaviour
- Raising awareness regionally regarding placements
- Improving the work on domestic abuse and the young person's pathway to support
- Continued scrutiny of the front door to safeguarding to ensure the right kind of referrals, a prompt response and appropriate feedback
- Recognising and supporting the children's workforce who are operating in a system that is full to capacity

5.1 Parental views

1. Communication, communication, communication
2. Don't leave help and support until crisis point
3. Good sharing and co-ordination of info between agencies

5.2 Children and young people's views

1. Get in early *"make a difference as early as possible*".
2. Relationships have got to work to build trust and progress "*click and connect*"
3. Children and young people want to be informed and involved "*listen to me*" – increase views being reflected in plans and decisions

6. Recommended actions for 2018/19 from the summary of themes

1. **Priorities for the business plan** for 2018/19 to ensure that the issues of neglect, and working with adolescents are addressed - the quantitative data is pointing to these areas as continued safeguarding concerns and especially criminal exploitation and mental health.
2. **Training priorities** e.g. need to establish the multi-agency domestic abuse training and neglect training (see 4.2 above)
3. **Learning events** to ensure that improvement themes cover thresholds and chronologies when working with neglect; awareness raising of child exploitation, working with families and children with respect to domestic abuse; working with adolescents on healthy relationships
4. **Audit work** to ensure that improvement is consistent and learning is robust. The voice of children and young people should continue to be involved in audit work.

Section 2: Full Report

2.1 Quantitative themes and findings

Introduction

This section aims to summarise the quantitative information available to the OSCB from datasets as well as the impact assessment. It provides facts and figures and a summary of findings.

The Child's Journey:

The performance data for last year can be summarised against the following steps in a child's journey through the safeguarding system:

Impact of changes to early intervention:
In 2016/17 Oxfordshire introduced the Early Help Assessment which replaced the Common Assessment Framework or CAF. In 2017/18, 1255 Early Help Assessments were completed which was significantly more than the 458 recorded in 2016/17. Continuing to improve Early Help is a key priority of the Children's Trust going forward and a target to increase this figure to 2,100 (an average of 175 per month) has been set for the coming year.

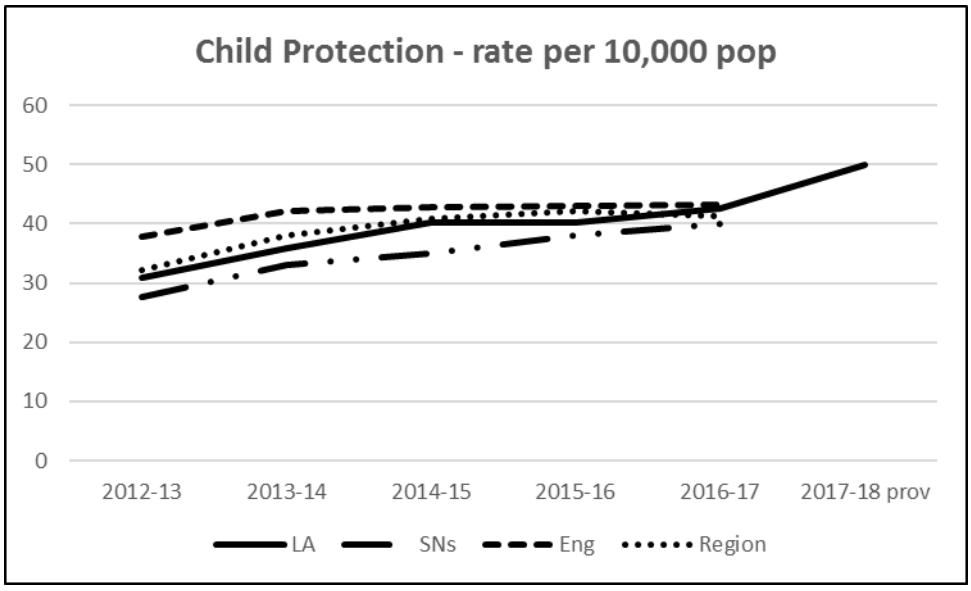
The number of troubled families worked with rose from 1549 in 2016/17 to 2398 in 2017/18 and remains on target.

Increasing levels of activity in child protection planning:
The number of children on a child protection plan rose to 730 at the end of March 2018 compared with 607 at the end of 2016/17 and 569 at the end of 2015/16. This is a rise of 28% over the 2-year period.

The rate of growth is higher than both the national average and the average of similar authorities such that at March 2011 we had 38% fewer children subject to a plan than the national average and are now likely to rise above the national average. The increase has been due to both more children becoming the subject of plans and fewer children ceasing. The increase in children becoming the subject of a plan is despite a 5% decrease in the number of child protection investigations; as more children were taken to case conference and then to a plan.

Neglect is the most common reason for children to be subject to child protection plans (65%). This is higher than the national average where the proportion of children subject to child protection plans for reason of neglect is 48% (SFR 61/2017) but lower than our figure for last year which was 67%.

Social care assessments in Oxfordshire that identify neglect are much more likely to result in a child protection plan for neglect than elsewhere in the country. This raises questions about how we identify, name and tackle neglect earlier in the child's journey.



Graph 1: Child protection rates per 10,000 population

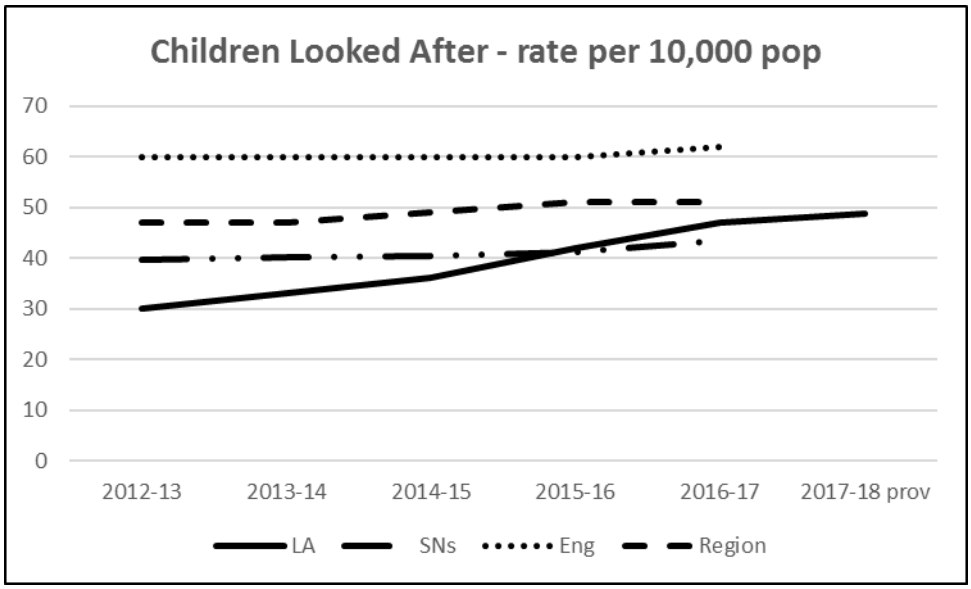
Referrals to Children's and Adolescent Mental Health Service: (CAMHS)
The percentage of children referrals to CAMHS who are seen within 12 weeks continues to be a cause for concern. At the end of the year this was only 56% compared with a target of 75%. The service continues to face high levels of demand.

Attendance at A&E for self-harm of children who are 12-17.
Alongside this we continue to collect and report the number of A&E attendances for self-harm of children who are 12-17. This has risen from 542 in 2016-17 to 660 in 2017-18 – a rise of 22%.

Disabled Children:
At the end of March there were 13 disabled children with a child protection plan compared to 16 last year.

Increasing numbers of children in care and the impact on provision:
Children in care are those looked after by the local authority. This rose by 6% in the year from 667 at the end of 16/17 to 691 at the end of March 2018. During the year the target was adjusted to be 700 based on the latest comparative figures and the realigned budget.

Safeguarding partners want to ensure that where children and young people are looked after, those who are most risk are closest to home. However, with the continuing rise in the number of looked after children, the number of children placed out of county and not in neighbouring authorities also continued to rise – from 118 to 155 or 17.5% to 22.5% of the looked after population. Some of the out of county placements are positive – at the end of December; 15 of these children were placed with family and friends and another 8 placed for adoption. Additionally, two thirds of the people placed out of county are in foster placements, with 41 children in residential placements.



Graph 2: Children looked after rates per 10,000 population

Children at risk of sexual exploitation:
Multi-agency work to identify children and young people who may be at risk of child sexual exploitation (CSE) in Oxfordshire is coordinated by the Kingfisher Team. There were 239 CSE screening tools completed in 2017-18 compared with 236 CSE screening tools in 2016-17 compared and 223 in 15/16. The number of boys identified as victims has increased. The number of children worked with who have additional learning needs are reported to be 70% of the cohort. The Team has also reported concerns regarding interwoven problems of drug exploitation alongside child sexual exploitation which is had led to a new focus on criminal exploitation and the development of work to address this.

In 2017, Thames Valley Police recorded a total of 106 victims of child sexual exploitation in Oxfordshire, almost 40% below that in 2016 (170) with the greatest reduction in Oxford (21 in 2017 compared with 94 in 2016).

Over 40% (44%) of victims recorded in the four years between 2014 and 2017 were in Oxford city and a further 26% were in Cherwell.

Children missing from home:
The number of children who have gone missing from home has fallen in the last year from 798 to 773 or from 2105 incidents of children going missing to 1913. The number who went missing 3 or more times was 149 or 19.3%. This compares with 18.5% last year.

Children involved in crime:
In 2017/18 the number of *child victims* of crime in Oxfordshire rose 3.6% from 2189 in 2016/17. Analysis on the timing of crimes revealed that 31% took place during the school day.

The numbers of domestic crimes involving children also rose from 1780 in 2016/17 to 1804 in 2017/18 – a rise of 1.3%. On the positive side – the numbers of domestic incidents involving children was 6.1% lower than last year and there has also been a 28% reduction in the numbers of child perpetrators of crime over the year.

Children missing from education:
At the end of 2017-18 – the county council were aware of 378 pupils who were on a reduced timetable; 6 pupils who were currently on a fixed term exclusion as well as 34 pupils who were permanently excluded from their school. With the latter – there is a statutory obligation to provide alternative provision within 6 days but this had only been achieved for 24% of these children. 499 children were recorded as receiving elective home education in Oxfordshire.

Allegations made against adults working with children.
In the academic year 2016/17 there was a 41% increase in recorded allegations to 234. A substantial proportion were low level cases, requiring advice. The largest percentage of allegations originated from schools (in both the maintained and independent sector) although referrals came from a wide variety of voluntary and statutory organisations.

The highest category of referrals are allegations about physical abuse, totalling 108 referrals. Referrals of inappropriate behaviour have increased (to 55), these in the main relate to breaches of policies and procedures, for example code of conducts, safeguarding policies, social media policy etc.

Safeguarding in transport
A total of 275 complaints of a safeguarding nature were received by the OCC Transport Quality Safeguarding team in the last academic year, which is a positive sign that children and families know that they can escalate concerns. These are against drivers and personal assistants that hold an OCC badge. 94% of Oxfordshire taxi drivers are now trained in safeguarding.

Children and young people involved with Oxfordshire Youth Justice Service:
The young people who are involved with Oxfordshire Youth Justice Service (YJS) often present with complex needs requiring significant support both in and out of custody. The number of young people offending (receiving a caution or above) rose slightly to 280 in 2016/17 from 246 in the previous 2 years. Figures for 17/18 are not available until May 2018.

The proportion of children receiving a custodial sentence dropped to 4.0% in 2017/18 from 4.3% in 2016/17 and 7.1% in 2015/16. The proportion of children receiving remand to custody increased to 16% in 2017/18 from 6.3% in 2016/17 and from 5.2% in 2015/16

Children who are privately fostered:
At the end of March 2018, the local authority was aware of 12 children living in a privately foster placement compared to 50 children at the end of March 2017 and 43 at 31 March 2016.

Mapping of vulnerable children 2016/17:
In the year the OSCB quality assurance group looked at the overview of activity across agencies at a ward level and published data on the use of social care; health and police services at ward level and school attendance by school partnerships.

There are clear geographical overlaps e.g. areas of higher incidences of domestic violence notifications tend to have higher levels of social care referrals, and more children are victims of crime. These are also linked to levels of deprivation, with areas with higher deprivation having higher levels of activity. There is less of an overlap with referrals to the CAMHS service. Additional work was carried out on children as victims of crime and a quarter of all victims were of school age; and the crime was during the school day in term time.

Oxford City and Cherwell have higher prevalence rates than Oxfordshire as a whole; the Vale is in line with the county average and South and West Oxfordshire have lower prevalence rates. All 4 wards in Banbury have particularly high rates as do Blackbird Leys, Barton and Northfield Brook in Oxford City. This has led to the development of Community Impact Zones in Banbury and Oxford.

Targets tracking the safeguarding system

The OSCB monitors and scrutinises performance data following up any measures which are off target. Over the last 12 months these have been:

- Children's safeguarding - increasing volumes of activity
- Multi-agency safeguarding hub (MASH) timeliness of enquiries - below the target of 75% at 45%
- Fathers attendance at child protection conferences - only 50% of fathers were attending conferences regarding their children.
- Child and Adolescent Mental Health Services waiting times for children - below the target of 75% in 12 weeks
- Children's attendance at A&E increasing

PAQA has escalated the following safeguarding concerns to the board:

1. The poor achievement of children with SEN and other vulnerable groups
2. The need for more data from schools regarding the use of part-time tables
3. The concern that targets should be set for children missing from education i.e. exclusions, attendance, not on roll and part-time timetables.
4. The use of hospital beds for children in mental health crisis because there is no suitable alternative

Pressures on the safeguarding system

Oxfordshire faces three key pressures on its system: **rising demand**, **diminishing resources** and staffing shortfalls as well as **difficulties with staff recruitment** and retention. An in-depth look at how these are being addressed through an impact assessment conducted by the children and adult's boards in 2017/18 would indicate several common approaches to keeping children safe. These include demand management and early intervention strategies, continuing to refine multi-agency approaches and the need to 'think family'.

Partners recognise the need to manage risk and pressures and regularly review them. Their impact assessment recommends

1. Further development of early help strategies and initiatives
2. Improving multi-agency working

3. Maintaining services and monitoring key issues: 5 priorities remain at the forefront of safeguarding work: mental health; domestic abuse; alcohol and drug abuse; exploitation and housing.

Section 2.2 Qualitative

Introduction

This section summarises the qualitative information available to the OSCB. The sources of information include multi-agency and single agency audits, safeguarding self-assessments agency and school audits which have been reported to PAQA as well as serious case reviews. This section aims to draw out themes and learning points.

Multi-Agency Audits:

Four multi-agency audits covered the issues of neglect, domestic abuse, children with a disability and 'Education, health and Care Plans[1]' for children and young people with learning difficulties or disabilities (aged 0 to 25). The audits concerned a small percentage of the hundreds of children and families supported through the safeguarding partnership but there are some common themes for joint working which can be drawn out.

The themes were selected by the quality assurance group from issues arising in recent OSCB case reviews: Child Q, Child K, Child C[2], Child A and Child B. Audits tended to look in-depth at up to six different cases tracking them from the perspective of the different agencies and families involved as far as possible.

Key strengths and learning points are recorded, general points feed into training and overarching developmental work, and individual services take away their own actions. Overall the findings from audits were positive and considerable good practice was evidenced in relation to decision making, ensuring a wide perspective of underlying causes, the quality of information sharing, the voice of the child, good use of tools, a strong focus on other siblings and a whole family approach.

There was good evidence of strong multi-agency working across key partners in very complex and challenging circumstances for the children and families involved. Child protection planning was seen to be effective and achieving results although could have been instigated earlier in some cases. Learning points from the audits are summarised at appendix B

Summary of themes and findings from each of the audits

The neglect audit confirmed the complexity of family life for children in this situation. Domestic abuse was an overwhelming theme throughout the audit and mental health and substance misuse were evident in 67% of cases.

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[1] Education, Health and Care Plans (EHCP) were introduced in September 2014 in accordance with the Children and Families Act and replace Statements of SEN.
'The purpose of an EHC plan is to make special educational provision to meet the special educational needs of the child or young person, to secure the best possible outcomes for them across education, health and social care and, as they get older, prepare them for adulthood.' SEN and Disabilities Code of Practice, January 2015

[2] Child C Review was a partnership review

The domestic abuse audit revealed that a history of domestic abuse within the home and sexual violence was a common feature. The circulation of indecent images of children involved by abusive intimate partners also featured highly. Disappointingly it indicated that referrals to MARAC[3] for children and young people are not happening as a matter of course. Children and young people's ability to recognise they needed help, their understanding of consent and precisely what constitutes abuse were found to be lacking in a number of cases.

The audit on cases for disabled children picked up on several issues. The first resonated with case review findings that children not being brought to appointments should be identified early and noted in this way rather than 'not attending'. The second resonated with the SCR for Child A and Child B in that, where the child is non-verbal, greater consideration should be given to means of communication and that colleagues should seek to understand what a specific disability means and how this might impact on safeguarding. To this end the need for more active engagement and communication with GPs was identified. Finally, it confirmed that school is pivotal in ensuring resilience and identifying key issues and changes early. School attendance was highlighted as a critical factor to support opportunity, well-being, safety and in achieving positive outcomes including for very young children.

The audit on cases for children who had education, health and care plans showed that the quality of these plans could be better especially in terms of health and social care information and also where a child was transitioning form one setting to another. There was some lack of knowledge by professionals on what was required which impacted on quality, timeliness and reassurance that protective factors were sufficiently in place.

The views of families and children were sought in the first three audits and can be summarised as them (families) needing to be clearer about why agencies were involved in their lives; valuing the role of an advocate in meetings and lacking an understanding of process. With respect to domestic abuse they did not feel informed about plans and 'pathways' for support. With respect to disabled children some said that they relied on their parents to forward their views and opinions, which has implications where circumstances might make this more difficult.

Single Agency Audits:

Agencies reported back to OSCB in 2017/18 on their internal safeguarding practice. Comprehensive submissions were received and often scrutinised a specific area of work e.g. hospital maternity services or police investigation of domestic incidents or OH NHS FT dental services. Findings were positive and improvements were noted with planned actions. There were lots of examples good joint working and strong adherence to safeguarding standards.

Positive examples of improved safeguarding work from these audit reports can be found in section 5. Below is a selection of learning themes only.

[3] MARAC is a 'Multi-agency risk assessment conference. It is a multi-agency meeting which domestic abuse victims who have been identified as at high risk of serious harm or homicide are referred to in order to ensure that the victim stays safe.

Youth Justice Service, Oxfordshire County Council
The audit work highlighted the difficulties in finding appropriate resources for children who are at risk of drug exploitation. It confirmed the complexity involved in working across the services with children who presenting behaviours that are a risk to the public and themselves whist being vulnerable. It also cautioned that there is a lack of understanding from partners regarding the role and nature of the youth justice system which is not a preventative service.

Children's social care, Oxfordshire County Council
This service had undertaken a range of different audits which captured a lot of good practice. Areas for improvement were cited as consistently involving fathers; better capturing the voice of the child by ensuring that they are seen alone as well as ensuring that they are up-to-date and shared.

Schools safeguarding team, Oxfordshire County Council
An overview of audits showed that in general school record keeping could be better and include more outcomes for children and that multi-agency work could be improved by liaising more with other professionals. Schools reported the frustrations of not being included in strategy meetings when referrals are made to MASH about children in their settings as well as being unable to receive information attend meetings during holiday periods.

Education and learning, Oxfordshire County Council
Whilst acknowledging that circumstances are challenging and families may prefer not to engage the audits showed that more effort should be made to obtain the views of families and vulnerable learners when planning their education.

Oxford Health NHS FT
This service had undertaken a number of different audits which generated a lot of learning. A key point was to consistently 'Think Family' e.g. the importance of keeping children in mind where the adults have mental health problems and there are often very challenging family situations. Audits indicated the high prevalence of domestic abuse and neglect in the families that mental health clinicians are working with.

Oxford University Hospitals NHS FT:
Several services areas were audited for safeguarding standards. Learning included the need to use the OSCB safeguarding tools to aid identification and recording information. Practitioners could make more use of tools to identify levels of need and to track neglectful parenting.

Community Rehabilitation Company (CRC)
This service highlighted the need for better understanding from the workforce when working with young adult male service users.

Thames Valley Police
An audit on domestic incidents showed that there is improved recording the voice of the child at the scene of the domestic abuse incident. However, audits showed more room for improvement – it had occurred in less than 50% of all reported incidents.

Safeguarding self-assessment:

The self-assessment provided assurance on the overall safeguarding frameworks within partner agencies. A few areas were highlighted as amber and these were attributed to potential risks arising from the introduction of GDPR; increased caution when assessing risk as well as organisational change. Some concerns were raise about board member effectiveness and the need to ensure challenge, improvements and impact.

Serious Case Reviews:

The OSCB has worked on four serious case reviews since the last report to PAQA.
Since 2013 twelve serious case reviews and three learning reviews have been worked on. They concern nineteen children. The children fall into two main age groups; pre-school and secondary school age children – just over 50% are older children aged between thirteen and eighteen which is in part due to the completion of the A-F review. It is worth noting that seven of the twelve cases concern children who are pre-school or just in the first year at school. In addition, either the child, their siblings or parents have previously been known to children's services (either current at time of incident or historic).

Over the last year some of the emerging, repeated themes have been:

1. **Curiosity**: being curious about the family's past history, relationships and current circumstances in a way that moves beyond reliance on self-reported information
2. **Responding to physical abuse**: professionals identifying it, listening to children and following procedures to properly investigate
3. **The role of schools in keeping children safe**: understanding that school attendance is a critical factor to support opportunity, well-being and safety
4. **Professional understanding of the implications of elective home education**: actively knowing which agencies are in touch with the family and to what effect
5. **Taking a cumulative view when working with children**: not seeing events in a linear way but weighing up risks over time and keeping previous events in mind (using chronologies)
6. **Parental wellbeing**: mental health, substance misuse and domestic abuse are recurring themes
7. **Fragmented management of health needs**: ensuring effective communication across services for co-ordinated and consistent management of care
8. **Children's emotional wellbeing**: increasing evidence of self-harm by children aged 10 years & above
9. **Children's limited capacity to protect themselves** as they move into adolescence after experiencing a lack of consistent, supportive parenting in their early years (long lasting impact of neglect)

Section 2.3 Involvement of Practitioners

This section aims to summarise the views of the practitioner in Oxfordshire.

The sources of information include safeguarding subgroups, reporting from Independent Reviewing Officers and Child Protection Chairs, Children's Services Practice Week feedback, practitioner listening events, serious case reviews, audits and training and learning events, and workshops attended by the voluntary, community and faith sector.

Safeguarding themes regarding practice and process

Many issues relate to frontline practice in the safeguarding system from early help through to more complex support and show pressure points for actions and change.

Awareness of thresholds, in particular, for early help but across the whole spectrum of need still needs to be greater and properly applied.

There is a need for better co-ordination of the routes for referral and assessment between early help (LCSS[4]) and immediate safeguarding concerns to the multi-agency safeguarding hub (MASH) including Police domestic abuse referrals to MASH.

Capacity is a problem in a system under pressure: both in terms of rising caseloads and the coverage of administrative functions. Professional time is being spent on administrative functions for social care staff in particular because of reduced capacity in support staff.

Complexity of cases dealt with by professionals not only within the children's safeguarding arena but also in relation to adults in those children's lives is presenting challenges.

Finally, the need for assurance that families whose first language is not English are supported fully to engage in the safeguarding process and the appropriateness of interpretation for children through a family member has emerged as a theme for frontline practice.

Safeguarding themes raised by practitioners

The following relate to themes observed by practitioners in the safeguarding system as they support children and families. They are reassuringly reflective of those throughout this learning and improvement framework.

Supporting vulnerable adolescents to develop protective behaviours. The complexity of working with children presenting behaviours that are a risk to the public and themselves whilst being vulnerable and the tenacity required to support children with complex issues

Young people exploited in crime-related activity. The difficulties for practitioners in finding appropriate resources for children who are at risk. The need for better screening of need, referral routes and provision before children become identified as 'offenders'.

[4] Locality and Community support service

Placement Sufficiency. The lack of availability of placements for some groups of vulnerable children and young people e.g. children in care and children with acute mental health needs as well as the lack of quality of some of this provision e.g. secure estate or therapeutic placements.

Young people's domestic abuse pathway. Awareness and use of the pathway needs to be improved across the partnership. Multi-agency training is needed not just on domestic abuse but on understanding consent and healthy relationships.

Links between safeguarding risk and safeguarding in education. Attendance, exclusions, elective home education, attainment and achievement of pupils with SEND have all been raised as concerns.

Young people's mental health and self-harm. Ensuring consistency of approach across the county and accessing care in a timely way for children.

Housing themes. The lack of appropriate housing for vulnerable young people and families is a consistent concern and when location of school is not taken into account when children are taken into care, which can increase instability at an already vulnerable time.

Safeguarding themes from the voluntary sector leads

The two key safeguarding concerns communicated by the sector concern the funding environment and the anxiety of carrying risk. An increasing number of local charities with skills and a track record of making a difference for children and young people state that they are at risk in the current funding environment. Organisations have also stated their concern that, despite the establishment of the Locality and Community Support Service (LCSS), they feel that they are holding a growing number of increasingly complex cases. These are children who fall just below rising statutory thresholds and/or who can't access specialist services because of lengthy waiting lists.

Safeguarding themes through the OSCB training

OSCB trainers meet over 2000 members of the children's workforce each year. They provide anecdotal feedback to the OSCB. This year they have heard delegates raise the issue of increasing mental health issues in adolescents and long waiting times; drug exploitation; unaccompanied minors within the education system who have difficulty with the English language.

Section 2.4 Views of Young People, Parents and Carers

This section aims to summarise views of young people, parents and carers. The sources of information include young people forums; audit work, children in care council and Oxme.info the county council's website for young people.

Parents: 3 simple messages

1. Communication, communication, communication
   - ✓ Clear, honest, straightforward language needed.
   - ✓ Jargon, 'service speak' and paperwork is disempowering and bewildering
   - ✓ Connect and click with workers is central "you've got to let them in"
   - ✓ Responsive communication – i.e. returning calls, texting is favoured
   - ✓ Out of hours assistance - access at pinch points – evenings and weekends
   - ✓ Accessibility of information, plain English, interpreters etc

2. Don't leave help and support until crisis point

3. Sharing and co-ordination of information between agencies
   - ✓ Co-ordination between services and agencies is vital
   - ✓ They want an effective service – they don't care who runs it
   - ✓ People with SEN / disabilities have to battle their corner and fight for services

Children: simple messages

Don't like

- Telling my story over and over
- Breaches of confidentiality
- Having to wait until crisis for a service (and things getting worse)
- Poor communication: professional not coming good on offers of help and actions, slow in replying
- Abrupt change of social worker is difficult; some change is acceptable, importance of managed endings
- Being labelled and judged as troubled child / naughty child. Behaviours are communication and staff must seek to understand and learn from behaviours "*look behind the behaviours"*
- Not knowing who to go for help and in what situations. Children normalise abuse experience.

Do like

- Get in early *"make a difference as early as possible*".
- Relationships have got to work to build trust and progress "*click and connect*"
- Show you care / "*get to know me as a person not just a case or a set of problems"*
- Children and young people want to be informed and involved "*listen to me*" – increase views being reflected in plans and decisions
- personal 1-2-1 advice
- small things matter and show you care

Voice Of Oxfordshire Youth (VOXY): recent messages on safeguarding themes

- Lack of mental health support for young people
- Lack of youth clubs – seen as an important source of advice and guidance
- Needs to be more of awareness for teens about drugs and alcohol
- Bullying is a big deal and young people reporting lack of effective action in schools
- Fabricated and induced illnesses is an emerging concern

Homophobic, bi-sexual, transgender bullying – recent messages

- Importance of creating safe spaces for LGBT+ youth and how much this is valued by young people.
- Empowerment of knowing 'I'm okay, I'm normal too'
- Value of knowing how to support the LGBTQ+ people in their school
- Significance of understanding the LGBT history

Young people's concerns reflected on Oxfordshire's Website for young people, oxme.info

In 2017-18 over 90,000 visitors accessed more than 175,000 pages on the oxme.info website. Children's Rights (33%) were a key concern this year alongside opportunities and finding a job (16%). Other key concerns among our site visitors include bullying with our content around anti-bullying week and the galleries from the poster competition (run jointly with the OSCB) proving popular both on the website and on our social media presences. Other popular content includes an internet safety page on sexting, activities for young people with disabilities and work experience.

YiPpEe – message for improvement in the university hospitals

YiPpEe is the Oxford University Hospitals FT's Public Partnership Group for children and young people. They were involved in the National Children and Young People's Inpatient and Day Case Survey (see section 5 for more details). Following this work the Trust has identified three areas for improvement in partnership with YiPpEe:

1. reducing avoidable noise on children's wards at night
2. improving the information provided on discharge
3. involving children and young people more in decisions about the care and treatment they receive

Summary of compliments and children's statutory social care complaints

Poor communication continues to be the top theme from complaints[5], closely followed by staff attitude. One prevalent theme from complaints this year is recording errors and the accuracy of assessments. The service continues to receive complaints that conference minutes and reports are sent out late.

73 formal compliments were received about Children's Services. The compliments praise the child focused work taking place which has been described as creative, insightful, reliable, professional, diligent and competent.

[5] The County Council's Complaints Service received 107 (stage one) complaints about Children's Services last year. The majority (77%) of those complaints were made by parents or grandparents. 32% of complaints were about children on a Child Protection Plan. 23% were about Looked After children.

Section 3: Impact of work to improve safeguarding practice

Below are examples of 'positive impact' as reported to the Performance, audit and quality assurance subgroup following the scrutiny of safeguarding practice over the last 12 months. Auditing of safeguarding work takes place annually and services demonstrate change and impact over time.

- Public Health, Oxfordshire County Council could demonstrate that the **services that they commission consider their safeguarding practice**. Feedback from a provider of substance misuse support was as follows, "It is intended that the (serious case review) learning points will be discussed at staff team meetings and to inform future training events for staff and partners agencies" they went on to state that they had "enhanced the package of care of service users with children on a child protection plan - which includes targeted parenting groups";

- 97% of **dental staff had an excellent knowledge of safeguarding policies**, procedure and guidelines when surveyed by Oxford Health NHS FT. (57 staff audited. 60% return rate. Jul 16)

- Oxford Health NHS FT were able to demonstrate that colleagues **were using the guidance for responding to non-recent (historic) abuse** citing an example which led to the prosecution of a perpetrator of historical abuse.

- OUH NHS FT has the 'yippee' forum for young people and uses the 'Wellbeing Monkey' to communicate issues to young people. Examples of good practice are: **involvement in the interview process** for a new paediatric rheumatology consultant. Contribution of feedback to the Children's Survey Advisory Group at CQC Headquarters alongside professionals from the Trust.

- OH NHS FT Children's **Safeguarding Consultation line** for staff to talk through safeguarding issues with Named Nurses has received positive feedback: good advice; better understanding of the safeguarding system and reassuring to practitioners. (Small sample audit Feb 17)

- The National Probation Service could demonstrate that Oxfordshire staff have a good **understanding and awareness of CSE**, recognised in recent visits from the National Executive Director and the Chief Executive Officer of the NPS in the past 3 months.

- The Community Rehabilitation Company audits identified improved attendance at **Core Groups and timely responses** to requests for information from the Multi Agency Safeguarding hub.

- Since the last audit the CRC has introduced fortnightly Sentence Planning Meetings which provide **management oversight of safeguarding casework** and enable safeguarding risks to children and domestic abuse to be identified when working with offenders.

- Children's social care, Oxfordshire County Council could identify positive themes across four audits: commitment of staff; good recording; joint working and assessment and plans.

- Schools and learning, Oxfordshire County Council. Following the audit work more information is being requested by this service with respect to the **vulnerability of the young person** being supported e.g. safeguarding risks in terms of CSE and prevent to ensure that **planning takes these safeguarding concerns in to consideration**

- Thames Valley Police could demonstrate **an increase in the recording of children's information** when attending domestic abuse incidents.

- Thames Valley Police reported that Cherwell & West Oxfordshire Local Police Authority had the highest number of crime reports with completed "**Voice of the child**" sections.

- 94% of **taxi drivers** are now trained in safeguarding which is a learning point form the serious case review on child exploitation

- In 2017 a local **taxi driver,** who had undertaken safeguarding training, was commended by Thames Valley Police for his actions in safeguarding a child who was at risk of significant harm from a dangerous individual. His actions ensured the child was kept safe and proved vital in ensuring the conviction of a predatory offender.

- In 2017 Thames Valley Police and Oxford City Council's Community Safety Team led a test purchase operation on to test the awareness of **hotel staff** with respect to CSE. The Team were pleased to report a positive outcome for an establishment that had featured prominently in previous CSE investigations in particular Bullfinch.

- YiPpEe is the Oxford University Hospitals Foundation Trust's Public Partnership Group for children and young people. The group have been involved in a wide range of activities over 2017/18, which include:
    - delivering a seminar to **children's nursing students**, at Oxford Brookes University, on service user involvement.
    - investigating the main causes of noise at night on children's wards, in response to the Trust's results for the National Children and Young People's Inpatient and Day Case Survey 2016.
    - attending the '**The Big Youth Forum Meet Up'**, at Great Ormond Street Hospital for Children, where they had the opportunity to meet similar groups from across the country.
    - YiPpEe also has two members elected to represent children and young people on the Trust's Council of Governors. They have a set agenda item at all **Council meetings** to update Governors on the work YiPpEe are involved in.

- November 2017, results were published for National Children and Young People's Inpatient and Day Case Survey. This surveyed patients, and their parents/carers, between the ages of 15 days and 15 years old. Questionnaires were sent by the Trust to 1,250 patients, with 462 returned, giving a response rate of 37%. OUH had more questionnaires returned than any other NHS Trust that took part in the survey. The Trust performed better than most Trusts on fifteen questions including, patients being able to talk to staff without parents or carers present, parents having enough information to be involved in care decisions and overall patient experience.

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
GDPR	General Data Protection Regulation
LAC	Looked After Children
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
TVPS	Thames Valley Probation Service
VCS	Voluntary and Community Sector

Appendix A

JSNA data mapping

http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment

Appendix B

What did we learn?

Working to tackle neglect

- Use 'tools of the trade' earlier. Find the Child Care Development Checklist on Practitioner Portal and use it.
- Ensure child protection procedures are followed rigorously for children who are already subject to a plan e.g. new bruises, new safeguarding concerns
- Make more use of professionals-only meetings, multi-agency chronologies, case mapping, deputy role for core groups.

Dealing with domestic abuse

- All cases concerning young people cases should be referred to MARAC regardless of assessed level of risk this means both victims and those perpetrating harmful behaviours
- Need for greater understanding amongst professionals of online and social media abuse: the circulation of indecent images of children involved by abusive intimate partners features highly
- Professionals sometimes report a lack of confidence in knowing what to share with parents
- Professionals responses are sometimes clouded by how children and young people define their own peer relationships

Working with disabled children

- Ensure practitioners keep a clear record of 'was not brought' episodes to identify any patters or gaps and work with partners to ensure this is collated
- Children not being brought to appointments should be escalated as a risk factor where there is a concern about neglect and needs to be cross-checked across different health professionals
- Raise awareness of the importance of understanding how a child's impairments may impact on and contribute to their safeguarding vulnerability
- School is pivotal in ensuring resilience and identifying key issues and changes early

Completing the 'Education, health and social care plans (EHCP)

- Need to ensure that protective factors are in place as young people transfer to college
- Transition points need careful planning of expected outcomes for the child
- Health colleagues to better understand what information is required for the EHCP to get the best possible plan in place for children

Division(s): N/A

PERFORMANCE SCRUTINY COMMITTEE - 8 November 2018

Children Missing from Home and Care in Oxfordshire

Report by Director for Children's Services

Prevalence of Children going Missing in Oxfordshire

1. Introduction

This report provides a strategic update on the number of children reported as missing from home, care and school in Oxfordshire, including children looked after by Oxfordshire County Council. It covers the period between **01st January 2018 and 31st June 2018.**

The report focuses on the main patterns, trends and concerns across the county which will be of note to the strategic leads. It covers best practice in line with the agreed 'joint protocol' and current risks or shortfalls and how these are being managed to ensure compliance with the relevant guidance issued by the Department for Education (DfE) and the College of Policing.

It is not intended to reflect the full picture of all the work undertaken by the Missing Children's Panel and partners within the period. Many investigations and analyses are active, awaiting further intelligence development or exploration with operational partners, third party agencies, and the children and families whom we are working to safeguard.

Safeguarding missing children is a key priority for the Oxfordshire Safeguarding Children Board (OSCB). The OSCB Child Exploitation Sub-Group is responsible for overseeing the partnership arrangements for missing children across the county.

A wide variety of information and intelligence has informed this report. Sources include information held on both Oxfordshire County Council's and Thames Valley Police databases (including crime, intelligence and missing persons), local authority databases and multi-agency records.

There remains evidence of risks related to missing children across all of Oxfordshire, with varying patterns and trends in each locality.

2. Current overview

On 31 June 2018, Oxfordshire was responsible for the welfare of 668 Looked After Children (LAC), excluding Unaccompanied Asylum-Seeking Children (UASC); this represents a 3% increase since 31st December 2017. In addition, across the same period, the Local Authority supported 55 UASC; which represents an increase of 1% and results in a total number of 723 LAC.

Of these: 104 children were in residential placements, 86 with private providers.

Increases were noted for; children placed with their parents (25.5%) whilst children moving into independent living decreased (-16.7%). Children placed for adoption has remained the same compared to the previous six months, with children placed in foster placement or kinship care increasing (22.2%) and IFA placements increased (10.3%).

Comparison and Trends (June to December 2016 compared with January to June 2017)

	LAC 31/12/17	LAC 30/06/18	Difference	% Change
LAC	701	723	22	3.1%

3. Comparison and Trends (January/July 18 compared with June/December 17)

When the above figures are compared, we can see there has been a 3.1% increase in our LAC population (including UASCs).

Analysis - across the period, the number of all (LAC and non-LAC) children reported missing has decreased by -2.0%. Across same period, we have seen occurrences of children repeatedly reported decrease -8.8%. There has also been a decrease in looked after children reported missing -3.8% and a decrease in LAC repeatedly going missing -20.1%

	Total	July – December 2017	January - June 2018	% Change
Number of children	757	450	441	-2.0%
Number of episodes	2119	1108	1011	-8.8%
Number of children whom were LAC	120	79	76	-3.8%
Number of repeat missing episodes for LAC	574	319	275	-20.1%

Conclusion – across this period, we can see that the number of children being reported missing reduced as did children reported missing more frequently. It is noted that there has been a specific reduction of both numbers of LAC reported missing and the frequency of repeat missing episodes for this cohort.

Of the 441 children, 281 were reported missing on one occasion only, a reduction of - 7.3%. Children reported missing on 2 to 4 occasions increased by 19.6%. There was also a decrease in children being reported missing on 5 to 9 occasions - 6.9%, 10 to14 occasions -18.2%, 15 to 19 100% and on 20+ occasions -71.4%.
occasions remaining the same.

	Total	July - Dec 2017	Jan - June 2018	% change
One Episode	479	303	281	-7.3%
2-4 Episodes	179	97	116	19.6%
5-9 Episodes	61	29	27	-6.9%
10-14 Episodes	16	11	9	-18.2%
15-19 Episodes	6	3	6	100.0%
20+ Episodes	16	7	2	-71.4%

Conclusion – this is the fifth report which notes a reduction in children being reported missing in Oxfordshire (when you consider the increased number of children currently coming into care, this represents a reduction greater than –2%). The increases in the presentation of children reported missing on 2 to 4 occurrences have been explored further. These refer to a small number of children and are specially linked to periods across the Easter and May half terms school holidays and are representative of the pattern noted each year. The number was slightly higher than last year and panel are of the view that the fair warm weather in the early summer months was a contributory factor. The strategic leads are of the view that, on evidence presented at the Missing Children's Panel, the overall decrease in children being reported missing for the first time and repeatedly, are attributable to the improved understanding of the risks children are exposed to when missing and Thames Valley Police's and Children's Social Care's effective local partnerships working prior to escalation to the Missing Children's Panel forum. The strategic leads have quality assured this as part of the functionality of the Missing Children's Panel and evidences the effective identification of the risks, communication of the strategic plan/process, tighter Q&A/reporting and the sharing/recording of information being used to keep children safe.

4. Unaccompanied Asylum-Seeking Children

There has been a decrease in -16.7% in the presentation of UASCs across the past 12 months.

Analysis – during this period, there has been a decrease (% per person per missing report) of the number of UASCs being reported missing, with only 2 UASC being reported missing across this period and only one child reported more than once.

	Total	July - Dec 2017	Jan - June 2018	% Change
Number of UASCs	7	6	2	-66.7%
Number of episodes (UASCs)	11	8	3	-62.5%

Conclusion – the data set reported notes a sustained decrease in UASC missing episodes and the level of risk present for these children. Following the Child Exploitation Sub-Group approving the recommendation made by the strategic lead in March 2018, a Missing UASC procedure is imbedding and is now included within the Missing Children's Joint Protocol this is being presented to Procedures Sub-Group in October 2018 and will be noted at the next available OSCB Executive Sub-Group.

The reporting of Missing Children within Oxfordshire has been divided into the following geographical areas in line with District Council Authority boundaries.

- Cherwell & West Oxford
- South Oxfordshire & Vale of the White Horse
- Oxford City

5. Cherwell & West Oxfordshire

	July - Dec 2017		Jan - June 2018		% Change	
	Children	Episodes	Children	Episodes	Children	Episodes
Northern	173	486	177	506	2.3%	4.1%

Analysis - as noted in the table above, children being reported missing and frequency of repeat missing reports has slightly increased the past six months. The pattern and trend as noted in the previous report remains; with the majority of children reported missing on only one occasion; often reported from school or

by a parent due to challenging behaviour in line with the child's age and development, or as the result of returning back to school or home later than expected.

The last report to the Child Exploitation Sub-Group noted that four children whom reside within this LAP accounted for the total increase in repeat missing episodes between July and December 2017, the indicators were indicated problems with the individual care planning arrangements, the pattern and trend evidencing a push factor form the providers and LPA has recorded a spike in low level anti-social behaviour linked to these reports.

Following this, an agreed action plan was implemented for each child and across the past six months this has resulted in two of the children being reconnected back to their placing local authorities and a reduction of - 87% in the presentation of the other two children being reported missing. Across this period several eateries have been raised as locations of concern around missing children. The partnership has utilised intelligence gathered from missing children reports and return interviews to assist and inform a piece of multi-agency licensing work.

In addition, persons of interest in an ongoing police investigation continue to be monitored for any new information or intelligence relating to children reported missing within the LPA, whist there are no new CSE intelligence in relation to these adults, in some cases there is evidence of other criminality/exploitation which is being managed. this resulted in several CAWNs being issued and the situation continues to be monitored.

Conclusion – As anticipated once the care planning needs of the four identified children in the previous report was better understood and an appropriate/proportionate strategy implemented by the partnership with the provider there was an evident reduction in these children repeatedly going missing. The slight increase in presentation of missing and repeat missing reports noted within the data set, refer to a small number of children and are specially linked to periods across the Easter and May half terms holidays and are representative of the pattern noted each year and the warmer weather across June 2018. To fully explore this a separate local meeting relating to missing children has been held to analyses and review the partnership responses in within the LPA. The chairs report that this was effective in agreeing local cross agency strategies, the effectiveness of which will be monitored over the next six months.

6. South Oxfordshire & the Vale

	July - Dec 2017		Jan - June 2018		% Change	
	Children	Episodes	Children	Episodes	Children	Episodes
Southern	119	323	116	244	-2.5%	-24.5%

Analysis - there has been overall decrease in the number of children reported missing for the second consecutive report when comparing the previous six months, with the number of episodes relating to children reported missing more than once also decreasing. Like the North, many children reported missing went missing on only one occasion, often reported from school or by parents due to challenging behaviour in line with the child's age and development, or because of returning to school or home later than expected. The previous report to the Child Exploitation Sub-Group noted intelligence gathering took place in relation to three children, which led to several joint tactical responses by the LPA and CSC, resulting in several Child Abduction Warning Notices (CAWNs) being issued. On review it is noted that all three children have either not been reported missing or have been subject to a significantly reduced number of repeat missing episodes - 76%.

Information from missing children's reports and return interviews are currently supporting an active investigation in relation to an adult who it is suspected has allowed there house to be used by groups of missing teenagers in the area. It suspected that risky activities have taken place between the children as well as drug usage and suggestions of more exploitative behaviours.

Conclusion – The strategies put in place by the partnership, kingfisher and LPA had an impact on the pull factors, pattern, trend and risk trajectory identified in the previous report for the three children noted and has resulted in a positive outcome as these have now either ceased or significantly reduced. In relation to the adult and the risks noted above, the LPA and Kingfisher team have worked with partners, including local schools and the CSC assessment teams, to fully analyse the risk and take safeguarding measures where necessary.

It is noteworthy to highlight that 18 months ago there were substantial concerns related to number and frequency of children being reported missing within this LPA. A year on from a targeted strategy by the LPA, CSC and Kingfisher team, has resulted in both the number of children being reported missing and repeatedly going missing reducing by - 41% and - 42% respectively when we compare a specific reference point (July 17 to June 18).

7. <u>Oxford City</u>

	July - Dec 2017		Jan - June 2018		% Change	
	Children	Episodes	Children	Episodes	Children	Episodes

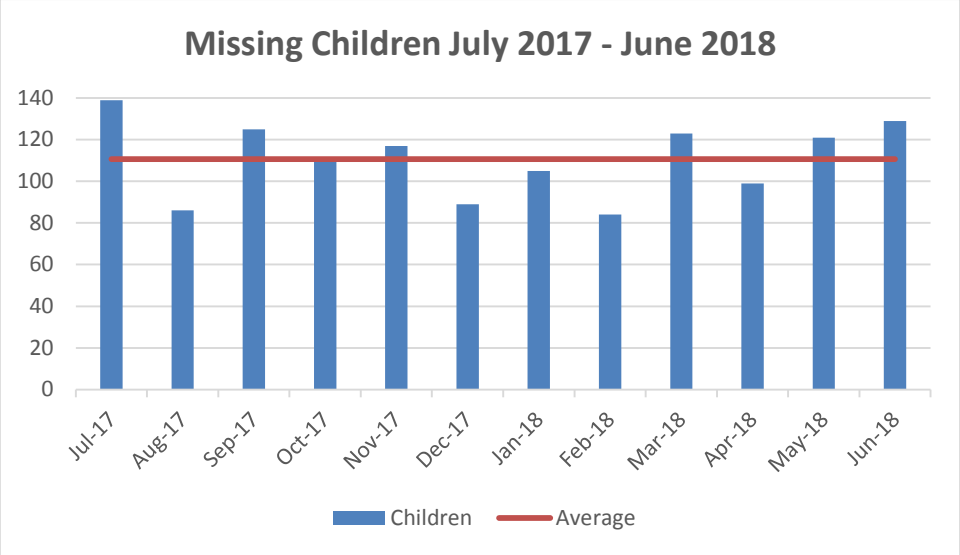
Central	157	297	148	260	-5.7%	-12.5%

Analysis - Both initial and repeat missing reporting has reduced over the past six months. Within this reporting period most of reports are like the North and South areas of the county, relate to children reported missing on only one occasion, often reported from school or by parents due to challenging behaviour in line with the child's age and development, or because of returning to school or home later than expected. Positive action has been taken in each case and in several cases, have resulted in Child Abduction Warning Notices have been issued to assist in managing the on-going risk, following intelligence gathering and analysis from the missing children's panel.

Conclusion – In two cases the use of CAWNs was achieved due to the prompt evidence gathering by the LPA from missing children's reports, return home interviews and other intelligence mapping. This is reflective of the improved recording practices an increased awareness by the partnership of the notices being utilised as a tactical option. In both these cases exploitation and missing children associated markers were evident. The notices provided an effective degree of safeguarding in a problematic situation, as whilst there were concerns no disclosure of a crime was made by either child. The CAWNS issued in relation to these two males provided an effective tool in combatting the exploitation and missing risk present and since they have been served there has been a marked reducing in missing reports and no further known contact with the persons of interest subject to the CAWN, this remains under close monitoring by the partnership.

8. <u>Countywide:</u>

Analysis - across this period, most children reported missing were aged 13-16 years of age and, in the main, were first identifications. When we compare the data from July to December 2017 vs January to June 2018, we can see that the number of children coming to the attention of the Local Authority has risen in all key vulnerable cohorts and we are now placing more LAC in Oxfordshire than we have previously. In the same period, the overall number of LAC, non-LAC and UASC reported missing has reduced. The Missing Children's Panel continues to scrutinise the partnership's operational responses and risk assessment processes, which is maintaining a robust risk management benchmarking. The reductions in children that are repeatedly reported missing reflect the work being undertaken by CSC and the LPA with families in the localities and multiagency risk management plans.



9. Reporting of Out of County LAC Missing Episodes

There is a set procedure for providers commissioned by CSC to report on missing Oxfordshire LAC placed out of county. Under the current contract arrangements, a missing episode is a notifiable event and, therefore providers (IFA and residential) must notify CSC of any missing episode. As previously reported, a new process has been implemented that allows IROs to retain oversight of children being reported missing out or area to ensure appropriate quality assurance of the local care planning arrangements. In October 2017, an IRO reported that an Oxfordshire LAC placed out of area was frequently being reported missing from his residential placement and that the provider was not adequately keeping the LA update on these events.

Analysis - Following the last report a review was undertaken by CSC which indicates improved reporting to the local authority by providers. This will be kept under close monitoring and further analysis will be undertaken in December to review if the improvements are being sustained.

10. Reporting of Out of Area LAC Children placed within Oxfordshire

The strategic leads for missing children continue to make quality assurance challenges to those authorities which place their LAC in Oxfordshire, ensuring that, as the host authority, the same safeguarding benchmark is applied to all children in Oxfordshire.

11. Return Interviews

As reported in January, the maintenance of ensuring timely completion of return interviews in line with statutory guidance remains a challenge for the

partnerships. Whilst overall the completion of return interviews across the past six months has improved (99%), they are not always being recorded within the 72-hour timeframe (57%). It will take a continued joint effort from senior management to fully embed these processes to strengthen accountability; including, on-going training for staff, resourcing considerations, discussion at meetings and oversight of quality and performance.

The new missing children workflow within CSC's I.T system has been designed and completed and has a go live date of 01st September 2018. This new workflow automatically sends the completed return home interview to a dedicated Police Team which is now set up within CSC I.T systems.

	% completed	% recorded within 72 hours
Central	98.1%	57.6%
Northern	99.2%	56.0%
Southern	98.4%	57.5%
Disability	100.0%	**0.0%
Total	**98.7%**	**56.7%**

** the reason this is such a low % is because it relates to two (2) missing reports in total

The CSC strategic lead for missing children has completed an options appraisal to identify if a system could be commissioned to deliver a more effective solution to the completion and recording of return home interviews within a 72-hour period. This is being taken forward by the CSC Joint Commissioning Service to determine if a provider can be procured to undertake this function, it is anticipated that feedback will be available by early 2019.

12. Conclusion

This prevalence report is an assessment of the emerging patterns and trends in Oxfordshire as of 01st July 2018.

The Missing Children's Panel are of the view that the overall reduction in both missing and repeat missing episodes can be attributed to improved reporting and recording of information and are a sign of families, agencies (including schools and supported housing providers) being far more effective and proactive in reporting missing children and correct identification of possible risks they are exposed to.

It is evident that the number of children reported missing or repeatedly missing has reduced across the reporting period. When set against the increases in our LAC population, and more children placed in Oxfordshire than we have

previously as we keep our most vulnerable and riskiest children close to home, it suggests that we continue to manage our repeat missing children cohort more effectively across the partnerships. The new I.T cross-agency framework for sharing information in a timelier manner, specifically return home interviews with TVP, will improve the current arrangements and the overall effectiveness of safeguarding children and families. The first report on the new system will be undertaken in December 2018 and a report available from February 2018.

There continues to be a daily reporting interface between TVP and CSC to ensure effective individual risk management, strategic oversight, escalation and reporting systems to senior officers within both agencies.

There continues to be robust evidence of improving practice within the partnership around children who go missing, exposed to child exploitation and other risks, are appropriately managed. All missing children processes continue to be monitored and quality assured on a daily basis, including the implementation of strategy discussions for those children that meet the threshold.

The strategic leads for missing children continue to highlight that the partnership will increasingly come under pressure to ensure that appropriate resources are directed towards safeguarding those children who are repeatedly missing, responses need to be balanced, proportionate and targeted.

13. RECOMMENDATION

The Committee is RECOMMENDED to note the report.

Daniel Ruaux
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Children, Education and Families

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PERFORMANCE SCRUTINY COMMITTEE

PROPOSED WORK PROGRAMME

ITEM	NOTES
13 December 2018	
Corporate Plan and Priority Delivery Plans	To provide context for a discussion about resources and budget pressures, Directors will share their priorities within the overarching delivery pans and service plans.
Service and Resource Planning 2019/20 – 2022/23	Scrutiny of proposed revenue budget 2019/20 and medium term financial plan for 2019/20 – 2022/23.
10 January 2019	
Service and Resource Planning 2019/20 – 2028/29	Scrutiny to consider draft capital proposals and draft Treasury Management Strategy and provide comment to the Cabinet before proposals are reviewed on 22 January. This discussion will include proposals for an Investment Strategy and Capital Strategy.
Q2 Corporate Performance	An overview of the council's performance in Q2 and identification of areas that the committee may wish scrutinise in further detail.
Scrutiny Young Carers Deep Dive	A further report on the findings and recommendations from the Committee's deep dive into inequalities faced by young carers, particularly focusing on areas highlighted by the Cabinet in its response to the initial scrutiny report.
Scrutiny Highways Deep Dive	A discussion about the findings and recommendations from the Committee's deep dive into the condition of highways in Oxfordshire and customer satisfaction rates.
14 March 2019	
Q3 Corporate Performance	An overview of the council's performance in Q3 and identification of areas that the committee may wish scrutinise in further detail.
Co-production	Scrutiny of progress embedding co-production within Adult Social Care, but also as a key principle in how the Council operates across the board.
Adult Social Care Contributions Policy	Scrutiny of how changes to the way the council charges for adult social care services are being implemented and the impact this is having on residents and their carers
Oxfordshire Local Enterprise Partnership	Scrutiny of the LEP's activity in supporting innovation and driving productivity. Scrutiny members may wish to consider a deep dive in preparation for this item, focusing on: - How the LEP is accountable to the public,

	- How the County Council operates as the accountable body, - Governance and transparency around decision-making.
Recycling Rates	An update on progress made with implementing the recommendations from the recycling deep dive and how this may have affected performance.
9 May 2019	
4 July 2019	
5 September 2019	
Young Carers	Review of progress in relation to the recommendations from the Young Carers' scrutiny deep dive and the impact of moving the Young Carers Service into the Family Solutions Service.
7 November 2019	
12 December 2019	

TO BE SCHEDULED	
ITEM	**NOTES**
Drug use in Oxfordshire	Links with health, domestic violence, housing – examine relationship with districts and Thames Valley Police.
Contract performance	Scrutiny of how high value contracts with key providers, such as SKANSKA or Adult Social Care providers are managed.
Use of s.106 monies	Update on progress since the PSC deep dive into s.106/Community Infrastructure Levy (CIL) payments.
Plans to tackle roadside NO2 concentrations	Council's approach to dealing with the impact of national policy to tackle roadside NO2 concentrations on Oxfordshire's transport network/ road infrastructure (i.e. ending the sale of diesel/petrol cars by 2040)
Strategic drivers	How the council is meeting its identified strategic risks, including council transformation and culture change, its relationship with external partners, building communities, etc.
Income generation	Scrutiny of the council's principles in relation to income generation, the opportunities available to the Authority and plans for increased income generation.

Operational Assessment – Community Safety	Scrutiny's comments on the proposed next steps following the report on the operational assessment.
Daytime Support Services	Review of the impact of changes to Daytime Support Services and whether there are clients who did not get places in the new service – to include an Age UK representative.
Ofsted inspection response	Scrutiny of the actions the Council is planning to take in response to the findings of the inspection into local authority services for children in need of help and protection, children in care and care leavers.
Council workforce	How the Council is meeting its Investors in People standard, ensuring its workforce is diverse and representative of local communities, and building workforce resilience, including its relationship with Unison.
Oxfordshire Local Transport Plan	Scrutiny of the Council's overall transport vision, goals and objectives to support population and economic growth.
Key worker housing	A report on progress with addressing housing and affordability issues in Oxfordshire as one of the biggest barriers to attracting key workers for the care workforce.

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