OSCB Annual Report 2016/17 - Executive Summary

Summary of the OSCB annual report.
The full OSCB report is published on the OSCB website.

The key purpose of the OSCB Annual Report is to assess the impact of the Board's work in 2016/17 on:

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

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

It celebrates a number of areas of success and achievement but also identifies areas that present continuing challenge in safeguarding children and young people in Oxfordshire, challenges which form the basis of priorities for improvement in the Business Plan for 2017/18.

THE LOCAL SAFEGUARDING CONTEXT AND PROFILE

The first chapter of the Annual Report examines the safeguarding profile of the child population in Oxfordshire. It presents a picture of increasing demand on services and higher rates of escalation into child protection and care which clearly create concern for the OSCB.

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

Key data presented shows that:

- **458 early help assessments** – a considerable reduction in comparison to the number of CAFs undertaken in the previous year;
- A rise to **1549** in the number of **troubled families** worked with in 2016/17;
- A rise from 569 (2015/16) to **607** (2016/17) in the number of **children subject to child protection plans**. This is higher than both the national average and the average for similar authorities;

- **67%** of children newly subject to child protection plans become so **as a result of neglect.** This compares to 58% of cases last year and is higher than the national average of 45%;
- The number of **disabled children with a child protection plan (16)** is in line with previous years;
- 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
- Since **2011 the percentage of children with child protection plans and in care has progressively increased** at a higher rate than the national average;
- The number of **children placed out of county** and not in neighbouring authorities **has increased from 77 to 118**;
- The number of **unaccompanied asylum seeker children** who came into the care of the local authority **rose by 38% from 42 to 58.**
- 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** though performance improved in 2015/16
- **236 CSE screening tools completed** in 2016-17 compared with 223 in 2015/16.
- 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.
- 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) - the proportion of children who repeatedly went missing from home remained at around 18.5%;
- There was a **21% increase** in the numbers of children **in elective home education** since last year, taking the total number of cases to over 450;
- **Persistent absence increased** from 6.7% in 2014/15 to 13.9% in 2015/16 which is higher than the national average;
- **Permanent exclusions** from school are on an **upward trend** compared to last year;
- 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;
- 50 children were identified as living in a privately arranged foster placement, compared to 43 at 31 March 2016;
- 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 CAMHS referrals were either inappropriate or signposted to alternative provisions;
- The open CAMHS caseload average is 4800 young people at any given time across Oxfordshire;

- CAMHS continue to meet targets for young people who need to be seen urgently or as an emergency;
- Targeted work to reduce waiting times has secured improvement and at the time of publishing this report 71% of all routine referrals are seen within 12 weeks across the county.

What does this mean for the OSCB?

The increased demand on specialist and high cost services and rises against other key indicator measures creates concern for the OSCB in a number of ways:

- Children appear not to have been as regularly identified for early help and the opportunity to address needs early missed – the recent launch of the Locality and Community Support Service (LCSS) is intended to reverse this trend and the OSCB will be scrutinising progress regularly to ensure this happens;
- The hypothesis that effective early help can reduce escalation to child protection and care interventions needs to be rigorously pursued to 'turn the curve' in the long-term increases in numbers in the child protection and care systems;
- Increased demand can result in higher caseloads for staff creating pressure and risk around sustained quality and effectiveness of safeguarding work;
- We need to be confident that agencies are working collectively, efficiently and effectively to manage and reduce demand;
- We need to be confident that the workforce has the skills and competences to maximise the impact of new initiatives designed to reduce demand and the workforce development impacts positively on service quality and safeguarding outcomes for children and young people.
- 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 – and this is why we also need to work with the Safeguarding Adults Board on these issues to improve our capacity and impact.

During 2017/18 this will translate into a number of key priorities for the 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.

GOVERNANCE AND ACCOUNTABILITY ARRANGEMENTS

The second chapter of the Annual Report focused on the Board's governance and accountability arrangements. This outlines the current frameworks under which the OSCB operates and headlines changes that will take place as a result of the Children and Social Work Act 2017.

The key purposes of the OSCB are to:

- Ensure effective safeguarding across Oxfordshire
- Co-ordinate what is done by individuals and agencies represented on the Board to ensure effective safeguarding and promote the welfare of children in Oxfordshire

The report outlines the:

- Current governance structure and the roles of the OSCB, the Executive and the subgroups
- Independent nature of the Board including the role of the Independent Chair
- Relationship of the Board with the County Council, other partners and other partnerships operating in Oxfordshire
- Links to the Safeguarding Adult Board which is a key partner in securing effective safeguarding in Oxfordshire
- Changes in representation from the voluntary and community sector
- Representation from the Soldiers, Sailors, Airmen and Families Association (SSAFA)
- Work of our lay members

The report on the budget illustrates that we have operated within budget and sustained a reserve that is largely held to resource serious case reviews that may be required in the coming year.

Most importantly the Annual Report evaluates performance against the OSCB Business Plan for 2016/17.

PROGRESS AND ACHIEVEMENTS IN 2016/17

The Annual Report evaluates performance against the 3 key aims of the OSCB as set out in the Business Plan 2016/17:

Aim 1: To provide leadership and governance

Aim 2: To drive forward practice improvement

Aim 3: To scrutinise and quality assure

Headline progress, achievements and areas for further improvement are as follows:

To provide leadership and governance

The OSCB set three priorities for leadership and governance – to ensure that:

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

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 and is committed to:
    - 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.
    - A 'safeguarding self-assessment' of partners compliance against safeguarding standards for working with children and adults was undertaken

- ✓ The OSCB and Community Safety Partnerships worked on case reviews, Prevent training to address radicalisation and used funding from the Police and Crime Commissioner to build the 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 has three priorities: early help, educational attainment of vulnerable groups and transitions to adult services.

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 children and young people's views being reflected within the OSCB partnership

- ✓ The OSCB has engaged with VOXY – the Voice of Young People in Oxfordshire – both to enable them to work in partnership with the OSCB in agreeing strategic priorities and action to secure improvement and to widen engagement with children and young people at both community of interest and service user levels
- ✓ The on-line bullying survey that continues to enable us to monitor and scrutinise prevalence in Oxfordshire
- ✓ Work to address the needs of Oxfordshire's young LGBT community which was a focus of our annual conference

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

The OSCB is assured that the local partnership is focussed on the effectiveness of safeguarding 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 of success 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.

To drive forward practice improvement

The OSCB priorities in this areas has been **to protect younger children from the harm of neglect and parental risk factors** and **to protect older children from harm**

Progress on protecting children from the harm of neglect and parental risk factors

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**.

Progress on protecting older children from harm

Strategic leadership and co-ordination

- ✓ Self-harm networks for professionals have been expanded: they identify young people, share good practice and ensure there is good interagency join up for them
- ✓ 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 ensure good communication with schools and colleagues as appropriate following an admission due to self-harm (tested by audit)
- ✓ Oxfordshire County Council and Barnardo's have jointly 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 of all crime amongst bed and breakfast/hoteliers and partners
- ✓ 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

- ✓ Resources invested into the county's "Placement Strategy" in 2013 have created additional capacity to meet demand of 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, which these children are vulnerable to
- ✓ Oxford Sexual Abuse and Rape Crisis Centre has 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

- ✓ Work has been done to understand the level of health practitioner 'knowledge and attitude' to consent by undertaking a survey of a wide range of health staff across all Trusts and services.
- ✓ CSE learning summary; a presentation on working with parents; guide for parents on the OSCB website
- ✓ OSCB partner learning events for over 150 practitioners on online safety
- ✓ OSCB conference for over 200 practitioners attended the on young people and their 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.

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

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 re-enforces this message. **The OSCB partners must keep the work to protect older children from harm as a priority.**

Improving Mental Health Services

The increased demands on mental health services have been a concern for the OSCB for some time. This annual report therefore sets out in more detail what work is taking place to meet those needs.

The Oxford Health Mental Health Foundation Trust has been awarded a new five year contract for delivering mental health services in Oxfordshire. The new service 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 and providers to deliver a service that increases resilience and self-help, reduces waiting times to ensure easy and timely access to the most appropriate interventions, safeguards children and young people from harm and offers a range of evidence based interventions targeted at those who require them. 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 arrangements include the delivery of:

The Oxon Specialist Eating Disorder Service
The Horizon service which aims to support young people and their families who have been affected by sexual harm
The School In-Reach service
The Autism Diagnostic Clinic pilot

To scrutinise and quality assure

The OSCB priorities under this heading has been to **check the effectiveness of joint working through audit, to scrutinise OSCB agencies' safeguarding practice**

Progress on checking the effectiveness of joint working through audit:

- ✓ 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

Progress on scrutinising OSCB agencies' safeguarding practice:

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.** A peer review was held to reinforce the OSCB's culture of challenge. 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 partner 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.
- The Emergency Department within OUH NHS FT consistently informs schools where there has been an admission due to self-harm

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

Workforce Development

The OSCB delivered over **150 free safeguarding training and learning events** plus online learning that **reached over 9000 members of the Oxfordshire workforce.**

Over 85% of delegates reported that they found the training good or excellent.

A recent phone survey showed that 96% of respondents said that they had better safeguarding practice as a result of their training.

The majority of training is delivered by a pool of professionals working in our services – and they are highly regarded by delegates.

CSE has been a major focus and these programmes have reached over 4000 staff.

In addition to training courses we have delivered a programme of **Learning Events** to **over 400 local practitioners.** Learning Events have targeted:

- Safeguarding risks online
- Relationships and identity
- Working with children with disability
- Working with neglect

The Child Death Overview Panel (CDOP)

CDOP is a sub-group of the OSCB. It carries out a systematic review of all child deaths to help understand why children have died.

In 2016-17 the CDOP reviewed 36 cases and identified the following modifiable factors:

- 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

This service provides an immediate response to reported child deaths. The team is coordinated the Oxford University Hospitals NHS Foundation Trust. It 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

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.

Serious Case Reviews

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.

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.

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).

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.

Key learning points from SCRs undertaken are:

1. The role of the fathers in the family system together with communication with and involvement of fathers and male carers;
2. The need for curiosity about family history, relationships and current circumstances that moves beyond reliance on self-reported information;
3. More challenges are 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 children;
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.

CHALLENGES AHEAD AND FUTURE PRIORITIES

The annual report concludes with headlines about our future priorities which include:

National drivers

- Implications of the Children and Social Work Act 2016-17 for LSCBs
- Implications of reduced resources from Government
- Planned statutory changes to elective home education

For the Board business plan

- Improving the effectiveness of the board; collaboration with Oxfordshire Safeguarding Adults Board (OSAB) and engagement with local communities including the VCS
- Tackling neglect and safeguarding adolescents at risk of exploitation
- Taking robust action following learning; to ensure continuous improvement and to assess risk and capacity across the partnership

For local multi-agency work

- Ensuring good understanding of thresholds;
- Being vigilant to emerging pressure points and concerns: safety online; self-harm; modern slavery; transgender young people and the potential radicalisation of children
- Managing and improving change (transitions) for young people
- Long-term planning for children in a multi-agency context

Future priorities

- Early Help. Increasing access to early help and securing assurance it prevents escalation to child protection and care
- Increasing school attendance and reducing exclusions – leading to improved attainment and improved safeguarding
- Tackling criminal exploitation of children in relation 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
- Improving the confidence and capability of the whole workforce.
- Work effectively with families experiencing domestic abuse , parental mental health and drug and alcohol issues

WHAT NEXT FOR CHILD PROTECTION IN OXFORDSHIRE –SOME KEY MESSAGES

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

The community, faith and voluntary sector:

- Undertake your safeguarding training;
- Consider becoming an OSCB trainer yourself;
- Find out how 'early help' works in Oxfordshire and play your role in its implementation

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's workforce:

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

Senior managers and leaders:

- Engage with our priorities and lead your organisations in support of these
- 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

CONCLUSION- A MESSAGE FROM THE INDEPENDENT CHAIR, PAUL BURNETT

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.

Paul Burnett, Independent Chair, Oxfordshire Safeguarding Children Board

The full version of the OSCB Annual Report is available on our website at www.oscb.org.uk