OSCB Annual Report 2016 - 2017

Contents

	Annual report introduction by Paul Burnett, Independent Chair of the Board	
Chapter 1	Local safeguarding context	Page: 4
Chapter 2	Governance and accountability arrangements	Page: 13
Chapter 3	Progress made in 2016/17	Page: 20
Chapter 4	What happens when a child dies in Oxfordshire	Page: 38
Chapter 5	Challenges ahead and future priorities	Page: 43
Chapter 6	What next for child protection in Oxfordshire	Page: 44
	Glossary	Page: 45

Annual Report Introduction
By Paul Burnett

I am delighted to present the Oxfordshire Safeguarding Children Board's Annual Report for 2016/17.

The key purpose of the report is to assess the impact of our work in 2016/17 on service quality and effectiveness and on safeguarding outcomes for children and young people in Oxfordshire. Specifically it evaluates our performance against the priorities that we set in our Business Plan for the year and against other statutory functions that the LSCB must undertake.

There is much to celebrate in terms of improvement and achievement such as the service redesign of early help in the context of reduced budgets, the continued drive to tackle child sexual exploitation, the progress made by mental health services to reduce waiting times for children and the work to take on board young people's concerns regarding LGBT issues. It is encouraging to see a new group, "VOXY" representing the voices of young people in Oxfordshire and they are beginning to engage with the work of the OSCB. Our robust quality assurance and performance management has identified priorities for action as we move into 2017/18. These feature in our new Business Plan.

They include:
Providing strong leadership and governance - increasing the effectiveness of the Board, partnership working with the Oxfordshire Safeguarding Adults Board and Community Engagement;
Driving forward practice improvement - working to address neglect and working to safeguard adolescents;
Quality assuring and scrutinising the effectiveness of practice - taking robust action following learning, to secure improvement and to assess risk and capacity across the partnership

A key piece of new legislation will impact on our work next year. The Children & Social Work Act became law in April 2017 and starts the process of implementing recommendations that were made by Alan Wood in his review of LSCBs published last year. As well as setting our frameworks for future local safeguarding arrangements the act also includes proposals for local and national practice learning reviews to replace SCRs and reform of CDOP arrangements.

From an LSCB perspective there will be no immediate impact from the legislation. The expectation is that local plans will be drawn up by April 2018 and agreed for implementation by April 2019.

In Oxfordshire there has been little appetite for major change and a strong belief that we must retain an inclusive Board which enables all partners to have a voice in our overall safeguarding arrangements and direction of travel. However we will need to agree our future arrangements within the next year.

I would like to take this opportunity to thank all Board members and those who have participated in subgroups for their continued commitment in 2016/17. In addition I would like to thank staff from across our partnerships for their motivation, enthusiasm and continued contribution to keeping the children and young people of Oxfordshire safe.

Safeguarding is everyone's business. The achievements set out in this Annual Report have been achieved not just by the Safeguarding Board but by staff working in the agencies that form the partnership. The further improvements we seek to achieve in 2017/18 will require continued commitment from all and I look forward to continuing to work with you next year in ensuring that children and young people in Oxfordshire are safe.
I commend this report to all our partner agencies.

CHAPTER ONE – LOCAL SAFEGUARDING CONTEXT

There are 141,800 young people aged under-18 in Oxfordshire *(mid-2015 estimates)*. This population has grown around 6% in the last ten years mainly in urban areas such as Oxford, Didcot, Witney, Bicester, and Carterton. This chapter of the report sets outs the needs of the most vulnerable children in Oxfordshire in the context of the 'Child's Journey' - ranging from those children needing early help support to those in need of protection and care arising from their family and social circumstances.

Changes to Early Help in Oxfordshire in 2016/17

Early help is the most effective, least intrusive solution to children's needs. Last year the Locality and Community Support Service was created by Oxfordshire County Council as part of the children's services integration programme to support partner agencies across Oxfordshire. It is a professional facing service providing support to the private, community and voluntary sectors. It is the route into Early Help services.

The Locality and Community Support service offers an 'early help assessment', which replaced the 'common assessment framework' (CAF). The service works with partners to identify those families who require additional support from the Early Help Team in the Family Solutions Service, and will facilitate a service from the team.

The Locality and Community Support Service should be contacted when professionals:

- Have emerging concerns for a child that does not require an immediate safeguarding response
- Need support or guidance with an early help assessments or 'team around the family'
- Wish to complete a 'No Names Consultation' to talk through concerns they have for children when there is not an immediate safeguarding concern and where there is no consent from the family.

The Multi-Agency Safeguarding Hub (MASH) remains the front door to Children's Social Care for all child protection and immediate safeguarding concerns.

Impact of these Changes to Early Help:

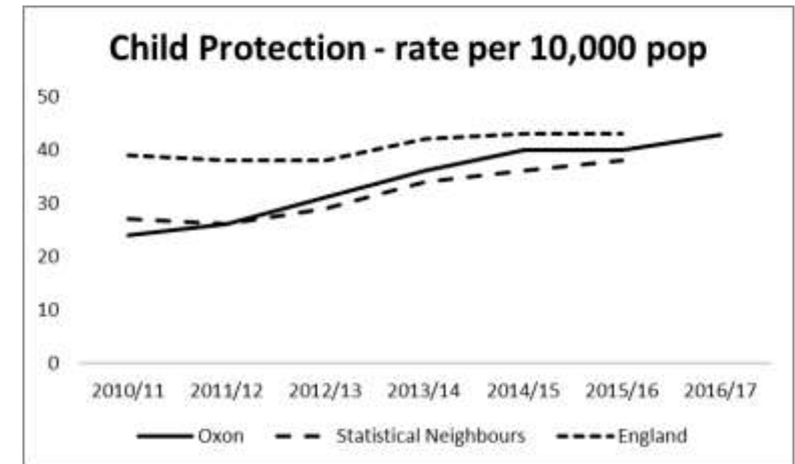
In 2016/17 there were 458 recorded early help assessments which is considerably less than recorded CAFs in the previous year. The number of troubled families worked with rose to 1549 in 2016/17 and remains on target.

The OSCB would want to see the number of early help assessments substantially increase in the coming year. It is assumed that the lower number in 2016/17 is in part due to the uncertainty created by the restructure of services and the introduction of new systems to record data

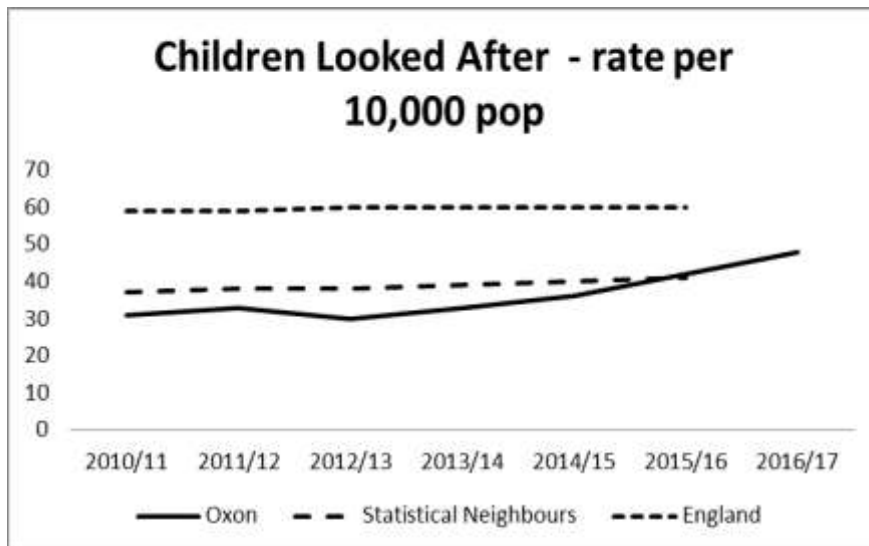
Increasing levels of activity in Child Protection Planning:

The number of children on a child protection plan rose from 569 at the end of 2015/16 to 607 at the end of 2016/17. The rate of growth in the number of children subject to child protection plans is higher than both the national average and the average of similar authorities. In March 2011 there were 38% fewer children subject to a plan than the national average and the figure is now in line with the national average.

Neglect is the most common reason for children becoming subject to child protection plans (67%). This is higher than the national average where the proportion of children subject to child protection plans for the reason of neglect is 45% and higher than the local figure for last year which was 58%.



Graph 1: Child protection rates per 10,000 population



Increasing numbers of Children in Care and the impact on provision:

Children in care are those looked after by the local authority. The number of children in care rose by 14% in the year from 592 to 675. In March 2011 the county had 47% fewer looked after children than the national average - the county currently has 27% fewer.

This increase correlates to the high levels of activity in every part of the social care system including the child protection system and care proceedings. The county's 'Placement Strategy' has been effective in delivering increased edge of care, fostering and residential capacity but has struggled to keep pace with the unforeseen significant increases in demand for placements. With the considerable increase in the number of looked after children, the number of children placed out of county and not in neighbouring authorities has increased from 77 to 118, which, as our children in care have told us is a "second abuse" of moving them away from their support networks.

The OSCB commends the degree of scrutiny and attention to this area of work. It has also noted that the REoC service, which provides intervention to young people on edge of care, has received increasing compliments from service users in the last 12 months. It supports the urgent need to see the number of children in care reducing (safely) as well as the number of children placed out of the county. The OSCB recognises the effort that it is being made to deliver much earlier interventions by working effectively with families through locality and family support.

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

Increasing numbers of children in care who are unaccompanied asylum seekers

The number of unaccompanied asylum seeker children who came into the care of the local authority rose by 38% from 42 to 58. A strategy has been created to enable a countywide response to support these young people.

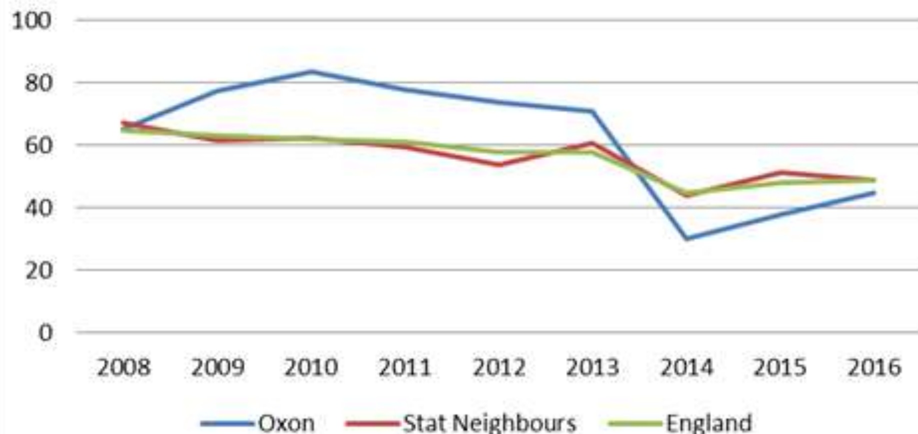
Disabled Children:

At the end of March there were 16 disabled children with a child protection plan, which is in line with previous years.

Children Leaving Care

Between 2014 and 2016 the percentage rate of 19 year old care leavers in education, employment or training was less than both the national figure and that of our statistical neighbours. However, the performance has improved - the proportion in 2016 was 45%, a rise from 30% in 2014. The figure for 2016-17 has yet to be released.

The percentage of care leavers in suitable accommodation in Oxfordshire was also less than the national average and that of our statistical neighbours between 2014 and 2016 despite local improvement reported for 2015-16. Figures for 2016-17 have yet to be published.



Graph 3: & of care leavers in education, employment or training

Children at risk of sexual exploitation (CSE) 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 were 236 CSE screening tools completed in 2016-17 compared with 223 in 2015/16. The OSCB notes the feedback on this service which includes comments that suggest 'without the support of the Kingfisher Team the young person would not have been able to cope or become the person that they are today'.

Prevalence reporting continues to evidence that CSE is an issue across Oxfordshire with varying models of grooming and patterns of offending and some 'hot spot' areas. There is evidence of varying forms of CSE, ranging from peer to peer, older suspect – younger victim, on-line grooming, and offending by groups. The vast majority of cases open to the Kingfisher Team relate to peer on peer offending or older suspect, younger victim. On-line or cyber-enabled offending continues to be a factor, in the main as a means of communication or facilitation of later physical contact offending. There is concern that there is perhaps an under-representation of boys in the victims who have been identified. In addition it has become apparent that children who have learning disabilities, are particularly vulnerable as victims of CSE and that their needs should also be considered in prevention planning.

Children and young people who offend: increase in numbers involved with Youth Justice Service (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. We know from audits that there is added complexity when working across the services with vulnerable children who present behaviours that are a risk, sometimes to the public, and often to themselves. The number of young people offending (receiving a caution or above) rose slightly to 280 in 2016/17 from 246 in the previous 2 years.

The proportion of children receiving a custodial sentence dropped to 4.3% in 2016/17 from 7.1% in 2015/16.

The proportion of children remanded to custody increased to 6.3% from 5.2% in 2015/16.

Children missing from home: consistent reporting of those missing repeatedly:

The number of children who have gone missing from home has fallen in the last year from 817 to 798. The number who went missing three or more times was 148 (compared to 149 last year), meaning the proportion of children who repeatedly went missing from home remained at around 18.5%.

Over the year the OSCB's CSE subgroup has also noted the interrelated safeguarding factors present for those children missing from home, education or care; those at risk of CSE and those being exploited or trafficked in relation to drug running.

Children's attendance at school

The issues of elective home education, persistent absence and permanent exclusions are increasing safeguarding concerns. All of these issues have seen increases in the last 12 months making them a priority for action.

For example, there has been a 21% increase in the numbers of children in elective home education since last year, taking the total to over 450. There is some concern that elective home education may be used as a solution to a difficult situation in school e.g. where the relationship with parents has broken down. The safeguarding concern is that the local authority does not have many statutory powers to assess the quality of education taking place in the home, which in the case of vulnerable children, increases their risk.

Persistent absence increased from 6.7% in 2014/15 to 13.9% in 2015/16. This may be due to the DfE changing the criteria for persistent absence from 15% absence to just 10%, therefore making it easier to become a persistent absentee. However, Oxfordshire still remains higher than the national average. The data tells us that it is the most vulnerable children, those subject to child protection plans or identified as 'children in need', who are most frequently absent.

Permanent exclusions are on an upward trend compared to last year. The ratio of boys to girls is approximately 3:1, and a significant proportion had Education Health and Care Plans at the time of being permanently excluded. Exclusions can have a knock on effect on children as there can be delays as schools try and re-establish the young person back in learning.

Anecdotally the OSCB is hearing messages of concern from practitioners attending safeguarding training. Our trainers have fed back this message.

The challenges that individual schools face trying to keep children in school (learning and safe) are apparent and it is clear that a system led approach is required. The OSCB will want reassurance that senior leaders are addressing this issue in Oxfordshire.

Children who are living with another family (privately fostered): Increase in numbers reported

At the end of March 2017 the local authority were aware of 50 children living in a privately arranged foster placement, compared to 43 at 31 March 2016.

YOUNGMINDS

Children who are at risk of poor mental health

Oxford Health NHS Foundation Trust Child and Adolescent Mental Health Services (CAMHS) continue to receive increasing numbers of referrals of children and young people year on year. This increase follows the national trend.

During 2016/17 6153 children and young people were referred to Oxford CAMHS of which 5371 were accepted as appropriate referrals (87%) and 3362 young people were assessed by CAMHS during this period. 13% of the referrals in this 12 month period were either inappropriate or signposted to alternative provisions. The numbers open to CAMHS continue to increase and there has been a noted intensification in the complexity of children and young people. The open caseload average is 4800 young people at any given time across Oxfordshire.

Overall the average percentage of children and young people who did not attend their appointments was 6.2%. The Tier 3 CAMHS non- attendance figure was 10% with other services at 3%. The national average through CAMHS National Benchmarking is 10%.

CAMHS continue to meet targets for young people who need to be seen urgently or as an emergency. Over the last 12 months the services have worked very hard to decrease the waiting times into CAMHS for routine referrals, performance over 2016/17 is as below:

04/16	**05/16**	**06/16**	**07/16**	**08/16**	**09/16**	**10/16**	**11/16**	**12/16**	**01/17**	**02/17**	**03/17**
32%	30%	29%	30%	41%	47%	39%	64%	70%	69%	73%	68%

The position as at time of writing this update is that services are seeing 71% of all routine referrals within 12 weeks across the county.

The implications of increased workloads on ensuring children are kept safe

The annual "impact assessment" survey of partner agencies, conducted by the Safeguarding Children Board and Safeguarding Adults Board, identified increased activity in the safeguarding system and resultant pressures created the following two recommendations. These were made in the light of increased workloads:

- Both boards require rigorous scrutiny of activity: Each board to review its own arrangements to ensure that the appropriate mechanisms are in place to check that partnership working remains effective and strong in the light of the increased activity, pressure on budgets, and limited pool of workers and levels of organisational changes.

- Workforce Development and Support: The Boards need to be reassured that training and support is robust and that partners are engaged with it, as complexity of cases; expectations and activity levels all increase. As organisations and roles change, more complex cases are held in universal services and more support and training is needed for these services. The workforces needs to know how to work effectively with families experiencing domestic abuse, parental mental health and drug and alcohol issues

What the data is telling us:

- **Early help**. The number of early help assessments was lower than expected. In 2016/17 a new early help system was implemented.
- **School attendance.** Elective home education, persistent absence and permanent exclusions are increasing safeguarding concerns.
- **Numbers of child protection plans.** The rate of growth of children subject to child protection plans is higher than both the national average.
- **Neglect** is the most common reason why children are subject to a plan.
- **Complex set of challenges.** Domestic abuse, parental mental health and drug and alcohol issues are consistent factors in cases of neglect.
- **Numbers of looked after children**. The numbers of children in care and placed out of county was higher than expected.
- **Criminal exploitation of children**. This is an emerging concern.
- **Emotional and mental wellbeing of young people**. Demand for mental health services is high and is increasing. Issues are complex.
- **The system is under pressure**

What practitioners have also told us:

Practitioners in statutory agencies have told us that the increased capacity in the system is leading to a large workload and adding associated risks. They are finding it challenging to support high risk young people: children who self-harm and have mental health concerns.

They state that they are finding it difficult to find appropriate resources for children who are at risk of drug exploitation. They have told us that they are working with families where there are highly complex needs and they need more support working with parents where there are domestic abuse, mental health and substance misuse problems. They have also told us of the complexity involved in working across services with children who presenting behaviours that are a risk to the public and themselves whilst being vulnerable.

What this means going forward for OSCB

- Work needs be to done to ensure that partners in the safeguarding system understand early help and their role in it. The workforce needs to be competent, confident and capable. The OSCB needs to be **assured** that resources are allocated to work at the correct threshold level and that the right level of work passes through children's services for full assessment.
- OSCB partners should **support a co-ordinated and multi-agency response** to neglect by ensuring that the neglect strategy is fully implemented across the county. Parental issues such as substance misuse, mental health problems and domestic abuse are addressed as part of this problem.
- OSCB partners should **improve multi-agency responses** to safeguard vulnerable adolescents in particular where they are (1) transitioning from children to adult services (2) at risk of domestic abuse or peer abuse (3) at risk of criminal exploitation including drug and sexual exploitation (4) not in full time education

Case Study Feature

A day in the life of a Locality Worker….

I am a Locality Worker based in the new Locality Community Support Service (LCSS) in the Central area. There are also teams based in the North and South of the County. We provide advice and support to professional partner agencies and voluntary organisations when there are emerging concerns about a child.

Our work is varied; one of our core pieces of work is the offer of the No Names Consultation. This is a service which enables professionals to talk through a concern they may have for a child when there is not an immediate safeguarding concern. This week I am on duty and undertaking all the No Names Consultations with an additional worker to support during busy periods. We take all No Names Consultation requests from Oxford City and our experience in the first 3 months (March-May) has averaged 76 calls per month. These calls come from a wide range of professionals including schools, health visitors, nurseries, GPs, and drug and alcohol services.

There are times whilst carrying out a No Names Consultation that an immediate safeguarding concern is raised – when this happens, I talk directly to colleagues in the MASH, explain the concern and they will progress as appropriate. The MASH also contacts us when they have deemed an inquiry not to meet the threshold for an assessment. I would then contact the agency who made the referral and offer some advice and support about possible next steps. This could include recommending they complete an Early Help Assessment, or setting up a Team around the Family meeting.

I am the named link worker to the Rose Hill/ Marston area of schools, pre-schools, nurseries and health centres. As part of my role I offer support and advice to professionals around completing Early Help Assessments and conducting TAF meetings, I am able to attend TAF meetings to case map particularly difficult cases or where there has been little progress. It may be that we continue to offer advice, support and guidance for a particular family for a length of time, or it may be just a one off piece of work. Involvement in particular cases will vary depending on the family's circumstances and the support required from the agency. This could also involve liaising with our colleagues in CAFAT if it is identified that no progress is being made with a particular case or there are escalating concerns. Sitting alongside this team means that we are able to have a face to face discussion around the best way forward.

As a team, we receive all the completed Early Help Assessments and TAF minutes. If an Early Help Assessment is received from my area then it is assigned to me as the worker linked with that particular school/agency and it is then reviewed. The review of the EHA ensures that any safeguarding issues that have been raised have been addressed appropriately and to ensure that all the relevant information has been gathered to produce a comprehensive assessment which informs any support that may be required.

CHAPTER TWO: GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

Governance and accountability arrangements

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

Changes to the national framework for safeguarding boards are outlined within the Children and Social Work Act 2017. As well as provision for new local safeguarding arrangements which could replace safeguarding boards; the Act sets out proposals for local and national practice learning reviews to replace serious case reviews and the reform of the child death review process. The Act contains important proposals on social work regulation, care leavers, the statutory inclusion of PHSE in schools and other measures

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

Co-ordinating local work by:

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

Ensuring that local work is effective by:

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

How the Board works

Statutory Body

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

Independence

As an independent Board we hold each other and our respective governance bodies to account for how they are working together. The Board's Independent Chair is directly accountable to the Chief Executive at the County Council and works very closely with the Director of Children's Services. The Independent Chair also liaises regularly with Thames Valley Police and the Police and Crime Commissioner, the Council's executive member for children's services and the Chair of the Health and Wellbeing Board in driving forward improvement in practice. Moreover, the Independent Chair maintains a close relationship with the Oxfordshire Clinical Commissioning Group and NHS Trusts. The OSCB is pleased to have strengthened representation from the voluntary and community sector during 2016/17.

Local Authority

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

Oxfordshire Childrens Trust

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

The OSCB is formally consulted as part of any commissioning proposals regarding safeguarding children made by Children's Trust. OSCB presents its annual report to the Children's Trust outlining key safeguarding challenges and any action required from the Children's Trust. In this sense we aim to sustain a process of reciprocal scrutiny and challenge between the two Boards.

Individual Partners

Member agencies retain their own lines of accountability for safeguarding practice. Members of the Board hold a strategic role within their organisation and are able to speak for their organisation with authority and commit their organisation on policy and practice matters. On the Board we share responsibility collectively for the whole system, not just for our own agency. These governance and accountability arrangements are set out in a constitution. A Partnerships Protocol is also in place which outlines the relationships and accountabilities across all the key bodies in Oxfordshire.

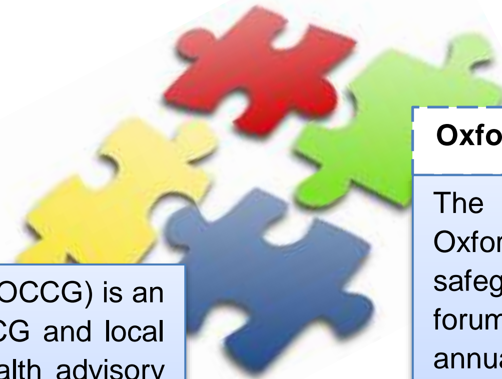
Safer Oxfordshire Partnership

The Safer Oxfordshire Partnership aims to reduce crime and create safer communities in Oxfordshire. It has a co-ordination function. It is supported in this task by the district level Community Safety Partnership (CSPs), which develop local community safety plans for their areas and are accountable for delivery. A core part of the role of the Safer Oxfordshire Partnership is to distribute funding from the Police and Crime Commissioner to support our community safety priorities: training for domestic abuse champions across the county; raising awareness of Child Sexual Exploitation and Female Genital Mutilation with local practitioners; activities to support young people and prevent them from engaging in Anti-Social Behaviour and from entering the criminal justice system; education and training opportunities for ex-offenders with drug and alcohol problems; and training on preventing extremism for frontline staff.

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

Community safety partnerships

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



Health Economy

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

Oxfordshire Safeguarding Adults Board

The Board leads on arrangements for safeguarding adults across Oxfordshire. It oversees and coordinates the effectiveness of the safeguarding work of its member and partner agencies. As a strategic forum it has three core duties: to develop a strategic plan; publish an annual report and commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these. Partners include adult social care, trading standards, the Police, probation services, fire and rescue services, health commissioners and providers, the voluntary sector and Bullingdon Prison. During 2016/17 significant progress has been made in securing closer working between the two Boards. The OSCB now works jointly with the OSAB on three priority areas: safeguarding training, domestic abuse and transitions from children to adult services.

Community safety partnerships

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

Clive Fathers

Former Headteacher of an Oxfordshire Special School and Head of the Oxfordshire Physical Disability Service, he retired in 2007. He is presently a governor of one Oxfordshire school, where he is the governor link for Safeguarding issues. Clive is also a Trustee of the Oxfordshire Outdoor Learning Trust (OOLT) (www.oolt.org.uk) and of the Borien Educational Foundation for South Africa (BEFSA) (www.befsa.org)

Romy Briant

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

Simon Brown

Simon Brown is CEO of The FASD Trust, an Oxford based charity, which he founded with his wife.(www.fasdtrust.co.uk) It has grown from humble roots in Witney to be the UK's leading charity in this field, supporting thousands of individuals and families affected by FASD (foetal alcohol spectrum disorders) not only in the UK, but increasingly overseas. Simon is also one of the Directors of The Oxford Foundation for FASD, (www.oxfordfoundation-fasd.com) a project of The FASD Trust, engaging with professionals and encouraging research in the field of FASD. Simon has experience from engaging at Governmental level (see www.appg-fasd.org.uk) to a personal level being a "service user" as dad of a child with special needs. Simon and Julia have 3 children, two of whom they originally fostered.

The VCS's voice is heard

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

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

Soldiers, Sailors, Airmen and Families Association (SSAFA)

SSAFA is British based charity that offers help and support to all serving members and former members of all ranks of the United Kingdom British Armed Forces and their families or dependents.

SSAFA supplies support for the RAF Social Care and Welfare needs and also the Tri Service requirements. SSAFA has recently celebrated 25 years of a Social Work Service. They offer practical, emotional and financial support to anyone who is serving or has ever served and their families. With qualified Social Work Practitioners and Counsellors they offer advice and support. As a matter of normal practice they work with all community services from housing, education, Children and Adult service provided by the Local Authorities, Police and all Health Services.

Clare Periton

I continue to be committed to contributing to safeguarding vulnerable people, and am grateful to be able to extend this commitment as a Lay Member on Oxfordshire's Safeguarding children Board. I have now been a board member for over 5 years and continue to be impressed with how the board develops and respond to change and how organisations around the table work together to promote the welfare of children and young people and to do their upmost to protect them.

Lay members

Working Together 2015 sets out a requirement for all LSCBs to have at least two Lay Members on their Board, operating as full members of the LSCB, participating as appropriate on the Board itself and on relevant committees. In 2016/17 the OSCB has been fortunate to have had Clare Periton representing the local community as a lay member. She offers challenge to the board, demanding plain English and clear discussions. She brings a fresh perspective on local concerns.

End of year summary

	Projected budget 2016/17	Actual budget 2016/17
Funding Streams		
OCC Early Years funding	-£21,437.00	-£25,000.00
Public Health funding	-£31,625.00	-£31,625.00
Contributions		
OCC Children, Education & Families	-£196,610.00	-£196,610.00
OCC Dedicated schools grant	-£64,000.00	-£64,000.00
Oxfordshire OCCG	-£60,000.00	-£60,000.00
Thames Valley Police	-£21,000.00	-£21,000.00
National Probation Service	-£2,500.00	-£2,500.00
CRC	-£1,410.00	-£1,410.00
Oxford City Council	-£10,000.00	-£10,000.00
Cherwell DC	-£5,000.00	-£5,000.00
South Oxfordshire DC	-£5,000.00	-£5,000.00
West Oxfordshire DC	-£5,000.00	-£5,000.00
Vale of White Horse DC	-£5,000.00	-£5,000.00
Cafcass	-£500.00	-£500.00
Total income	**-£429,082.00**	**-£432,645.00**
Expenditure		
Independent Chair	£39,000.00	£36,390.00
Business Unit	£253,000.00	£249,858.00
Comms	£12,000.00	£12,217.00
Training & Learning	£56,082.00	£53,530.00
Subgroups	£10,000.00	£9,892.00
All Case Reviews	£59,000.00	£21,150.00
Total	**£429,082.00**	**£383,037.00**
Overspend:	£0.00	£0.00
Available reserves	£21,942.00	£49,608.00
Drawdown	£0.00	£0.00
Reserves Balance	£21,942.00	£71,550.00

Financial arrangements

Board partners contribute to the OSCB's joint budget as well as providing resources in kind. The original funding for 2016/17 was projected to be £429,082. - The actual budget was £432,645. This increased by a small amount due to extra funds to cover early years training. This figure does not include the funding of the Oxfordshire Child Death Overview Panel which is funded through Oxfordshire Clinical Commissioning Group. Expenditure was less than expected due to fewer serious case reviews being commissioned than in previous years - only one new review was commissioned. The Board has agreed to carry forward the reserves from 2016/17 to the 2017/18 budget to fund changes to the OSCB training provision and is revising its forward plan.

CHAPTER THREE: PROGRESS MADE IN 2016 / 2017

The OSCB has three aims. This chapter outlines the priorities within the three aims, the progress made against them as well as an assessment by the Board of the effectiveness of this progress.

The OSCB has three priorities for leadership and governance

1. Local partnership arrangements are understood and the Multi-agency Safeguarding Hub (MASH) provides a swift and robust response to all children.
2. Local communities are better engaged in the work of the Board and within the partnership
3. Children and young people's views are reflected within the partnership

Why these priorities

The OSCB is in essence a scrutiny and challenge partnership which holds to account the key strategic partnerships impacting on safeguarding arrangements in the county. Referrals into the child protection system should be dealt with robustly by all agencies and any unresolved safeguarding concerns should be escalated and responded to.

AIM ONE:
To provide leadership and governance

Progress on partnership arrangements includes:

- ✓ **The Multi-agency Safeguarding Hub has been a consistent area of scrutiny. The Chair has visited the hub; the board has checked risk management, timeliness and feedback.**
- ✓ The OSCB and the Safeguarding Adults Board now meet twice a year.
  - Joint work on: training, domestic abuse, transitions from children to adult services.
  - An 'impact assessment' on the effect of efficiency savings and transformation of services across on the child protection partnership. (See Chapter 1)
  - A 'safeguarding self-assessment' of partners compliance against safeguarding standards for working with children and adults was undertaken
- ✓ **OSCB and Community Safety Partnerships worked on case reviews, Prevent training to address radicalisation and funding from the Police and Crime Commissioner to build resilience of vulnerable children and tackle child sexual exploitation. Grants given to:**
  - **Barnardo's: intervention work with young people in Oxford schools**
  - **Nomad: one to one mentoring sessions to children moving to secondary**
  - **Damascus: building resilience in targeted young people**
  - **Sunrise: work with boys aged 14 to 19**
- ✓ OSCB and Children's Trust linked up on priority setting The Trust now

Progress on community engagement includes:

- ✓ **Relaunch of Area Safeguarding Group meetings on a termly basis**
- ✓ Mapping of community safety groups to ensure consistency of approach safeguarding
- ✓ **Checking children with care and support needs are safely transported**
- ✓ Improved links with Oxfordshire Community and Voluntary Association (OCVA)
- ✓ **Better connection to the OCVA's 'Children and young people Forum'**
- ✓ Three board members and at least five subgroup members come from the private, community and voluntary sector

Progress on community engagement includes:

VOXY - Voice of young people in Oxfordshire.

"VOXY" is a newly formed steering group for young people, which is supported by an adult Advisory Group. They are formally represented on the county's Childrens Trust and will play an active role in reflecting the views of children and young people. The OSCB knows that they actively consider and discuss safeguarding concerns. Some of these views are already reflected in our partnership work:

Child sexual exploitation, missing young people, bullying both face to face and online; domestic abuse; alcohol and smoking; mental health and self-harm (including through exam stress); the role of the media: issues raised by the Netflix series 13 Reasons Why; Female Genital Mutilation;

…and some views we can do more to reflect in partnership work:

Road safety and taking risks on the road; gender stereotypes; victims sometimes feeling that their issue is small (due to a lack of response); supporting safeguarding concerns for children who have special educational needs; taking drugs at younger age; racism;….

These are all issues that the OSCB takes seriously.

"***Every child needs at least one adult who is irrationally crazy about him or her***", Urie Bronfenbrenner.

This quote was conveyed to delegates at the OSCB annual conference and has been reiterated by young people. They have told us that the impact of one person can be incredible: they could be a teacher, a foster parent, social worker. Children have said that we should never underestimate the positive impact a professional can have. They have said:

- *"one person (professional) can make a really massive difference"*
- *"regular consistent support"*
- *"one person is all it takes "*
- *"show you care"*
- And they have reminded us that small things matter *"he (social worker) pops in for casual chats"*

They have repeated that listening to and then acting on what's important to the child is vital. Showing you care is everything: "*get to know me as a person not just a case or a set of problems.*" And as they become older 14, 15, 16 years then being very involved in decisions becomes even more important. They need to understand why social services involved.

The online bullying survey

This free service (for all schools) continues to be an effective way of finding out the experience of children and young people in terms of bullying at school. The survey continues to show that those young people who are "different" from the majority in terms of experience of a long-term illness or disability, race, religion, or sexuality are likely to experience increased frequency of bullying and "feeling unsafe".

Of this group, young people who identify as lesbian, gay, bisexual or transgender (LGBT) appear to be very vulnerable with 10% never feeling safe in the classroom (compared to 1% of those identifying as heterosexual) and experiencing increased rates of regular bullying.

Here are some quotes:
"A lot of students use the word 'gay' as an offensive word to ridicule other students"
"People only consider severe forms of discrimination to be bullying, but I think that the little things are always happening"

OSCB partners have run training and learning events about staying safe on line; the annual conference picked up on the issue of identity and safeguarding and partners are checking what provision there is for LGBT children:

**Mini good practice example:
Wheatley Park Gay-Straight Alliance**

This is a student organisation dedicated to supporting and helping the school's LGBT+ community and embracing individual identity. It has done a lot to promote solidarity and support these young people and also led to the introduction of a gender neutral bathroom to their school.

**Mini good practice example:
Mind of My Own (MOMO)**

This app will be rolled out across children's social care in 2017. MOMO is a web based app that helps young people express their views and complain if necessary. Young people have said that one of the barriers to making a complaint is the lack of Council technology, for example, social media. MOMO can be used directly from a young person's smart phone, either independently or with the help of a social worker.

Wheatley
Park
GSA

Wheatley wasn't always the most accepting place

We didn't have a large LGBT+ community

It was easy to feel like we were alone

But things can change
?
!

And eventually we stopped feeling so alone

And we realised there were more of us than we thought

And that one brave act...
im_gay

Could inspire so many more

Thanks to efforts of the LGBt+ community we

-eventually-

Founded the Gay Straight Alliance

We now have non-binary toilets

And we're working on a
#PRAYFOR
ORLANDO
Memorial to the Pulse Nightclub Massacre

We Can Be Happy

Wheatley Park GSA

"A student organisation dedicated to supporting and helping the school's LGBT+ community and embracing individual identity."

What is the GSA?

The Gay-Straight Alliance is a safe and friendly place for people of any sexuality and gender. We meet weekly and discuss recent events and current projects.

Some of our biggest accomplishments include:

- The introduction of a gender neutral bathroom to our school.
- The distribution of badges with the GSA logo amongst the staff to display their solidarity and support.

The Meaning of Our Logo

"I wanted to combine the spirit and history of our school (represented by the oak tree that is the Wheatley Park logo) with the celebration of diversity (shown by the LGBT flag), so I coloured our tree with the rainbow to create what is now the GSA's "Dooms-gay tree" (an affectionate nickname)."

- Beth Bayliss, designer

<u>The Wheatley Park Doomsday Tree</u>

Our school's logo is inspired by one of the site's oldest landmarks: the Doomsday oak (named thusly due to its mention in William the Conqueror's Doomsday book).

<u>The LGBT Rainbow Flag</u>

The rainbow flag symbolises LGBT (lesbian, gay, bisexual, transgender) pride and it was originally designed by Gilbert Baker in 1978.

Quotes From Members

"It gave me the confidence to come out as transgender."

- Charlie, Year 9

"I always felt like I was being judged and now I have a non-judgmental place I can go where I feel safe."

- Becky Kelly, Year 9

"The GSA is a really great place. Even if half the time is spent making puns, it's time spent in good, supportive company.

"Gender is just a concept; it doesn't matter how you identify."

- Charlie, Year 9

Staff

"Since 2015, I have supervised the Gay-Straight-Alliance meetings and advocated for these students. I help the students effect positive change in the school, such as the introduction of gender-neutral toilets. I liaise between the students, staff, their parents and the school administration regarding their welfare. I now formally mentor some of these students outside of the group. I design and deliver educational resources and curriculum - designed to educate both Wheatley Park pupils and staff - to try and make the school a more LGBTQI+ friendly space.

I ask the students questions. Their responses, perceptions and concerns are the basis of every resource I design, and every presentation I deliver. The project has now evolved into a research fellowship through the Oxford Education Deanery. I won't sugar coat it: there has been a lot of work involved. However, it has been one of the highlights of my career.

If you would like me to visit the staff or pupils at your school, or you are an educator interested in fostering a LGBTQI+ inclusive atmosphere at your school, it would be a pleasure to hear from you."

Emma J.B. Mc Nicol emcnicol@wheatleypark.org

OSCB plans for working with young people

OSCB to focus efforts on working with:

1. Groups such as VOXY to help set priorities and direction for work
2. Those who are at greatest safeguarding risk such as victims of CSE, disabled young people and young people with mental health issues.
3. Those who use local services.

OSCB view of progress made in terms of aim 1: leadership and governance:

The OSCB is assured that the local partnership is focussed on the effectiveness of arrangements. There is commitment to ensure that the MASH provides a swift and robust response. However the OSCB needs to be **further assured** that front-door arrangements are understood, early assessments are completed and that new processes are fully embedded. The evidence is not yet sufficient. Improvement should also be **evidenced** in terms of feedback on referrals and timeliness of action.

There is assurance that work has begun to better engage local communities in the work of the Board and within the partnership. This **must continue** if it is to have impact.

There is evidence that Children and young people's views are reflected within the partnership but the OSCB is clear that there is **room for improvement** and is keen to review what impact 'MOMO' will have for children in the safeguarding system.

AIM TWO:
To drive forward practice improvement

The OSCB priority has been to protect younger children from the harm of neglect and parental risk factors

Why this priority?

Neglect is still the most common reason for a child to be subject to a child protection plan. The contributory factors of domestic abuse; parental substance misuse and parental mental health often underpin situations of neglect. Addressing these parental concerns is part of the solution to tackling neglect.

Progress includes

Strategic leadership

- ✓ **Multi-agency Task and Finish Group led by Oxford Health NHS FT and Children's Social Care to oversee the work on neglect different way to address the issue of neglect**
- ✓ Implementation of a resources budget for work to address neglect

Resources

- ✓ **New threshold of needs matrix - which helps everyone in the safeguarding partnership identify need in the same way and use the same language**
- ✓ New early help assessment to replace the common assessment framework
- ✓ **Work to collate all guidance and toolkits online**

Learning and improvement

- ✓ New learning summary following the serious case review on child Q
- ✓ Workshops on neglect rolled out for social workers

Listening to those who need support

- ✓ The views of families and children were collated through audit work. They had all been involved in child protection planning where 'neglect' was the main reason. Some of the messages were:
    - **Practical help and advice matters**. Families said want more of this.
    - **Clear, honest, straightforward language is best**. Families said that jargon, language and paperwork is disempowering and bewildering.
    - **Needing and wanting to understand** is a common theme. Some children said they needed more communication and didn't understand why they had a child protection plan.
    - **Children want more say in their care as they get older**.

The OSCB priority has been to protect older children from harm

Why this priority?

Older children face a range of risks such as self-harm and suicide, drug and alcohol misuse, mental health and domestic violence in peer relationships. We know from what 'VOXY' told us that these are real safeguarding concerns for all children. More vulnerable children are more susceptible to these risks. This is reflected in the increased numbers of older children subject to child protection plans and those older children who subsequently become looked after. The increased demands on mental health services and the work to address child sexual exploitation indicate that there are a large number of young people with challenging needs.

Progress includes

Strategic leadership and co-ordination

- ✓ **Self-harm networks for professionals have expanded: they identify young people, share good practice and ensure good interagency join up**
- ✓ Co-ordinated response from the County Council, NHS Trusts and Voluntary Groups in supporting families, school community after a suicide or serious self-harm incident
- ✓ **OUH NHS FT emergency duty team communicating well with schools and colleagues following an admission due to self-harm (tested by audit)**
- ✓ Oxfordshire County Council and Barnardo's have delivered *Safer Futures* – for parents, carers and families of young people thought to be at risk of CSE
- ✓ **Oxford City Council, the County Council and Thames Valley Police led an event for local faith and community groups on addressing CSE**
- ✓ District councils launched Hotel Watch to increase awareness of exploitation and intelligence sharing amongst bed and breakfast/hoteliers
- ✓ **District councils promoted training to all hotel staff in order to safeguard victims and potential victims of crime**
- ✓ Thames Valley Police has co-ordinated investigations which led to successful prosecutions against perpetrators of Child sexual exploitation

Resources

- ✓ **Investment into the "Placement Strategy" in 2013 has created capacity to meet increasing numbers of children with complex needs**.
- ✓ Out of the 265 children referred to Residential and Edge of Care Service specifically to prevent imminent accommodation into care 203 (77%) were diverted from the care system.
- ✓ **There was a 14% increase of in-house fostering - the overall proportion of children in fostering settings has climbed from 66.9% to 68.8%. Family based options avoid many of the peer association risks arising in residential settings.**
- ✓ Oxford Sexual Abuse and Rape Crisis Centre have provided a face-to-face counselling service to young adult female survivors of sexual violence, including child sexual exploitation. Feedback has rated the service as 'excellent'.
- ✓ **New CSE screening tool - shorter, easier to complete, mindful of boys as victims.**
- ✓ Revised CSE professionals' handbook - clear guidance and direction
- ✓ **New toolkit for practitioners working with lesbian, gay, bi-sexual and transgender young people**

Learning and improvement

- ✓ **Survey of health practitioner 'knowledge and attitude' to consent has led to better resources and training**
- ✓ CSE learning summary; a presentation on working with parents; guide for parents on the OSCB website
- ✓ **OSCB learning events for over 150 practitioners on online safety**
- ✓ OSCB conference for over 200 practitioners on 'young people and identity' – thanks to pupils from the Warriner School from Project Q
- ✓ **OSCB launch of the My Normal film. My Normal is a creativity based project aiming to give LGBTQ+ youth safe spaces and a bigger voice in Oxfordshire.**
- ✓ Work to develop new training to reduce bullying amongst children, with a particular focus on children with Special Educational Needs and Disabilities
- ✓ **The My Normal Project and Ark T Centre in Oxford City has also set up a new music project working with LGBTQ+ young people and young people with disabilities.**

Good practice example young people leaving care

Oxfordshire County Council has helped a group of care leavers become a social enterprise called Oxfordshire Care Leaver Association (OCLA). These dynamic young people are helping to design future services and to coach and mentor children in care. They are keen to become mentors for employers to help create job opportunities and support for young people in and leaving the care system. They are also keen to design independence sessions to help young people live in independence as adults. This social enterprise is being supported by Mark Walker from Virtual School, Luke Rodgers of Foster Focus and George ?? from Turl Street Kitchen.

Good practice example joint problem solving for the riskiest children

The multi-agency Complex Case Panel problem-solves for the riskiest children and young people by working collaboratively and by ensuring that issues of high concern are escalated and addressed. This includes high risk domestic abuse or offending behaviour, CAMHS and child sexual exploitation. The panel has developed a policy to determine the most appropriate mechanism for managing risk/concerns for children and young people who do not meet Multi-Agency Public Protection Arrangements (MAPPA) criteria or court orders. This has been tested through case studies and shown to be providing good support.

Good practice example addressing self-harm

Following concerns from schools and health professionals about self-harm , a play for secondary schools was commissioned by the County Council. 'Under My Skin' received positive feedback , achieved finalist status in the mental wellbeing category at the RSPH Awards and was recommissioned for a subsequent tour in 2016/17. The play was performed in 29 schools to 5470 young people in Years 8 and 9. The reported outcomes were:

- *71% of young people were very confident in knowing how and where to seek advice/support about self-harming after having seen the play*

Of 100 professionals who provided feedback:

- *73% felt more confident in supporting a young person who approaches them with concerns about self-harm*
- *96% felt the play positively engaged the majority of pupils in their class*
- *90% felt that follow-up tutorial time activity with the SHN was a useful way to reinforce the overall messages about self-harm*

Of 25 teachers who used the preparatory resources 92% found the resources very useful

OSCB view of progress made in terms of practice improvement against these two priorities:

The OSCB partners have had a strategic drive to focus on neglect and resources have been identifies to support practice improvement. Being clear on what children and families think is essential and commendable. However, the evidence is that neglect is the most common reason for children to be subject to child protection plans. At 67% this is higher than the national average. **This local drive must continue in order to embed new tools and for changes in practice to have an impact on neglect**. Neglect must remain a priority for the OSCB.

The concerns regarding older children are reflected in the data that we have on our safeguarding system. We know that their needs are placing a pressure on the system. It is there re-assuring to see the many examples of work by OSCB partners in terms of strategic leadership and co-ordination, resource allocation and work to improve practice. The partnership is stepping up to and not shirking from these challenges. However, these safeguarding concerns are a challenge. Recent serious case reviews and current data reinforce this message. **The OSCB partners must keep the work to protect older children from harm as a priority.**

Improving mental health services for young people

The increased demand on mental health services is a concern.
This annual report therefore sets out in more detail what work is taking place to meet those needs:
The Oxford Health NHS FT has been awarded a five year contract for delivering mental health services in Oxfordshire. The model has been developed in response to the parliamentary review of CAMHS nationally, the Department of Health report "Future in Mind" 2015, the OCCG review of CAMHS 2014/15 and the NHS England Five Year Transformation Plan for CAMHS.

New partnerships have developed for CAMHS and the service is integrating with other local agencies. The aim is to deliver a service that increases resilience and self-help, reduces waiting times, safeguards children and young people from harm and offers a range of evidence based interventions. The new model introduces a 'pathway approach' for service users with access via a county wide Single Point of Access (SPA) launching approximately September 2017.

The Oxon Specialist Eating Disorder Service

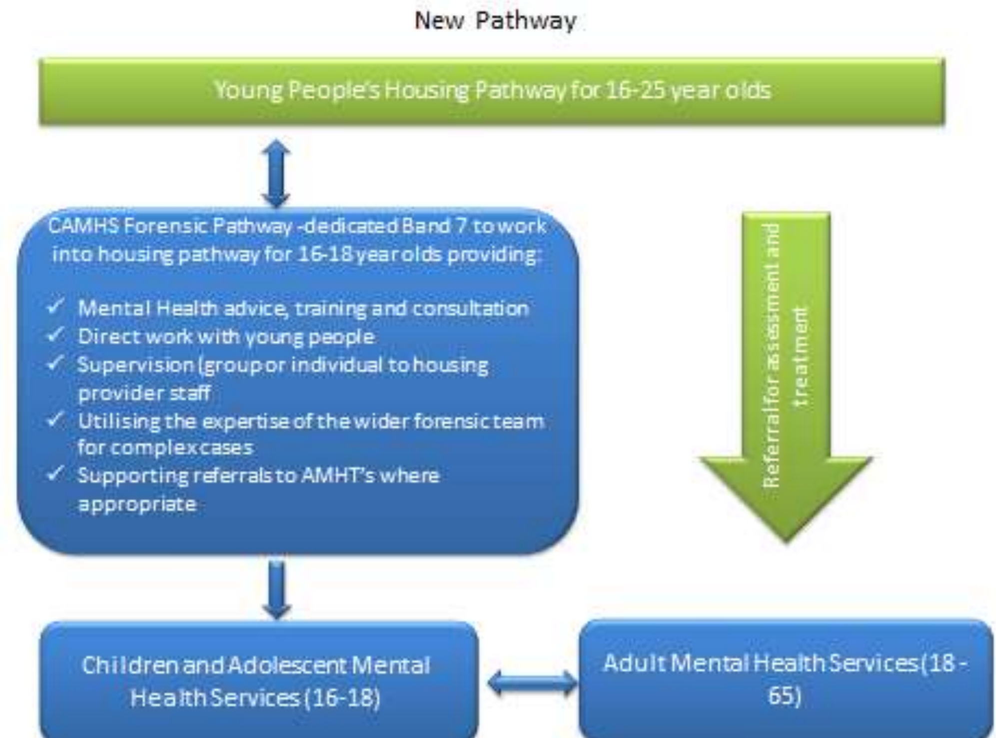
Launched in October 2016 this is embedding a route to help. It encourages early intervention and provides promptly assessment and treatment for young people and families experiencing eating disorders. The service aims to restore physical health and psychological wellbeing in a safe and collaborative manner.

Family Feedback: *"The whole service has been helpful, most especially the understanding of herself and how her mind works, and how she must always be aware of this going forward. Nothing of the service has been unhelpful to us!"*

The Horizon service

Launched in 2016, this service works alongside professionals to support young people and their families who have been affected by sexual harm, and has quickly developed links with key partner agencies within the area. In particular, Horizon and SAFE! have worked in close partnership over the year to support each other's clinical work and to develop joint projects in order to better support the community. During 2016/17 the service received 128 referrals, most of which were for young people above age of 13, the majority within Central Oxfordshire catchment area, 91 of these referrals were for Sexual Violence. Referrals came from CAMHS, SAFE!, Social Care, Police and Education. Initial consultations for new referrals happen with 10 working days of receipt of a referral.

Parent Feedback: *"I believe this is an essential service for children who have suffered any form of sexual abuse. As a parent of an adoptive child we experienced particular behaviours which were very distressing. Adoption services were unable to link us with a professional service such as Horizon as it was not available at the time. So glad that this service is now available"*
Professional Feedback: *"(Horizon) Works on an individual child basis, acknowledging what they need at that time rather than generalising support. Also the consultations are invaluable." - Social Worker*



The Trust is continually enhancing services for high-risk young people, offering several closely-coordinated services for young people who present with high-risk behaviours, or who come into contact with the youth justice system. The services include:

- **Forensic CAMHS** for young people who show a range of risky behaviours towards others;
- **Child & Adolescent Harmful Behaviour Service (CAHBS)** for concerns in relation to sexualised or sexually-harmful behaviour;
- **Criminal Justice & Liaison Service** for concerns in relation to mental health or neuro-developmental difficulty at the first point of contact with the youth justice system;
- **Horizon** to restore sense of safeness and well-being for those experiencing distress as a result of sexual harm.

The Trust in partnership with OCCG successfully won a tender, with NHS England/Health & Justice to implement a new Forensic CAMHS post to work into The Young People's Supported Housing Pathway. This service is commissioned by Oxfordshire county council and provides accommodation, housing management services and housing related support to Young people Leaving Care, Looked After Children and Unaccompanied Asylum Seekers.

The School In-Reach work

Every main stream secondary school has a named CAMHS Link Worker.

Through the new service model there is a requirement for CAMHS to increase offers to primary schools.

The School In-Reach development project team are currently working on how best to offer this to the high numbers of primary schools and are mapping partnerships and working closely with other service provisions to establish the most effective and efficient relationship's.

The Autism Diagnostic Clinic pilot

The partnership project streamlines the referral, assessment, diagnosis and health outcomes of children and young people through direct engagement with the specialist multidisciplinary professionals.

There will be a 'Neuro Developmental pathway' which incorporates this successful new model for ASD diagnosis, in the meantime the two day a week clinic continues, moving to five days a week later in 2017.

Family Feedback:

"In this pathway the process is quick, felt understood and not judged, enabled access to support"

A Day in the life of a School Health Nurse

It's 8:30 and as I park my car in the school carpark I can already see one of my students approaching; we walk to my office together. She is subject to child protection plan and regularly seeks me out to off load, share her worries and ask me questions regarding the decisions being taken on her care.

She is very distracted and upset due to an argument with her sister. I decide to try some Mindfulness. The effect is amazing and she leaves my office much calmer and actually smiling. I send a quick email to the social worker to update her and then update our electronic records.

No time for that first cup of coffee as I'm due at the year 11 assembly to do a short presentation on handling exam stress. Assembly is well received and is a good opportunity to remind the students of where and how to find me. It is now 09:30 and time for my first one to one. This student referred herself and tells me that she has been self-harming by using a blade. She says that she only does it when stressed and that she is worried about her exams and results! (Note to self 'need to do year 13 Assembly on exam stress').

Following our discussion I am reassured that an urgent referral to CAMHS is not required; she agrees for me to talk to her mother and her tutor. We talk about some relaxation strategies to reduce her stress. I give her the PCAMHS self-referral number should she need more support and arrange to see her again next week.

Break time, a quick cup of coffee before another student comes in. She is 15 years old and has been in a relationship for nearly a year with a boy of the same age at this school. They haven't had intercourse and she wants to talk about contraception. We discuss consent in depth and then complete a Spotting the Signs Form, as she is under 16yrs. Completing this form gives me an opportunity to discuss on line safety, sexting, exploitation, STIs and the value of talking to her parents. We talk about forms of contraception in detail, and I give her some information to take away. I then write up both appointments.

I manage to find time to plan the 'Personal, Social, Health and Emotional' sessions I am delivering to year 7 & 8. The year 7 sessions will follow on from the puberty talks they had at Primary school and the year 8 will be on the harmful effects of smoking. A subject close to my heart!

Lunchtime is my weekly drop-in when students can come for a chat or to pick up information on a range of health subjects. However today I have a display on healthy eating and have lots of hands-on resources from the Health Promotion Unit.

After lunch I have my fortnightly meeting with the Pastoral Director/Safeguarding Lead and the Heads of Year to discuss vulnerable students, and what support can be given. I really value these meetings and am able to act as an advocate for the students. At the end of the meeting one of the Student Wellbeing Managers tell me that the student I saw first thing this morning had told her about the Mindfulness session, and said she had enjoyed it! So a good end to the day.

About the Family Nurse Partnership (FNP)

FNP is an evidence-based home visiting programme for first time young Mums age 19 and under. A specially trained Nurse works with the family from early pregnancy until the child is 2. The aim of the programme is to support a healthy pregnancy, sensitive parenting and the child's health and development and to break the cycle of deprivation by exploring and supporting aspirational futures.

Day in the life of a Family Nurse (FNP)

Today begins with supervision - my opportunity to discuss clients, explore more challenging cases, celebrate achievements and plan how to achieve the best impact.

My first client is 18, living with her partner and their toddler. This young mum has been subjected to two counts of rape and as a consequence suffers low self-esteem and confidence. Her partner has severe autism, was badly affected by growing up in a home with domestic violence and has been homeless. Parenting is a massive challenge. Their lack of social confidence prevents them from accessing community resources for their baby. I try to use visits to attend toddler groups with them to bolster their confidence and show them what they can do with their children. I have tried really hard to support this family unit. I use the visit as a chance to talk about help from the new early help service. Their parenting may be good enough, but the environment is not. The toddler is confined to one room which is cluttered. The talk goes well and the client has accepted the idea of help and actually looks a little relieved.

My next client is 19 years old, living alone with her toddler. She split from the father following escalating domestic violence. She is no longer at college. She could not afford her higher level course as she is no longer entitled to all the benefits. We have talked about the risks to her child from abusive relationships and have discussed support programmes, which may help her think carefully when she meets a new partner. She needs support to understand how quickly toddlers form attachments and how if she or her ex-partner have new relationships they will impact on the child. It makes being single again seem complicated.

Next for today is a young mum who left home at 15 to live with her boyfriend who was abusive - coercive and controlling. They were mostly sofa surfing. She returned to her family when she was 17 and he was in prison. Almost immediately she became pregnant with a new partner, the new relationship did not survive. The first boyfriend has continued to contact her always impacting negatively on her mental health and mood. Today she is struggling with the idea of parenthood. The baby spends at least 2 days a week with her biological father and Granny helps her a lot. I set up an appointment for her with the GP. We will refer her to adult mental health for support. I feel sad at the end of this meeting as I know what a good mum she is when she is on form; it's a marked deterioration.

Today's last client is aged 19 and pregnant. I am concerned for her. She has had a damaging childhood: one parent is an alcoholic, one is a drug addict. Her partner is over twice her age and has been in prison. She is anxious that she will not be able to keep her baby as she is not safe - an appropriate anxiety for her to have. This client loves the programme; she relishes being able to focus just on her baby. Today we discuss her diet and keeping her baby safe now. She assures me she is not smoking or using drugs. Her partner is a dealer and she has used drugs previously. We discuss what family means to her. Whilst it is difficult, making her angry and tearful, she manages to stay for over an hour.

All of today's clients had pre-birth assessments. The strain of parenting is greater than any young mother can anticipate. Yet every day I see evidence of clients making great strides and being fun and thoughtful with their babies in what can be very challenging circumstances.

AIM THREE:
To Scrutinise and Quality Assure

The OSCB priority has been to check the effectiveness of joint working through audit

Why? Over the last few years a significant amount of learning has been achieved. The OSCB uses its local framework to test this.

Progress includes:

- ✓ **Multi-agency audits reviewed over 20 cases from the perspectives of the different agencies involved. Partner agencies included Thames Valley Police, Oxford University Hospitals NHS FT, Oxford Health NHS FT, the County Council – services for children and adults, the National Probation Service, Educationalists and voluntary sector groups such as 'Reducing the Risk' and PACT (Bounceback4kids).**
- ✓ Learning summaries produced on serious case reviews for Baby L, Child Q and Children A & B
- ✓ **Data mapping work from young victims of crime and vulnerable groups to highlight need and improved joint action**
- ✓ Checking actions have been seen through by agencies e.g. The National Probation Service's Public Protection Unit have received the national Child Safeguarding Training mandated by the service which, along with learning from the child sexual exploitation case reviews, has widened the skills set of officers

Audit work has shown

The complexity involved in working across the services with vulnerable children who present behaviours that are a risk, sometimes to the public, and often to themselves.

They have also highlighted how straight talking; responding to the views of children; a 'think family' approach and strong connections between agencies can make a difference to the protective factors put in

The OSCB priority has been to scrutinise OSCB agencies' safeguarding practice

Why? The OSCB evaluates the effectiveness of the local safeguarding system to ensure that children and young people are kept as safe as possible.

Progress includes:

- ✓ **OSCB partner agencies completed Safeguarding Self-assessments last year. A peer review was held to challenge assessments. The returns demonstrated good compliance and regard to safeguarding practice as well as positive direction of travel. They provided *broad* assurance that partner agencies understand the safeguarding obligations and have frameworks in place to deliver them. For example:**
  - Senior management commitment is strong
  - Information sharing is effective
  - Safer Recruitment and Vetting procedures are in place and working
  - The Effectiveness of the Safeguarding Boards is deemed sufficient

  The one area that agencies were not always able to provided evidence of was:
  - Involvement of service users in service development, where the responses were not as robust as other areas

- ✓ **Single agency audits enabled an in-depth look at safeguarding practice. There were some good examples of how safeguarding had improved:**
  - Thames Valley Police have improved the collation of information with respect to children in the home at the time when responding to domestic abuse incidents
  - The Children's Directorate within OUH NHS FT has increased feedback from children, and parents or carers by 73% ensuring that they are capturing views of those coming in to hospital in order to improve change
  - Children's Social Care case has demonstrated that 'planning and review of cases' has effectively involved fathers in 70% of cases sampled
  - National Probation Service officers have wider skills sets following learning from the child sexual exploitation case reviews, in particular to be alert to 'relationships' with children under 18.

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

The extent of the agency auditing of safeguarding work is positive and there are some examples of changes made to improve working.

To improve this learning and improvement work OSCB partners should seek to better demonstrate how they involve service users in the development of services; how young people's views are sought in audit work as well as how the voice of the practitioner is captured too.

Learning and improvement work

Training undertaken by over 9000 practitioners

The OSCB delivers over **150** free safeguarding training and learning events plus online learning each year. The training is overseen by a multi-agency subgroup. In 2016/17 the training reached over **9000** members of the Oxfordshire workforce.

Feedback

Over 85% of delegates report that they have found the training good or excellent. In a recent phone survey 96% of respondents said that they had better safeguarding practice as a result of their training.

Child sexual exploitation (CSE) training

The OSCB has run CSE multi-agency training and sexual health awareness and consent through the Public Health funded, 'risky behaviours' programme. An initiative through Oxford City and Oxfordshire County Council has led to the roll out of training targeting primary schools in the county. All core safeguarding courses include CSE. Approximately 4000 delegates will be trained in 2016/17. In early 2016 the OSCB ran a learning event which included the issue of consent and sought to question practitioners on their knowledge and understanding of the issue. OSCB is updating its CSE training to include more information on boys and children who are

OSCB Trainers

All training was delivered free of charge by the local practitioner volunteers: doctors, nurses, teachers, residential workers, early help advisers and children's centre workers amongst others. We value these committed colleagues in our safeguarding partnership. They fit training in amongst a busy working week and help us connect practitioners across the county.

We know we have a great team of trainers as:

- **They know they are part of a safeguarding system**: telling of us safeguarding concerns they are hearing on a repeat basis and check that the board is aware of them at a strategic level
- **They know their topic**: sending us film clips, case studies etc to include in training
- **They stay ahead of the game**: attending safeguarding briefings for trainers to receive the latest local updates and inputting in to new courses
- **They are passionate**: volunteering to facilitate roundtable discussions at our annual conference for 200 delegates and inputting in to new courses
- **They look for improvement**: informing us where changes need to be made to material
- **They focus on the child**: for example telling us that sexual health training needs more time for practitioners to cover 'conversations on consent with children' as this needs to be right and needs to be protective of the children
- **They think family**: ensure that the learning considers carers, mum, dad and child - which, local learning from our SCRs reminds us, can be a gap
- **They love what they do**: we walk in to the room post-training and the trainer is beaming, the chairs have been moved and the walls are covered in flip-chart paper
- **The feedback from delegates says so**!

Thank you to Oxfordshire's volunteer trainers who consistently deliver high quality training and ensure that connections across the safeguarding partnership are made and stay strong.

Learning events were run for over 400 local practitioners

Safeguarding risks online:

Effective learning event on safeguarding risks that come through the world of social media, gaming and simply being online. This event was run for a second time thanks to Thames Valley Police. Over 200 practitioners benefited.

Relationships and identity:

The OSCB conference included a powerful performance by pupils in 'Project Q' from the Warriner School on sexual identity, being gay, lesbian or transgender. Thoughtful presentations on risks inherent in forming relationships when autistic. Inspiring film from Rickie Beadle on identity. Practitioners did a case study on how to support children at an early point of need. Over 200 practitioners benefited.

Working with children with disability:

Practitioner event with learning from a serious case that was reviewed by OSCB partners

Working with neglect:

Practitioner event with learning from serious case review on Child Q

CHAPTER FOUR: WHAT HAPPENS WHEN A CHILD DIES IN OXFORDSHIRE

The Child Death Overview Panel (CDOP)

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

Preventable child deaths can be defined as "those in which modifiable factors may have contributed to the death. These factors are defined as those which by means of nationally or locally achievable interventions could be modified to reduce the risk of future child deaths. http://www.workingtogetheronline.co.uk/chapters/chapter_five.html
The panel considers all the available information and makes a decision as to whether there were any modifiable factors in each case. These include factors in the family, environment, parenting capacity and service provision. Consideration should be made as to what action could be taken at a regional and or national level to prevent future deaths and improve service provision to children, families and the wider community. When considering modifiable factors the panel is required to make a decision on whether the factors contributed to or caused the death.

In the year 2016-17 the CDOP panel concluded that in the 36 cases reviewed the following modifiable factors were identified that contributed to or caused the death.

- Co sleeping
- Domestic Abuse
- Smoking and alcohol
- Potential risk of car seat use by neonates
- Maternal obesity and diabetes
- Lack of lifesaving aids at riverside
- Housing issues

Actions and activities were undertaken to address these identified factors.

The rapid response service

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

The RRC Team provides a safe, consistent and sensitive response to unexpected child deaths up to the age of 18, where the child dies in or is brought to hospital immediately after their death. This culturally sensitive approach provides support to the bereaved parents and family. In collaboration with the Designated Doctor for Child Deaths (in working hours) the rapid response coordination team ensure families are provided with support in the event of a sudden and unexpected child death. They work collaboratively with other organisations including the Coroner's office, Schools, Youth Projects, Social Care, South Central Ambulance Service, Thames Valley Police, Oxford University Hospitals NHS Trust, Oxford Health NHS Foundation Trust, Helen and Douglas House Hospice and the child bereavement charity SEE SAW, in order to enhance the quality of care provided to all those whose work brings them into contact with bereaved families. The process ensures that the rapid response team makes a vital contribution not only to the CDOP review but to the immediate response provided in the event of an unexpected child death. This difficult and sensitive work provides robust support for families and professionals in the tragic circumstances surrounding a child death.

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

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

Currently families do not attend the Rapid Response meeting however the role of the coroner is to keep them fully informed throughout the process. To this end the notes and actions of the Rapid response meeting are shared with the Coroner and a Coroner's officer attends the meeting.

In 2016/17, 88 child deaths were reported to the Oxfordshire CDOP and were discussed with the Designated Doctor for child deaths. Thirty-six of the child deaths reported were of children normally resident in Oxfordshire.

Review of cases

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

LSCBs must always undertake a review of cases that meet the criteria for a SCR.

The purpose of a serious case review is:

To establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.

Serious case reviews in Oxfordshire

The OSCB has worked on five serious case reviews since the last annual report. Of those five reviews: three were published, one is active and one has been completed as far as possible, whilst a parallel investigation is underway.

The published reports are Baby L (September 2016), Child Q (January 2017), Child A and Child B (February 2017). In all cases family members or carers, who had played a significant role in the children's lives, were involved in the process. This often takes courage and the OSCB thanks them for their contribution. Their involvement made the reviews better and helped all parties to understand the impact of actions taken. Families were offered feedback prior to publication. Practitioners also participated: making learning stronger. The reviews showed that there were members of staff who were dedicated, worked well together and were striving for a positive outcome.

Four new cases were brought to the attention of the OSCB for consideration in 2016/17. One was referred by Thames Valley Police and three were referred by Children's Social Care. Of these four referrals three serious case reviews have been commissioned for 2017/18 and one was deemed not to meet the criteria but has led to a partnership review.

All reviews and learning summaries can be found on the OSCB website. The OSCB generates learning about how we can work better together. It takes seriously its responsibilities to ensure that lessons learned from case reviews are disseminated and embedded into frontline practice and used to support improvements across agencies.

From the three recently published reviews these are the ten most common learning points:

1. The importance of thinking carefully about the role of the **father** in the family system as well as communication with and involvement of fathers and male carers
2. The need for curiosity about the families past history, relationships and current circumstances that moves beyond reliance on **self-reported information**.
3. There are more challenges faced by professionals working with vulnerable families where **neglect** is an embedded issue.
4. The impact of the **parent's mental health** problems on the safety and wellbeing of the child.
5. Understanding of **substance misuse** and interventions, the changing levels of risk, and the impact on the child.
6. **Normalising and misinterpreting behaviour** - linked to Special Educational Needs.
7. Identifying the increased safeguarding **risks for children with learning disabilities** and Special Educational Needs.
8. Identification of physical abuse and **following safeguarding processes thoroughly.**
9. Multi-agency work must be well co-ordinated in order to **share planning** and to better understand what is happening to the child. Effective risk management requires **systematic planning** across the multi-agency partnership.
10. 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.

The Story of Child Q

Context

This case concerned a 14-month old child who died, as the result of drowning, having been left unattended in the bath. The child is referred to as Child Q in order to protect her identity. Child Q lived with her mother and an older half-sibling. At the time of Q's death, both children were subject of a Child Protection (CP) Plan, due to significant concerns about neglect and parental inability to protect them from harm.

Child Q's mother had a difficult personal history, and there was little consistent support from her wider family, whereas Q's father and paternal relatives were involved in regular 'respite' care for Q. The family received a good level of support from a range of professionals. The concerns about Mother's ability to care for her children centred around her immaturity, her (poorly understood) level of drug and alcohol misuse, her periodic depression, and her exposure of the children

to unsuitable teenagers and adults. There was a large network of universal and specialist services working with the family, with Children's Centres taking a prominent role in 'teaching' parenting skills and monitoring the children's care. However, Mother was an inconsistent user of services, and found it hard to sustain any improvements. She moved twice in the children's early years, with her last move

placing the family in a more isolated situation. These moves meant that relations with professionals were broken and had to be built up again.

The **full reports and findings** can be accessed from the OSCB website. They concerned how partners work together to manage cases of poor parenting / neglect and respond to new incidents. They also included the need to ensure that the input and cooperation of the mother, is not prioritized at the expense of engaging the other parent (father) in the child protection process.

Responding to the findings - these are some of the actions taken since

- ✓ Social workers can now use a chronology for all colleagues working together with a family where neglect is an issue so that there is a clear story of risk, concerns, actions and progress to date
- ✓ A recent audit on the involvement of fathers in Children's Social Care case planning and review showed that 70% of them effectively involved fathers. The service has subsequently made the views of parents, where there is a child protection plan, an area for development.
- ✓ Health visitors routinely record information relating to a child's father at a Primary Birth Visit
- ✓ Oxford Health NHS FT have set up a system to help practitioners summarise concerns and current health involvement when passing on work
- ✓ A local housing provider has changes its 'Mutual Exchange' application form so that applicants advise if there is any Children's social care involvement so that any information can be appropriately shared
- ✓ Workshops for Children's Social Care staff on working with neglect included guidance about the management of incidents on open cases and strategy meetings
- ✓ Procedures now set out the reasons and circumstances in which professionals only meetings can be held so that the case can be discussed openly

The **full report and findings** were identified and can be accessed from the OSCB website.

The Story of children A and B

Oxfordshire Safeguarding Children Board (the Board) conducted a Serious Case Review (SCR) after it emerged that two young children had been seriously abused by a man. He and his female partner were looking after them under a Special Guardianship Order. The children had previously been in the care of Oxfordshire County Council (the Council) and the Council's Children's Social Care (CSC) services had been instrumental in arranging for the children to live with the Special Guardians.

Responding to the findings - these are some of the actions taken since

- ✓ Specialist learning event was held for all those involved. Childrens Social Care has run three practitioner sessions on learning from Case Reviews; area safeguarding groups and all have OSCB trainers have attended learning events
- ✓ Training on working with Disabled Children has been updated to reflect learning
- ✓ Family Group Conference arrangements improved
- ✓ Special Guardianship arrangements reviewed and improved
- ✓ Audit work on child protection plans and responding to new concerns
- ✓ The local authority is required to demonstrate that it has used the findings of this review to inform its arrangements for care planning for "looked after" children (Reporting in September 2017)

The Story of children A and B

This serious case review was carried out following the death of Baby L aged eleven weeks. Baby L died as a result of significant internal injuries and multiple fractures, his father was charged with murder, convicted of manslaughter and is serving a prison sentence.

Baby L was born in Oxfordshire and has one older half sibling. His mother had been known to Thames Valley Police since 2005 due to a significant number of incidents of domestic abuse from more than one partner, as well as her being identified as the perpetrator on at least one occasion. Children's social care was aware of some (but not all) of these incidents; none were recorded in GP records.

Health professionals working with Mother during her pregnancy with Baby L were unaware of a number of stresses in the family including past experience of domestic abuse and threat of eviction. Following Baby L's birth, Mother and Father moved into accommodation together in Oxfordshire but twenty miles from their home area.

The injuries to Baby L were reported by Father who called an ambulance. Baby L was taken to two other hospitals outside of Oxfordshire. The immediate focus in hospital was on saving his life and the review has explored the degree to which effective safeguarding measures were in place both in respect of parental contact with Baby L and the protection of his half sibling.

Responding to the findings - these are some of the actions taken since

- ✓ Health visitors routinely follow up the records of siblings in families who are receiving a service and there are recognized vulnerabilities
- ✓ Health providers are reviewing and improving information sharing systems.
- ✓ Oxford Health NHS FT are improving the electronic information system which should lead to a greater understanding of the safeguarding work undertaken by staff. It should also enable staff to be able to identify children linked to an adult they may be working with.

The **full report and findings** were identified and can be accessed from the OSCB website.

CHAPTER FIVE: CHALLENGES AHEAD AND FUTURE PRIORITIES

National Drivers

- Implications of the Children and Social Work Act 2016-17
- Implications of reduced resources at a national level
- Potential changes to elective home education

Board Business Plan

- Improve the effectiveness of the board; collaborate with Oxfordshire Safeguarding Adults Board (OSAB) and engage with local communities
- Address neglect and safeguard adolescents at risk of exploitation
- Take robust action following learning; to ensure continuous improvement and to assess risk and capacity across the partnership

For local multi-agency work

- Ensure good understanding of thresholds and use resources to understand and work with them;
- Be vigilant to emerging pressure points and concerns: safety online; self-harm; modern slavery; transgender young people and the potential radicalisation of children
- Managing change (transitions) for young people goes well when partners understand what is required of them e.g. know what that is
- Long-term planning is effective when partners have strong links with one another and know how to contribute them e.g. know how to record and sharing information effectively

For local multi-agency work

- Help early. Partners know that this is the most effective, least intrusive way to solve problems.
- Increase school attendance, reduce exclusions – leading to improved attainment
- Address emerging concerns of criminal exploitation of children related to drugs
- Safely reduce the number of looked after children. Work needs to be done to work effectively with families at an earlier stage to reduce the need to place children in care
- Improve the confidence and capability of the whole workforce. Work effectively with families experiencing domestic abuse , parental mental health and drug and alcohol issues

CHAPTER SIX: WHAT NEXT FOR CHILD PROTECTION IN OXFORDSHIRE

Our Local Community

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

Heads and Governors of Schools

- Check your pupil attendance and take action – know their 'whereabouts' – we know that children are safer in school and that this remains a safeguarding issue in Oxfordshire
- Be informed. Know how to support pupils dealing with concerns like self-harm; radicalisation; sexting; sexual identity
- Undertake the on-line Prevent training and RAP training
- Use the termly e-bulletin to stay up-to-date on safeguarding issues – this comes directly from the safeguarding in education subgroup of the OSCB and ties you in to current issues in the safeguarding system.

Community and Voluntary Sector

- Do safeguarding training;
- consider becoming an OSCB trainer yourself;
- find out how 'early help' works in Oxfordshire

Children

Thank you for telling us what you think. We understand that LGBT is something that you want to talk more about; that we need to find better ways to talk about healthy relationships, consent and sex; that what we understand as 'sexting' is something we need to be better at dealing with.

Children Workforce

You are our biggest asset. We know that the volumes of work in the system are higher than ever and that you feel that you are dealing with more complex cases than ever before. As partners we have had excellent feedback on the work that you are doing.

- Use supervision to check your thinking and decision making
- Escalate your concerns and follow up if necessary
- Make sure you understand the new early help arrangements
- Remember "**Every child needs at least one adult who is irrationally crazy about him or her**", Urie Bronfenbrenner. The message that the OSCB heard at the annual conference has been reiterated by young people. The impact of one person like you can be incredible: you could be a volunteer, a teacher, a foster parent, a social worker… Children have said that we should never underestimate the positive impact a professional can have.

Senior Managers and Leaders

Improve the confidence and capability of the whole workforce – to work effectively with families experiencing domestic abuse, parental mental health and drug and alcohol issues

Glossary

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