OSCB ANNUAL REPORT 2014-2015

Oxfordshire Safeguarding Children Board

Annual Report Introduction:

I am pleased to introduce the Annual Report for Oxfordshire Safeguarding Children Board 2014/15. I have now been in post just over a year and would like to thank all organisations represented on the OSCB for their commitment; grip and engagement in making sure improvements continue to be made in protecting all children from harm in Oxfordshire. The standard set remains high.

The findings from audits, data, serious case reviews and reporting schedules provided to the OSCB during 2014/15 have given me a clear view of how well child protection work is being managed. The findings give me a clear picture of the pressure points across children's social care services, across NHS organisations, within schools and from policing. The OSCB has examined carefully the work that is being done to improve services and how best to ensure that those working on the front line, as social workers, police officers, health visitors, teachers and any part of the children's workforce are part of the key learning and development. This has included actively listening to the voices of children, families, and the welfare of disabled children, and to the most vulnerable children. In particular, there has been a focus on older children in the child protection system and systems and practice have been strengthened to ensure that this group of children are being supported appropriately and not disadvantaged in the transition into adulthood. Children who go missing from their care, school or home are much better responded to so as to better mitigate their vulnerability.

Oxfordshire maintains a focus on children leaving care. All these issues remain priorities within next year's Business Plan.

Furthermore, during 2014/15 the OSCB has worked with the wider community through engagement with faith groups, community groups and the voluntary sector to raise awareness of child protection matters and this is recognised as an ongoing priority. This has also led to a greater understanding of new challenges facing the child protection system linked to safer transportation of children across the County.

There have been many and varied examples of working, innovative approaches to service delivery and commitment in Oxfordshire that I have seen. I have reported very recently on the progress made to tackling CSE and it seems to me that this has led to progression in tackling other problems facing children across Oxfordshire. Everyone knows the part they have to play in keeping children safe.

As this Annual Report is published there are clearly increased pressures for the child protection partnership across the County as the activity in the system continues to increase with the numbers of children on child protection plans and coming into care, continuing to rise. There are also implications for the extent to which partner agencies are able to maintain existing approaches to early intervention and the OSCB will be monitoring carefully the outcome of any changes to child protection arrangements in Oxfordshire during 2016.

by **Maggie Blyth**
the Chair of the Board

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CHAPTER 1: LOCAL SAFEGUARDING CONTEXT

Oxfordshire demographics

Oxfordshire is the most rural county in the south east. It has a population of approximately 635,000 of which 140,000 are children aged under-18. The number of children has grown approximately 6% in the last ten years – mainly in urban areas such as Oxford, Didcot, Witney, Bicester, and Carterton. The percentage of the county's population from minority ethnic backgrounds is 9.2%, although this figure more than doubles in Oxford City. In the next ten years there is likely to be significant population growth among children born to first generation migrants, particularly those from Middle Eastern, Asian, and new EU countries.

According to the IDACI rankings, Oxfordshire's more deprived areas tend to be in the urban centres of Oxford and Banbury, with further pockets in Abingdon and Didcot. Overall, Oxfordshire is ranked twelfth lowest on IDACI measure.

Oxfordshire performs above both national and statistical neighbour averages for the proportion of both primary and secondary schools judged as good or outstanding. Despite this the proportion of outstanding schools in Oxfordshire remains low. In addition persistent absence rates, permanent exclusions and fixed term exclusions in secondary schools are a concern.

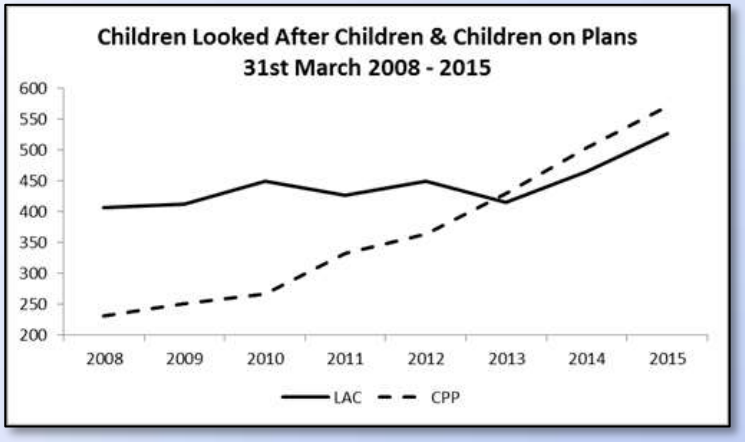
Vulnerable groups

The OSCB focuses on those children who are most vulnerable or at risk of suffering harm. We know that there are many reasons why children can become vulnerable or at increased risk of harm. For example children living in households where there is domestic abuse, substance misuse or their parents are mentally ill are known to be at a greater risk. Children whose family life is neglectful will struggle to get a good start in life. Children who go missing from school or missing from home are placed in greater danger of harm. The needs of these children, and other vulnerable groups, are outlined below to provide an understanding of the local context. The impact of the work done to support these children is outlined extensively later in this report in chapter 3.

The OSCB is aware that it is not always possible to know the complete picture of the children whose safety is at risk. Some abuse or neglect may be hidden and it is important to understand that the local context is a changing one and that new concerns should be escalated as they emerge.

Children with a child protection plan

Children who have a child protection plan are considered to be in need of protection from either neglect, physical, sexual or emotional abuse; or a combination of two or more of these. The plan details the main areas of concern, what action will be taken to reduce those concerns and by whom, and how we will know when progress is being made.



At the end of March 2015 there were 572 children subject to a plan compared with 504 children the previous year. There were an additional 24 children who were the responsibility of another local authority living within Oxfordshire. This is the highest level for many years. Nationally there has been a rise in the number of children subject to a Child Protection Plan though not to the extent seen in Oxfordshire. OSCB has analysed this increase in general activity and concluded that it reflects greater identification, recognition and response to signs of abuse and neglect as well as sensitivity to risk.

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

When Oxfordshire's rate of increase in child protection numbers is compared against the rates in other local authorities which have been through high profile CSE cases, a common trend is detected. We looked at Derby, Rochdale, Blackpool, Rotherham, Oldham, Torbay, Peterborough, and Manchester. All areas have seen steep rises in their numbers of a CP plan, which is not reflected across the whole country. Oxfordshire's rate of growth is slightly below the group average, increasing by 124% compared with 134% for the whole group. Oxfordshire also has the lowest rate of children on a plan of any of these areas.

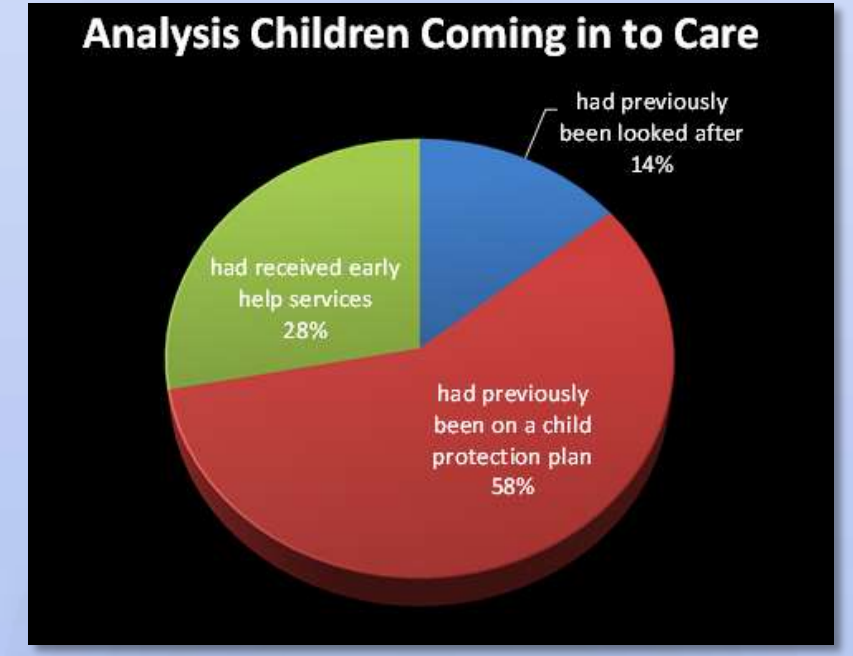
In Oxfordshire this has not led to significantly more referrals; it has led to more referrals converting into assessments and CP plans. This would indicate more in-depth appreciation of risk and responsibility. There is a better recognition of the combined accountability of professionals to identify and protect children.

Children are staying on plans for longer and also having a new plan when risk is deemed to have increased. We know that the majority of children are subject to a plan due to neglect. Addressing neglect is a strategic priority for the Board in 2015.

Children in Care

Children in care are those looked after by the local authority. Only after exploring every possibility of protecting a child at home will the local authority seek a parent's consent or a court decision to move a child away from his or her family. Such decisions, whilst incredibly difficult, are made when it is in the best interest of the child.

There were 527 children in care at the end of March 2015, compared with 463 at the end of March 2014. There has been a consequential increase in the rate of children in care per 10,000 of the child population which has risen from 30.0 in 2013 to 38.1 in 2015. This compares to 40 per 10,000 for Oxfordshire's statistical neighbours. Work has started to review the reasons behind the growth. To some extent it appears to be responsive to perceived risk. We know that 14% of children becoming looked after had previously been in care, over half had been on a children protection plan, 28% had been subject of a children in need plan and a third had received early help. However, even with the increase in numbers there are relatively few children looked after in Oxfordshire.

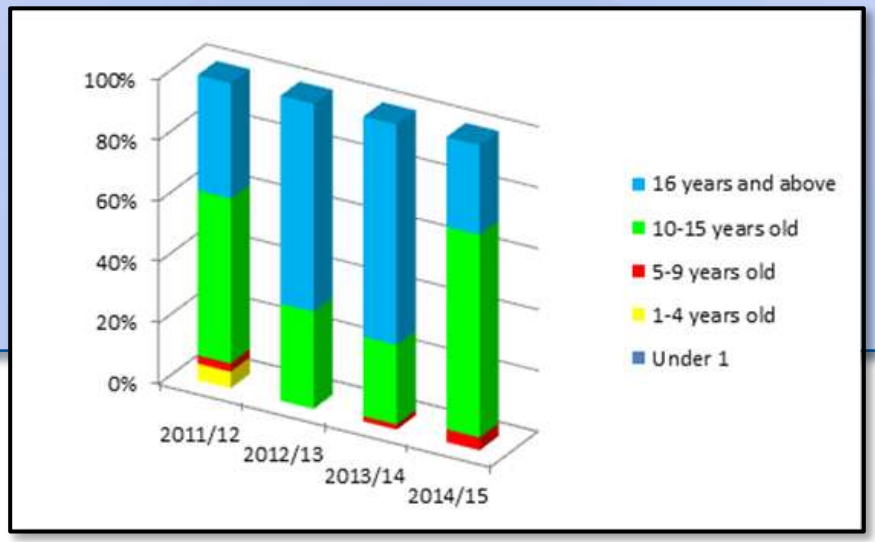


The majority of children (355) were living with foster families.

Children who are privately fostered

Parents may make their own arrangements for their children to live away from home. These are privately fostered children. The local authority must be notified of these arrangements. At the end of March 2015 the local authority were aware of 46 children living in a privately arranged foster placement which is an increase from 34 at the end of March 2014 (a snapshot figure). The number of new arrangements which began over the course of the whole year was 119. This increase is due to the innovative work undertaken by the local authority's private fostering team (1.5 f/t workers) who raise awareness of the need to notify the local authority and ensure the arrangements are visited and checked so that children are safe. This year they have targeted teams working with vulnerable children and had new referrals from the assessment teams and the multi-agency safeguarding hub.

International students have made up the majority of referrals. There has been an increase this year in the number of international students who are attending UK schools rather than specialist language colleges or international schools. Over the last year there has been an increase in the number of 5-9 year olds and also the 10-15 year olds. This reflects language school students coming over to the UK to study at a younger age.



Graph: age breakdown of children privately fostered 2011-12 to 2014-15.

Disabled children

At the end of March 2015 there were 17 disabled children with a Child Protection Plan; this is a small rise on the previous

Children who offend

The children who are involved with Oxfordshire Youth Offending Service (YOS) often present with complex needs requiring significant support both in and out of custody.

The YOS has continued to see the number of children they work with decrease from previous years. In 2014-15, 246 children received a substantive outcome (a caution or above) compared with 282 in 2013-14. The proportion of children receiving a custodial sentence reduced from 4.2% in 2013-14 to 0.6% in 2014-15. The proportion of children receiving a remand to custody also fell from 4.8% in 2013-14 to 0.9% in 2014-15.

Children who are at risk of sexual exploitation

It is estimated that in the period from 1999 to 2014 approximately 370 children have been identified as at risk of abuse through Child Sexual Exploitation. Since 2012 we have had a systematic data collection. We know that there are barriers to children coming forward and reporting this type of abuse which means that children from minority ethnic groups and boys are likely to be significantly under reported.

From 2012 when the Kingfisher Team was established to February 2015 287 children have been identified as suspected to have been at risk of this form of abuse. Of these 238 (83%) were girls and 49 (17%) boys. 215 of these children were identified as of white British or other white origin (90%), 31(10.8%) were described as Asian, black or mixed origin with 7 children where their ethnic origin was not given or recorded.

The use of the CSE Screening Tool enables data to be collected and collated and by March 2015 287 completed screening tools have been sent to the Kingfisher Team.

The predominant age profile for girls starting to be groomed is 13 – 15 years. The predominant age for concerns being raised about boys tends to be older with a peak of boys aged 14 -17 years. Figures for boys are also more complex because they include boys who may be both victims and perpetrators.

Of the 287 children 4 (1.4%) have a statement of Special Educational Needs and a further 116 (40.4%) are recorded as being on some form of additional support in school ranging from School Action to additional SEN support.

Children with mental health issues

Along with many areas across the country there has been a significant increase in referrals to Oxford Health FT Child and Adolescent Mental Health Services (CAMHS). 5308 referrals received and 3407 children assessed by CAMHS during 2014-15. Like last year, along with an increase in the numbers of cases there is an increase in the complexity of mental health issues. This is an on-going concern. As noted in the recent DH report “Future in Mind” there has been an increase nationally on the number and complexity of cases of children being referred to CAMHS. This is also what is happening locally across Oxfordshire, with an increase in accepted referrals. Although Oxford Health FT CAMHS meet the target of seeing children who need to be seen urgently or as an emergency they are working hard to reduce the waiting times for those children who are referred for a routine or non-urgent assessment. A partnership review of the service, which has included key stakeholders e.g. children, parents, social care, schools, GPs etc. has been undertaken in year and a new model which is in line with all the recommendations from the Future in Mind report has been developed. There are strong working relationships between CAMHS and others in respect of working together to safeguard children from harm.

Local transformation plans are currently in development which will enable children and parents to have easier access to targeted and specialist mental health services when needed.

Oxford Health NHS FT continues to see children in an emergency or who are urgently requiring CAMHS within agreed time frames but there has been an increase in waiting times for routine referrals. Oxford Health NHS FT is working hard with partners across the system to reduce waiting times and to ensure that children are seen as quickly as possible.

Children who self-harm

Schools, parents and professionals have expressed concern that there is a rise in the numbers of cases they are seeing. In the last year the numbers presenting at accident and emergency departments has increased (in particular in the north of the county) but we know that the problem is often hidden as children can be worried about talking to their parents or others about self-harming.

Oxford Health FT, which provides mental health services, is working with children social services, schools, GPs, and others to increase awareness of self-harm and the issues that may lead to it. A pilot has taken place which has involved a mental health worker placed in a small number of secondary schools, working with teachers, children social services and the School Health Nurse to increase awareness of mental health issues and support children quickly in familiar surroundings.

A North Oxfordshire network has been set up to identify those children at risk, assess them for support and provide them with the help that they need to manage this issue.

Children missing from home

The number of children who have gone missing from home has risen from last year (694 children compared with 636 last year). The number who went missing three or more times rose from 97 to 132, meaning the proportion of children who repeatedly went missing from home rose from 15.3% to 19%. There are now better processes in place for monitoring children going missing with a rigorous follow up action: a welfare check by the Police as well as return interview to ascertain why the child went missing, where they have been, what they were doing and what support should be put in place to prevent this happening. Deadlines are set to ensure that this takes place in a timely manner and agencies failing to work to this standard are challenged. All of which is reported to key partners, including the OSCB. Whilst the numbers of children going missing have increased, this has provided some initial assurance that children's whereabouts are being monitored and the safe return home pursued. The OSCB partners are analysing responses from interviews to improve prevention work and

Chapter 2: Governance and accountability arrangements

What is the OSCB?

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

The Board's remit is set out in the government guidance, Working Together 2015 and is to co-ordinate and ensure the effectiveness of what is done by each agency on the Board for the purposes of safeguarding and promoting the welfare of children in Oxfordshire. We aim to do this in two ways:

To co-ordinate 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.

To ensure the effectiveness of that work:

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

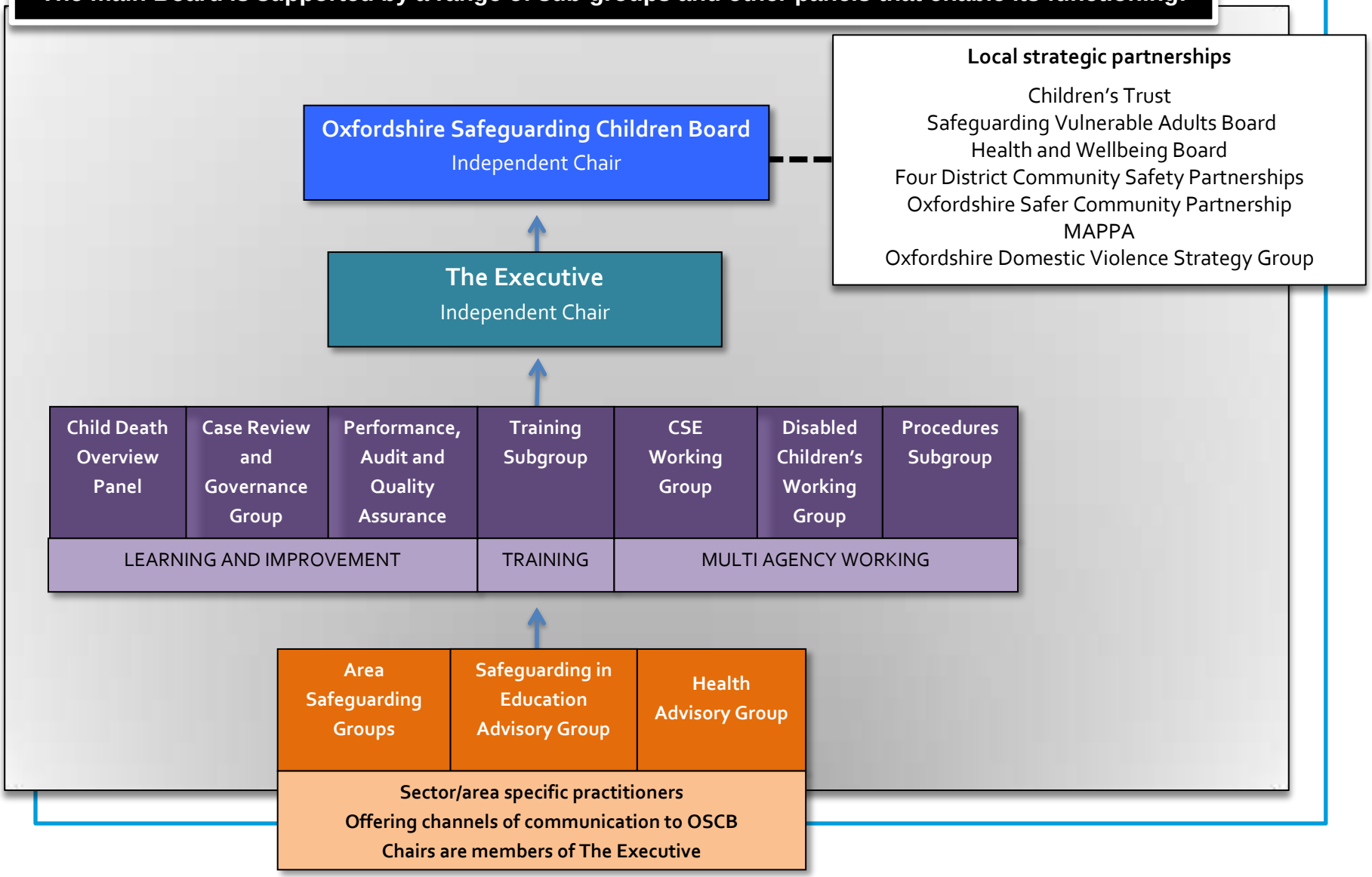
Board Membership:

➢ Independent Chair	➢ West Oxfordshire District Council
➢ Oxfordshire County Council including Children's Services, Adult Services and Public Health	➢ Children and Family Courts Advisory and Support Service
➢ Oxford University Hospitals NHS Trust	➢ Thames Valley Police
➢ Oxfordshire Clinical Commissioning Group	➢ Oxfordshire Fire and Rescue Service
➢ Oxford Health NHS Foundation Trust	➢ Community Rehabilitation Company
➢ 2 Lay Members	➢ National Probation Service
➢ NHS England Area Team	➢ Oxfordshire Youth Offending Service
➢ Cherwell District Council	➢ Representation from schools and colleges
➢ Oxford City Council	➢ Representation from the voluntary sector
➢ South Oxfordshire and Vale of White Horse District Council	➢ Representation from the military

Attendance at the Board and its subgroups continues to be good.

OSCB Structure

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



How the Board works

Statutory body

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

Local Authority

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

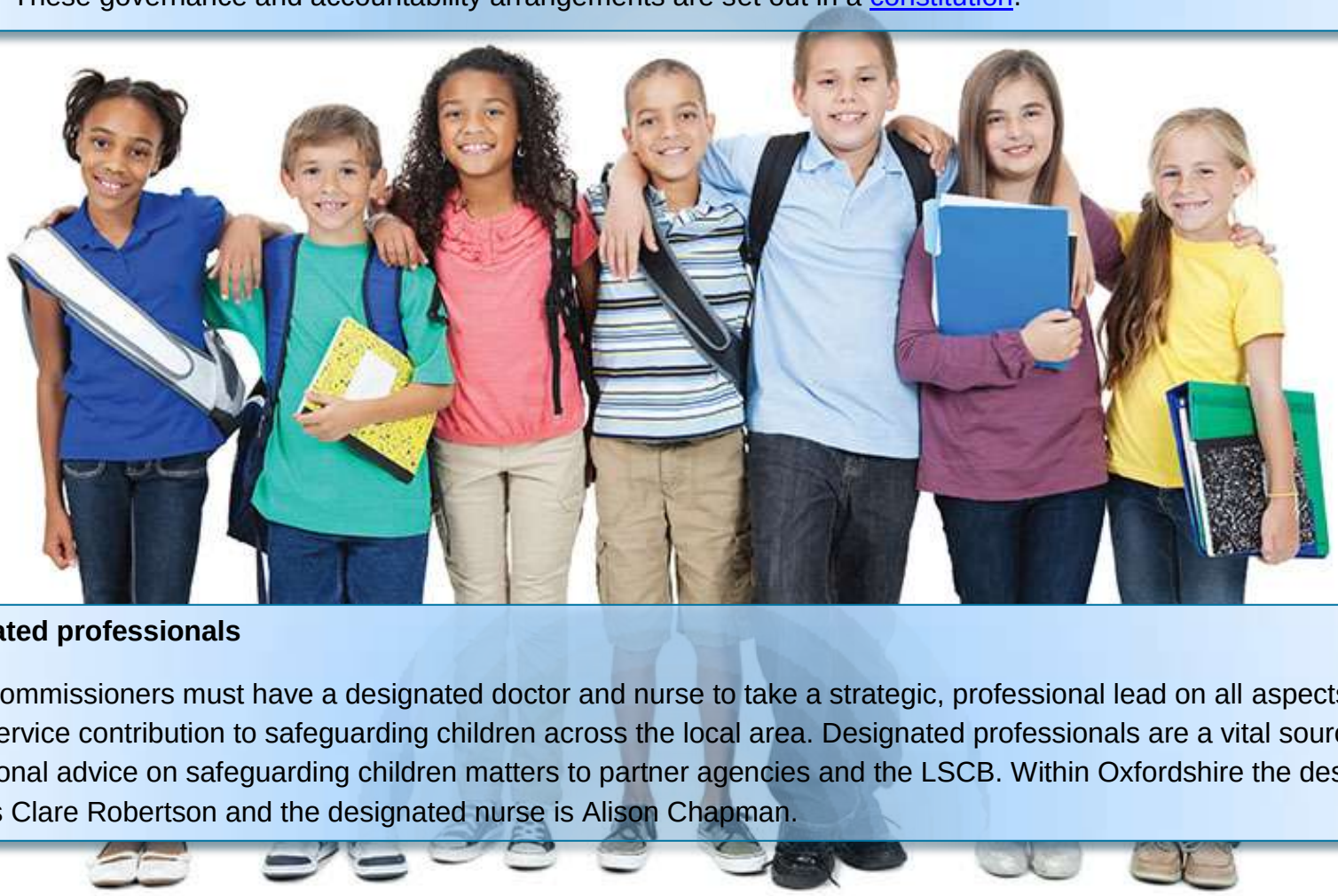
Independence

As an independent Board we hold each other and our respective governance bodies to account for how they are working together. The Board's Independent Chair, Maggie Blyth is directly accountable to the Head of Paid Service 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 military and local schools during 2014-15, and to have positive discussion with the Oxfordshire Community and Voluntary Action (OCVA) about nominating voluntary sector representatives with a clear mandate across the third sector.

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.



Designated professionals

Health commissioners must have a designated doctor and nurse to take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the local area. Designated professionals are a vital source of professional advice on safeguarding children matters to partner agencies and the LSCB. Within Oxfordshire the designated doctor is Clare Robertson and the designated nurse is Alison Chapman.

Key Relationships

The Board is part of a set of strategic partnerships in Oxfordshire which exist to provide oversight of the planning, commissioning and delivery of services to children. The Board has the specific oversight of safeguarding children within this partnership structure. Protocols are in place to maintain healthy working relationships with the Children's Trust; the Safeguarding Vulnerable Adults Board; the Oxfordshire Safety Communities Partnership and the districts' Community Safety Partnerships in particular. In 2014-5 the OSCB created an additional 'Strategic Partnerships' post within the Business Unit to develop these working relationships and strengthen, in particular, the shared oversight of the children and vulnerable adults board.

'This is an exciting opportunity to ensure that both boards are each channeling their efforts on the key safeguarding issues for vulnerable adults and children and also to ensure that areas of commonality across both boards are addressed effectively in order to improve our safeguarding services and outcomes for vulnerable adults and children.'

Oxfordshire Children's Trust

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

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

The Health and Wellbeing Board (HWB)

The HWB, set up in 2012, brings together leaders from the County Council, NHS and District Councils to develop a shared understanding of local needs, priorities and service developments. The OSCB is formally consulted as part of any commissioning proposals regarding safeguarding children made by the HWB. OSCB reports annually to the HWB and will hold it to account to ensure that it too tackles the key safeguarding issues for children in Oxfordshire.

Police and Crime Commissioner

The Police and Crime Commissioner (PCC) is an elected official charged with securing efficient and effective policing in the area. OSCB presents its annual report to the PCC outlining key safeguarding challenges and any action required of policing in the area. During 2014/15 the Independent Chair has met with the PCC to discuss key priorities for children and outline respective priorities in relation to tackling child sexual exploitation and female genital mutilation in particular. The PCC's second strategic objective is to protect vulnerable people.

Health Economy

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 Hospital Trust and Oxford Health NHS Foundation Trust are key partners on the Board and important providers within the Oxfordshire safeguarding system.

Oxfordshire Safer Community Partnership (OxSCP)

The Partnership Board identifies and agrees the community safety risks, opportunities and priorities for partners to address on a county-wide basis. Partners include the Police, probation services, fire and rescue services, the county and district councils, the health sector and voluntary sector. The Police and Crime Commissioner attends at least one meeting each year. The OxSCP has priorities in 15-16 to reduce the risk domestic abuse and human exploitation as well as reduce the risk of harm caused by alcohol and drugs misuse, which the OSCB endorses and supports.

Community Safety Partnerships

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

The Safeguarding Adults Board

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

Financial arrangements

Board partners contribute to the OSCB's joint budget as well as providing resources in kind. Funding for 2014-15 was £425,951. This includes partner contributions and funding for specific training, the play "Chelsea's Choice" as well as the joint serious case review / domestic homicide review. It does not include the funding the Oxfordshire Child Death Overview Panel which is funded through Oxfordshire Clinical Commissioning Group. 2014-15 has been an exceptional year for the OSCB. Over the course of the year the Board has worked on seven serious case reviews and channelled a lot of resources in to addressing child sexual exploitation. As a result planned expenditure was higher than income and required the use of £189,742 from the reserves.

As set out in last year's annual report, the biggest pressure on the budget has been serious case reviews. The Board worked on seven serious case reviews, one executive summary was updated and published and three full reviews were completed and published. This work included the publication of the A-F SCR, which followed Operation Bullfinch - an investigation which resulted in seven men being jailed for serious offences relating to child sexual exploitation for an extensive period of time. The serious case review included six victims and was unprecedented in terms of scale, format and profile as well as the level of involvement of victims. This review led to additional spend as it impacted on chair's time; reviewer time; practitioner learning events and communications costs to ensure that Oxfordshire's community understood the learning and what work has taken place in the county to address child sexual exploitation. It was determined to cover this spend through the reserves rather than requesting additional contributions from partners.

The Board has agreed to carry forward the reserves from 2014-15 to the 2016-17 budget and is revising its forward plan.

	Revised annual projection - 2014/15	2014/15 - Actuals	Variation from revised projection - 2014/15
Funding streams	£	£	£
CSP funding for DHR / SCR	0	-10,000	10,000
OCC Chelsea's Choice funding	0	-15,326	15,326
OCC Early Years funding	-14,465	-14,465	0
Public Health Risky behaviours	-31,625	-31,625	0
Contributions			
OCC Children, Education &	-196,535	-196,535	0
OCC Dedicated schools grant	-64,000	-64,000	0
Oxfordshire CCCG	-60,000	-60,000	0
Thames Valley Police	-16,000	-16,000	0
Probation Service	-5,000	-5,000	0
Oxford City Council	-4,000	-4,000	0
Cherwell DC	-2,500	-2,500	0
South Oxfordshire DC	-2,000	-2,000	0
West Oxfordshire DC	-2,000	-2,000	0
Vale of White Horse DC	-2,000	-2,000	0
Cafcass	-500	-500	0
Public Health	0	0	0
Total income	**-400,625**	**-425,951**	**0**
Expenditure			
Independent Chair	39,856	39,856	0
Independent Chair SCR costs	0	24,630	24,630
CRAG chair	6,600	6,875	275
Business unit	270,000	278,227	8,227
Comms	15,000	15,000	0
Training & learning	50,000	67,352	17,352
Subgroups	12,000	12,000	0
Chelsea's Choice	0	15,326	15,326
Serious case reviews	94,000	156,427	62,427
	487,456	**615,693**	**128,237**
Overspend:	**86,831**	**189,742**	**102,911**
Reserves	221,431	221,431	0
Drawdown	86,831	189,742	102,911
Reserves Balance	**134,600**	**31,689**	0

CHAPTER 3: PROGRESS AGAINST THE BUSINESS PLAN IN 2014-15

Key priorities:

The OSCB had 5 priorities which were to ensure:

1. there is effective safeguarding practice from early help to very high need

…and to improve…

2. our quality assurance work
3. how we capture the engagement of children and children & practitioners
4. the inter-agency focus on safeguarding-risk groups
5. our effectiveness as a Board.

Priority 1: there is effective safeguarding practice in the child's journey from early help to very high need

The OSCB has a role in ensuring that the child's journey through the safeguarding system works well. This means effective assessment, shared threshold points and plans which are good quality, responsive and well-co-ordinated.

Identifying need

The OSCB has a 'threshold of needs matrix' which supports practitioners to make the right referral to the right service. All OSCB core training includes the use of this matrix. There are a wide range of services providing early help to families in Oxfordshire. This includes the early intervention service's hubs and children's centres, health partners, schools, the voluntary sector, local and district borough councils and social care.

Early help

Early help assessments (CAFs) are completed and families are then supported by regular 'team around the child' (TACs) meetings to monitor progress. Support includes help for children where parents or carers misuse substances and help for those families when social care intervention ends. In the academic year 2013/14 this work increased. There were 821 recorded CAFs and 716 recorded TACs; with schools predominantly taking the lead in this work.

The number of under 5s reached in Oxfordshire i.e. seen at least once at an event or activity at any Oxfordshire children's centre was 18,564 or 44.5% of the population of under 5s. In the recent inspection of Oxfordshire Children's Services Ofsted commented that there was *'evidence that early help is making a difference and improving outcomes for children'.*

The Thriving Families initiative is working with the most vulnerable families. The initiative has identified 493 families with 219 having a named worker from a County Council service and of which 73 families have intensive family support over the last year. Ofsted reported; '*It is intensive, well organised and cost effective and has led to clear improvement in the lives of particular families*.'

A longer term piece of work is underway to integrate early help and statutory work to support vulnerable children and families. The focus is on services for 'children in need' i.e. for those who meet the statutory thresholds for services but are not deemed to be at the level of significant harm which would warrant a child protection plan. The intention is to develop more robust early help and reduce the numbers of children who are escalated to children's social care. Following an update to the Board on the impact of this work in April 2015 the OSCB is holding Children's Services to account for a further report in 2015 on implications of this change.

Multi-agency safeguarding hub

The Oxfordshire MASH (Multi Agency Safeguarding Hub) has been live since September 2014. The team comprises Children's Social Care, The Early Intervention Service, Thames Valley Police, Health, the Youth Offending Service and the South Central Ambulance Service and Education. Work is underway to increase the MASH partnership to include Probation and the District Councils. The MASH has receives all enquiries which previously went to children's social care teams.

The OSCB partners have influenced the planning and implementation of this new service and its development has been reported in to the Board. The Chair has requested a full report from the MASH project Board evaluating its effectiveness after the first year of delivery. The OSCB needs to be assured that assessment is effective, risks are identified and concerns are appropriately escalated.

Multi- agency tools

The OSCB has a role in ensuring effective assessment, shared threshold points and plans which are good quality, responsive and well-coordinated at each stage. Emerging safeguarding concerns in the last year have led to the development of new 'practitioner tools' for self-harm and female genital mutilation. Embedding the tools remains a priority for OSCB partners.

- **Threshold of needs matrix**
- **Neglect toolkit: the child care and development checklist**
- **Child sexual exploitation screening tool**
- **Self-harm screening tool**
- **Female genital mutilation screening tool**
- **Parental substance misuse toolkit**
- **The multi-agency risk assessment and management plan**
- **Guide for Good multi-agency practice incorporation the Local Assessment Protocol**
- **Aide Memoire**
- **7 Golden Rules to Information Sharing**

The audits undertaken by the OSCB this year showed there was variable use of these tools by practitioners. For the childcare system to work effectively this usage needs to be consistent. A pilot led by the County Council to address neglect, reported that practitioners were not always using the neglect toolkit effectively. The challenge for OSCB partners is to ensure that neglect strategy gives clear leadership on the multi-agency tools having first checked that they are fit for purpose.

Addressing issues of neglect:
A pilot project has been run in 2014-15 to use as an evidence-base for the long term programme of change to children's services. The intention is to ensure that neglect is understood in the same way that child sexual exploitation is now understood so that practitioners can identify neglect and intervene directly and promptly. In order to do this the project will build a full picture of the extent and depth of neglect and then test new models of service delivery to ensure services address the needs of the whole family.

The pilot will build on the learning from the Thriving Families programme by seeking to develop whole family working, where families have a lead worker and one plan supporting them. The aims are to reduce the number of children requiring child protection plans due to neglect; to reduce the number of children becoming looked after due to chronic neglect and to introduce new ways of working that provide effective help and support to families. The OSCB endorses the dynamism behind this approach and expects a full evaluation of impact in 2015.

Child Protection Activity
During the year there were 5,278 referrals to Children's Services which was 9% lower than the previous year. However, referrals have met the criteria for support and have led to an increase in activity levels at all other key points across the child protection process. This increase in general activity reflects the analysis that there is greater identification, recognition and response to signs of abuse and neglect as well as sensitivity to risk. In short, children are staying on plans for longer and also having a new plan when risk is deemed to have increased. Ofsted inspectors agreed that services demonstrated '*improvements in the targeting of intervention, better decision making and more robust management oversight'.* The ability to complete 'section 47' enquiries to a timeframe of 15 days is slipping which reflects the level of activity in the system.

% of Initial Child Protection Conferences within 15 working days of Section 47 enquiry:

National 2013-14	**69%**
Oxfordshire 2013-14	85%
National 2014-15	Not yet available
Oxfordshire 2014-15	79%

During 2014/15 the numbers of children subject to a CPP have steadily increased. At the end of March 2013 the numbers stood at 430 and at the end of March 2014, 504. At 31st March 2015 it was 572 and at the time of this report is 616.

The number of children on a child protection plan for a second or subsequent time within 18 months has decreased from 9.3% in 2013/14 to 6.2% this year. This decrease is in part due to children being subject to a Child Protection Plan for longer periods of time.

96.9% of plans were reviewed within timescales in 2013/14 but this has decreased slightly in 2014/15 to 95.3%. This decrease in timeliness reflects the increased pressure on the Independent Reviewing Service in particular who have to chair each Initial and Review Child Protection Conference, however performance remains better than the national average or that of comparable authorities:

	2013-14
Oxfordshire	96.9%
Stat Neighbour	90.4%
England	94.6%

The pressures on the system are apparent. The challenge for the OSCB is to check that the effectiveness of work is not being compromised. Feedback from practitioners is clear that issues are more complex and are multiple. The OSCB quality assurance subgroup should use its report card system to analyse and report back on the impact of increased activity not just on the experience of the child but on practitioners also.

Children in care

At the end of March 2015 28.1% of looked after children (148/527) were placed out of county in foster homes, residential children's homes, residential schools. This also includes those children placed for adoption. This is a rise from 26.8% (125/467) at the end of March 2014. 14% (74/527) of looked after children were placed more than 20 miles away (not in a neighbouring county) at the end of March 2015 which was an increase from 10.9% (51/467) at the end of March 2014.

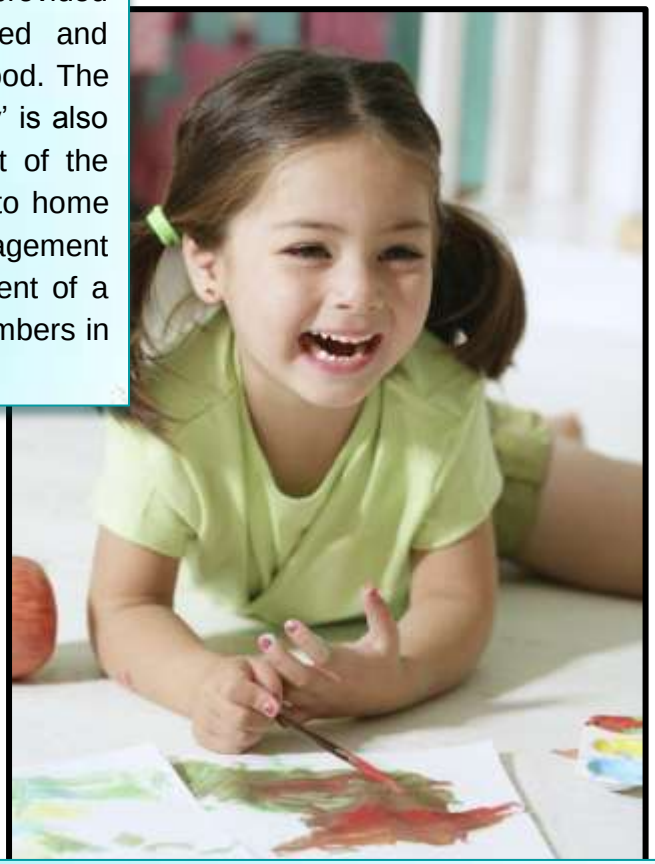
Children in care and leaving care have high level emotional and behavioural needs compared to Oxfordshire's statistical neighbours and the national average. This brings into sharp relief the importance of social care, health and education services working together to provide high quality support, therapeutic interventions and learning opportunities for our young people.

The county council currently supports 383 care leavers to become independent adults. 256 of these are former relevant young people and 79 of these are unaccompanied asylum seeking children. The county council's teams are in contact with 96% of the leaving care population which gives them the ability to assess needs and risks appropriately so that they are safe. It means that the young person will have an allocated Social Worker or Leaving Care Personal Advisor.

One of the biggest challenges is the housing: housing stock in Oxford is limited and there is a large university student population competing for space. In 2014-15 92% of leaving care young people were suitably housed. These young people are also supported by the 0-25 ys virtual school which include the provisions of a specialist 16+ 'education, employment and training' (EET) team 63% (211 young people) were engaged in EET.

Given the high levels of emotional and behavioural needs identified the OSCB wants reassurance that focus is tightened on the risks faced by this group to ensure that they are prepared for adulthood and have the skills and resilience they need to live healthy, happy adult lives.

The OSCB partners acknowledge that the Ofsted inspection May 2014 provided assurance that looked after children are being appropriately safeguarded and performance for both looked after children and care leavers were judged as good. The county's aspiration to become 'the most fostering friendly county in the country' is also endorsed. Challenges are also noted, however, as being the development of the county capacity to ensure that those children with highest needs are closest to home (through the creation of new homes for children in care) as well as the full engagement of partners in health, schools, police and housing providers in the development of a therapeutic model of care. This is set against the context of the rise in the numbers in care and the need for more effective earlier interventions to prevent this.



In summary,

The OSCB is able to endorse the Ofsted 2014 assessment that there is effective safeguarding practice **in the child's journey** from early help to very high need. However the challenges can be summarised as follows: developing more robust interventions to avoid children becoming subject to a plan or being taken in to care; assessing the impact of pressures on the safeguarding system; implementing the promise to manage risk locally for children in care; delivering the aspiration to increase the foster care capacity in the county and also remembering the duty of care not just to children but to the workforce facing the challenges of increased pressures on family life and parenting. Finally, the emerging evidence of increased numbers of adolescents in the child protection system requires a more co-ordinated, strategic response. These challenges cannot be underestimated especially within the context of financial pressures on the safeguarding system.

Oxfordshire's children's workforce comprises practitioners working in all fields in different ways to keep children safe.

Here is…

A day in the life of a district council anti-social behaviour officer, from Cherwell district council

My working day is a mixture of being out on the street, multi-agency meetings and direct engagement with alleged offenders and victims in their homes.

For example I may receive a call from a resident raising a concern and alleging anti-social behaviour by a neighbour. Dependent on the content of their complaint I would do a couple of things before visiting: I might contact the local neighbourhood police team and, if they are in social housing, their housing provider. Complaints range from excessive noise to minor damage and, sometimes, abuse as a result of taking up with the issue the other resident. Many agencies get involved in the solution to these circumstances.

My role in relation to safeguarding is to be a link to those children who are hanging about and making their own fun in ways we wouldn't promote. This involves identification of children not in school or on the edges of criminal behaviour; consultation with other agencies to raise concerns and support for plans to re-engage the child or teenager with their school and their family.

I work closely with the Thames Valley Police to engage with children who are believed to be in possession of or consuming alcohol; this can be as a result of reports of underage House parties or large gatherings in parks or recreational facilities. Any child under 18 found in possession of alcohol will have it seized from them and an assessment will be made to ascertain if they are able to get home safely or if they need to be taken home by the Officers.

Since the recent prosecutions for child sexual exploitation we have changed the way that we work. Now when we approach a group of children we engage with all of them and not just the underage offenders; specifically any person present over the age of 18 questions will be asked as to what his/ her connection to the children is.

Priority 2: improving our quality assurance work

The OSCB links its quality assurance work to learning and improvement. Quality assurance work includes agencies self-auditing, joint-agency auditing, the schools' and early years' audit; the section 11 safeguarding self-assessment; reporting from the Local Authority Designated Officer (LADO); reporting from the Independent Reviewing Officers of the County Council and the OSCB data set.

OCSB partners audit work

Eight agencies reported back on their internal safeguarding practice having reviewed 478 case records. The audits have enabled partners to have an informed view of the safeguarding arrangements and performance in single agencies. At least 50% of audits rated safeguarding practice as effective or better. They demonstrated that agencies were challenging internal safeguarding practice and they had good practice which could be shared with others. Areas highlighted for learning concerned management of self-harm cases in emergency departments and work to ensure that information on children is always considered when working with parents who have mental health problems. Follow up audits in 2015-16 will check that learning from these findings has had an impact.

Three multi-agency audits were reported on last year which reviewed 27 cases from the perspective of the key agencies involved. The purpose was to check how well agencies worked together. OCSB partners reviewed cases against the themes of mental health, assessment and decision making in multi-agency working and the Multi-agency Risk Assessment Management Plan (MARAMP) for children at higher risk of harm. They have provided an oversight of the quality of frontline multiagency practice and given good examples of risks being identified, responded to and reduced through both child protection conferences and the use of the multi-agency risk assessment and management plan. Areas highlighted for learning concerned participation in child protection conferences and core groups: this keeps the plan around a child strong and supports sharing of information. Absence from these can hinder the development of joint plans. This learning has informed the OSCB business plan for 2015-17 which includes a focus on core group working to effectively address neglectful parenting. Learning summaries are produced for all multi-agency audits and shared with practitioners at the safeguarding groups across the county.

A gap in the audits has been the inclusion of feedback from children. The challenge for OSCB partners is to ensure that the experience of children is a standard part of audit work.

100% audit return rate from schools including academies, independent and free schools.

Schools and further education colleges audit work

Primary and secondary schools in the county are requested to complete the schools' safeguarding audit. The DfE statutory guidance 'Keeping Safe in Education' released in 2014, states that 'Under section 14B of the Childrens Act 2004 the LSCB can require a school or college to supply information in order to perform its functions; this must be complied with'. In 2014-15 there was a 100% (338) audit return rate from schools (including academies, independent and free schools). Two free schools and six independent schools opened in 2013/2014 so have not been audited. The returned audits report on the full range of safeguarding requirements in schools and showed good compliance e.g. whether the school has had child protection training, adheres to safer recruitment guidance, implements child protection procedures. The audits indicate good levels of compliance with the guidance, the most frequently recommended action for the coming year, is to update safeguarding training for staff.

The requirement for Further Education (FE) colleges to report on their safeguarding arrangements was not an explicit expectation under the 2014 guidance, and one college responded out of five. The OSCB welcomed at the end of this reporting year the guidance 'Keeping Safe in Education' March 2015 which now places an expectation on all FE colleges to return an annual report for the 2014/2015 academic year.

Tutorial and language colleges do not fall within the remit of the DfE guidance and are not currently audited. Some colleges have started to accept students between the ages of 14 – 18. They will have to register with Ofsted and become subject to the inspection regime. It is of concern that the OSCB may not be able to require all of these colleges to return an annual safeguarding report. At present the Local Authority Designated Officer (LADO) Team is supporting those tutorial colleges that are actively seeking help to make them compliant but they cannot compel all to do so. They have also run training for host families. Some are 'pop-up' establishments who rent premises for short periods of time and then close.

The challenges for the OSCB are to extend its reach in terms of voluntary compliance with safeguarding audit processes and encourage peer review of self-assessed returns.

Early years audit work

Private, voluntary and independent nurseries and pre-schools are audited annually using e-consult. The county council followed up all settings which resulted in a final response rate of 100%. The 2014 safeguarding audit had a positive impact on the quality of provision as evidenced in inspection reports: the number judged to be inadequate by Ofsted for safeguarding reasons decreased. The challenge for the OSCB is to further improve safeguarding as only 43% of settings were fully 100% compliant with local requirements. Childminders registered with Ofsted were encouraged to use the audit for self-assessment prior to 2014. The response rate was so low it was not sufficient to assess current strengths and weaknesses in these sectors. The OSCB will promote this self-assessment audit in 2015.

The section 11 safeguarding self-assessment

OSCB received Section 11 self-audit responses from 26 agencies. This was 100% compliance of statutory returns as well as additional returns from commissioned services such as provider services British Pregnancy Advisory Service, Outdoor Learning and Lifeline. Five agencies returned completed practitioners questionnaires. A peer review was held by OSCB in April 2015, which reinforced the responsibility of all Board members to challenge. Providers, commissioners and senior leads scrutinised and compared the results of their S11 audits. Twenty agencies attended.

The peer review provided good examples of improved ways of working, such as feedback from district council housing services about how they incorporate the risk management assessment into their work with children; fire and rescue service staff who were showing a greater awareness of how to report concerns as a direct result of safeguarding training; children's social care managers as to how they promptly challenge children's placements which fall below safeguarding standards and from the hospital trust safeguarding leads on their close work with colleagues to handle complaints in relation to safeguarding work in a sensitive and supportive way for parents.

The challenge for statutory board members is to more clearly gather practitioner feedback. Only 5 out of the 26 agencies completed the practitioner questionnaire. The OSCB chair will participate in the next peer review to monitor if this takes place. A good LSCB can demonstrate that board members are involved in meeting frontline workers to assure themselves that safeguarding practice is well understood and part of their everyday practice.

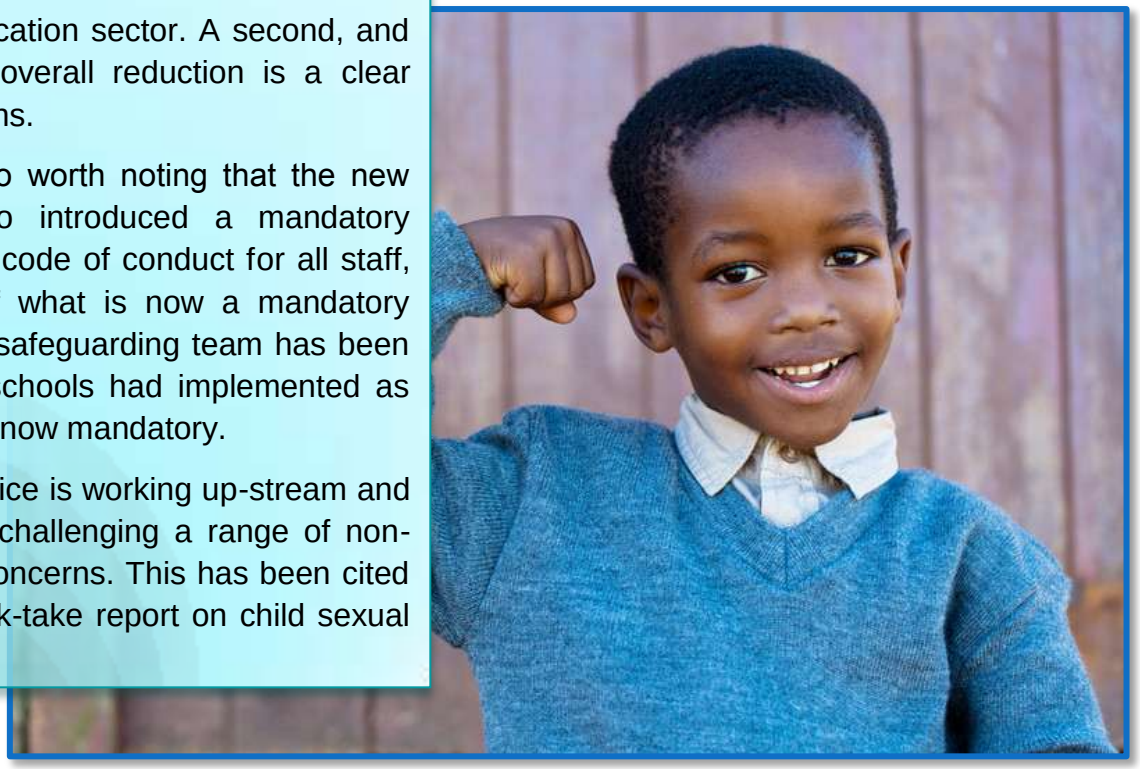
Local Authority Designated Officer

The LADO should be informed of all allegations against adults working with children and provides advice and guidance to ensure individual cases are resolved as quickly as possible. There has been a 22% decrease in referrals, a total of 138, to the LADO service during the academic year September 2013 to August 2014 compared to the previous year when there were 177. Most referrals come from schools but in the last year they have increased from non-educational settings.

There are a number of factors that have influenced this decrease. Firstly, in April 2014 the DFE released revised safeguarding guidance for the education sector. This guidance changed one of the referral criteria for referral into LADO for allegations in the education sector. A second, and an additional possibility, in explaining the overall reduction is a clear reduction in the number of historical allegations.

While it's hard to measure impact, it is also worth noting that the new guidance for education settings has also introduced a mandatory expectation that all schools will now have a code of conduct for all staff, which will be provided to them as part of what is now a mandatory induction period. This is something that the safeguarding team has been advising for many years and which many schools had implemented as good practice. From April 2014 however, it is now mandatory.

As awareness is being raised the LADO service is working up-stream and playing an effective role in supporting and challenging a range of non-educational organisations on safeguarding concerns. This has been cited as good practice nationally in the 2015 stock-take report on child sexual exploitation.



Independent Reviewing Officers of the County Council

The Independent Reviewing Officer (IRO)/ Independent Chairs (IC) service has expanded over the last year as part of a drive to reduce caseloads and thus ensure IRO's are able to meet all of their statutory responsibilities for the children that they work with. Key objectives have been to ensure that meetings for children looked after by the local authority and children with a child protection plan are held in a safe and timely manner and written records are distributed appropriately, that children remain central to all work and that Looked After children are seen by their IRO between the reviews of their care and fully engaged in the process which reviews their care. Further, that children of a sufficient age and understanding are able to be part of Child Protection Conferences as and where safe and appropriate for them to be so. The administration support for IRO's has been increased, and it is anticipated will be further, to reduce the time IRO's have to spend undertaking administrative tasks and recording, freeing up their time to be able to give a greater focus on the children.

There has been an increase in staffing, which is positive, but this has been matched by an increase over the past year of children subject to Child Protection and in care. With caseloads remaining relatively high, and the statutory responsibilities of IRO's increasing, it is more challenging for IRO's to maintain contact with and/or see all of the children on their caseload between LAC reviews. This remains a key target for the service.

The IRO service plays a critical role in ensuring all Looked After children and children subject to CP planning have safe and effective plans which are rigorously reviewed. The IRO service also plays an essential quality assurance role for the department with a view to maintaining best practice across all areas of child care. The OSCB raises the serious concern presented to it by the IRO services that not all children have contact with and/or see their IRO between LAC reviews. Children's Services need to respond promptly as to how this shortfall is being addressed.

The OSCB data set: what does it tell us?

The Board has an agreed dataset which views key points across the child protection arrangements in the county. There are eight messages from the data on the safeguarding system in Oxfordshire:

1. Increase in early intervention work**:** more assessments done using the Common Assessment Framework. 44.5% of the population of under 5's were seen at least once at an event or activity at a children's centre.
2. Increasing levels of general activity across child protection plans; neglect being the most common reason for a child protection plan
3. Increasing numbers of children in care; the highest level for many years
4. Lower levels of children becoming subject to a second or subsequent plan
5. Children at risk of sexual exploitation continue to be identified at the same rate
6. Children missing from home: increased reporting of those missing repeatedly
7. Children who offend: fall in numbers involved with YOS
8. The implications of increased workloads on ensuring children are kept safe; the system is under pressure.

These messages have informed the business plan. The challenge for OSCB partner agencies is to better analyse the performance information within the dataset. The quality assurance group which oversees this dataset has set up a 'report card' system for 2015-16 to provide analytical commentary for the purpose of the OSCB and the Children's Trust. This includes reviewing the capacity with the safeguarding system.

Day in the life of a health visitor...

I arrive at the office at 8.30 and check the answer machine for messages. I check my electronic diary and make preparations for my day ahead – allocation meeting with the team, core group meeting, home visits then back to the surgery for the baby clinic and some scheduled developmental checks.

During the team meeting work is allocated depending on who knows each family and the team skill mix. After ensuring I have the addresses and phone numbers for my visits on my iPad I set off.

A 'core group' meeting is held at the Children's Centre which mum's her preference. She has a toddler and a young baby. The professional team arrives – social worker, children's centre outreach worker, and a lady from Connections. Productive discussion around housing issues, and some health issues of both children which could possibly be a consequence of the current very damp environment each member takes ownership of actions at the end of the meeting, the mother appears very satisfied with this joint approach to supporting her and we plan to meet again the following month.

First visit – a pregnant lady and her partner – I use the evidence based tool Promotional Guides to make an assessment of any anxieties they may have about becoming parents. The agenda of the visit is led by the parents. The mother expresses her concern about giving up work, and feeling isolated. I discuss with her about the groups which run at the local Children's Centre. Both parents are encouraged to be present at this visit.

Second visit – I find the address using my iPad to a lady I have never met with post natal depression. I spend nearly an hour with her as she talks at length about how she is finding it difficult to bond with her baby, and the guilt feelings she is experiencing as a consequence. I refer her to one of the post natal depression groups facilitated by health visitors. I love the fact health visitors can plan to make longer appointments with clients, based on clinical need.

Short break with colleagues, informal discussions around the morning work and then back to documenting today's contacts.

Back at the surgery I prepare the room for the drop in baby clinic – parents and carers come in and ask advice on a range of issues such as feeding their babies, skin rashes, and sleep. Then 3 scheduled appointments for developmental checks which are carried out using evidence based Ages and Stages tool. These checks are part of the Healthy Child Programme for all children aged 9 months and 2 years old. I make a referral to a speech and language therapist after seeing one of the 2 year olds.

Before the end of the day, I return a phone message to a Social Worker about a child who is on a child protection plan, and phone a mother to make an appointment to visit her the following week with her newborn baby.

I finish my day preparing for a meeting the following day as I am leading a project on increasing the public health role of health visitors in managing minor illnesses - high on the political agenda!

Priority 3: capturing the views of children and practitioners

The OSCB has collated the views and experiences of children, parents and carers as part of its quality assurance work. They have told us a range of things, some of which are captured below:

What children, parents & carers said:	What OSCB partners are doing:
The serious case review conversations with parents told us a range of things for example, that they wanted: To have their concerns listened to and be taken seriously, To not have to chase the services for answers and information, To receive interventions sooner, for them and their child, especially when it was so painful to have to ask for help The conversations with children told us: Sometimes the fear of speaking up is too great They would give lots of small details thinking (hoping) that workers would connect the dots They want workers to meet them at their starting point	OSCB has had input from families at four of the multi-agency learning events in 2014/2015. The moving talks from children and parents formed an integral part of the learning for frontline and senior staff, and practitioners reported them having an impact on the messages they took away with them. One of the multi-agency learning events was dedicated to listening to parents / children The OSCB has included parents' messages in the training on child sexual exploitation The OSCB child sexual exploitation strategy is being developed in partnership with previous victims of this abuse The OSCB is putting together a summary of learning points from parents and carers involved in case reviews for use by practitioners so that we fully understand what it means to be a child in the safeguarding system
The Youth Parliament told us they didn't know enough about the role of school health nurses and what they could talk to the nurse about	This was taken on board by the service and posters were available in each school. Oxford Health NHS FT school health nurses are now an integral part of partnership working and are linked in more closely to the board, for training, sharing of learning resources, and a helpful way of raising awareness with children.
The sounding board meetings told us: their safeguarding concerns: fear of speaking up; boundaries and safe relationships; mental health and suicide; drugs	From this initial meeting a group of 12 will be established (some children in care and some not) to take forward issues form the Sounding Board and 'new issues' which arose such as "how police talk to children and children". The OSCB supported the 'keeping safe' section of the Oxford City council 'Bungee app' for use by children in the school holidays The OSCB endorsed the NSPCC Childline assemblies for all primary schools in Oxfordshire OSCB partners (the county council and the police) funded Values versus Violence which encourages children to speak up and make good decisions for themselves OSCB partner (the county council) funded Chelsea's Choice for the third year running for all secondary schools in Oxfordshire
The Children in Care Council told us: they have developed a pledge with the Corporate Parenting Panel and includes issues raised about keep safe	Ensuring that the issues regarding staying safe are reported back to the OSCB as part of the annual children in care report by the county council

The OSCB has collated the views of practitioners. This includes views from children's social care practitioner listening events; serious case reviews; audits; child protection conferences and reviews, training and the three area safeguarding groups. Through this means practitioners have told us a range of things, some of which are captured below:

What practitioners told the OSCB:	What the OSCB partners are doing:
The area safeguarding groups which meet across the county told us: - Child protection cases are more complex now; children and families have a range of issues which take time to address – the volume of children in the child protection system at presents additional pressures - …as a result multi-agency work is more effective when everyone understands their own role and what is expected of them: - The issues that are coming to the fore currently are: self-harming, sexting (and e-safety), male harmful sexual behaviour, appropriate and healthy relationships between children, accessing mental health support for children; unaccompanied asylum seekers, tackling child sexual exploitation; domestic violence amongst children	- Training on 'working as part of a core group' for children with child protection plans is being developed; the good-practice guide to multi-agency working has been promoted at the four learning events - Ran multi-agency learning events on tackling child sexual exploitation; accessing mental health support for children which reached over 200 practitioners - Developed training on sexual health and consent and developing more of a focus on appropriate and healthy relationships to meet the needs of practitioners - Ran awareness raising on 'sexting' through the area safeguarding groups - The Business plan for 2015-17 is taking on board the safeguarding issues raised by practitioners - The OSCB 2015 annual conference is covering safeguarding risks facing vulnerable adolescents, which will pick up on issues such as domestic violence amongst children
Practitioners told us through their Board members they had concerns about: - female genital mutilation highlighted through health settings - self-harm amongst children in particular in the north of the county highlighted through the LADO, schools and health settings - transport for disabled children highlighted through schools and voluntary organisations - representation of community, voluntary and faith organisations on the board's structures	- OSCB partners assessed the prevalence of **FGM** in the county; produced a screening tool and procedures for working on this and worked with the Department of Health to run a conference on FGM in the county. The OSCB supported the community organisation "Oxford Against Cutting" to access local schools and run an awareness raising project. OSCB trainers received training on FGM. - OSCB partners formed a North Oxfordshire Self-Harm Network which produced a screening tool and provides a regular information-share to ensure that children were safe and had supported - OSCB partners are including a focus on transport for vulnerable children in the 2015 section 11 safeguarding self-assessment and set up a Task and Finish Group to review transport issues across the county and districts. - The OSCB worked with the OCVA to run two forums to recruit VCS members to the Board and subgroups; OSCB attended VCS workshops and conferences to raise awareness of safeguarding messages, opportunities to participate and training

Priority 4: improving our inter-agency focus on safeguarding risk groups

In the last year the Independent Chair has requested safeguarding updates on work with the most vulnerable groups of children, who are known to be most at risk of harm. For example: the referral processes and management of information for children living in homes with domestic abuse; the licensing of taxis; information sharing by voluntary agencies supporting vulnerable children; improvement to mental health services and the emotional wellbeing of adolescents and young adults. All these issues are challenged at Board level. A regular reporting schedule the OSCB maintains a focus on safeguarding risk groups. Below is a summary of this challenge.

Troubled children with a complex range of needs

The OSCB scrutinised the work of the complex case panel which brings together senior manager to support practitioners to move forward on the most complex cases through focused discussion, clear decision making an identification of actions. The OSCB has set in place a more robust mechanism now so that twice yearly reports are submitted to the OSCB executive on those children most at risk so that there is a collective response for those most at risk and in need. These 'needs' have been summarised through the quality assurance group and informed the Business plan: peer on peer domestic abuse; issues of self-harm; mental health problems; homelessness and sofa-surfing. They also informed the practitioner learning events.

Self-harm

The issue was escalated to the Board in 2014 through the county's schools safeguarding team. A uniform approach in assessing risk and sharing information has been developed to assist schools and agencies. Guidance has been provided, such as The Oxfordshire Self Harm Forum's Guidance for Professionals (2012) and DfE Guidance 'Mental health and Behaviour in Schools' (June 2014). School Nurses, Camhs and Children's Drug & Alcohol service have provided advice and training to schools.

A Risk and Resilience Tool has been designed to provide teachers and practitioners with a means to assess risk and target the right support and services for children and their parents. The schools are reporting that they are finding this a useful tool. Recent anecdotal evidence is showing that coping strategies implemented over the year have helped children during periods of increased anxiety such as during the exam period.

An agreed set of information from the schools and colleges is analysed for the network by Public Health to understand prevalence. Guidance on information-sharing is provided, based on the OSCB information-sharing protocol for incidents of self-harm/attempted suicide. This is to help teachers and practitioners make judgements about when it is appropriate and justified to share information without parental consent. Links have been made with the Oxfordshire Self-Harm Forum that meets termly in Oxford.

Children missing

The county council has a strategic lead for missing children, who receives daily missing reports from Thames Valley Police and is connected in to the Kingfisher Team. This daily update along with information from the Police 'Safe and Well' sighting of the child ensures that each missing person's case is individually understood and any concerns addressed. Oxfordshire has implemented the timescales outlined in the DfE January 2014 statutory guidance to ensure that when a child, who is known to Children's Social Care or the Youth Offending Service, has gone missing a return interview is completed within 72 hours of the child returning.

An operational group has been set up to co-ordinate efforts. The aim is to ensure that the response is proportionate to risk and need and that partners are effective in reducing the likelihood of missing episodes and risky behaviour. Missing episodes are also monitored on a monthly basis to maintain oversight. This includes return interviews, responses, and how missing information is followed up and escalated to senior management and police accordingly. The group quality assures the Multi Agency Risk Assessment and Management Plans (MARAMPS) and return interviews for all frequent runaways, ensuring there is a collation between the information and intelligence gathering, the analysis, and how this is used to inform risk management strategies cross agency. The OSCB is pleased to see the improved vigilance and recording but is concerned by the increase of children who are repeatedly going missing.

Vulnerable Learners

Recent serious case reviews have highlighted increased risks faced by vulnerable learners and raised awareness of school as a protective factor for them. Children who are not in school during normal school hours are at an increased risk of harm. The findings of a recent learning review also included comments from victims of CSE questioning the appropriateness of the use of prosecution for non-attendance when a child is a possible victim of CSE.

The county's Vulnerable Learners Service was re-structured in 2014. This resulted in the reduction in a number of teams responsible for closing the attainment gap for vulnerable pupils. The Pupils Missing Out team was created as part of the re-structure and has specific responsibility for maintaining a list of children who are missing from education either due to lack of a school place or who because they are on a reduced timetable at their current school. The team work directly with schools to ensure that reduced timetables are kept to a minimum and are within the law, they also work with colleagues to minimise the length of time that children are without school places and challenge processes that cause delays in admission.

The OSCB notes that financial pressures have led to reductions in staff within these teams and needs reassurance as to how this cohort of children and their families will be supported.

There has been significant investment into school health nursing which Oxford Health NHS FT provides. The dedicated team of school health nurses for primary schools and, as recognised the nurses in each state secondary school are having a positive impact in identifying cases of CSE and helping to safeguard children who are at risk of exploitation as well as neglect and other types of harm.

A Day in the life of a School Nurse from a school in West Oxfordshire...

Over the last 18 months Public Health at Oxfordshire County Council has ensured that every secondary school in the county has a qualified School Health Nurse. Our service works hand in hand with school staff, parents, carers and the young people themselves to address all aspects of health. The vision is to develop young adults who are resilient, can manage their own health needs and are equipped to seek appropriate advice and help to do so.

At 8.30am I arrive at the school and can often find students waiting to see me. I try to be flexible and either deal with the problem immediately, or book an appointment at a more appropriate time. Today I am able to do some preparation for an assembly I am giving later in the week. I will be talking to the Year 11 students about drink, drugs and vulnerability.

I have five students booked to see me today. The students value the privacy of seeing the School Health Nurse so I always make my confidentiality boundaries clear when I first see a student. Their safety is the most important consideration, and I have to be clear that it is not always possible to guarantee keeping all information confidential; it is a difficult area at times. I consult with our Safeguarding Named Nurses on occasion, to assist me when deciding whether a young person's confidence needs to be broken.

I love working with teenagers, no two days are the same! A large proportion of my work centres on emotional support. Of the five students I see today, four have anxiety and emotional problems, and two of them are known to self-harm. I am trained to take a non- judgmental approach, which is reported helpful by the students. There is much misinformation about this subject. We have good links with our PCAMHS colleagues and are able to consult with them on a regular basis.

My fifth student is here to see me for a follow up appointment. She required emergency hormonal contraception three weeks ago. Being school based allows me the opportunity to spend time discussing healthy relationships, and giving detailed sexual health advice. I can deliver this work at the pace of the student and ensure they have plenty of time for questions and follow up. When working with sexually active teenagers, I am aware of the potential for sexual exploitation and abuse. I assess all students for risk factors that may raise safeguarding concerns and complete an assessment tool to support this. I am also required to assess any sexually active students under the age of 16yrs in accordance with the Fraser and Gillick guidance. These processes provide me with robust support for this element of the role.

In addition to individual student support, I work closely with school teaching staff to assist with input into health related aspects of the curriculum. I love teaching and there is nothing more entertaining and enjoyable than teaching a classroom of 13 & 14 yr olds about contraception. The condom demonstrations have to be the highlight of the session; I challenge any teenager to put a condom on a plastic condom demonstrator (in a vile green colour too!) without giggling! I also provide a "drop in" at lunchtime. Students can stop by to see me for advice and support. Today a group of students have come to ask about smoking cessation and another student has come to tell me of concerns he has for a friend.

I attend TACs (Team Around the Child), Core Groups and Child Protection meetings. I signpost students to their GPs, Mental Health services, Early Intervention HUBs and other health services. Importantly I link in with the school and their aim to provide the best environment for a happy, healthy and successful future for all the young people at school through the school health improvement plan.
I feel that the support I have provided today will help increase resilience and give the young people tools and strategies which can be used now and in the future. Now that's job satisfaction!

FGM – Female Genital Mutilation

A combined effort has led to some real progress in Oxfordshire to address the issue of 'female genital mutilation'. It has been a priority for OSCB partners as well as the Police and Crime Commissioner. Agencies have assessed the prevalence of FGM in the county which is low but is being tracked now that risk factors and indicators are more widely understood. A screening tool and procedures for local working have been developed. OSCB partners also worked with the Department of Health to run a conference on FGM in the county. The OSCB supported the community organisation 'Oxford against Cutting' to access local schools and run an awareness raising project, which produced a booklet for children. OSCB trainers received training on FGM so that they are confident in communicating the issue to delegates.

Radicalisation

Radicalisation is defined as the process by which people come to support terrorism and extremism and, in some cases, to then participate in terrorism. "*Extremism is vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs. We also include in our definition of extremism calls for the death of members of our armed forces, whether in this country or overseas*" (HM Government Prevent Strategy 2011)

Children should be protected from messages of all extremism including, but not restricted to, those linked to Islamist ideology, or to Far Right / Neo Nazi / White Supremacist ideology, Irish Nationalist and Loyalist paramilitary groups, and extremist Animal Rights movements. Over the last 12 months the OSCB has worked alongside the Oxfordshire Safe Communities Partnership to safeguard children from extremism. All training includes these messages, procedures have been updated to reflect this and partners are working on improved co-ordination of other preventative measure.

Children at risk of domestic abuse

Emerging learning from serious case reviews this year led to OSCB partners setting out a new 'referral pathway' for children involved in domestic abuse through their own relationship. The referral pathway is for all new and open cases where there is a notification of a domestic abuse incident between two children. The group consists of representatives from the county council, police and health and a range of agencies supporting families around Domestic Abuse, including Refuge, the Helpline and IDVA's.

All cases are subject to a 'Strategy Meeting', the purpose of which is to share as much information as possible about the victim and perpetrator even if the incident presents as relatively low level. The reason for this is, whilst the presenting incident may be low level, there may be intelligence relating to incidents in previous relationships that inform the risk assessment and any action that needs to be taken.

The county council has also developed new post to support address the issue of domestic abuse across both adults and children's services, which should lead to greater co-ordination going forward.

Child sexual exploitation

The partnership in Oxfordshire has moved a long way to address the problem of child sexual exploitation, identify collective solutions and produce some tangible evidence of impact. The Board is informed and engaged in this issue.

The Kingfisher Team has been at the heart of the change in Oxfordshire enabling the identification of need and the provision of specialist services for children at risk. A parent of a child victim of Operation Bullfinch told the OSCB chair in April 2015, *'I have no doubt the Kingfisher team would have been very helpful to us if they had existed 12 years ago.'*

The team comprising health, police and social care colleagues gathers intelligence and information about children and suspects of concern. The Missing Person's Co-ordinator is also part of the team; this has increased knowledge on potential perpetrators or venues where CSE may be taking place. The Team also provides consultancy and support to other professionals working with children at risk of CSE and co-ordinates information sharing through 'extended team meetings'.

A huge amount of training and awareness-raising has been and continues to be delivered to a wide range of professionals across the county. This includes staff in schools and GPs. In 2014 over 7,500 practitioners who have contact with children received training on CSE. The impact from this can be seen in the significant increase in the number of CSE screening tools completed and the range of agencies referring into the Kingfisher team. Training and awareness raising has taken place across a range of faith and community groups including the pastor's forum and mosques. However, the OSCB notes the…

difficulty in mandating safeguarding training to wider sectors of the community and recommends that licensing of taxi drivers should be linked to mandatory safeguarding training across Oxfordshire and the rest of the country. Training to hotels, guest houses, door staff, parks and street scene staff and others who can act as 'eyes and ears' on the ground is equally important.

More than 18,000 children have seen Chelsea's Choice, a drama that tours Oxfordshire schools to raise awareness of child sexual exploitation. Thousands more children have viewed the drama this last year. Oxford primary schools have been involved in piloting the Values Versus Violence programme which aims to develop children's core values, self-esteem and resilience and as such is seen as a very early preventive measure in terms of children becoming victims or perpetrators.

CSE is seen as child abuse and responded to as a crime. In 2013 32 Abduction Warning Notices were issued with 2 recorded breaches. In 2014 28 Abduction Warning Notices were issued with 1 recorded breach. Two of the 3 males breached were charged with substantive offences. Through the profiling and convictions for CSE in Oxfordshire we are aware that particular groups of young men are being drawn into offending. In 2014 Operation Reportage, March 2015 was an example of using experience from Operation Bullfinch to inform new investigations. It also demonstrated on-going commitment to never giving up on children, allowing the time they need to build trusting relationships and to disclose their abuse and a determination to hold perpetrators to account for their actions.

CSE is understood as a community safety issue and the district community safety partnerships are well embedded into the county-wide approach to tackling CSE through the CSE sub group. Prevalence reports detailing the current risks, hot spots and planned disruptions and operations are routinely shared. The impact of operations and interventions and outcomes from prosecutions is monitored. The CSE sub group has undertaken a mapping exercise of community based provision and will use the information to identify which services are currently meeting identified needs, which could do so and where there are gaps which will need to be filled through the commissioning of services. It is leading on an update of the strategy to address CSE in 2015.

Priority 5: improving our effectiveness as a board

Ofsted's review of the LSCB

The OSCB was judged as **"GOOD"** by Ofsted published during this reporting in May 2014. This provided assurances to the OSCB, partners and the public that local partnership work is effective in safeguarding the welfare of children. Ofsted proposed five areas for improvement which have been addressed as follows:

Increase the influence of the Board by clarifying relationships with key strategic groups in Oxfordshire	The Board has protocols with Children's Trust and the HWB to show clear lines of accountability. The Board's business plan reflects shared objectives with these partnerships. The Independent Chair has set up a twice yearly safeguarding summit with chief officers. The Board has a renewed constitution and refreshed terms of reference for all subgroups. It has effective governance arrangements and operating structure. The Performance, Audit and Quality Assurance subgroup is now formally accountable to both the Children's Trust and the OSCB. The challenge now is to improve cross agency engagement with the City and District Councils on safeguarding.
Ensure that this annual report has a closer focus on the child's experiences of safeguarding services	Children's views from serious case reviews, the Children in Care Council; the Youth Parliament and local sounding boards have contributed to this report. This report challenges board members to provide more focus on the child's experiences in their auditing work.
Ensure that the views of children and their families inform planning and training and that this contribution is then fed back to families	Parents and children 's views have directly contributed to OSCB training events on parental substance misuse, mental health, child sexual exploitation and managing risk for vulnerable teenagers. Partner agencies have examples of views informing the 'placement strategy', the child sexual exploitation strategy, FGM promotion, school health nurse promotion and the Values versus violence programme.
Evaluate the learning and impact of training delivered across the partnership particularly its longer term impact on the quality of practice in partners agencies	A review was undertaken on the impact of training, which collated feedback from trainers and delegates. Responses confirmed the practical application of the OSCB training courses; that attendees felt more knowledgeable about local safeguarding issues; that they knew how and where to raise a concern; that they would share their learning with colleagues. Agencies are now also required to gain feedback through the section 11 feedback and through an annual report in to the training subgroup. Read more about training below.
Accelerate the implementation of a strategy in relation to female genital mutilation.	OSCB partners assessed the prevalence of FGM in the county; produced a screening tool and procedures for working on this and worked with the Department of Health to run a conference on FGM in the county. The OSCB supported the community organisation 'Oxford against Cutting' to access local schools and run an awareness raising project, which produced a booklet for children. OSCB trainers received training on FGM so that they are confident in communicating the issue to delegates.

Learning and improvement: OSCB safeguarding training

Who delivers it?

Free OSCB training is delivered on a voluntary basis by over 30 local practitioners including police officers, teachers, social workers and clinical leads from across health. OSCB trainers work with children, childcare professionals and safeguarding issues on a regular basis. Many are specialists in their own setting. They are first trained by the OSCB, observe and then co-train before they are fully fledged. They are then kept up-to-date on the learning from case reviews and local tools endorsed by the OSCB. Over the last year they have helped to develop the new core safeguarding courses due to be launched in 2015/2016.

What is delivered?

The OSCB delivered nearly 150 learning events last year. It has a comprehensive range of training. As well as core safeguarding courses the OSCB runs courses for practitioners working with vulnerable groups such as young g carers or disabled children. It also runs early years courses funded through the county council and risky behaviours courses funded through public health such as: child sexual exploitation; sexual health awareness; substance misuse; healthy and unhealthy sexual behaviour; mental health and anxieties.

How many people benefit?

Training in 2014/15 deserves a big thank-you to all involved as over 8000 learning events were recorded. More face to face training and learning was delivered: 3664 delegates compared to 2170 last year. More online learning was completed: 4537 courses compared to 1338 last year. There was a roll-out of a new format for learning following serious case reviews.

What difference does it make?

An OSCB training review in 2014 evidenced the provision as being of good quality. Evaluation indicated that training is highly valued and confirmed the practical application of the learning e.g. increased awareness of local safeguarding issues as well as how and where to raise a concern. Course feedback is that 80% of delegates rate it as good or excellent. They have told us:

- *It was very informative and offered reassurance in confirming the referral process*
- *Really enjoyed this course. The content and timings were pitched perfectly. There was plenty of information exchange*

In 2015/16 the OSCB needs to set up automatic post-course evaluation after a three-month time period has elapsed.

Learning and improvement: OSCB procedures

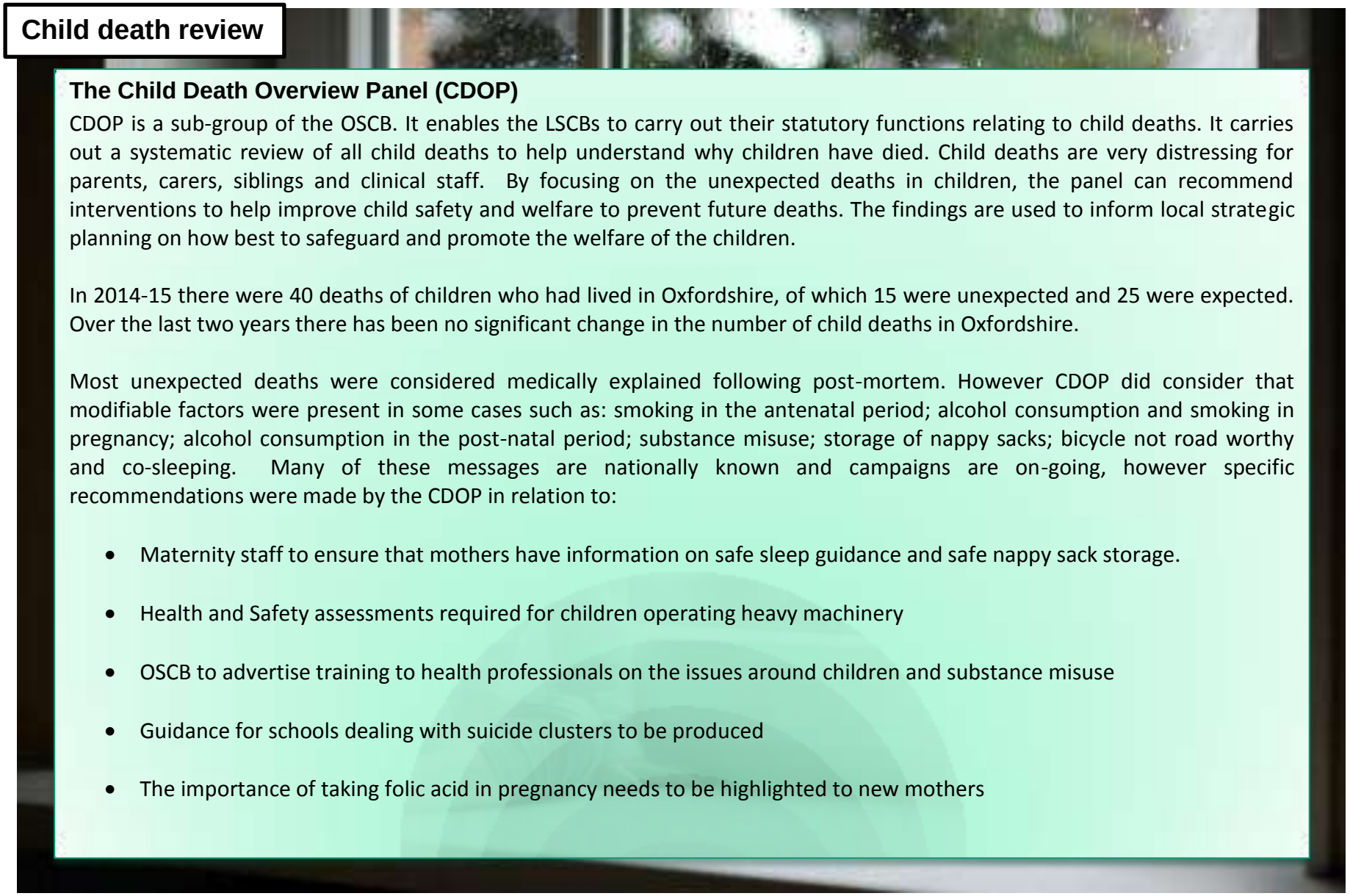
OSCB online procedures were rated by Inspectors as "*comprehensive and up to date*". All priority procedures have been reviewed and updated in light of new legislation and guidance. The layout has been improved to provide better clarity and more coherent formatting. Emerging national and local issues, such as Female Genital Mutilation, have been addressed and procedures have been put in place in a timely fashion. The group is currently reviewing the procedures on self-harm. The challenge is to increase reference to and usage of the online manual.

Learning and improvement: OSCB communication

The OSCB was highly productive in ensuring that the learning from the three audits and three newly published case reviews reached frontline practitioner and was used to develop practice. Examples of work to communicate safeguarding messages are:

- Five multi-agency learning events following case review and audit themes. They were on neglect, parental substance misuses; tackling child sexual exploitation; accessing mental health support for children and working with vulnerable adolescents. Most of these events were chaired by the OSCB Independent Chair and involved the county's interim deputy director for safeguarding, the county's designated nurse, parents and children and experts in the chosen field. which reached over 200 practitioners
- 'Eyes on' learning documents were produce on the themes from case reviews and audits. They cover neglect; parental substance misuse, another successful annual conference for over 200 delegates with 6 workshops on key subjects such as; self-harm, behaviour and attendance, child sexual exploitation, social media and the internet, drugs & alcohol and working together on high risk cases.
- e- bulletin on safeguarding issues for safeguarding leads in education
- workshops on MASH; female genital mutilation and the 'prevent' programme for OSCB trainers
- meetings with the children in care council; sounding boards; Children's Parliament to explain OSCB purpose and role in safeguarding
- meetings with voluntary, community and faith groups at conferences OSCB purpose and their role in safeguarding
- new cross-agency communications group and strategy in order to communicate messages from case reviews

Child death review



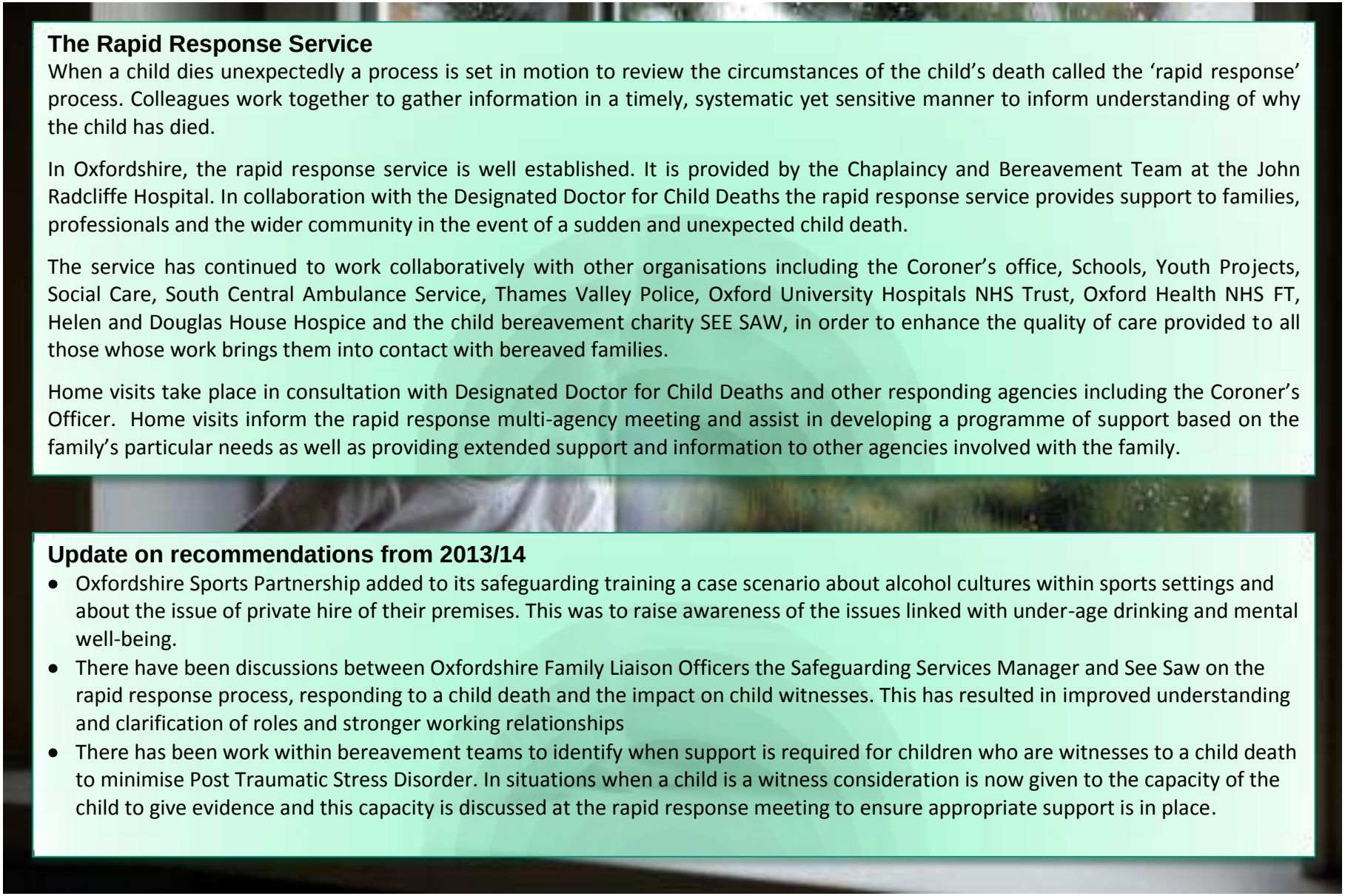
The Child Death Overview Panel (CDOP)

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

In 2014-15 there were 40 deaths of children who had lived in Oxfordshire, of which 15 were unexpected and 25 were expected. Over the last two years there has been no significant change in the number of child deaths in Oxfordshire.

Most unexpected deaths were considered medically explained following post-mortem. However CDOP did consider that modifiable factors were present in some cases such as: smoking in the antenatal period; alcohol consumption and smoking in pregnancy; alcohol consumption in the post-natal period; substance misuse; storage of nappy sacks; bicycle not road worthy and co-sleeping. Many of these messages are nationally known and campaigns are on-going, however specific recommendations were made by the CDOP in relation to:

- Maternity staff to ensure that mothers have information on safe sleep guidance and safe nappy sack storage.
- Health and Safety assessments required for children operating heavy machinery
- OSCB to advertise training to health professionals on the issues around children and substance misuse
- Guidance for schools dealing with suicide clusters to be produced
- The importance of taking folic acid in pregnancy needs to be highlighted to new mothers



The Rapid Response Service

When a child dies unexpectedly a process is set in motion to review the circumstances of the child's death called the 'rapid response' process. Colleagues work together to gather information in a timely, systematic yet sensitive manner to inform understanding of why the child has died.

In Oxfordshire, the rapid response service is well established. It is provided by the Chaplaincy and Bereavement Team at the John Radcliffe Hospital. In collaboration with the Designated Doctor for Child Deaths the rapid response service provides support to families, professionals and the wider community in the event of a sudden and unexpected child death.

The service has continued to 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 FT, Helen and Douglas House Hospice and the child bereavement charity SEE SAW, in order to enhance the quality of care provided to all those whose work brings them into contact with bereaved families.

Home visits take place in consultation with Designated Doctor for Child Deaths and other responding agencies including the Coroner's Officer. Home visits inform the rapid response multi-agency meeting and assist in developing a programme of support based on the family's particular needs as well as providing extended support and information to other agencies involved with the family.

Update on recommendations from 2013/14

- Oxfordshire Sports Partnership added to its safeguarding training a case scenario about alcohol cultures within sports settings and about the issue of private hire of their premises. This was to raise awareness of the issues linked with under-age drinking and mental well-being.
- There have been discussions between Oxfordshire Family Liaison Officers the Safeguarding Services Manager and See Saw on the rapid response process, responding to a child death and the impact on child witnesses. This has resulted in improved understanding and clarification of roles and stronger working relationships
- There has been work within bereavement teams to identify when support is required for children who are witnesses to a child death to minimise Post Traumatic Stress Disorder. In situations when a child is a witness consideration is now given to the capacity of the child to give evidence and this capacity is discussed at the rapid response meeting to ensure appropriate support is in place.

Reviews of serious cases

A serious case is one where:

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

Serious case reviews (SCR)

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

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

The OSCB is generating a lot of learning f about how we can work better together. It takes seriously its responsibilities to ensure that lessons learned from case reviews are disseminated and embedded into frontline practice and used to support improvements across agencies. The themes of sexual exploitation, supporting adolescents at risk, the impact of mental health problems and substance misuse on parental capacity have emerged from the three serious case reviews published in 2014/15. The outlines of the three reviews completed are provided below.

Story of Child H

This case concerned a one year old child accidentally ingesting 40-50ml of prescribed methadone that had been in a bottle in the mother's handbag, whilst temporarily alone in the room. There was a delay in emergency services being called and Child H needed resuscitation. However Child H made a full recovery.

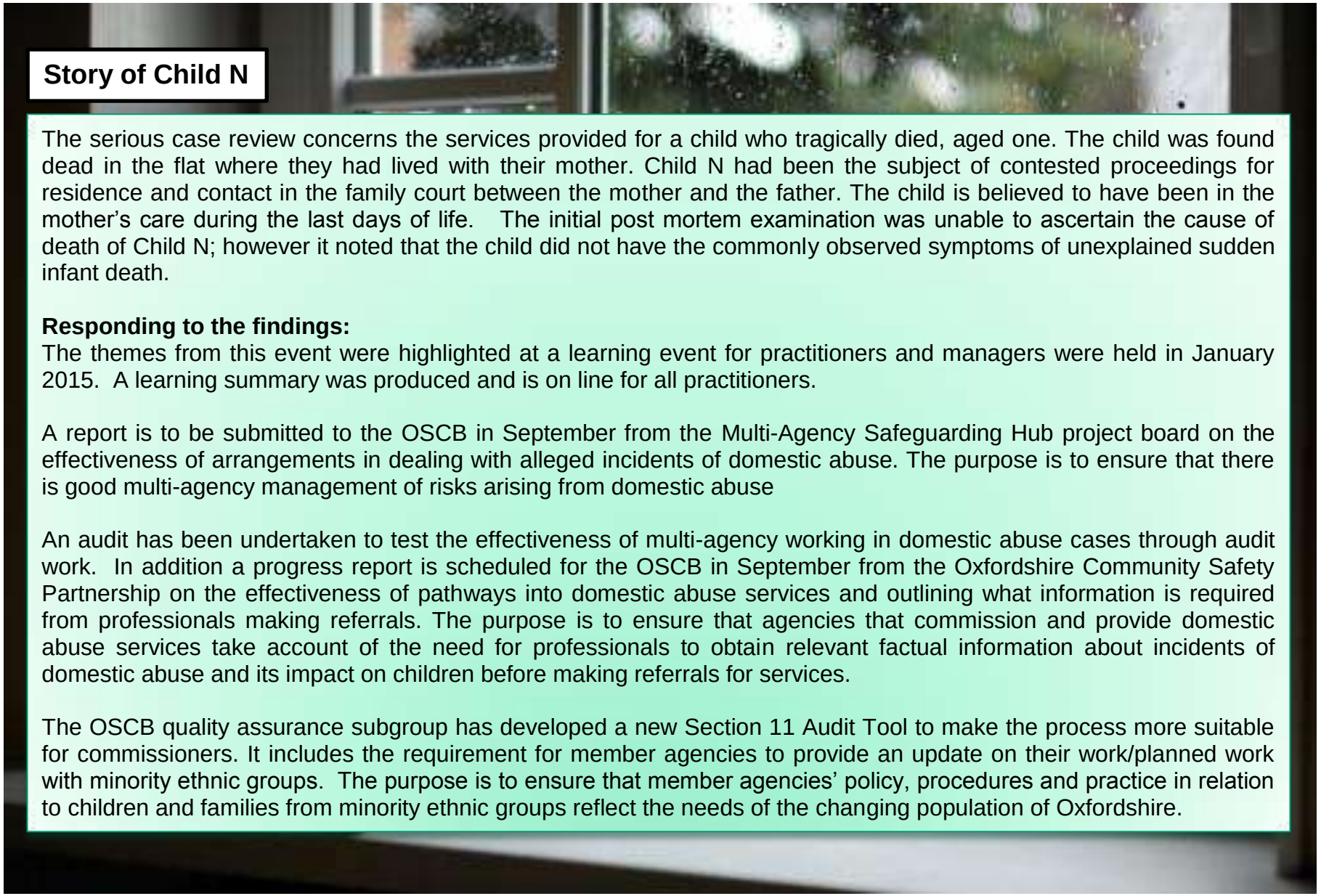
Child H's mother had been known to Children's Social Care since the age of 15 and had a history of drug use. Child H's older sibling was removed at the age of 5 months due to concerns about mother's substance abuse and its impact on her ability to parent.
When child H was born the case was monitored via a 'child protection plan'. This was stepped down to a 'child in need plan' when he was aged seven months and closed five months later. The case remained open to other services.

At the time of the incident, child H lived with their mother and the father was not involved in child H's upbringing. Mother was known to a number of different universal and specialist services including adult drug services, police and social care.

Responding to the findings:
A learning event for practitioners and managers was held in December 2014. A learning summary was produced and is on line for all practitioners.

The Board has ensured that pharmacists in the county are reminded of the expectation that Children's Social Care or Police should be informed if they are concerned a drug dependent person might pose a risk to their own or another child.

Commissioners of GP Services and Public Health Commissioners have been asked to review their monitoring processes to ensure collaborative management of contracted services provided in General Practice in particular drug and alcohol services.



Story of Child N

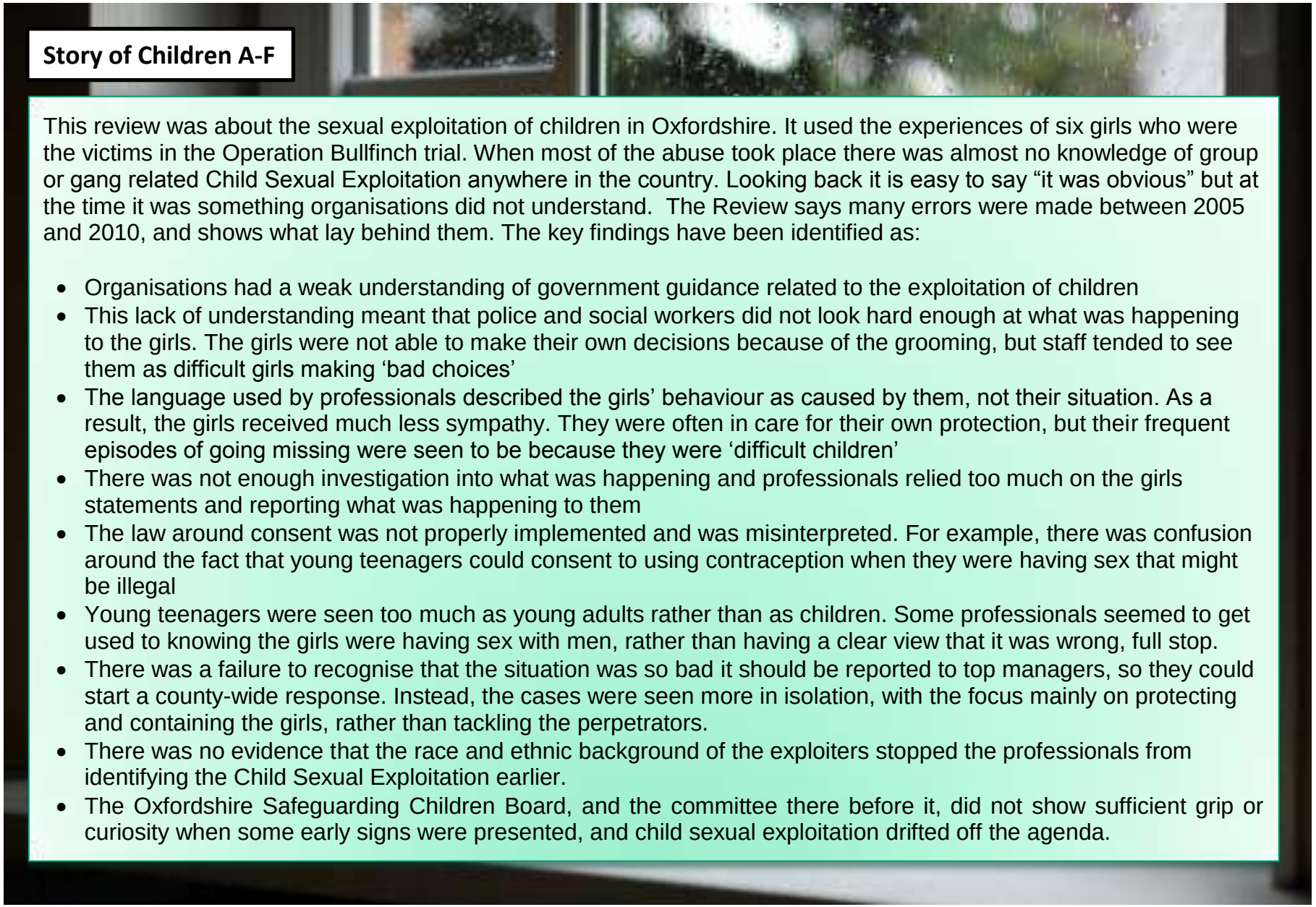
The serious case review concerns the services provided for a child who tragically died, aged one. The child was found dead in the flat where they had lived with their mother. Child N had been the subject of contested proceedings for residence and contact in the family court between the mother and the father. The child is believed to have been in the mother's care during the last days of life. The initial post mortem examination was unable to ascertain the cause of death of Child N; however it noted that the child did not have the commonly observed symptoms of unexplained sudden infant death.

Responding to the findings:
The themes from this event were highlighted at a learning event for practitioners and managers were held in January 2015. A learning summary was produced and is on line for all practitioners.

A report is to be submitted to the OSCB in September from the Multi-Agency Safeguarding Hub project board on the effectiveness of arrangements in dealing with alleged incidents of domestic abuse. The purpose is to ensure that there is good multi-agency management of risks arising from domestic abuse

An audit has been undertaken to test the effectiveness of multi-agency working in domestic abuse cases through audit work. In addition a progress report is scheduled for the OSCB in September from the Oxfordshire Community Safety Partnership on the effectiveness of pathways into domestic abuse services and outlining what information is required from professionals making referrals. The purpose is to ensure that agencies that commission and provide domestic abuse services take account of the need for professionals to obtain relevant factual information about incidents of domestic abuse and its impact on children before making referrals for services.

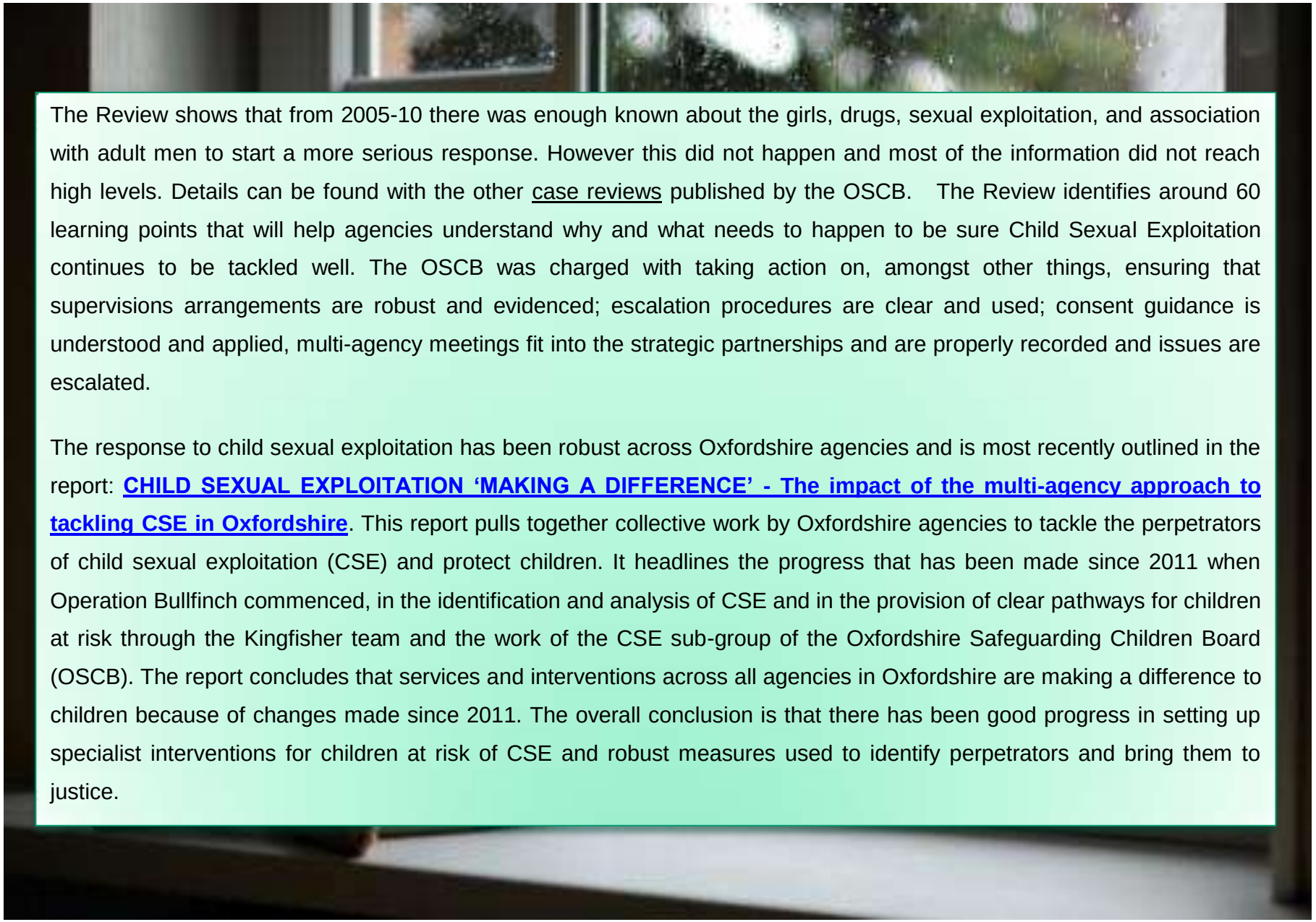
The OSCB quality assurance subgroup has developed a new Section 11 Audit Tool to make the process more suitable for commissioners. It includes the requirement for member agencies to provide an update on their work/planned work with minority ethnic groups. The purpose is to ensure that member agencies' policy, procedures and practice in relation to children and families from minority ethnic groups reflect the needs of the changing population of Oxfordshire.



Story of Children A-F

This review was about the sexual exploitation of children in Oxfordshire. It used the experiences of six girls who were the victims in the Operation Bullfinch trial. When most of the abuse took place there was almost no knowledge of group or gang related Child Sexual Exploitation anywhere in the country. Looking back it is easy to say “it was obvious” but at the time it was something organisations did not understand. The Review says many errors were made between 2005 and 2010, and shows what lay behind them. The key findings have been identified as:

- Organisations had a weak understanding of government guidance related to the exploitation of children
- This lack of understanding meant that police and social workers did not look hard enough at what was happening to the girls. The girls were not able to make their own decisions because of the grooming, but staff tended to see them as difficult girls making ‘bad choices’
- The language used by professionals described the girls’ behaviour as caused by them, not their situation. As a result, the girls received much less sympathy. They were often in care for their own protection, but their frequent episodes of going missing were seen to be because they were ‘difficult children’
- There was not enough investigation into what was happening and professionals relied too much on the girls statements and reporting what was happening to them
- The law around consent was not properly implemented and was misinterpreted. For example, there was confusion around the fact that young teenagers could consent to using contraception when they were having sex that might be illegal
- Young teenagers were seen too much as young adults rather than as children. Some professionals seemed to get used to knowing the girls were having sex with men, rather than having a clear view that it was wrong, full stop.
- There was a failure to recognise that the situation was so bad it should be reported to top managers, so they could start a county-wide response. Instead, the cases were seen more in isolation, with the focus mainly on protecting and containing the girls, rather than tackling the perpetrators.
- There was no evidence that the race and ethnic background of the exploiters stopped the professionals from identifying the Child Sexual Exploitation earlier.
- The Oxfordshire Safeguarding Children Board, and the committee there before it, did not show sufficient grip or curiosity when some early signs were presented, and child sexual exploitation drifted off the agenda.



The Review shows that from 2005-10 there was enough known about the girls, drugs, sexual exploitation, and association with adult men to start a more serious response. However this did not happen and most of the information did not reach high levels. Details can be found with the other case reviews published by the OSCB. The Review identifies around 60 learning points that will help agencies understand why and what needs to happen to be sure Child Sexual Exploitation continues to be tackled well. The OSCB was charged with taking action on, amongst other things, ensuring that supervisions arrangements are robust and evidenced; escalation procedures are clear and used; consent guidance is understood and applied, multi-agency meetings fit into the strategic partnerships and are properly recorded and issues are escalated.

The response to child sexual exploitation has been robust across Oxfordshire agencies and is most recently outlined in the report: **CHILD SEXUAL EXPLOITATION 'MAKING A DIFFERENCE' - The impact of the multi-agency approach to tackling CSE in Oxfordshire**. This report pulls together collective work by Oxfordshire agencies to tackle the perpetrators of child sexual exploitation (CSE) and protect children. It headlines the progress that has been made since 2011 when Operation Bullfinch commenced, in the identification and analysis of CSE and in the provision of clear pathways for children at risk through the Kingfisher team and the work of the CSE sub-group of the Oxfordshire Safeguarding Children Board (OSCB). The report concludes that services and interventions across all agencies in Oxfordshire are making a difference to children because of changes made since 2011. The overall conclusion is that there has been good progress in setting up specialist interventions for children at risk of CSE and robust measures used to identify perpetrators and bring them to justice.

Chapter 5: Challenges ahead and future priorities

National Drivers

- Addressing child sexual exploitation
- Implementation of new safeguarding guidance
- Focus on safeguarding across the inspection regime to drive local compliance with audits

For the Board

- Strengthening partnership arrangements
- Working and engaging with local community, voluntary and faith groups
- Ensuring compliance against safeguarding standards
- Testing if learning from case reviews is embedded across partner agencies

For local multi-agency work

- Improving practice to address neglect
- Progressing work to better safeguard vulnerable adolescents
- Remaining vigilant to where the next pressure points lie and escalating safeguarding concerns
- Ensuring there is sufficient provision of 'early help' and services are integrated

Key priority areas

Reviewing the challenges ahead the Board is committed to delivering on its priorities with due attention to

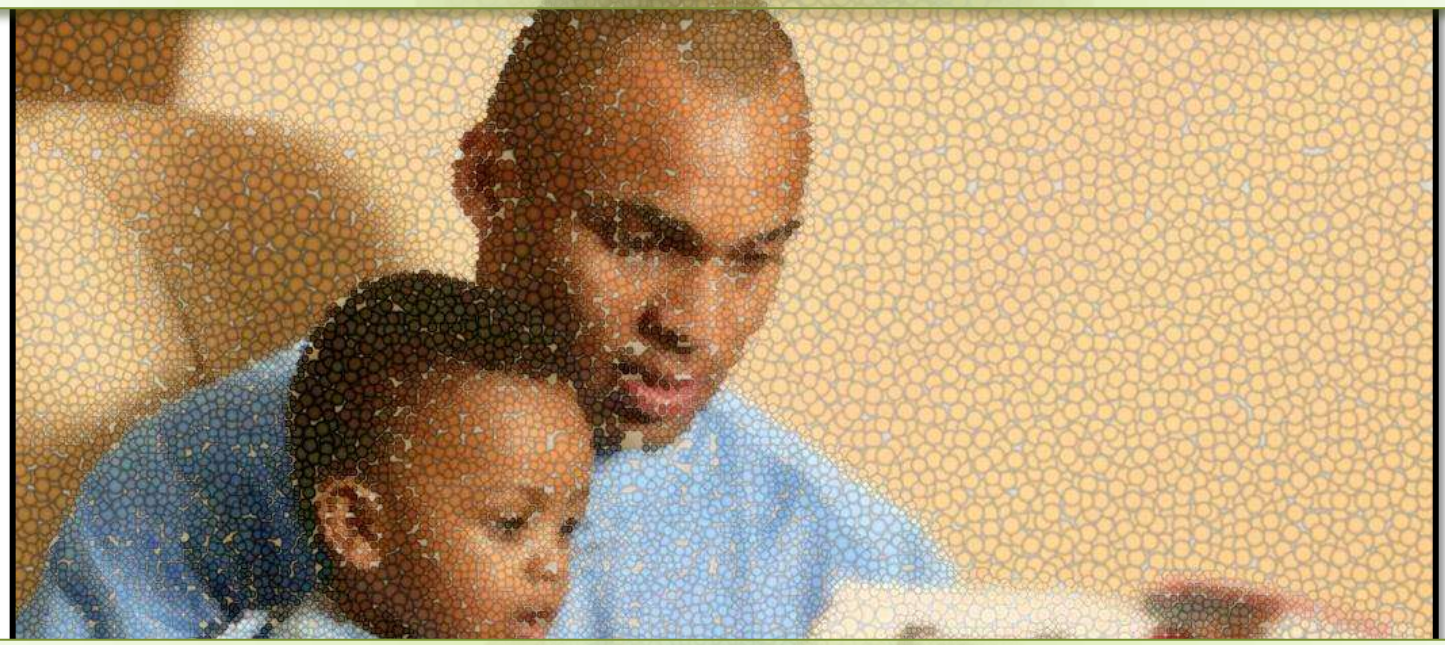
- The increasing pressures on the safeguarding system as the number of children with child protection plans and in care rises
- Safeguarding in transport: regulation of taxis and commissioning of transport for vulnerable children
- Commissioning of services to provide help and therapy for children into adulthood

CHAPTER 6: WHAT NEXT FOR CHILD PROTECTION IN OXFORDSHIRE

Key messages to:

Children

Your voices are most important. Tell us what you think when we ask and help us to improve the way that agencies help you and your family



Children's workforce

- Ensure that you have attended all safeguarding courses and learning that is relevant to your role
- Get the basics right: be informed; use the multi-agency tools and procedures on the OSCB website
- Use your representative on the safeguarding board to escalate concerns
- Be connected to your local safeguarding group as appropriate

The community

- You are in the best place to look out for children and to raise the alarm if something goes wrong
- We all share responsibility for protecting children. Report a concern if you are worried.

The community, faith and voluntary sector

- Ensure that you have attended all safeguarding courses and learning that is relevant to your role
- Use online resources available through the NSPCC
- Find out about and use the multi-agency tools where they are relevant to your role

Head and Governors of schools

- Complete the OSCB endorsed safeguarding audit for your setting
- Ensure your workforce is trained and get involved in the delivery of OSCB safeguarding training
- Be aware of the latest statutory guidance on safeguarding and ensure your safeguarding lead is signed up to the OSCB e-bulletin
- Understand and know how to deal with safeguarding concerns like self-harm; sexting; online safety and radicalisation of children
- Access and promote road safety information for pupils and their families
- Take responsibility for ensuring that all pupils' whereabouts are known; children out of school are at increased risk of harm
- Make the most of local safeguarding initiatives e.g. NSPCC Childline assemblies and Chelsea's Choice

Clinical commissioning groups

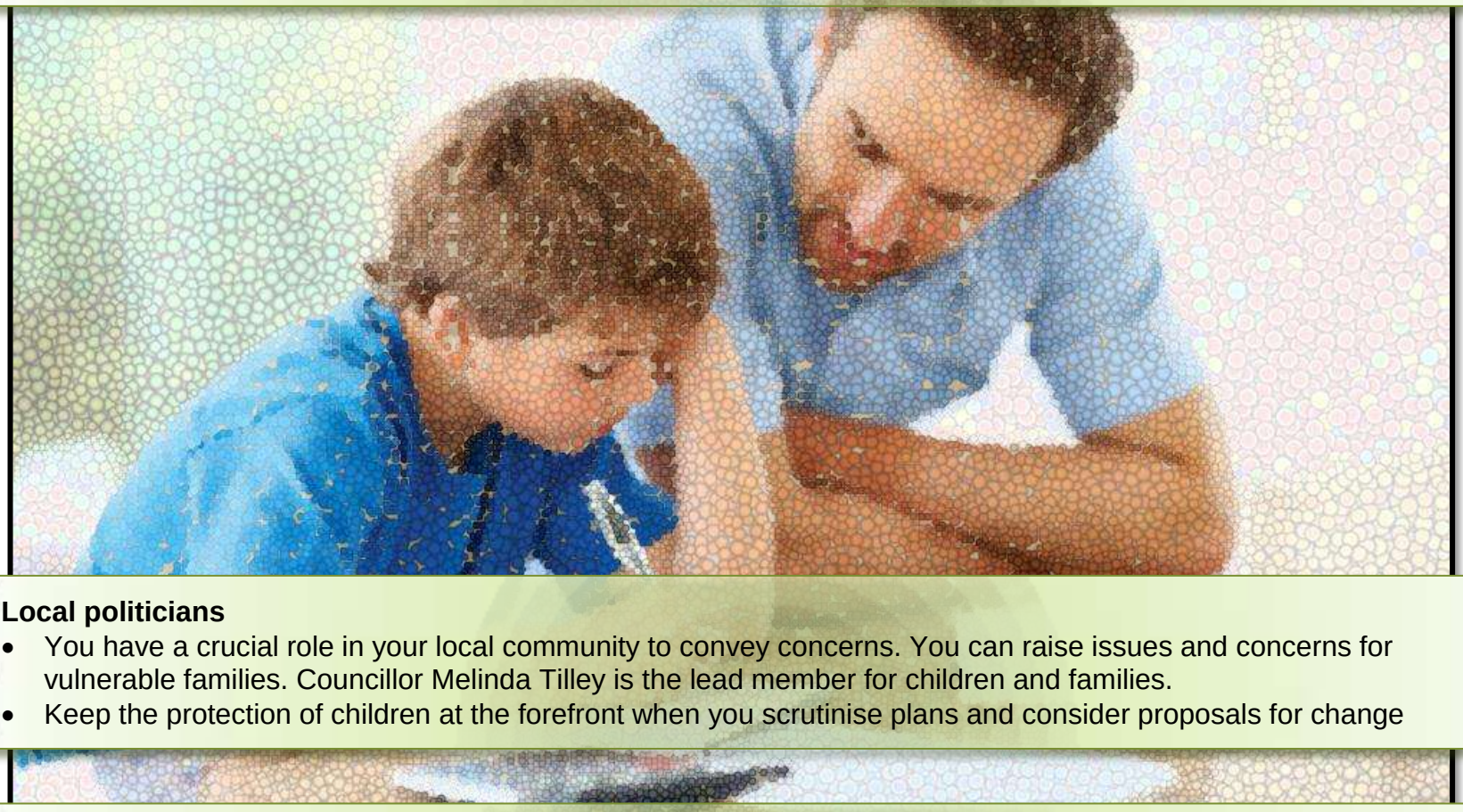
- You have a key role in the health sector to scrutinise the governance and planning across a range of organisations. Consider the needs to vulnerable families within the course of this work
- You are required to discharge your safeguarding duties effectively and ensure that services are commissioned for the most vulnerable children

Chief executives and directors

- Your agency's contribution to the work of the OSCB should be of the highest priority; you have made good progress in working collectively to tackle issues such as child sexual exploitation, female genital mutilation and self-harm but there is *continuing* need of strategic co-ordination of activity across your organisations
- Take responsibility to ensure that all serious safeguarding matters are escalated to the Board for challenge by the partnership
- Ensure that senior managers meet with frontline practitioners and are assured that safeguarding practice is well understood
- Strong and persistent leadership will change culture and attitudes towards vulnerable children; be vigilant to where the next pressure points lie

Police and crime commissioner

- Ensure that victims voices are taken notice of within the criminal justice system
- Monitor and support the work of the Oxfordshire Safer Community Partnerships and the local community safety partnerships



Local politicians

- You have a crucial role in your local community to convey concerns. You can raise issues and concerns for vulnerable families. Councillor Melinda Tilley is the lead member for children and families.
- Keep the protection of children at the forefront when you scrutinise plans and consider proposals for change

Local media

- We all share responsibility for protecting children; you are in a crucial position to convey this to your readers
- Find out about the Safeguarding Board and current concerns; this will be of interest to your readers

Reporting Concerns

Multi-Agency Safeguarding Hub (MASH) **For any new concerns or enquiries please contact the MASH:**	**0845 050 7666**
Oxford City (including Cowley, Botley, Headington, the Leys and Kidlington)	**01865 328563**
North Oxfordshire (including Banbury, Witney, Bicester, Carterton and Woodstock)	**01865 323039**
South Oxfordshire (including Faringdon, Wantage, Thame, Didcot and Henley)	**01865 323041**
The Emergency Duty Team Please contact this number if your call is outside of normal office hours	**0800 833 408**
John Radcliffe Hospital Assessment Team for antenatal safeguarding concerns and issues concerning children in the hospital	**01865 221236**
Child Sexual Exploitation (the Kingfisher Team) If a child or young person has made a disclosure regarding sexual exploitation or if you think a child may be at risk of being sexually exploited, please contact the Kingfisher Team on: *Out of hours calls to this number will be diverted to the Thames Valley Police Referral Centre*	**01865 335276**