Oxfordshire Safeguarding Children Board

Annual Report

2012 - 2013

April 2013

Contents

Introduction by the Independent Chair

This is my fourth annual report as the Independent Chair of the Oxfordshire Safeguarding Children Board (OSCB). I am able to report on a year of action, consolidating the work begun in 2011/12. OSCB partner agencies have done much to improve understanding of common problems affecting parents and carers and their impact on family life. Progress has also been made in terms of tackling child sexual abuse through the creation of a new team and the implementation of a strategy, procedures and training. There has been robust challenge to local safeguarding systems and increased accountability through agency peer review, four multi agency audits and the reporting of single agency audit work. These developments are down to the commitment and drive of local professionals. I would like to thank all those involved in the work of the Board and its subgroups, which remain so keenly focussed on the need to safeguard children in Oxfordshire.

Section 1: Purpose of this report

'Working together to safeguard children' (2013) sets out the requirement for Local Safeguarding Children Boards to produce an annual report with an analysis of the effectiveness of local safeguarding arrangements. This report aims to address this requirement by outlining what has been done and assessing how well it has been done for year ending 31 March 2013.

Sections two and three set out the structure of our local safeguarding board, the current priorities and functions. Sections four and five provide an update on progress made against the priorities and functions. Challenges for the Board, its members and its partners are picked out at key points throughout the text. The final section provides conclusions as to how effective safeguarding arrangements are and what needs to be done next.

Section 2: Safeguarding in context

This report covers the financial year 2012/13 which provided a backdrop of change and re-structure. Nationally the safeguarding guidelines of 'Working Together' were published at year-end, which have strengthened the LSCBs remit as a framework for local learning and improvement. The Department for Education published a new national safeguarding framework, which extended performance reporting on safeguarding to encompass a wider group of people and a wider definition of harm. The All Party Parliamentary Grouping inquiry in to children who go missing from home or care was published. The focus on child sexual exploitation increased as reports were issued from the DfE and the Office of the Children's Commissioner for England. These were amongst some of the national developments which shaped our work.

Locally the shadow Health and Wellbeing Board, which was established by the Health and Social Care Act 2012, began to operate. The serious case review workload increased. The numbers of children needing support through child protection plans also increased due to the plans lasting a longer amount of time. The need to determine common thresholds for support and check compliance remained. New themes have emerged, such as the increased number of children presenting with a complex set of needs as well as issues in relation to suicides.

Member agencies have continued to make financial contributions to the OSCB budget which has ensured the delivery of an improved multi-agency training programme and business plan. The OSCB will be using the learning themes from case reviews and audits, the local contextual and performance data as well as the assessment of this annual report to set the agenda for the next two years in the new business plan.

Section 3: About the Board

What the Oxfordshire Safeguarding Children Board is:

The role of the Oxfordshire Safeguarding Children Board is to safeguard and promote the welfare of children in Oxfordshire and to ensure that local agencies co-operate and work well to achieve this. Its core objectives are set out in law, in Section 14 (1) of the Childrens Act 2004.

What the Oxfordshire Safeguarding Children Board's priorities are:

The Board provides strategic direction and challenge across the relevant local agencies in Oxfordshire. Following the 2011/12 annual report the OSCB redefined its priorities to 2014 to include:

1. Improving understanding of parental risk factors
2. Developing work on child sexual abuse
3. Developing performance information to promote improvement and accountability
4. Monitoring and challenging agencies' self-assessment of safeguarding arrangements

What the Oxfordshire Safeguarding Children Board does:

These priorities sit alongside the general business of the Board. For this financial year we were guided by 'Working together to safeguard children' (2010), which set out the key functions of a local safeguarding board. In practical terms this meant the following:

a. Learning from Serious Case Reviews
b. Learning and development through training
c. Quality assurance, monitoring and evaluating
d. Safeguarding policies and procedures
e. Communicating and raising awareness of safeguarding arrangements
f. Review of all child deaths in Oxfordshire

In order to deliver this core business the Board has 34 members, two of which are lay-members (see appendix 1) who meet on a quarterly basis (see appendix 2). The Board also has a clear structure to support its wide-ranging business (see appendix 3).

In 2012/13 the new Health and Wellbeing Board began to operate. As an overarching body it promotes greater integration of health and local government services and sets the joint strategic aims for children and young people. The Children and Young People's Partnership Board (CYPPB) is the forum for driving them forward. The OSCB is primarily concerned with the Board's strategic aim to keep children and young people safe. Over the course of the year work has been undertaken to ensure that the local Health and Wellbeing Board structure and priorities are linked with those of the Safeguarding Children Board. The OSCB would however challenge *the pace of development of the performance management arrangements* of the CYPPB. This has been raised as an issue through the quality assurance subgroup and the OSCB cautions that *this needs further work in 2013/14 to operate effectively.*

Section 4: Progress made against the Oxfordshire Safeguarding Children Board's five priorities in 2011/12

Priority 1: Improving understanding of parental risk factors and the impact on the wellbeing of children and young people

Why?

Domestic abuse, substance misuse and poor mental health are identified parental risk factors. The combination of these factors has been highlighted as a recurring theme in serious case reviews. We know that they can be common problems affecting parents and carers and can provide extra challenges to family life. The Board set the priority of improving professional awareness and understanding of these issues and the risks that they present to children. This priority overlaps with work of the Oxfordshire Safeguarding Vulnerable Adults Board, which aims to improve responses for vulnerable victims of domestic abuse.

What did we do and what was the impact?

In 2012/13 the OSCB set about testing local systems to find out how effectively we are working to safeguard children where there are parental risk factors. A series of three multi-agency audits showed good commitment from the workforce, dedicated social workers and the positive impact of the child protection planning system. They also highlighted some common themes for learning across all agencies: undue professional optimism in response to parental behaviour; parent hostility keeping professionals at bay; failure to involve men / fathers as potentially protective influences; the challenges of planning and managing risk when a number of agencies are involved; ensuring the voice of the child is heard over the needs of the parents.

The audit on joint agency working with fathers and male care givers highlighted that, where low level domestic abuse was present, workers needed more support to know how and when to effectively involve fathers in the planning of care for their children. The parental substance misuse audit led by the Drug and Alcohol Action Team (DAAT) highlighted the need for improved understanding and co-operation between substance misuse services and other partners in the safeguarding system. The audit on cases where neglect was a factor identified highlighted the need to promote the local tool for recording and measuring neglect in order to evidence concern.

These themes for continued learning are counterbalanced by some very positive steps forward. The 'Think Family' programme has continued to raise awareness of safeguarding amongst adult and community services staff in order to make the connection between the parents' difficulties and the impact that these have on their capacity to keep children safe from potential harm. Examples include the continued work by Adult mental health services at Oxford Health NHS Foundation Trust which led to Oxfordshire's work being cited as an example of good practice in an Ofsted Thematic Inspection; a Think Family training session and prompt cards which were disseminated for professionals at Oxford University Hospitals; a training DVD for GPs on domestic abuse and the impact on children developed by designated professionals from the Clinical Commissioning Group (CCG).

Multi agency work to tackle domestic abuse is led by the Children's Domestic Abuse Strategy Group. The focus in 2012/13 was to consolidate work begun in the previous year. Achievements included 37 new domestic abuse champions from schools and children's settings; training to promote 'early help' provided through the new early intervention services as well as enhanced training for social workers developed in partnership with Co-ordinate Action Against Domestic Abuse. The group is now in the process of developing a means to map and evaluate the work to tackle domestic abuse in Oxfordshire.

The DAAT and local providers have worked together to produce a pathway for managing safeguarding children information. This will improve recording and sharing of information to highlight potential risks to children when working with their parents. The DAAT and local providers have also agreed to vary their standard contracts to include specific safeguarding children clauses and responsibilities.

On-going issues and next steps:

Improving understanding of parental risk factors remains a safeguarding theme. Whilst progress has been made in our local systems there is room for improvement. Interagency audits have highlighted that child and adult services need to better exploit what they can offer each other and challenge each other to address the needs of the whole family. We will seek better strategic co-ordination with the Safeguarding Vulnerable Adults Board on this work as appropriate. They also indicated that a strategic challenge remains to promote usage of the neglect tool. The information indicated that this was an obvious area for improvement that could generate a lot of positive outcomes. These themes will be incorporated in to the Learning and Improvement Framework.

Priority 2: Developing work on child sexual abuse

The Board set out this priority to tackle two elements of child sexual abuse in Oxfordshire: child sexual exploitation and intra-familial abuse.

Why?

Oxfordshire, like many other areas of the country, has identified an issue of children being abused through child sexual exploitation (CSE). As a result there has been a major inter-agency focus on the development of inter-agency procedures, training and a tool kit to recognise and assess child sexual exploitation.

What did we do and what was the impact?:

Having set the foundations in the preceding year, OSCB partner agencies made great progress in tackling this problem in 2012/13. Work has been wide ranging and directed by a multi-agency strategy and action plan, which connects to single agency plans such as that from Thames Valley Police. The strategy is supported by the identification of a CSE lead within each partner agency. The scoping of the problem has accompanied the establishment of a new dataset to map and monitor information across the county - this links to one of the Health and Wellbeing Board targets. Together this has created a strong and co-ordinated network of colleagues across the county.

A multi-agency child sexual exploitation training programme and briefing sessions have been developed in partnership with Oxford City Council. They have been running bi-monthly and have been targeted at agencies such as children's homes, hubs and Thames Valley Police. This is supported by the production of a Professionals Handbook and procedures for working together, largely driven by the efforts of Oxfordshire County Council.

The OSCB Annual Conference in 2012 was on child sexual exploitation. It was attended by approximately 300 local professionals and included presentations by survivors of this abuse, parents and carers, a colleague from the National Working Group on CSE and an Oxfordshire MP who cares passionately about this issue. The conference provoked a powerful response from local professionals. Feedback included, "It must rate as one of the best conferences I've ever been to – and it will stay with me for a very long time. You managed a balance between intensely emotional presentations; purposeful thinking about ways we are / plan to address CSE in Oxfordshire…" Young people contributed to the event. The conference was preceded by a workshop with young people involved in the Children in Care Council and included a DVD of the young people offering their view point. The conference had a direct impact on work within Oxfordshire. It led to the commitment to health involvement within the Kingfisher team outlined below and the commitment to resource forty performances of "Chelsea's Choice" outlined below. It was powerful in its ability to turn heads and raise awareness across the County in a very short period of time.

A significant development has been the investment by local agencies in the new interagency team "Kingfisher" comprising police, nurse, social workers. The team works alongside the statutory agencies as well as community organisations such as Donnington Doorstep. The team's work covers four strands: Prevention, Disruption, Protection and Prosecution. Children missing from care as well as children placed out of county are now monitored by the team. In spring Kingfisher supported a massive awareness raising campaign in secondary schools, taking the play "Chelsea's Choice" to over 10,000 pupils in the county. They talked to teachers about the screening tool for making referrals and distributed new leaflets for children and parents to better understand this issue. The OSCB is grateful to pupils at Banbury Academy who did a 'test run' of the performance and gave use their views on who should see the performance.

Oxfordshire agencies have moved to address this problem. Thames Valley Police (TVP) has invested additional resources, staff and money into safeguarding children in the TVP Child Abuse Investigation Units. Designated professionals from the Clinical Commissioning Group have co-ordinated specialised training and work with the sexual health clinic (Genitourinary medicine clinic) in relation to child sexual exploitation. These are just a few examples.

Audit and case review work over the year has also improved the OSCB's understanding of the links between neglect and intra-familial sexual abuse as well as neglect and child sexual exploitation. This was noted as a persistent vulnerability factor both in parents and children. A new means of providing better co-ordinated therapeutic support for those children who have suffered sexual abuse was endorsed by the OSCB in June 2012. This was developed by a multi-agency working group comprising Oxford Health, Oxford University Hospitals, Children's Social Care, Education & Early intervention, the voluntary organisation: SAFE! It set out the pathway of care from generalist to specialist support. This will be reviewed and reported back to the OSCB.

On-going issues and next steps:

This remains one of the safeguarding risks identified by the OSCB. The work is led through the Child sexual exploitation subgroup of the OSCB and outlined in its action plan. This group steers the work of the Kingfisher Team and a review of that team will be undertaken in 2013/14. A key aspect of the child sexual exploitation action plan is the mapping of prevalence within Oxfordshire and a targeted disruption plan in relation to how to address these matters robustly, effectively and promptly. The challenge now is to embed the use of the screening tool and to ensure that associated issues such as e-safety and substance misuse are addressed and that related procedures on sexually active under 18 year olds, children placed out of county, children missing from home or care are up-to-date and adhered to. Information and learning will be shared with the Safeguarding Vulnerable Adults Board as appropriate.

Priority 3: Developing performance information to promote improvement and accountability

Why?

The OSCB recognises the importance of scrutiny and sharing performance information across agencies. Through our subgroup working on quality assurance and audit we commission audits to look at frontline inter-agency working; we receive feedback from individual agencies on their safeguarding audits; we review the range of data produced by agencies to see if there are key messages to take on board; in addition we track the implementation of actions set out in serious case reviews, which state where agencies could learn some lessons and better safeguard children.

We also monitor the three Health and Wellbeing Board targets:

1. A regular pattern of quality assurance audits is undertaken and reviewed through Oxfordshire Safeguarding Children Board covering the following agencies: children's social care; youth offending service; education service; children and adult health; early intervention service; Thames Valley Police. Over 50% of these audits will show a positive overall impact (baseline to be confirmed in 2012/13).
2. No more than 15% of children who become subject to a child protection plan have previously had a plan
3. The establishment of child sexual exploitationbaseline data

What did we do and what was the impact?

The OSCB business team and partner agencies co-ordinated four **multi-agency audits**. These independent audits required agencies to consider how well they work together to support: (1) fathers or male care-givers when we are working with a child; (2) families where neglect has been identified as a risk factor; (3) adults who are parents, where substance misuse has been identified as a risk factor (4) looked after children with specific vulnerabilities.

A programme of **single agency audit** reporting was established to learn how well safeguarding is assessed across the county. This will address the first Health and Wellbeing Board target above and needs further work.

Performance information, summarised in appendix 4, has been monitored. The data on child protection plans presents new concerns. The second Health and Wellbeing Board target to reduce the number of repeat child protection plans has been met. However there has been an increase in the number of children with plans as a result of children staying on plans for longer. Monitoring the attendance and engagement of agencies in child protection planning is now essential but this detailed information is not yet available to the Board. This shortfall should be addressed with urgency.

In June 2012 the Department for Education published the new national safeguarding framework. This extended performance reporting to encompass a wider group of people and a wider definition of harm. This information indicates that Oxfordshire is the 13th lowest in the country on the measure of children in need achieving **any** GCSE's. This is a safeguarding risk and a challenge to the Children and Young People's Board. It also raises concerns regarding the attendance of children and the use of fixed term exclusions, which impacts on engagement in learning.

Actions from case reviews have been monitored. During this time one serious case review was signed off as having completed its recommended actions. See section 5 for more detail.

The comprehensive set of audits alongside the information from complaints, collated views of young people and case reviews has led the QAA Subgroup to inform that Board of the following.

We have identified that we have:

- Good processes managed in a timely manner
- Clear single agency plans
- Dedicated professionals who worked hard to accommodate families' needs and support them well
- Professionals delivering to the best of their ability despite heavy and stressful workloads
- Good communication between agencies
- Strong relationships between agencies

We have learnt that agencies within the OSCB need to improve these processes:

- Care planning that produces fully integrated plans rather than a series of single agency plans
- Performance information that shows which agencies provide sustained engagement in child protection plans
- Agreeing contingency plans and managing risk when a number of agencies are involved
- Using information productively to inform good decision making
- Co-ordinating efforts for more complex cases and increasing challenge especially for children who are looked after and have additional vulnerabilities
- Maximising the knowledge that we hold as a group of children and adults' agencies to the benefit of children and young people
- Holding partners to account and increasing challenge

We have drawn out these key safeguarding themes

- **Neglect** - a strategic push is needed to encourage and monitor better usage of the neglect tool. It is effective when it is used but this set of information has indicated that it is not embedded in common practice.

- **Working with fathers and male care givers** – a more analytical understanding of the roles of father and male care givers in protection and risk factors is necessary. The information indicated that there was a lack of visibility of this group in the work undertaken with families and that it was a common cause of complaint to Children, Education and Families at OCC. It also acknowledged that fathers/male care givers in many of these cases were challenging and at best ambivalent parents to engage.

- **Parental risk factors** – child and adult services need to better exploit what they can offer each other and challenge each other to address the needs of the whole family. The information indicated that this was an obvious area for improvement that could generate a lot of positive outcomes

- **Sexual abuse** – this was noted as persistent vulnerability factor both in parents and children and there were links between neglect and intra-familial sexual abuse, and neglect and child sexual exploitation.

- **Developing resilience and supporting the needs of complex young people** – better integrated planning is necessary to work with the more complex cases, *especially when the young person is in care*. A long view of the young person and their family is necessary for all partners, including education partners, to understand their contribution and the difference that they can make at critical points in the development of these young people's lives.

- **Self-harm and suicide** – more national benchmarking from the 'Child Death Review Process' would enable colleagues to understand more about the issues being seen in Oxfordshire. The OSCB needs more research and evidence to determine what action to take.

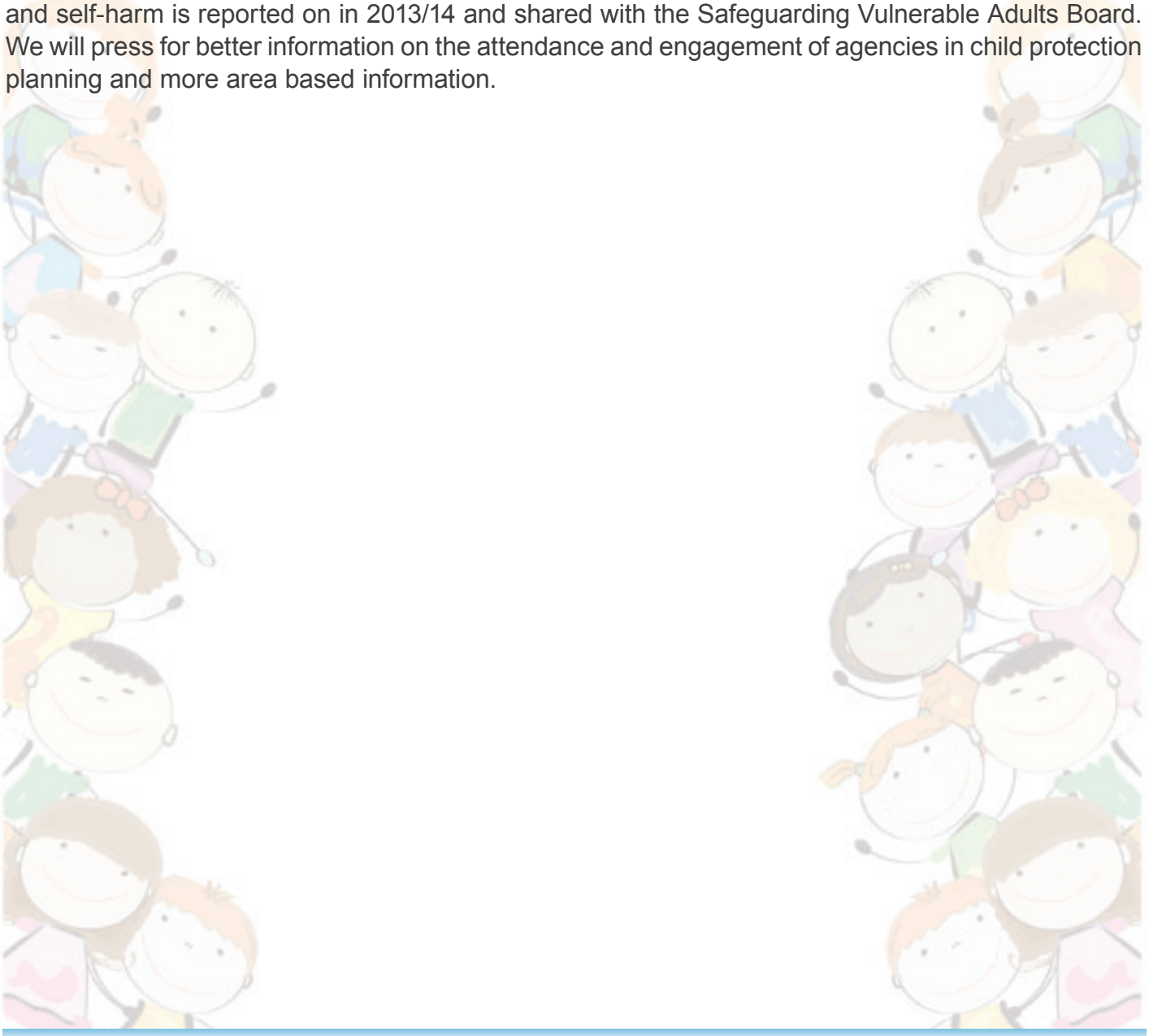
- **Maximising the life chances of the most vulnerable children through education** – measures need to be put in place to ensure that children are consistently engaged in school life and that the most vulnerable learners are achieving. In particular, looked after children, children subject to a child protection plan and children in need should be targeted for help.

On-going issues and next steps:

Independent and robust challenge of the local system is a priority. We require the Children and Young People's Board to take a stronger lead in its responsibility for overall performance monitoring across the partnership. We draw their attention to the themes which emerge from our quality assurance work, which should form a basis for actions within the county's Children's Plan.

The above themes will be fed in to the OSCB business planning process as safeguarding risks.

Board members will be encouraged to promote and encourage the use of the complex case panel to support a co-ordinated approach to complex cases. The Board will ensure that research on suicides and self-harm is reported on in 2013/14 and shared with the Safeguarding Vulnerable Adults Board. We will press for better information on the attendance and engagement of agencies in child protection planning and more area based information.



Priority 4: Developing performance information to promote improvement and accountability

Why?

An important function of the OSCB is to evaluate and challenge what is done by Board partners individually to safeguard and promote the welfare of children, and advise them on ways to improve. We call this the 'Section 11 safeguarding audit'.

What did we do and what was the impact?

In 2012/13 all required agencies completed a Section 11 safeguarding audit. These included Thames Valley Police, Probation services, the County Council, the District Councils as well as Oxford Health, Oxford University Hospitals and the Primary Care Trust.

A positive development was the peer review of agencies' self-assessments. Each agency was able to review and compare their safeguarding standards and challenge returns made by others. It not only provided the opportunity for scrutiny but for building relations. Board members shared ideas for good ways of working and in many cases improved their return as a result. Board members such as the Fire and Rescue Service reported back confidence in being able to compare their position against others.

The review showed that agencies rated themselves as having good managerial commitment, effective information sharing arrangements and good complaints and allegations procedures. It also highlighted that there were areas for improvement such as safer recruitment practice and training .

District Councils highlighted the particular disjoint that they have from other settings where they do not necessarily provide services directly to children and young people but may contract these services out to others e.g. leisure services. This has highlighted the need for a better standard approach to contractors and safeguarding requirements of commissioned work.

In response to this year's review the OSCB Team is developing bespoke safeguarding training for senior managers in District Councils and briefing material for Councillors.

On-going issues and next steps:

The OSCB is committed to improving this process and is developing an online return. The OSCB would like a broader picture of safeguarding self-assessments in Oxfordshire e.g. those completed by local schools and commissioners. The OSCB aims to include safeguarding themes from the quality assurance work i.e. audits and case reviews in to the return and peer review next year to see how well learning is embedded.

Section 5: The business of the Board in 2012/13

The Board oversees a vast range of business to fulfil its statutory functions, which are outlined in section three. Here is an overview of work that has been undertaken within Oxfordshire to safeguard children against these six functions.

a. Learning from case reviews

In 2012/13 the OSCB undertook two types of case review: the serious case review and the partnership review.

A serious case review is required by government when a child or young person has been seriously harmed as a result of abuse, and a number of different organisations have been involved. The case must meet the criteria as set out in Chapter 8 of Working Together 2010.

A partnership review is undertaken when the OSCB Chair determines that the criteria set out in Chapter 8 has not been met but the case is sufficiently serious enough to warrant an in-depth review and draw out interagency learning. As with a Serious Case Review, all agencies involved in a family's life are involved in the review process and an overview author produces a report of the involvement.

In both cases a report is produced with recommendations and action plans for change detailing the improvements that can be made and the lessons that can be learnt. The final reports are published in due course and are anonymised to ensure no individual child or family can be identified.

What did we do?

At year end one serious case review remains ongoing, two new serious case reviews were initiated and one was completed. The ongoing case review has two emerging themes for interagency learning (1) related to improving professional awareness and understanding of mental health issues in parents and the risks that they present to children and (2) having clear means of escalating concerns and challenging decisions when agencies are working together. Over 40 different single agency actions have been implemented as a result.

Two new serious case reviews are underway and will incorporate learning events as appropriate so that opportunities are seized to make improvements as soon as they are identified.

Information on the completed case review is available on the OSCB website. It had nine significant recommendations which have already been put in to place. The learning concerned:

Practice boundaries: Workers need to ensure that separate but co-ordinated care is provided to a parent and child. This is really important when the parent is looked after, leaving care or receiving substantial support through social services

Quality of assessments: Managers should check that consistantly high standards exist for assessments within their agencies.

Effectiveness of core groups: Managers should ensure that these multi-agency groups develop and implement effective child protection plans. They should monitor progress, improve co-ordination across agencies and challenge where this is not working well.

- Support for fathers / male care givers- involving them in assessments and planning and training workers to do this better

Lessons learnt from the review were shared with local practitioners through the Area Sub Groups. The quality assurance audit work has also focused on these findings. For example there was a multi agency audit on working with fathers and new multi-agency training is being developed on working with young men.

Actions are monitored by the Quality Assurance and Audit subgroup on a quarterly basis. Any concerns or outstanding matters are fed through to the Executive where agencies are held to account to deliver their recommendations. The resulting changes are checked through the multi-agency audits on joint working as demonstrated in this report.

On-going issues and next steps

As a matter of priority the OSCB will be developing a Learning and Improvement Framework in line with Working Together 2013. This will encompass all types of learning from the serious case review through to audit work.

The OSCB Executive has determined to maintain a closer oversight of the learning from case reviews by ensuring recommendations with 'SMART' objectives and clear leads. Thematic learning from case reviews will be analysed and reported on to ensure that training, inter agency procedures and practice effectively reflect any learning.

b. Learning and development through training

What did we do?

Organisation:

The OSCB delivers a range of high quality courses which are overseen by a training subgroup. The group has oversight of course topics, content, quality, attendance and development. In 2012/13 three new courses on Child Sexual Exploitation, E-safety, Harmful Sexual Behaviour were scheduled to reflect our business priorities. They all form part of the 'Risky Behaviours' programme sponsored through Oxford County Council. The Harmful Sexual Behaviours training is run through a partnership with Oxford Health NHS Foundation Trust. Courses were amended to include learning from serious case reviews and partnership reviews e.g. domestic abuse training was updated to ensure that the cycle of abuse and reconciliation is adequately reflected and that an understanding of reactions to abuse are included.

Delivery:

The OSCB's training is run through a highly valued team of 'volunteer trainers' who are trained to deliver OSCB courses and commit to providing 3 sessions per year. 2012/13 saw an increase of 14 new trainers who undertook 'train the trainer' courses in order to work with the OSCB.

Courses:

The OSCB is in its third year of delivering an online introductory course on safeguarding. For the year 2012/13 **2648** members of the workforce undertook this training. This is an increase of approximately 42% on the previous year, when **1857** colleagues passed the online course.

The OSCB runs three core courses: Generalist Safeguarding; Specialist Safeguarding and Specialist Safeguarding Refresher Course. These courses received the most take up. Year on year the demand for these courses has increased and there is now a very healthy update by colleagues in the County Council. There is less take up by the Fire Service, Youth Offending Service and the Police.

In 2012/13 the OSCB also ran a series of courses aimed at raising awareness amongst the workforce with respect to domestic abuse, sexual abuse, and substance misuse and parenting in line with our business priority. In summary the greatest take up of these courses was amongst colleagues wanting to better understand parental risk factors with respect to substance misuse. 37 new 'domestic abuse champions' were trained for local schools. They form a network of approximately 800 champions across 165 agencies in the county of the OSCB multi-agency training - this does not however reflect the single agency training led by these agencies.

The OSCB courses are all provided free of charge. As non-attendance also incurs a cost for the Board the attendance as well as non-attendance is closely monitored. Across the course of the year and across all agencies there was 11% non-attendance, which was a better figure than the previous year.

How well did we do it?

In 2012/13 over 5000 members of the children's workforce were trained through the OSCB. This has increased from a figure of 300 per year in 2008. Over 90% of delegates attending generalist safeguarding training rated it as either 'good or excellent' in helping to understand their role in inter-agency working. All the OSCB core courses have received good feedback overall and are in line with feedback from previous years. Improved pre-course arrangements have been a focus following feedback from delegates and a new learning management system has been agreed for 2013/14. The new Risky Behaviours programme has received positive comments such as "Great training and very friendly trainers. I liked the atmosphere as it made it very easy to contribute and ask questions."

On-going issues and next steps

The new training plan for 2013/14 includes:

- Increase in the range of training available online supported by a robust communications strategy – up to ten new courses to be introduced in 2013/14
- Improved method for monitoring single agency safeguarding training
- Support and working arrangements for OSCB trainers
- Creation of a training network to capture agencies outside of the Board

In 2013/14 Board partners such as the Fire and Rescue Service are also keen to engage with the Risky Behaviours programme, like Oxford Health has done in 2012/13, in order to deliver educational programmes to young people making use of the Oxfordshire Fire and Rescue Safety Centre.

c. Quality assurance, monitoring and evaluating

The OSCB evaluates and challenges safeguarding arrangements. Much of this work has already been outlined in priority four of section four. In addition, the OSCB has a statutory duty to receive reports on allegations made against paid or voluntary staff and a responsibility to maintain an oversight of private fostering within Oxfordshire. Here is a summary of work in the year in question:

For the academic year Sept 11- July 12 there was an increase in referrals to the Local Authority Designated Officer (LADO) reflecting a greater awareness of this role and in some cases improved monitoring and recording by agencies. Noticeable trends are an increase in the primary school allegations; referrals from parents and carers and Special Schools including Independent Special Schools. Another noted increase in 'Transport' allegations is due to the change in CRB disclosure requirements which has revealed cautions that were previously unknown; this includes new CRB applications and 3 year renewals. There is improved monitoring of cautions and conviction within integrated transport and as a result the LADO service is being involved at an earlier stage for risk assessment purposes.

The majority of allegations are resolved within one month and where the cases have exceeded a three month time period they tend to involve either ICT related crime or individuals are potentially facing court hearings.

During the 2011-2012 academic year 87 audits have been undertaken in schools covering all sectors through independent and special. The purpose has been to support and improve safeguarding practice in schools and check that they meet Ofsted expectations. Since starting this work in 2009 no audited school has been identified as having concerns about safeguarding or gone into a category for safeguarding.

Considerable effort has been made to identify privately fostered children and young people within Oxfordshire. In 2012/13 there were 69 notifications of new private fostering arrangements. Notifications have increased particularly in relation to language school students, many of whom have previously been 'hidden'. However, it is younger children that are likely to remain the most under reported in line with the national picture. The number of children privately fostered from Africa continues to decline and numbers from Europe and Asia are increasing. The greatest numbers are still from the UK and 91% are 10-16 years.

In 2012/13 the majority of referrals came from language schools. Eleven referrals came from parents or carers which is an increase and may indicate that awareness of the need to notify the local authority of private fostering arrangements may be increasing. There was only one referral from the Police and none from the Young Offending Service. Attempts have been made to raise awareness with these agencies but with little response as yet.

There was an improvement in the timeliness of assessments of privately fostered children (x% within 7 days) and of statutory visits to where they live (x%). The Private fostering role moved in to the Fostering Team in March 2013. An Audit has been undertaken of records, guidance and standard letters have been updated. A service review in January 2013 reported comments from young people such as, "I am able to talk to someone alone if I have any problems or concerns. I feel like I always have someone to call if anything is wrong and the social worker is very helpful".

d. Safeguarding policies and procedures

In 2012/13 the countywide safeguarding procedures have undergone two scheduled updates. The online procedures manual is at *www.oscb.org.uk*. This has been managed through an inter-agency group. Notably the new child sexual exploitation procedures were added in the Autumn. A range of related procedures were being drafted at year end. The OSCB needs greater commitment from member agencies to make these procedures an effective tool for practitioners. Members need to tie this work into internal safeguarding management systems and to ensure that staff members are directed towards this practical means of 'knowing what to do when'.

e. Communicating and raising awareness of safeguarding arrangements

Area Safeguarding Groups

Three Area Safeguarding Groups across the county bringing together practitioners and team managers to look at local safeguarding arrangements. Colleagues attend from local schools, probation service, the Armed Forces, the police, early intervention hubs and different health services. They are a good forum for sharing information, learning lessons from recent case reviews and audits and communicating issues from practitioners to management and vice versa.

The Health Advisory Group

This group brings together the named, designated and other lead safeguarding health professionals for Oxfordshire. It meets every 3 months and discusses issues from interagency working, training, and safer recruitment through to case audits targeting specific areas such maternity services or short studies on cases where concerns have been raised. The group is an effective means of updating and sharing better practice across health professionals, and highlighting and escalating issues to other agencies.

The Disabled Children's Subgroup

This group was set up in 2012 and has good representation from all partner agencies. The group has produced a briefing paper *'Key learning re safeguarding disabled children'* which summarises the learning from thematic Ofsted reports and local and national SCRs relating to disabled children and young people. This will be used as part of the OSCB disability safeguarding training workshops. The group has also developed guidance notes for workers caring for disabled young people who are placed in out of area residential placements. An audit has been undertaken on records of some of disabled children placed in residential schools for more than 44 weeks a year to review the effectiveness of the information sharing across agencies. The group is promoting the use of the Child Development Checklist to assess concerns about neglect in relation to disabled children. It has also proposed some improvements. The subgroup has begun to scope the systemic difficulties which make disabled young people particularly vulnerable to poor safeguarding outcomes at times of transition from familiar Children's Services to Adult Service support.

f. Incorporating the views of young people in to our work

In September 2012 the Children in Care Council discussed the topic of child sexual exploitation and children going missing specifically to feed the messages back to the OSCB and inform the Annual Conference. Key messages included training for workers and parents in particular foster carers ; support from people who understood, who had been in care; support at schools if you do going missing; somewhere safe to run to; somewhere safe to call. They said, "There is a reason behind some behaviour. You need to look beneath and behind behaviour to see what is going on".

They also talked about advocacy. Young people said that they would like to see a profile of their potential carers before they move, to know what the house rules are, meal times, etc. They felt that they should be given a pack like foster carers are that identifies their rights and who they can talk to e.g. an advocate or a designated teacher in school – this pack needs to be kept updated.

We were grateful to the involvement of young people in the Conference and thank them for the short films that they produced for the workshop on child sexual exploitation and children in care.

The challenge now is to ensure that the findings from all Board members' engagement with young people is recorded and reported at Board meetings. The Board would benefit from receiving more information and understanding how inter-agency work might be delivered better, from the perspective of young people.

g. Review all child deaths in Oxfordshire

Since 2008, Local Safeguarding Boards have had a statutory duty to review all deaths of children aged 0-18 years. This is reiterated in in chapter of Working Together 2013. There are two aspects to the process

1. Responding to and reviewing an unexpected death
2. Responding to and reviewing an expected death

The purpose of the Child Death Review Process and Rapid Response is to ensure that procedures are in place to provide a coordinated response by the Oxfordshire Safeguarding Children's Board (OSCB), their board members and all other relevant agencies to a child's death. The process also ensures that robust procedures are in place or established for families and the wider community to be supported and informed within the Child Death Review Process.

The Child Death Overview Panel (CDOP) has a fixed core membership with other agencies being co-opted as necessary. Representatives of the CDOP are of sufficient seniority to contribute to informed analysis of cases, and speak for and influence their own agency's responses.

In 2012/13 97 deaths were reported to the Oxfordshire CDOP. Of these cases:

- 43 were children normally resident in Oxfordshire. 16 of these were unexpected.
- 54 were children normally resident in other areas. 6 of these were unexpected deaths and required a response from the Oxfordshire rapid response service.

The rapid response service is now well established in Oxfordshire and assists in gathering as much information as possible in a timely, systematic yet sensitive manner to inform our understanding of why the child has died, and to support the family through the early stages of shock, grief and also the process.

In the year 2011/12 the CDOP made the following recommendation:

"To raise awareness of parents to safe sleeping practices with infants through public campaigns and consistent professional advice."

As a result the following activities have been undertaken:

- 15 training sessions have been delivered to health and social care services.
- Every GP surgery in Oxfordshire has been sent safe-sleep advice posters and leaflets to display in waiting rooms and post-natal clinics.
- The safe sleep message will be expanded out to family centres and midwifery units across the region in 2013/14.

In addition from June 2013 every child born in Oxfordshire will receive a bedroom door hanger with a thermometer indicating safe sleep temperatures and general safe-sleep advice.

In 2012/13 no deaths were reported where co-sleeping was a factor.

Following the child deaths reviewed at the CDOP in 2012/13 the CDOP annual report will make further recommendations to the Board with regard to the following themes:

- Troubled adolescents with a complex range of needs as well as suicide amongst adolescents
- Ensuring information on the dangers of Air Rifles and BB Guns is appropriately available for children and young people.
- Improved understanding of the rapid response process in Oxfordshire, ensuring a co-ordinated response at the earliest point.

Section 6: Summary and looking ahead

The Independent Chair's concluding comments

As Independent Chair of the Board I believe this report provides a helpful reflection on how effectively safeguarding work has been undertaken across the county.

We have provided a simple snapshot in the tables below with an assessment of effectiveness.

I would like to pick out a few points which have struck me as significant. These include the learning on parental risk factors which was derived through three multi-agency audits. The OSCB 2012 Annual conference, which was felt by many to be one of the "best ever" and played a crucial role in raising awareness. The multi-agency training on Child Sexual Exploitation, which was developed by committed local practitioners alongside a professional's handbook and procedures. The robust challenge to local systems through interagency audit and review work, which has been constructive and led to engagement of senior management teams in addressing emerging themes e.g. in the care of looked after children with specific vulnerabilities and children with a complex set of needs. Finally the 5000 members of the children's workforce, which were trained through the OSCB, compared to 300 per year in 2008.

There is no doubt that challenges remain in terms of the development of a learning and improvement Framework to ensure that the Board builds on its ambition to ensure that all it does leads to better practice, agency wide use of procedures and co-ordinated inter-agency working with children , young people and their families. In order to do this we need to develop the Board's way of working, develop our challenge and scrutiny role within the structural arrangements of the Health and Wellbeing Board. We also need to improve our accessibility to professionals, children and young people and the public e.g. better website, better online learning, better online assessment of safeguarding standards for local agencies.

We must ensure that the message from young people with regards to training and information for foster carers on child sexual exploitation is taken on board and we will ask for feedback from Children's Social Care on the idea of a profile of their potential carers.

The information within this report provides a good basis on which we can plan ahead. For example we will follow up the challenges identified, specifically holding the Children and Young People's Partnership to account for improvement to performance monitoring and accountability for wider outcomes for children. The revised set of priorities, incorporating the key safeguarding themes, will be outlined in the OSCB business plan for 2013/15. Finally it gives me the opportunity to thank my fellow Board members for their leadership in ensuring that safeguarding children remains a top priority for their organisations. I have been impressed by the range of activities that have been undertaken.

Andrea Hickman

Independent Chair

Oxfordshire Safeguarding Children Board

Summary of work undertaken against the four priorities set out in the Business plan for 2012/13:

Priority 1 : Improving understanding of parental risk factors

Summary	Assessment
• 37 new domestic abuse champions trained for schools in Oxfordshire • Independent multi-agency audit reviewed work with families where there are concerns of neglect • Multi-agency audit to test how well agencies work with fathers and male care givers • The DAAT undertook a multi-agency audit on how well young people are safeguarded where parents are misusing substances • The DAAT worked with providers to develop a means of tracking and sharing safeguarding information to clarify the responsibility of providers in highlighting risk and reporting concerns manage risks for • Designated professionals from the Clinical Commissioning Group developed training DVD for identification, referral and management of domestic abuse including the impact on children which was sent to all GP practices and partners agencies • Designated professionals from the Clinical Commissioning Group encouraged the midwifery service to establish and then improve communication about 'health and social assessment of all pregnancies in order to detect high risk pregnancies • Oxford University Hospitals completed a 'Think family training session and distributed prompt cards for teams and professionals • Oxford University Hospitals' 'safeguarding snapshot audit' evidenced improved knowledge • Oxford University Hospitals reported increased and improved referral and consultation in relation to family factors influencing childcare and welfare • Oxford Health NHS Foundation Trust extended Level Three safeguarding training to all registered staff working in adult community health and substance misuse • Oxford Health NHS Foundation Trust increased awareness of Threshold of Needs Matrix and neglect tool amongst its staff through training	Good progress made in terms of scrutinising interagency work but this remains a priority for the OSCB and a challenge for agencies working with families. More work is required to embed the 'tools' that have been launched.

Priority 2: Developing work on child sexual abuse

Summary	Assessment
• OSCB Annual Conference on child sexual exploitation attended by approx. 300 local professionals which included the National Working • Kingfisher - new interagency team comprising police, nurse, social workers set up to tackle this problem • Interagency procedures to be clear on common approach to child sexual exploitation and other related concerns led by Oxfordshire County Council through the OSCB • CSE Strategy and Action Plan led by Oxfordshire County Council through the OSCB • Professional's handbook on child sexual exploitation led by Oxfordshire County Council through the OSCB • Screening tool launched for practitioners worried about young people • OSCB interagency training programme launched to develop professional knowledge with significant input from Oxford City Council • Oxford City Council seconded a worker to work on this agenda through the auspices of the OSCB • Local services identified and listed in the professionals' handbook • Chelsea's Choice awareness raising performance rolled out at 40 venues across the county to over 10,000 young people • Three awareness raising leaflets launched for parents; children in general; children for whom there are concerns • The OSCB area safeguarding groups have played a key role promoting and encouraging the use of the screening tool • Designated professionals from the Clinical Commissioning Group co-ordinated specialised training and work with the GUM clinic in relation to child sexual exploitation. • Thames Valley Police developed CSE action plan using CEOP template • Thames Valley Police Invested additional resources, staff and money, into safeguarding children in Thames Valley Police Child Abuse Investigation Units • Thames Valley Police implemented awareness raising and training programme for CSE • Thames Valley Police Chief officer oversight and central supervision of all CSE investigations • Oxfordshire County Council worked with Thames Valley Police and the voluntary sector to gather information and so identify this as a CSE network • Oxfordshire County Council worked with schools to consider the exclusion policies and better information sharing.	Good progress made in terms of setting out a robust strategic response to this issue. This remains a high safeguarding priority. More work required to ensure focus on intra-familial abuse too.

Priority 3: Developing performance information to promote improvement and accountability

Summary	Assessment
• Multi-agency audit to review inter-agency work with families where there are concerns of neglect with Oxford Health NHS Foundation Trust, the County Council, and Children's Centres • Multi-agency audit to test how well agencies work with fathers and male care givers • Multi-agency audits to review how young people are safeguarded where parents are misusing substances • Multi-agency audits to test how well we safeguard looked after children with specific vulnerabilities • Single agency reporting on safeguarding audit work implemented • Increased scrutiny of data to monitor interagency engagement in child protection work • Tracking of interagency actions and learning from three serious case reviews and one partnership Review • OSCB monitoring and analysis of safeguarding performance data • Designated professionals from the Clinical Commissioning Group undertook an audit of all GP practices and evidenced that nearly 80% of GP practices have all appropriate safeguarding procedures in place • The CCG designated nurse and doctor initiated a review with respect to four babies which had non-accidental injuries • Children's social care has improved the accuracy and timeliness of reporting on the private fostering arrangements • Children's Social Care has undertaken an audit of private fostering records • District Councils e.g. Cherwell District, building safeguarding in to the Annual Service Planning Process • The Public Health Sexual Health Commissioning service undertook a needs assessment to use data to inform future commissioning and improve performance and accountability of service providers in targeting work effectively • Oxford University Hospitals set up a data set that enables the Safeguarding Team to monitor and assess activity and effectiveness • Oxford University Hospitals included knowledge of activity and performance within divisional reports • Oxford University Hospitals has developed a clear audit plan with safeguarding health checks for colleagues • Midwifery Teams at Oxford University Hospitals are completing a health and social scoring in all booking appointments and assessing need for women with the safeguarding lead to improve information to support vulnerable families	Good challenge to agencies safeguarding work and positive steps in developing single agency reporting. Learning must now be embedded in actions. More challenge needed to ensure that learning from serious case reviews is effectively tracked and taken on board. More detail required on the single agency safeguarding reporting.

Priority 4: Monitoring and challenging agencies' self-assessment of safeguarding arrangements

Summary	Assessment
• Section 11 safeguarding self-assessment of eighteen local agencies with members reporting 'benefit derived from clearer reporting lines derived through the process' • Half day peer review of safeguarding self-assessments by Board members for increased scrutiny. Board members such as the Fire and Rescue Service reported back confidence in being able to compare their position amongst others. Challenges were highlighted as safer recruitment, new training for senior managers in District Councils with a safeguarding remit, better and briefing of Councillors. • Designated professionals from the Clinical Commissioning Group challenged a new disability provider to identify named doctor and nurse and to ensure that they link with other Oxon safeguarding health professionals • The County Council's Education and Early Intervention Service developed a safeguarding audit for 'satisfactory ' and 'inadequate' EYFS settings; they also undertook 150 case file audits in Early intervention which included a check on internal safeguarding practice • The County Council's Education and Early Intervention Service developed a safeguarding audit for the Special Educational Needs Support Service which is already leading to improvements in practice; this service also developed a (restricted access) incident tracking form to ensure that pre-safeguarding concerns are noted and not missed • The DAAT developed a new self-assessment tool for drug and alcohol services to ensure that they are meeting key standards i.e. safeguarding policies and recording information • The DAAT amended standard contracts with providers to include safeguarding responsibilities • The Disabled Children's Subgroup, led by Oxfordshire County Council, developed guidance for placing and monitoring disabled children in external placements, which will be used as standard against which to audit practice in 2013/14	The Peer Review has led to improved accountability and understanding of safeguarding roles and responsibilities. Challenges are identified and improvements in 2013/14 will be to develop an online return and further develop the peer review.

Appendix 1: Membership 2011/12

Modupe Adefala	Lay Member
Clare Edwards	Lay Member
Sally Thomas	Service Manager, Cafcass Oxford
Dr. Clare Robertson	Designated Child Protection Doctor, Oxford University Hospitals
Romy Briant	Voluntary Sector representative
Alison Chapman	Lead Nurse Safeguarding Children, Oxford University Hospitals NHS Trust
Jane Bell	Oxfordshire Designated Child Protection Nurse/ Safeguarding, Clinical commissioning Group
Christine Etheridge	NHS South of England, Strategic Health Authority
Kate Riddle	Trust Lead Nurse Safeguarding Children Oxford Health NHS Foundation Trust
Liz Shaw	Joint Head of Children and Families' Community Services, Oxford Health NHS Foundation Trust
Sula Wiltshire	Director of Nursing and Clinical Standards
Elaine Strachan-Hall	Children Young People and Maternity Lead, Oxford Health NHS Foundation Trust
Sally Truman	Shared Policy and Partnerships Manager, South Oxfordshire and Vale of White Horse District Councils
Val Johnson	Partnership Development Manager, Oxford City Council
Stephen Czajewski	Director of Oxfordshire's Probation Service
Di Batchelor	Deputy Principal - Abingdon & Witney Further Education College
Cllr Melinda Tilley	Councillor and Lead Member for Children & Families, Oxfordshire County Council
Jim Leivers	Director for Children Education and Families, Oxfordshire County Council
John Dixon	Director for Social & Community Services (adults), Oxfordshire County Council
Peter Clark	Monitoring Officer and Head of Law & Governance, Oxfordshire County Council
Amrik Panaser	Head of Youth Offending Service, Oxfordshire County Council
Hannah Farncombe	Safeguarding Manager - Children, Education & Families, Oxfordshire County Council
Penny Browne	Area Social Care Manager Central Area, Oxfordshire County Council
Tan Lea	Early Intervention Manager (Central) Oxfordshire County Council
Chris Rothwell	Head of Community Services, Cherwell and South Northants District Council
Diana Shelton	Head of Leisure and Tourism, West Oxfordshire District Council
Christian Bunt	Oxford LPA Commander, Thames Valley Police
Stuart Garner	Home and Community Safety Manager, Fire & Rescue Service Headquarters
Jo Melling	Director - Oxfordshire Drugs and Alcohol Action Team

Lay members:

Modupe Adefala

Modupe is Manager of Religious Affairs at Campsfield House, co-ordinating faith activities for Christians, Buddhists, Muslims, Hindus and Sikhs. Modupe is committed to bringing into focus issues that affect children, young people and families from the 'hard to reach' and migrant communities. She is an advocate for the training of those who lead and work with children and youths at the grassroots especially faith and community groups.

What she said about 2012/13:

Modupe said that in 2012/13 she has been committed to bringing a fresh pair of eyes to the Board. As a lay person "I try to understand how everything fits together and challenge where safeguarding issues aren't kept simple and clear".

Clare Edwards

Clare is a health professional currently working as Director of Clinical Services and Deputy CEO for Helen and Douglas House. She regards part of her role as ensuring that the language and the style that the board adopts is accessible to all. She is also keen to see whether learning has been maximized in an efficient way and whether we can do more to safeguard children.

What she said about 2012/13:

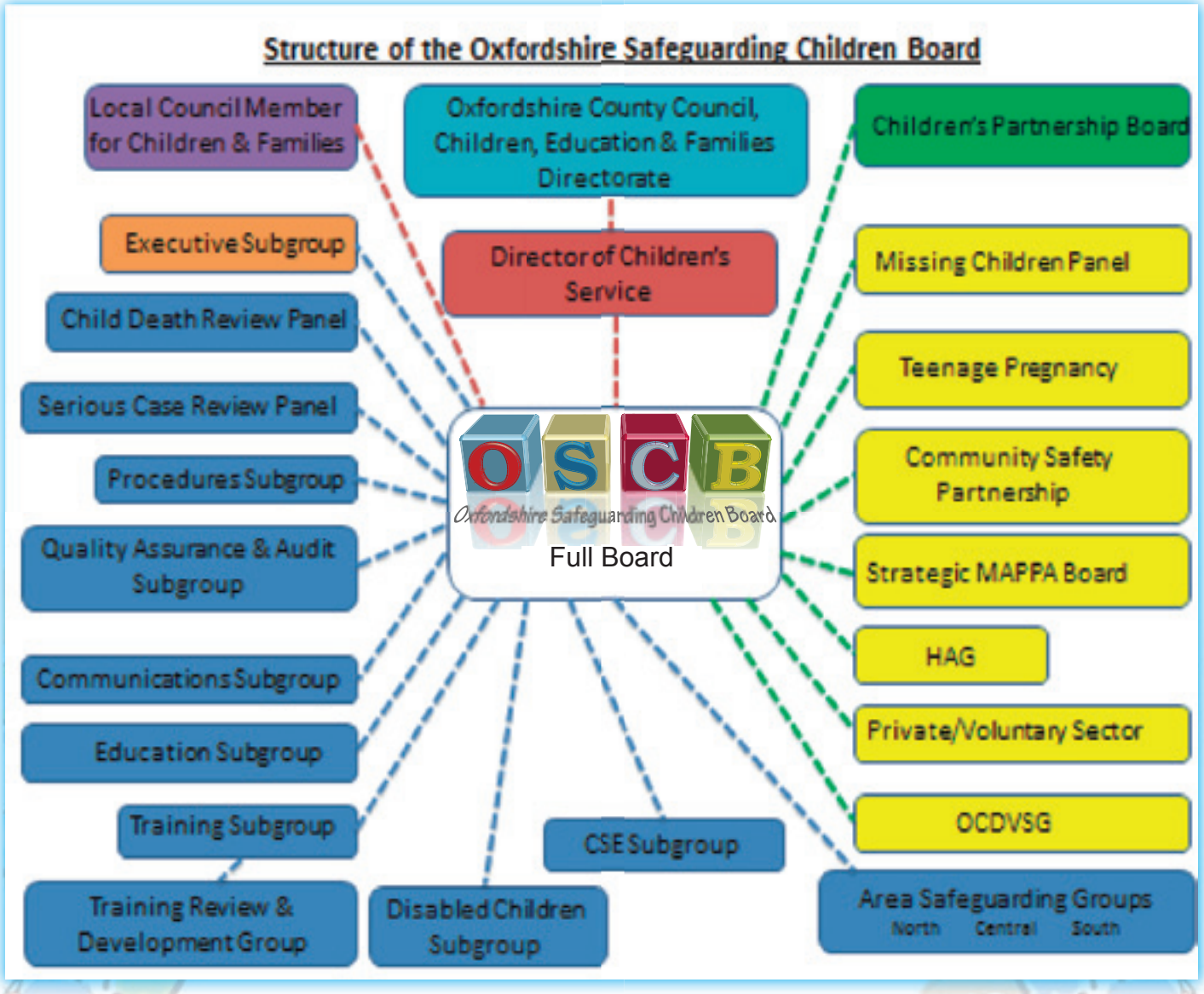
Clare said that, "In terms of the effectiveness of the board, I think over the last year I have seen greater collaboration between agencies and a fundamental desire to learn from working together and from cases. My feeling is that there is a real desire from board members to keep children in Oxfordshire safe".

Appendix 2: Attendance at Board meetings 2012/13

(1) Attendance summary by agency (please see the glossary for abbreviations)

Agency					
Councillor for Children, Young People and Families	Yes	Yes	No	No	50%
Children, Education and Families, Director	No	No	No	Yes	25%
Probation Services Director	Yes	No	Yes	Yes	75%
Primary Care Trust Lead	Yes	Yes	Yes	Yes	100%
Children Social Care Services, Safeguarding Manager, Oxfordshire County Council	Yes	Yes	Yes	Yes	100%
Youth Offending Service, Manager, Oxfordshire County Council	Yes	Yes	Yes	No	75%
Oxford University Hospitals Lead	Yes	Yes	Yes	Yes	100%
Oxfordshire Community Development and Voluntary Sector representative	Yes	Yes	Yes	Yes	100%
CAFCASS Area Manager	Yes	Yes	No	No	50%
Head of Legal Services, Oxfordshire County Council	Yes	Yes	Yes	Yes	100%
Education and Early Intervention Service Manager, Oxfordshire County Council	Yes	Yes	Yes	Yes	100%
Oxford Health NHS Foundation Trust	Yes	Yes	Yes	Yes	100%
Thames Valley Police Lead	Yes	Yes	Yes	Yes	100%
Fire & Rescue Service Lead	Yes	No	No	Yes	50%
District Council Representation	Yes	Yes	Yes	Yes	100%
Drug & Alcohol Team Lead	Yes	Yes	Yes	Yes	100%
Adult Services Manager, Oxfordshire County Council	Yes	Yes	No	No	50%

Appendix 3: Structure in 2012/13



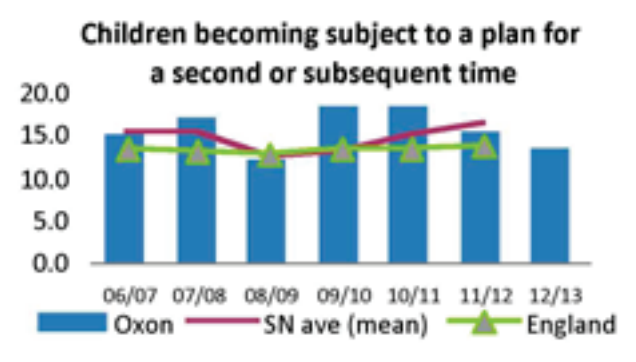
Appendix 4: Safeguarding Performance Summary 2012/13

Last year three concerns were highlighted to the OSCB:

1. Children becoming subject to repeat child protection plans
2. A continued growth of children subject to a plan, where nationally the figure was stabilising
3. Activity levels increasing across at key points across the pathway which are higher than the national average

Children becoming subject to a repeat child protection plan.

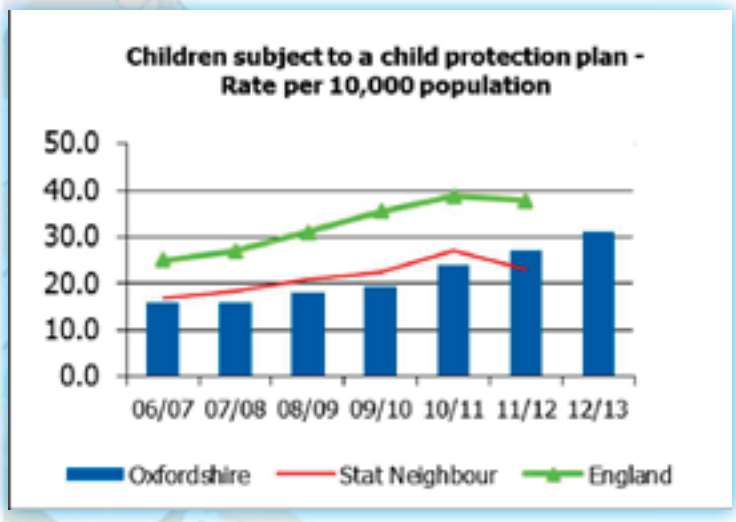
Oxfordshire has consistently had more children becoming subject to repeat plans than either the national average or that of statistical neighbours. A Health and Wellbeing Board target was set to reduce this to less than 15% in 2012/13. The target has been met and exceeded. We now have fewer repeat plans than both the national average and statistical neighbours' average.



A growth of children subject to a child protection plan, where nationally the figure is stabilising.

The number of children on plans in Oxfordshire is higher than we would expect based on our demography and is growing quicker than elsewhere. The table below shows the percentage change in children subject to plans at the end of March - which is also shown graphically below.

England from 2011 to 2012	-2.2%
Oxfordshire from 2011 to 2012	+10%
Oxfordshire from 2012 to 2013	**+18%**



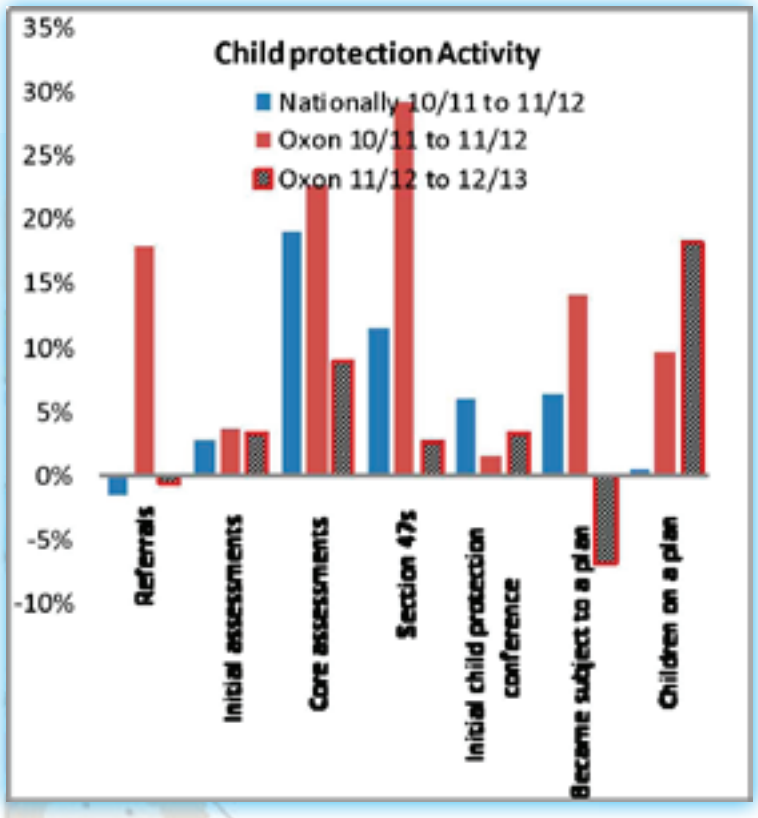
The increase in numbers relates to fewer people coming off a plan than in previous years. Paradoxically there were fewer people placed on a plan in 2012/13 than in the previous year. 'Front door' demand is therefore reduced but children are staying on plans for longer.

In 2011/12 477 people became the subject of a plan in Oxfordshire and in 2012/13 this dropped to 444 (a drop of 7%). At the same time 364 people ceased being on a plan this year compared with 444 the previous year (a drop of 18%)

Activity levels increasing at key points across the child protection process greater than the national average.

Last year the concern was raised that activity levels were higher than expected within the safeguarding system and were growing more quickly than elsewhere.

The following table shows activity levels in Oxfordshire for 2012/13 compared with those in 2011/12 for Oxfordshire and nationally. Although there has been increased activity at most points in the process (except referrals and people becoming subject to a plan), **overall activity has grown less than in previous years**, which is pleasing. However the concern as raised above is the growth of children on plans, caused by children staying on plans for longer.



Reviewing the 2012/13 Dataset

There are no significant performance concerns raised in the Safeguarding dataset. When children are believed to be at risk they are assessed quickly. Where they are the subject of a Child Protection Plan they are reviewed within statutory timescales.

	National (11/12)	Oxon (11/12)	Oxon (12/13)
% initials assessments < 10 days	77%	90%	90%
% of core assessments < 35 days	76%	81%	82%
% of ICPC within 15 days	73%	78%	87%
CP reviews held on time *	96.7%	98.1%	98.8%

*Late CP reviews relate to one family where the mother was admitted to hospital and the review was postponed in the best interests of the family.

The board set 28 local performance measures for 2012/13. Of these only four were not met at year end. The measures where performance was not met were:

- Percentage of child protection conferences where conference record and cp plan are circulated within timescale – taking longer than the target of 10 days
- Percentage of subsequent core groups held on time (within 30 working days) – taking longer than the target of within 30 days
- Rate of core assessments per 10,000 - higher than target and has risen for third year running
- Rate subject to a child protection plan per 10,000 - higher than target and has risen for third year running

New National Safeguarding Framework

In June 2012 the Department for Education published the new national safeguarding framework. This extended performance reporting on safeguarding to encompass a wider group of people and a wider definition of harm.

There are local three issues that need to be considered in light of the new framework

1. Growth of the number of child protection plans
2. A consistent understanding of thresholds between agencies
3. Supporting wider outcomes for children e.g. educational attainment

1. Growth of the number of child protection plans

The issue of the number of children on plans has been discussed above and relates to children staying on plans for longer.

2. A consistent understanding of thresholds between agencies

The new framework asks for OSCBs to understand the pattern of activity in their area and to ensure that there is consistent understanding of thresholds. In 2011/12 Oxfordshire had the 5th highest level of social care referrals which led to no further social care action in the country. This raises questions about whether there is a common understanding of thresholds. The table below shows the progress of referrals through the child protection system

	National (11/12)	Oxon (11/12)	**Oxon (12/13)**
Initial assessments as a % of referrals	74.6%	55.2%	**57.4%**
Core assessments as a % of referrals	36.5%	36.7%	**40.2%**
S47 enquiries as a % of referrals	20.6%	19.2%	**19.8%**
ICPC as a % of referrals	9.3%	7.9%	**7.7%**
Subject to a plan as a % of referrals	8.6%	7.5%	**7.0%**

3. Supporting wider outcomes for children e.g. educational attainment

The first question in the new national framework for safeguarding is around the educational attainment of children in need and emphasises the broader definition of harm.

Although on the two specific measures in the framework (children known to social care who achieve English and maths at KS2 and 5+ A*-C at GCSE) Oxfordshire is average, on the wider measure of children in need achieving any GCSE's we are 13th lowest in the country. In terms of supporting vulnerable people to maximise their life chances, this is clearly a concern for the Board.

Appendix 5 Overview of OSCB expenditure 2012/13

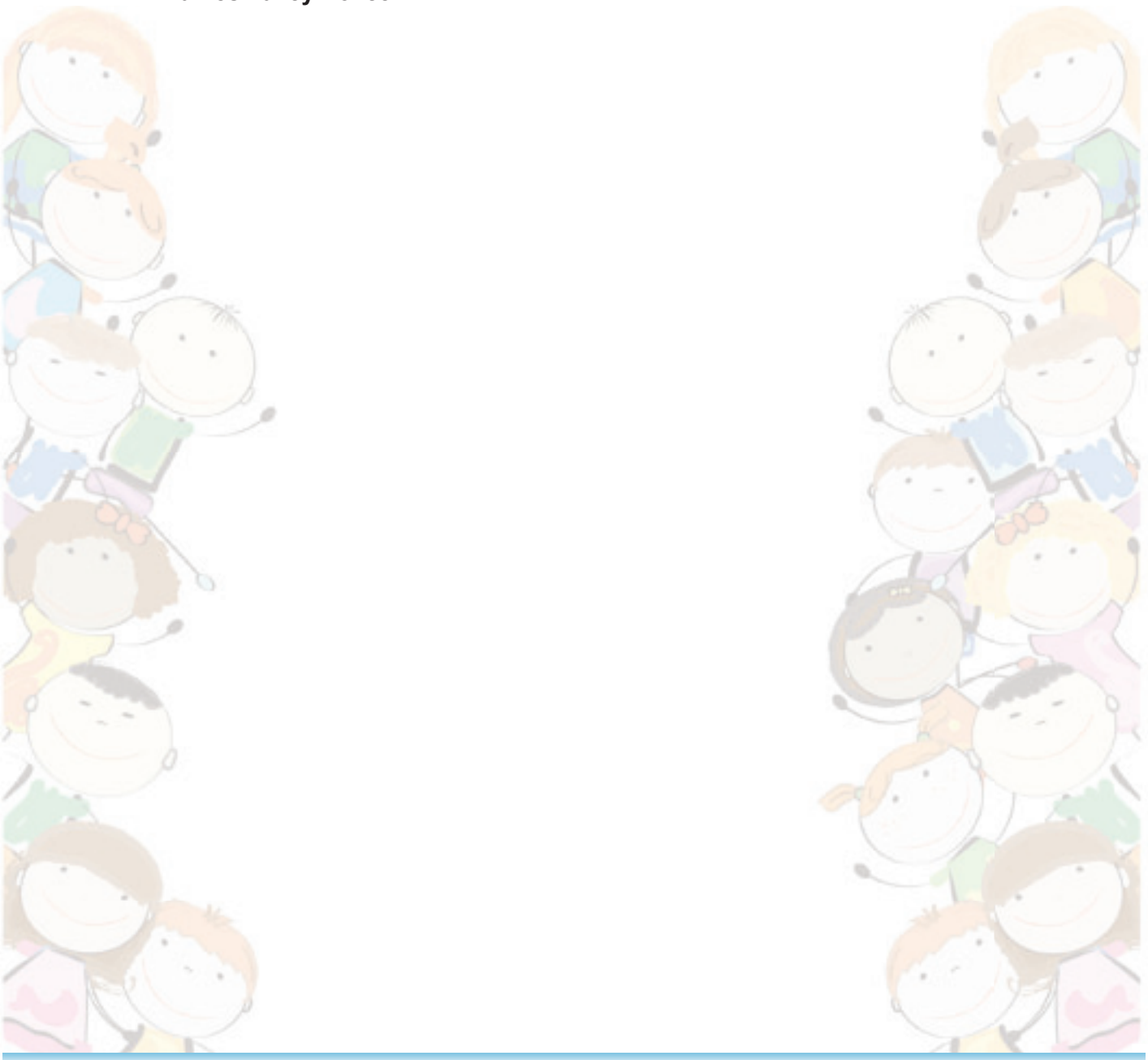
Income and Expenditure analysis and reserves for OSCB 2012/13	**£**
***Reserves balance brought forward from 11/12 excluding CDOP**	**212,593.00**
Income	
Oxford City Council	4,000.00
Oxfordshire Primary Care Trust	60,000.00
West Oxford District Council	2,000.00
Thames Valley Police	16,000.00
Cafcass	500.00
South Oxon DC & Vale Of White Horse DC	4,000.00
Dedicated Schools Grant	64,000.00
Risky Behaviours training	53,450.00
Early Years Safeguarding training	14,465.00
Cherwell District Council	2,500.00
Thames Valley Probation	5,000.00
Threshold Audits	10,000.00
Funding for Anti-bullying event	500.00
Oxfordshire County Council	192,947.00
Total Income received during the year (Not including the reserves 11/12 balance)	**428,862.00**
Expenditure	
• Business Unit (Staff costs only)	228,625.00
• Independent Chair (Andrea Hickman)	22,819.00
• Communications, Training, Case reviews, Subgroup work	84,846.00
Total Expenditure during the year excludes CDOP	**336,290.00**
Surplus + / - deficit for the year	**92,592.00**
Contribution to reserves for 2012/13	92,592.00
****Cumulative balance in reserves excluding CDOP (Opening position for 2013/14)**	**301,165.00**

* The balance includes receipt from Thames Valley Police for 2011/12 although income was not received until 2012/13

**At the OSCB meeting on 07.03.13 the OSCB committed significant funds from the reserves to a three year project to develop a suite of ten online courses, produce an online learning management system,produce a new online section 11 return, improve the OSCB website and appoint two new time limited posts to support training and learning and improvement.

Glossary

CAADA	**Co-ordinated Action Against Domestic Abuse**
CSE	**Child Sexual Exploitation**
CCG	**Clinical Commissioning Group (was PCT)**
DAAT	**The Drug and Alcohol Action Team**
EYFS	**Early Years Foundation Stage**
MARAC	**Multi Agency Risk Assessment Conferences**
MAPPA	**Multi-Agency Public Protection**
PCT	**Primary Care Trust (now CCG)**
TVP	**Thames Valley Police**



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April 2013