Performance, audit and quality assurance subgroup Annual Report for 2015/2016: Themes for learning and improvement

July 2016

Contents

1. Executive summary: themes for learning and improvement

Introduction

There are 141,200 young people aged under-18 in Oxfordshire. This population has grown around 6% in the last ten years – mainly in urban areas such as Oxford, Didcot, Witney, Bicester, and Carterton. The purpose of this annual report is to highlight common themes for learning and improvement to support these children. The following sources are used: section 11 audits, school audits, single and multi-agency audits, work with children and young people, annual reports and serious case reviews. The OSCB's framework for this work is based on:

1. Quantitative information
2. Qualitative information
3. Involvement of practitioners
4. Involvement of children, young people, parents & carers

The following pages provide detail against these four areas. A summary of these points is provided below:

Quantitative themes for learning and improvement drawn from audits and case reviews

A review of data would suggest that the child protection partnership should be mindful of the increasing levels of activity across the safeguarding system at a time when there is significant change in resources and agency structures. This is accompanied by an increasingly complex set of issues for vulnerable young people ranging from self-harm, to peer abuse to social media pressures. The partnership needs to better understand why there is an increase in the proportion of children becoming looked after who were previously subject to a plan. The partnership also needs to address the issue school attendance in Oxfordshire, which, for children subject to child protection planning in particular is not good in comparison to similar sized counties.

Over the last year the themes covered by case reviews have been: the long-lasting impact of neglect; child sexual abuse; physical abuse; self-harm; child and parental emotional wellbeing; parental substance misuse and peer on peer violence.

'Damaged and difficult' lives of young people and their capacity to protect themselves has become a repeated theme in recent years. The need for early intervention and the support for parents with children aged under 2 years by universal services is essential.

Qualitative themes: repeated process issues in joint working to embed in learning going forward and any repeated safeguarding themes

The child protection partnership has been able to demonstrate effectively what it does well through; the Ofsted inspection in 2014, the stocktake report on child sexual exploitation in 2015 and the Joint targeted area inspection in 2016. Areas of strength include strategic leadership, multi-agency responses and joint working. Audits show strengths in involving and listening to children and in working with families effectively to bring about change.
Systematic areas for learning and improvement include:

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

Across agencies the learning is that:

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

At a practice level the learning is that:

- When assessing: always make an assessment of what a father/male partner and his family can offer to a child (positives), as well as of the risks he/they may pose. Managers should remember that thoughtful assessment, reviewed over time, is fundamental to the success of future safeguarding..
- When responding to incidents: ensure that you speak to a child alone in relation to any allegation of harm or physical signs of harm.
- When you are working with complex adolescents seek out proper management support. Managers should remember that damaged and dangerous young people are often well known to services. Ensure that you service collates risk information so that it is easily accessible in records.

- Remember: the risk to a young person is not reduced if they do not live with the perpetrator
- Remember: the protective role of fathers

Practitioners' themes:

Themes highlighted from practitioners concern early help, the multi-agency safeguarding hub and struggling to 'keep up'. Practitioners raised concern about the resourcing of services to provide early help to children. There are concerns that schools and voluntary and community groups do not have the capacity to lead on CAFs. Practitioners were concerned about the responsiveness of the new Multi-Agency Safeguarding Hub in terms of timeliness of action and feedback. Finally there was a message that the system was under pressure and that it is difficult to sustain high quality work for a growing number of children and young people.

Young People, Parents and Carers themes:

A number of themes came through this year – these are just the key points. They include: being heard and knowing 'who' you are speaking to; the issues that worry them e.g. bullying, dealing with social media pressures and sexting, consent, sex and healthy relationships as well as the issues confronted by lesbian, gay bi-sexual and transgender young people in particular in terms of identity, information and bullying.

"*You know everything about me; I know nothing about you*." Young people, in particular those in care, want to know the professionals who know them. They also want the opportunity to be able to speak up and be heard.

Young people want more information - and not necessarily from teachers – on sex and relationships including single sex relationships and on being transgender. They want to discuss issues on a single-sex basis in an environment that felt more confidential. Children in care were concerned about this but also about care plans and reviews and how children 'going missing' are dealt with on return.

The message from parents was that they wanted to be listened to, taken seriously and have timely response to requests for help. A whole family approach – involving fathers - will make a bigger difference.

2. Themes and findings from case reviews, audits, complaints and engagement with young people

2.1 Quantitative

Introduction

This section aims to summarise the quantitative information available to the OSCB from datasets; case reviews; audits and the Child Death Overview Panel.

The Child's Journey:

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

Increase in early intervention

In the academic year 2014/2015 there were 957 recorded Common Assessment Framework's (CAF) and 912 recorded Team Around the Child's (TAC), with schools predominantly taking the lead in the work. This was an increase on the last two years. The number of under 5s reached in Oxfordshire, seen at least once at an event or activity at a children's centre, was 18, 251 or 43.8% of the population of under 5s, which was the same proportion as the previous year.

Increasing levels of activity in child protection planning

Neglect is the most common reason for children to be subject to child protection plans. The total number subject to a plan didn't alter too much (569 children) in 2015/16. However there was a significant amount of activity compared to the previous year. Whilst activity levels are slightly lower than the national average they are above those of statistical neighbours and higher than we would expect for an authority, which is the 14th least deprived in regard to children in the country.

Disabled Children

At the end of March there were 1 4disabled children with a a child protection plan, which is line with previous years.

Increasing numbers of children in care

Children in care are those looked after by the local authority. This rose by 18% in the year from 514 to 609. For comparison the national growth over the last 5 years has been 3% per annum. Despite this growth numbers remain comparatively low, the average for our

statistical neighbours (the authorities that are most demographically similar to Oxfordshire) would by 690. 61% of all children becoming looked after had previously been the subject of a child protection plan - 49% within 12 months of their looked after episode beginning. 11% of children becoming looked after had been previously looked after. Understanding what happens once a child stops being the subject of a plan and ensuring improvements are sustained will be an area of focus in the coming year.

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

Children at risk of sexual exploitation continue to be identified

Multi-agency work to identify children and young people who may be at risk of child sexual exploitation (CSE) in Oxfordshire is coordinated by the Kingfisher Team. There are currently 280 children open to social care at risk of CSE. 88 new assessments in 2014/15 identified children at risk. This reflected 2.5% of all social care assessment and was slightly below the national average of 3%

Children missing from home: increased reporting of those missing repeatedly

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

Children and young people who offend: fall in numbers involved with YJS

The young people who are involved with Oxfordshire Youth Justice Service (YJS) often present with complex needs requiring significant support both in and out of custody. The figures for the year 2015/16 (April to March) show "that the performance is satisfactory" and that we are "still better than both the regional and national rates". There were 12 custodial episodes within the last year period. This is measured against the rate of young people per 1000 in the population. The custodial episodes arise out of serious episodes of offending/ repeat serious episodes of offending.

The implications of increased workloads on ensuring children are kept safe.

The continuing pressures on the system are apparent against the context of reduced resources and changing structures.

Children who are privately fostered

At the end of March 2016 the local authority were aware of 43 children living in a privately arranged foster placement, similar to last year (44) but up from 34 at the end of March 2014.

Serious Case Reviews:

Five new cases were brought to the attention of the OSCB for consideration of a serious case review in 2015/16. Of these referrals one serious case review was commissioned.
The OSCB has worked on five serious case reviews over the last year, one of which is also a domestic homicide review. Of those reviews: two have been signed off in 2015/16; one is due to signed off in July 2016, one is active and one is complete as far as possible, whilst a police investigation is underway.

Over the last five years ten serious case reviews and two learning reviews have been commissioned. The reviews fall into two main age groups; pre-school and secondary school age children – just over 50% are older children aged between thirteen and eighteen. The majority of the reviews concern females. The proportion of pre-school children highlights the ongoing need for effective universal service provision for young children; for example health visitors and early-years services such as Children's Centres.

Over the last year the themes covered by case reviews have been: the long-lasting impact of neglect; child sexual abuse; physical abuse; self-harm; child and parental emotional wellbeing; parental substance misuse and peer on peer violence. Factors identified across all cases include:

- Neglect: it is a repeated theme in terms of the risks it presents to young children and the impact it continues to have as they grow up
- 'Damaged and difficult' lives of young people and their capacity to protect themselves has also become a repeated theme in recent years.
- Substance misuse by the victim or parents
- Parents of victims where there have been a number of different partners
- Children who have a number of siblings by different fathers
- Majority children/young people were previously known to children's social care (either current at time of incident or historic)

Multi-Agency Audits:

Multi-agency audits reviewed over 25 cases from the perspectives of the different agencies involved. The purpose was to check how well agencies worked together on issues of domestic abuse, child sexual exploitation and 'Education, health and Care Plans' for children and young people with learning difficulties or disabilities (aged 0 to 25). In addition an audit was undertaken on the multi-agency usage of the child sexual exploitation screening tool – a

sample of 178 screening tools was reviewed followed by an in-depth look at 20 completed tools.

Single-Agency Audits:
Board member agencies reported back to OSCB in 2015/2016 on their internal safeguarding practice covering issues such as training, supervision, assessment of need and escalation of issues. The findings are summarised in the qualitative section.

Section 11[1] Audits and Practitioner Questionnaires:

The 2015 Section 11 return saw a 100% return rate from Board Member agencies. All Board Member agencies provided a return, including several agencies which do not currently sit as Board Members, such as British Transport Police. This meant a total of 24 returns were received for analysis. 530 practitioner questionnaires were returned (more responses but less agencies than the previous year). A peer review was held by OSCB in April 2016 to reinforce the OSCB's culture of challenge. Providers, commissioners and senior leads scrutinised and compared the results of their S11 audits. Twenty agencies attended.

'Section 14B[2]' school safeguarding reports, audits and risk assessments

The Designated Officer team, Oxfordshire County Council, request an annual safeguarding report from each school against the requirements of 'section 14b'. There was 100% compliance from all independent and state schools requested to complete the report. Reports were requested from all four FE colleges as well but only Abingdon and Witney College submitted a return – the OSCB Chair has written to those organisations which failed to respond. These will be targeted in 2015/16 as will pop-up and permanent language schools. All schools state that they are up to date with their safeguarding training and comply with safe recruitment practices.

In addition to the annual report and those schools who self-audited, during the 2014/15 academic year, the team has also undertaken a total of 89 audits in schools; 39 joint visits to early years settings including child minders and 46 risk assessment for children and adults in schools and other settings. Risk assessments included where a staff member is to start work without a DBS disclosure; where they have had a positive disclosure or where a child is alleged to have committed a sexual assault on another child.

[1] Section 11 of the Children's Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.
[2] 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. This fulfils the same function as the section 11 reporting duty.

Early Years, Child-minder and 'out of school' Audits:

The Early Years Team received 100% return rate for their audit in 2015/16 from early years settings (295) and childminders (121). The returns demonstrated good compliance with safeguarding standards. This high level of returns was due to a great deal of support and follow up work by the team for any non-returns. Ofsted ratings have increased to 80% 'outstanding' or 'good' with very few safeguarding actions required by Ofsted.

However, only 64% (88) of 137 'out of school' providers had completed the audit by December 2015. More work will be done this year to encourage a higher uptake. Areas for improvement for out of school providers were noted as DBS checks (10% fell short). This is a decrease from 21% in 2014. Of the 28 settings who replied No to this question 18 settings provided an action response. 60% of out of school respondents had not undertaken Prevent training and 60% of out of school respondents did not wear identity badges. These settings are being targeted in 2016/17.

The issue of verifying and challenging the self-reported results and content of the audits remains a challenge.

Designated Officer

The Designated Officer should be informed of all allegations against adults working with children and provide advice and guidance to ensure individual cases are resolved as quickly as possible. During the academic year 2013/14 there were a total of 138 recorded allegations. During the academic year 2014/15 there were a total of 167 allegations. Approximately 5% of all allegations are of a historical nature but concern individuals who continue to act in a position of trust with children. Well over 50% of the referrals come from schools but in the last year referrals have increased from other settings both within the voluntary and statutory sector.

Child Death Overview Panel (CDOP):

CDOP monitors and records all child deaths in Oxfordshire. The information received from the panel informs the OSCB when identifying whether criteria for a serious case review is met. The annual CDOP report identifies the cause and risk factors relating to the deaths.

79 child deaths were reported to the Oxfordshire child death overview team. 35 of the child deaths reported were of children normally resident in Oxfordshire and 44 of the deaths were of children normally resident in other counties.

Oxfordshire CDOP reviewed the deaths of 39 children who usually reside in Oxfordshire. These reviews included 22 deaths that occurred in the year 2015-16 and 17 reviews that

occurred before 2015-16 but had been carried over due to alternative processes and investigations that prevented completion of the CDOP process. Over the last three financial years there has been no significant change in the number of child deaths in Oxfordshire.

2.2 Qualitative

Introduction

This section summarises the qualitative information available to the OSCB. The sources of information include serious case reviews, multi-agency and single agency audits, Section 11 agency and school audits, the Child Death Overview Panel and the Joint targeted area inspection.

Serious Case Reviews:

Case reviews signed off in 2015/16 have highlighted a number of areas for improvement as well as good practice. The messages are as follows:

Themes in common with other serious case reviews

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

Multi-agency learning points

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

Learning points for practitioners

- When assessing: always make an assessment of what a father/male partner and his family can offer to a child (positives), as well as of the risks he/they may pose.
- Remember: the quality of assessment can impact on all your future plans. Be sure to review and reappraise those assessments over time.
- When responding to incidents: ensure that you speak to a child alone in relation to any allegation of harm or physical signs of harm.
- When you are working with complex adolescents seek out proper management support
- Remember: the risk to a young person is not reduced if they do not live with the perpetrator

Learning points for managers

- **Assessment**: Comprehensive thoughtful assessment which is reviewed over time is fundamental to the success of future safeguarding. Ensure that systems for support, supervision and challenge are effective.
- **Supervision**: Ensure that reflective supervision is carried out in neglect cases, with a focus on the lived experiences of the child/ren.
- **Management**: Ensure that neglect cases have clear plans – with desired outcomes, timescales, etc. – which are reviewed robustly on a regular basis
- **Risk Management**: Make use of the multi-agency risk assessment and management plan (MARAMP) and support inter-agency colleagues to reduce risk and impose boundaries on dangerous behaviour.
- **Working with adolescents**: Damaged and dangerous young people are often well known to services. Ensure that your service collates risk information so that it is easily accessible in records. Working with adolescents: Consider what contribution you should be making to improving your organisation's approach and services for working with adolescents.

Multi-Agency Audits:

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

- ✓ **Good child, young person and family involvement.** It is recognised that parents and carers of the children are key partners in keeping them safe and that the needs of other children should also be taken in to account
- ✓ **Children are listened to, believed and drive planning;** in particular health partners demonstrated strong evidence of the voice of the child through a persistent approach

- ✓ **Strong partnership between agencies.** Good evidence of assessment; communication; information sharing
- ✓ **Dynamic meetings taking place behind plans** and some examples of good immediate action

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

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

Single Agency Audits:

Seven agencies reported back to OSCB in 2015/16 on their internal safeguarding practice. Children's social care and Thames Valley Police did not submit summaries of this work to the OSCB although the subgroup chair is aware of audit work taking place. An example of positive practice highlighted through the audit included the National Probation Service, which now routinely checks with Childrens' Services and Thames Valley Police PVP unit and Area intelligence teams are undertaken at point of sentence and at regular reviews of the offender assessment. Another example was OUH. The audit work completed on 'consent' has led to the revision of level 3 safeguarding children training to include scenarios related to child sexual exploitation, domestic abuse and consent. The audit undertaken by Schools and Learning has led to the challenge for school teams to vigorously seek and record parent and child views even if it is the responsibility of another agency

The learning summaries developed in response to the audits and serious case review findings have been promoted widely on the OSCB website, through training and learning events.

Section 11 Audits:

The returns demonstrated good compliance and regard to safeguarding practice as well as positive direction of travel. Key multi-agency messages can be summarised as follows:

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

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

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

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

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

Child Death Overview Panel (CDOP):

In the year 2015-2016 the CDOP panel concluded that in the 39 cases reviewed 6 modifiable factors were identified that contributed to or caused the death. Modifiable factors included co-sleeping; consanguinity; smoking and alcohol; health and safety in the home, drowning and suicide. As a result of the identified modifiable factors the following specific recommendations were made by the CDOP:

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

Joint targeted area inspection

The child protection partnership was jointly assessed this year on how effectively it responds to abuse and neglect in Oxfordshire. The headline judgement was that Oxfordshire now has '*a highly developed and well-functioning approach to tackling exploitation'.*
Key strengths identified by inspectors included:

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

2.3 Involvement of Practitioners

This section aims to summarise the views of the practitioner in Oxfordshire. The sources of information include practitioner listening events, serious case reviews, audits and training and learning events, safeguarding groups and workshops attended by the voluntary, community and faith sector.

Children's Social Care Practitioner Listening Events:

Children's social care held 3 listening events across the county attended by 40-50 staff. The staff survey highlighted that they are struggling with the increased volume of work - which this report notes as an 11% increase of children becoming subject to a plan and 24% increase in the number of children becoming looked after. The social work workforce has highlighted that they need support as they manage the changing face of social work.

Serious Case Reviews:

The serious case review published this year highlighted the complexity of situations that practitioners are dealing with on a daily basis: parents spoke of the tenacity of some of the workers who had supported them and their children. There were examples of excellent perseverance from professionals even when they no longer had a direct role in supporting a young person. A great deal of learning has come from reviews, which has been shared through OSCB themed learning events.

Audits:

The Section 11 Audits included a practitioner questionnaire to gather the levels of awareness and impact on frontline staff working with children and young people. Although

only a small number of agencies completed the questionnaires returns showed increased awareness of referral processes, how and where to raise concerns and good take up of safeguarding training.

Training

Following feedback and input from local, volunteer trainers, the core safeguarding courses have been updated over the last year. They have been involved in the quality assurance of the new courses. Over 9000 practitioners have completed face to face or online training. Satisfaction rates continue to be high for face to face courses and 96% told the OSCB that they felt satisfied or very satisfied that online courses gave them the information that they needed to know.

Learning

Two learning events and a conference have been run by the OSCB in 2015/2016 covering a range of themes emerging from local serious case reviews and audits such as child sexual exploitation, peer violence and domestic abuse, adolescents and risk. These have been attended by over 800 local practitioners, with a mixture of frontline staff, volunteers, management, and board members. The OCSB knows that practitioners are anxious about changes to services as a result of cuts in funding from Q&A sessions. Feedback has been gathered after each learning event which emphasises that practitioners value inter-agency discussions, want to hear the perspective of young people and value the opportunity to reflect on work:

"Young voices of experience seemed to shake the room and helped to see things from a service user's viewpoint"

"*It has given me time to reflect on the families that I work with and think who may best support them*"

Area Safeguarding Groups

These groups are chaired by Board members and attended by frontline practitioners across the county. The area groups provide an accessible way for smaller local agencies and settings to be involved with the Board and keep up to date with local safeguarding themes and projects and national guidance and requirements. Locally identified issues included:

- Multi-agency working: the positive message that practitioners value the Locality Link social workers who provide guidance and support in this area;
- Early help: the concern that schools in particular feel increasingly that they do not have the capacity to do CAFs and that they still have concerns about approaching parents with safeguarding issues
- Increased capacity in the system leading to a large workload and its associated risks

- Changes to service structures and the implementation of the MASH: feedback from practitioners has included comments that it can be difficult to contact and that partners are often not given the advice they need.
- Supporting high risk young people: young people worked with by the Kingfisher Team who are not looked after and do not have a transition pathway into adult services despite considerable vulnerability

The Voluntary, Community and Faith Sector

VCS have joined OSCB subgroups and the Board. Common themes from partners and attendees at workshops have been that they would welcome:

- more accessible training – particularly on Prevent
- support on safeguarding children policies and protocol within their settings
- better understanding of the threshold of needs matrix and the Common Assessment Framework

2.4 Involvement of Young People, Parents and Carers

This section aims to summarise the involvement of young people, parents and carers, and how this is fed back to the OSCB. The sources of information include young people forums; the 'neglect pilot' and sounding boards, youth parliament, children in care council and Oxme.info the county council's website for young people.

Voice of the Child:

Gathering feedback from young people is well developed within a number of the Board members agencies and provider services. OU NHS FT has the 'yippee' forum for young people and uses the 'Wellbeing Monkey' to communicate issues to young people. OH NHS FT has an 'Article 12' group, which is active and articulate in its provision of views. However the sharing of this learning to the Board and response back out to the young people continues to require development and a dedication from professionals. The County Council's engagement team are co-ordinating efforts across the children's partnership to do this 2016/17. A young person expressed it as a need to have a *'go-to place'* for young people to air and share their views with professionals. It was important that this could be online, face to face or in fora.

Neglect pilot: working to support better outcomes for children on Child Protection Plans for neglect.

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

Youth Parliament and Oxfordshire Youth Voice

After many years of having young people elected onto the UK Youth Parliament, with limited local young people involvement, our focus has turned to local issues and hearing the voices of local children and young people, before re-engaging back into the national agenda. In partnership with organisations of the Children's Trust, Voluntary Sector, District Councils, TVP, Oxford University Hospitals, CCG, Fire Service, etc. and with the support of the British Youth Council, the county council aims to create a more powerful, vibrant voice for young people who would like to be heard by the people who make decisions empowering them to have influence over the decisions that affect their lives. A 'virtual group' of children and young people will exist alongside the main group to reach out to those unable to attend meetings.

There would be clear outcomes from each meeting and accountabilities to take forward issues mentioned. Senior Officers would be expected to attend meetings and feedback to children and young people about what has happened as a result of feedback from previous meetings. The Childrens Trust would monitor the effectiveness of the Oxfordshire Youth Voice and the impact on its implementation, against the Children's Plan priorities, which would be its driver.

Following a concern of a UKYP Member of Parliament, whose campaign was to keep children and young people safe, a Sounding Board was held to discuss the experiences and views of young people on the issue of safeguarding in order to inform the work of the Oxfordshire Safeguarding Childrens Board. 28 young people spoke about their views on safeguarding and risky issues. The young people were aged between 11 - 23 years old, were from Oxfordshire Early Intervention Hubs, members of Oxfordshire Youth Parliament and the Children in Care Council and included young people with disabilities and those from ethnic minority groups.

Key areas were identified by the young people: fear of speaking up; feeling safe at home; boundaries and safe relationships; mental health and suicide and drugs.

Children in Care Council:

The Children in Care Council (CiCC) are a productive and engaging forum for young people in Oxfordshire. Meetings are chaired and organised by the young people themselves, with support from the Engagement and Participation team.

The reasons for young people going missing have been a regular theme discussed at the Children in Care Council (CiCC) over the last three years. The information is now frequently used in both missing and multi-agency risk assessments and management training to help practitioners think through the issues and will be annually updated to check whether new themes are emerging. Most critically, the young people were emphatic that a return interview should be undertaken by a trusted individual rather than someone independent. This should take place within the 72 hour window to maximise their readiness to open up.

They focused on children **knowing** their foster carers and key workers, **feeling wanted**, being able to **air their views** confidently and being properly **prepared for independent living** once they leave foster care. The following themes have emerged from our work with Looked After Children and Care Leavers as critical to improving outcomes for those at risk from going missing:

The **Oxfordshire Pledge** to its Children in Care and Care leavers was updated this year in response to specific concerns the CiCC had raised:

- "We will offer training to our foster carers and residential workers on community and internet risks and creating adverts for new foster carer's.
- We will encourage all Looked After Children to share with their foster carers where they are going and who with. We want children and young people to feel confident to speak out when there is a problem and to know who to speak to".

CiCC have developed a stronger relationship with Independent Reviewing Officers to tackle a number of issues raised in the Children in Care surveys to make being in care a 'better and more constructive experience' for Looked After Children and those leaving care. A new '*Intro Card*' developed so children get to know their IRO's better: "*You know everything about me; I know nothing about you*."

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

In the last year over 160,000 pages of oxme.info were read by over 40,000 visitors. Finding **jobs, training, apprenticeships** and **employment** continues to be by far the biggest concern on the website, accounting for almost half of the visits, and many of the comments and chats. Other pages which have received very high attention this year include **rights at**

different ages, Emergency Hormonal Contraception access, the National Citizen Service, GCSE choices, Youth Justice and the Early Intervention Hubs.

Early Intervention Hubs have been a focus of attention this year, linked to worries about services losing funding and closing down. This comment from a young woman in Didcot is an example: "*We were looking at how many Youth Clubs were actually being funded after looking for sometime we relised that the two that were there and down to one after closing down caused to not being able to find the funderings. All we want is somewhere to sit and hang out thats warm and safe, maybe a hall that is unlocked at all times that has electricity and heating with a bit of a garden or some chairs*."

Sustained interest, chats and comments were also seen on Bullying, Care Plans and Reviews Raising the Participation Age, and Sexual Health issues including access to condoms, the Safety C Cards, consent, safer sex and other enquiries.

Sexting project – views of young people

10 Focus groups about sexting were carried out with 99 young people aged 13 & 14 in single sex group across Oxfordshire. Key findings were that this is a concern for most young people. Many have seen explicit image and are aware of the risks involved, in terms of personal reputation, future prospects and also personal impact e.g. bullying, self-harm, low self-esteem. Knowledge of the law is inaccurate. There are gender differences with young women feeling in a 'no win' situation. Both boys and girls are affected by peer pressure, expectations and this is sometimes coercive. Young people felt current education isn't effective and isn't changing their behaviour. Recommendations included confidential, single-sex, relationships education delivered by those other than school staff.

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

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

Summary of compliments and of children's statutory Social Care Complaints 2015-16

34 formal compliments were received about Children's Services. The compliments were very encouraging and told Children's Social Care that people felt that there are good working relationships with parents and that work is child focused and proactive. They were also told that professionals go over and above to ensure that young people are supported, that there is a talent for engaging with parents and young people and that calls are returned promptly and efficiently.

84 Stage One children's social care statutory complaints in comparison with 104 received in 2014-15. This is a 19% decrease. The majority of complaints were about children looked after an a small proportion were statutory complaints related to the MASH.

8 of the complaints received were directly from young people. This is a reduction in the 13 received last year. Three of these young people received the support of an advocate.

3. Impact of work to date

Below are examples of 'positive impact' as reported to the Performance, audit and quality assurance subgroup following the scrutiny of safeguarding practice over the last 12 months.

1. '**Multi-agency risk assessment and management plans'**(MARAMP) training is being rolled out to County Council 'Edge of Care' services and partners in health and Thames Valley Police. The number of MARAMPs in place increased to 300 in 2015/16.

2. With respect to **child sexual exploitation** there has been a clear shift in the culture of organisations across Oxfordshire in attitudes to information sharing and joint planning for children. Examples included clear communication and planning between sexual health services and the Early Intervention Service to address concerns that the child has not acted on advice from the sexual health services. There was evidence that GPs are receiving information about the involvement of other agencies and are clear about the concerns and the support in place.

3. One of the GP surgeries involved in **child sexual exploitation** audit work has amended their internal safeguarding processes to ensure there is a forum for discussing and planning for vulnerable children.

4. There has been a change in professionals' attitude and understanding of victims of **child sexual exploitation**. There are examples of sexual health services spending time with children, exploring issues of consent and giving them time to talk about their home life and the support they are receiving. Evidence on Police files shows a recognition that these children are seen as vulnerable and that they may need to be dealt with in a different way.

5. The audit of the **child sexual exploitation screening tool** has led to a revised, much simpler version of the tool for professionals.

6. The '**consent**' audit has led to changes in the level 3 safeguarding children training at OUH NHS FT to include scenarios related to child sexual exploitation, young people experiencing domestic abuse and to also include the 'cup of tea' consent to sex video clip. It has also led to a consent workshop for staff working in the JR children adolescent unit.

7. Following an audit of self-harm the OUH NHS FT has updated the paediatric **self-harm** protocol, which incorporates the need for a a multi-professionals meeting in complex cases; an alert system for all looked after children has been added to the electronic patient record to ensure when young people attend A&E it is know that they have additional vulnerabilities and the practitioner needs to communicate with their social worker.

8. OUH NHS FT has produced a leaflet for staff on 'safeguarding adult and children at risk', which provides them with information about: their **roles and responsibilities to safeguard** and understand the vulnerability / categories of abuse; what to do if they are worried and who to contact.

9. OUH NHS FT has started to use the 'childcare development checklist', which is part of the neglect toolkit, as a routine tool for assessing children with diabetes.

10. Quarterly '**Think Family to safeguard'** meetings are held by OH NHS FT. An audit of this work has led to work more closely with adult services to increase the level of participation in child protection conferences – the most recent monitoring information (March 16) highlighted no non-attenders from adult services.

11. Court report guidance for staff employed by Oxford Health NHS FT was updated in July 2015 to reflect the **Think Family** Agenda.

12. Audit work has demonstrated that, in particular in response to the learning from the serious case review on **child sexual exploitation** the National Probation Service (NPS) has implemented the following:
    - PPU staff have all been directed to **attend learning events** and/or access OSCB on-line learning to develop skills/knowledge around this aspect of child sexual abuse.
    - **Case management of offenders** of this nature has been kept within a group of 3 experienced Probation Officers.
    - NPS has commenced a **new model of working** – liaising closely with TVP Major Crimes in respect of these offenders, and their ongoing investigations as many of the offenders will not be subject to MAPPA for some time. This model has also been adopted in Bucks to manage a similar group of offenders there.
    - **Regular checks** with Children's Services and Thames Valley Police PVP Unit and Area Intelligence Teams are undertaken at point of sentence and at regular reviews of the offender assessment.

13. The Community Rehabilitation Company has implemented a programme of change having undertaken an internal audit of safeguarding. As part of this they are developing a more **robust training programme** to ensure that new staff are properly equipped to do their job effectively and pick up on the safeguarding challenges within their work.

14. OSCB partners developed a report card to look at **capacity in the safeguarding system following analysis of data**. This comprehensive analysis has been used to inform the County Council decisions for managing resources and protecting the most vulnerable children and families as financial resources are subject to reductions.

15. An impact of the audit on 'education, health and care plans' has been the written **safeguarding guidance for professional and parents** who use personal budgets and an additional focus on transitions leading to a further check on older children (16-25 ys) for the most vulnerable learning disabled children.

16. The Public Health audit has led the service to **alter its data systems** to enable more effective recording of **safeguarding** related fields and **risk** across the county.

17. The county's Early Intervention Service was able to: demonstrate **a positive impact for those engaged** with the Early intervention service - 93% of 1,280 rated the service as good or very good; evidence the increased use of screening tools and outcome based indicators, such as 'Outcomes Star'.

18. The county's Youth Justice Service Team was able to demonstrate 92.5% of our **substance misuse** interventions have resulted in a reduction of health, social and other problems directly related to drug misuse. The most common substances that they have worked with during the year were Cannabis and Alcohol.

4. Recommended actions for 2016/17 from the summary of themes

- **Learning events and workshops** for children and adult services practitioners should continue throughout 2016/17 focussing themes, such as sexting and online risks, effective inter-agency working to deliver early help, effectiveness of work to address neglect
- **Learning summaries** should continue to be produced for the multi-agency audits and serious case reviews undertaken in 2016/17 and be available to all professionals and public on the OSCB website.
- OSCB to work with partners and members to ensure schools provide learning about taking risks or '**risky behaviours'** education to young people
- Updated **multi-agency tools and guidance** such as the Threshold of Needs Matrix and the Common Assessment Framework
- The MARAMP tool to be further embedded across children's services where possible to ensure joint approach to planning and **risk assessment**
- Public Health Oxfordshire to update the **suicide risk reduction** strategy and action plan and report back to the Board 2016/17
- OSCB to focus on **voluntary and community service engagement** and involvement in the subgroups and board and improve accessibility of training, understanding of prevent and early help
- **Safeguarding audit work** should target transition for young people and domestic abuse
- OSCB to adapt the new safeguarding self-assessment for commissioners and reinforce the completion of the practitioner questions
- OSCB (via the PAQA Subgroup) to **analyse** high number of young people in care who had previously been subject to child protection planning
- The OSCB needs to constructively **share the learning of 'why'** from case reviews e.g. what was the story of the child, what happened, why did it happen, what can I do differently

- OSCB to continue to seek views and **input from children and families** to direct learning events, training and learning resources for practitioners.
- Practitioners need to acknowledge the importance of including parents, and especially **male family members**, wherever appropriate throughout safeguarding and child protection processes
- Support the **Oxfordshire Pledge for young people with the Corporate Parenting Panel and the Children in Care Council**, in ensuring the delivery of actions and support by member organisations
- Increase local knowledge on **cyber bullying** and **social media pressures** on young people and how to support them

5. Glossary

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