Annual Report & Accounts 2017-18

OSCB

Oxfordshire Safeguarding Children Board

Contents

Introduction from the Independent Chair, Paul Burnett

I am delighted to present the Oxfordshire Safeguarding Children Board's Annual Report for 2017/18 – the last time I will be doing so as Independent Chair in the county.

The report evaluates the impact of the work we have undertaken in 2017/18 focusing on service quality and effectiveness and on safeguarding outcomes for the children and young people of Oxfordshire. Specifically it evaluates performance against the priorities that we set in our Business Plan for the year and other statutory functions that the LSCB must undertake.

There is much to celebrate in terms of improvement and achievement:

- Strong challenge at national and local level in relation to issues presenting safeguarding risks including: exploitation; domestic abuse; support to transgender children; elective home education; school attendance and exclusions; specialist residential placement for children in care and; availability of beds for children with acute mental health needs
- Stronger links and collaboration with the Adult Safeguarding Board and Voluntary and Community Sector
- An online practitioner portal for Neglect that has received 8000 hits
- Over 2000 staff attending learning events across the county
- Stronger engagement with young people including VOXY
- Examples of community impact on safeguarding, such as apprehening a perpetrator of CSE as a result of an alert from a taxi driver who had received the mandatory safeguarding training for drivers three months earlier.

A further success was a commendation received by the OSCB Training Pool from in the NSPCC/BASPCAN awards.

Our robust quality assurance and performance management has identified priorities for action as we move into 2018/19. These feature in our refreshed 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 legislation will impact on our work next year. The Children & Social Work Act 2017 creates a new framework for local safeguarding arrangements as well as revised procedures for local and national practice learning reviews (which replace Serious Case Reviews) and the reform of CDOP arrangements.

Revised local arrangements have to be in place by April 2019. In Oxfordshire we are not planning any radical change to existing arrangements. We intend to retain a Board with the current constitution and membership. We also intend to retain an Independent Chair though this may be provided through a different route to our current arrangement. Responsibility for local arrangements and their effectiveness will now rest with three organisations: the County Council, Thames Valley Police and the Oxfordshire CCG. The precise nature of this leadership does need to be agreed once the final version of the revised Working Together is published by the Department for Education.

In Oxfordshire there is 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.

I retire from my post at the end of June 2018. I would like to take this opportunity to thank all Board members and those who have participated in Subgroups for their continued commitment in 2017/18 and throughout my time in post. 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 2018/19 will require continued commitment from all to ensure that children and young people in Oxfordshire are safe.

I commend this report to all our partner agencies.

Independent Chair, Oxfordshire Safeguarding Children Board

Oxfordshire Safeguarding Children Board

Introduction

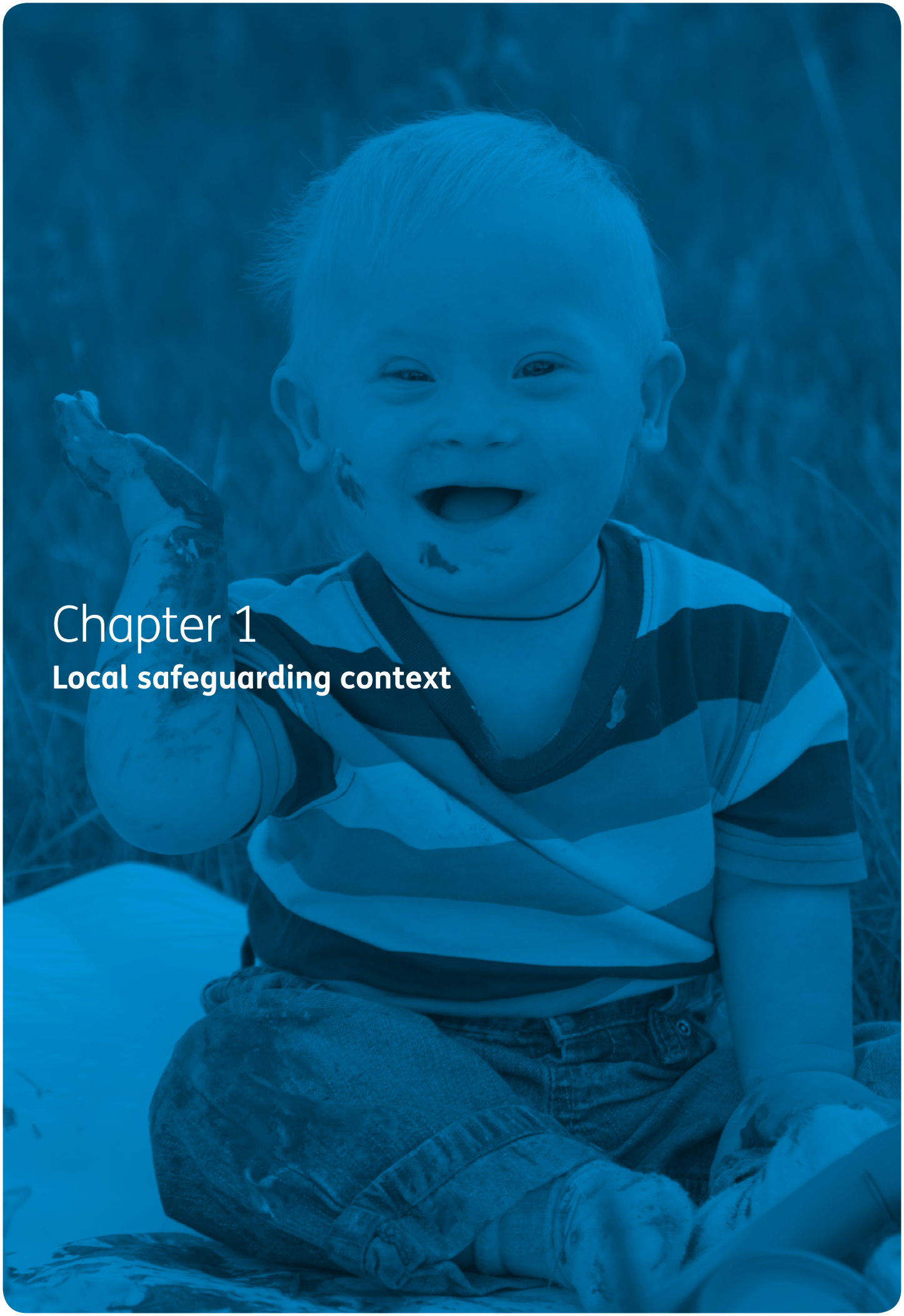
The reason for this report

The key purpose of the OSCB Annual Report is to assess the impact of the Board's work in 2017/18 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. See appendix A for these details.

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 2018/19.



Chapter 1
Local safeguarding context

The Local Safeguarding Children Board is a partnership set up under the Children Act 2004. The agencies in this partnership co-operate with each other to safeguard children and promote their welfare.

The local safeguarding profile of the child population is our business. This is what we know about 2017/18.

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 the local context is one of continued increasing demand on services and higher rates of escalation into child protection and care. This remains a concern for the OSCB but it was reassuring to see that the recent Ofsted judgement of children services stated that this context was being managed well locally.

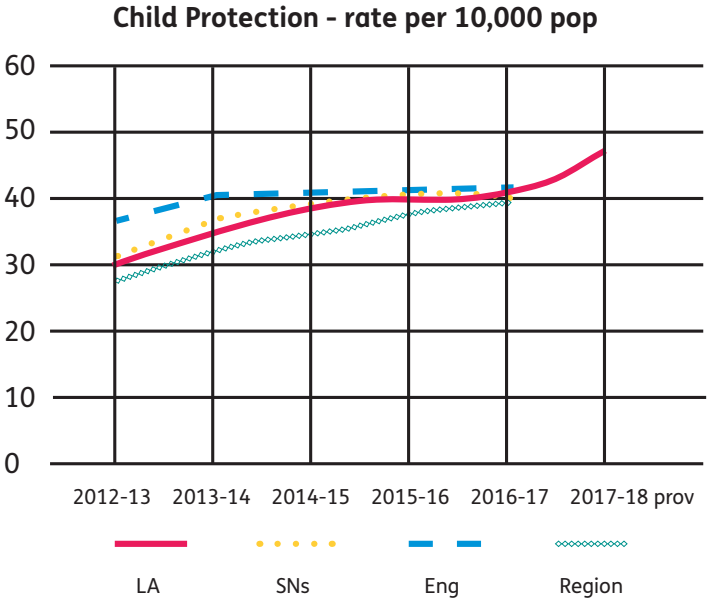
Help at the earliest point for families increases the chance of good outcomes for children. Early help assessments are the means for doing this. They have increased significantly from 458 recorded early help assessments last year to 1255 by end of year in 2017/18. This is commendable as Board partners know that not all agencies have found the early help assessments easy to complete and activity is underway to make it easier to do so. The number of troubled families worked with rose from 1549 last year to 2398. This increase is positive and would indicate that the work is on track.

Those families in need of immediate help and safeguarding support should be referred to the Multi-Agency Safeguarding Hub (MASH) which has been in place since 2013. This multi-agency team can assess need and ensure that the right kind of support is provided. The timeliness of enquiries managed by the Multi-Agency Safeguarding Hub are monitored closely. They show how quickly families are receiving help and have been a key indicator used by OSCB to gauge how well MASH is working.

The recent Ofsted inspection was positive about improvements made to the MASH so it is hoped that the improvements will soon be felt in the timeliness of services as at year end was below the target of 75% at 45%. This needs to be improved as does feedback to the referrers.

The number of children on a child protection plan rose from 569 last year to 730 at the end of March 2018 (higher than national average). Neglect is the most common reason for children to be subject to child protection plans (65%). This is higher than the national average where the proportion of children subject to child protection plans for reason of neglect is 48% (SFR 2016/17). Neglect is not however the most common reason for children to be subject to an early help assessment. This has raised questions to OSCB partners about how we identify, name and tackle neglect earlier in the child's journey. The recent Ofsted inspection agreed with this assessment.

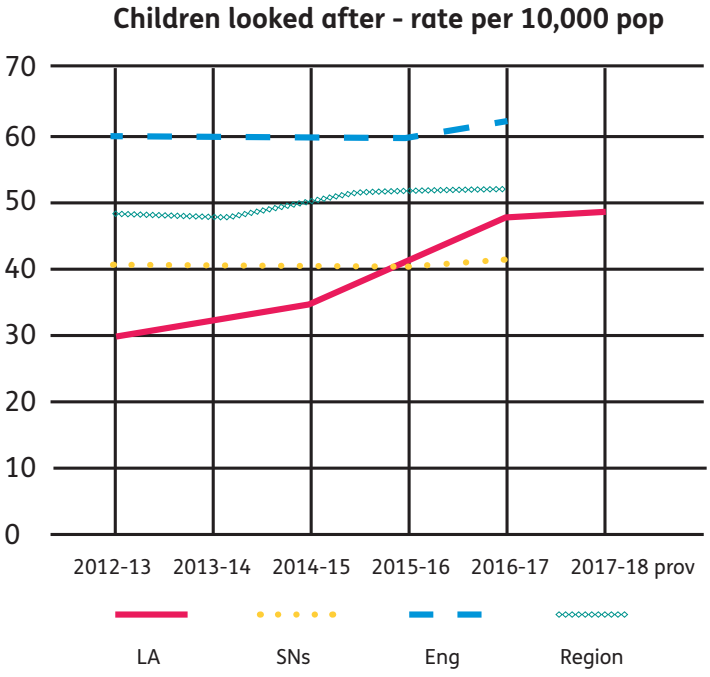
A close look at the management of child protection plans indicates that only 50% of fathers are attending children protection conferences regarding their children. 'Working with fathers' has been a focus for learning in 2017/18 and should remain one for now.



Graph 1: child protection

The number of children looked after by the local authority rose by 6% from 667 last year to 691 at the end of March 2018 (lower than national average). This is an increasing trend. The biggest increase has been in adolescent children, who are presenting with increasingly complex needs and elevated risk profiles particularly autism, mental health issues and risk of exploitation.

The OSCB closely monitors information on vulnerable children. Whilst the number of children who have gone missing from home has fallen from 798 to 773 the number who went missing 3 or more times was 149 or 19.3%. This needs further enquiry and consideration by the child exploitation subgroup.



Graph 2: looked after children

The numbers of child victims of crime rose from 2189 in 16/17 to 2268 in 17/18 – a rise of 3.6%. The numbers of domestic crime involving children rose from 1780 in 16/17 to 1804 in 17/18 – a rise of 1.3%

From national and local (children A-F and child J) case reviews the OSCB has evidence of links between safeguarding risk and safeguarding in education issues: attendance, exclusions, elective home education, attainment and achievement of pupils with special educational needs and disabilities. In 2017/18 499 children were recorded as receiving elective home education in Oxfordshire. At the end of 2017-18 the county council were aware of 378 pupils who were on a reduced timetable; 6 pupils who were currently on a fixed term exclusion and of 34 pupils who were permanently excluded from their school. Permanent exclusions of children with Special Education Needs have increased. The OSCB is very concerned about this vulnerable group of children and has made a priority to secure improvement. Data is showing us that children with additional needs make up at least 70% of the children worked with by the Kingfisher team, which specialises in supporting those children most at risk of child sexual exploitation. We know that this type of vulnerability often overlaps with drug exploitation. Data also shows that the proportion of Oxfordshire's disadvantaged pupils aged 10-11 achieving the expected standard was below the England average at Key Stage 2 in 2017.

The percentage of children referrals to Child and Adolescent Mental Health Services who are seen within 12 weeks continues to be a cause for concern. At the end of the year this was only 56% compared with a target of 75%. The service continues to face high levels of demand: in 2017/18 there were 6794 referrals into CAMHS, 11% higher than the previous year when there were 6128 referrals. An action plan has been put in place by the provider (Oxford Health NHS FT) which is routinely reviewed in contract meetings with the commissioner (CCG). Detailed updates are provided to both the Children's Trust and its Performance Audit and Quality Assurance sub group. Alongside this there has been a rise of 22% of children aged 12-17 who have attended A&E for self-harm of (542 in 2016-17 to 660 in 2017-18).

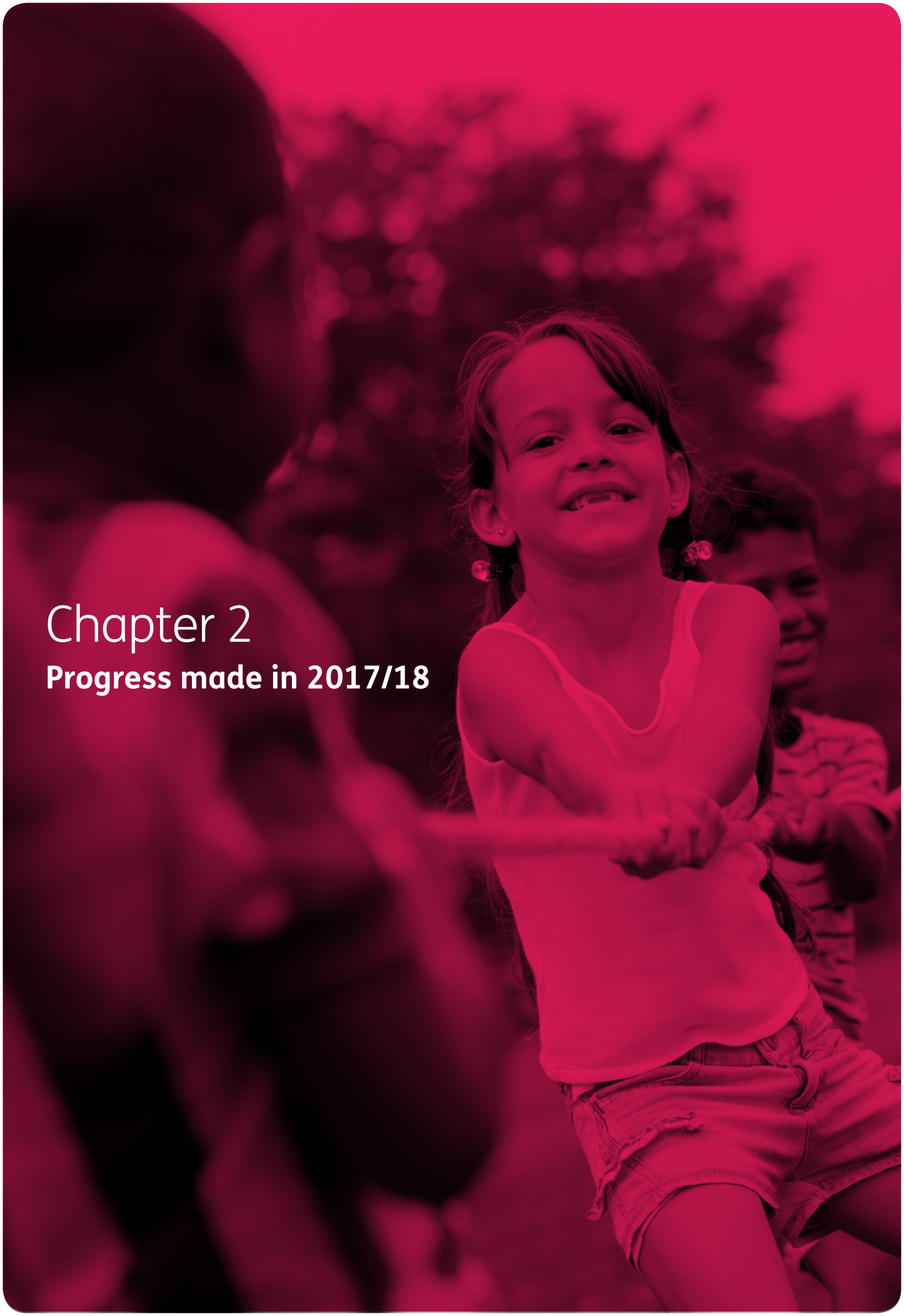
Health providers have also escalated the concern that there is a lack of provision for children with acute mental health needs, which had meant that it has not been possible to discharge them from hospital care to receive more appropriate support.

There are a higher than average numbers of young people remaining in their placement after 16 (84%) and high percentage of 19-21-year olds in suitable accommodate (88%). The county council maintains contact with 94% 19-21 year old care leavers. This is commendable as is the fact that 88% of the cohort are currently in employment, education or training.

What does this mean for the OSCB's priorities in 2018/19?

The local context is one of a system under pressure. There has been a long period of rising demand for services against a background of cuts. This pressure will be felt at the frontline in the hours and effort that colleagues put in every day. OSCB partners should:

- ensure that the early help process is improved and that partners in the safeguarding system understand thresholds, early help and their role in it. The aim is to reduce the number of families that are escalated for help through child protection planning of the care system
- ensure that partners know how to see and name neglect earlier and understand the value of a multi-agency chronology when working with children
- improve multi-agency responses to safeguarding vulnerable adolescents from criminal exploitation, in particular those children with special educational needs
- maintain an emphasis on risks identified through 'safeguarding in education': attendance, exclusions, elective home education, attainment and achievement of pupils with special educational needs and disabilities
- scrutinise pressure points until improvement is seen e.g. Early Help Assessments (EHA) completion rate, MASH timeliness, CAMHS waiting times
- escalate risks which sit outside of the local partnership e.g. lack of provision for looked after children and for children with acute mental health needs, elective home education
- ensure that the workforce is thinking family and thinking dads
- ensure that the workforce is capable and able to deal with:
  - parental issues such as substance misuse, mental health problems and domestic abuse are addressed as part of this problem
  - adolescent issues of substance misuse, mental health, healthy relationships as well as online well-being.



Chapter 2

Progress made in 2017/18

The Annual Report evaluates performance against the 3 aims of the OSCB as set out in the Business Plan 2017/18:

1. **To provide leadership and governance**
2. **To drive forward practice improvement**
3. **To scrutinise and quality assure**

Aim 1

To provide leadership and governance

Priorities have been to increase the effectiveness of the board, partnership working with Oxfordshire Safeguarding Adults Board and community engagement

Progress includes	
Increasing the effectiveness of the board	✓ Partnerships protocol updated and simplified (see appendix X) ✓ Annual impact assessment on the effect of efficiency savings and transformation of services across the child protection partnership ✓ Six monthly reports on key aspects of the system e.g. the Multi-Agency Safeguarding Hub and CAMHs waiting times ✓ Systematic challenge and escalation of safeguarding risks which have emerged in addition to the board's ongoing business
Challenge made	**Escalation by the OSCB**
Safeguarding of children in secure estates	✓ To the HMIP, the CRC and the AILC. The outcome is that a national level task group is now reviewing this serious concern. We are yet to see if this will lead to change at a national level.
Safeguarding risks for children in elective home education	✓ To the government via the association of independent. Government is consulting on this in 2018 and OSCB has submitted evidence from a recent case review. The outcome of this work will become clear in 2018/19.

Challenge made	Escalation by the OSCB
Specialist residential provision for looked after children	To the regional association of directors for children's service. The outcome has been that this has been escalated onward to the government to inform them of the problems with and lack of provision as well as particular concern for children with acute mental health needs. We are yet to see if this will lead to change at a national level.
Exploitation of children in the form of drug exploitation	To local partners. The outcome has been to set up an OSCB child exploitation group which is developing outputs such as a screening tool, referral routes and provision to be used by safeguarding partners across the county. The next annual report will comment on what difference these safeguarding arrangements are making to children.
Uptake of the police's 'Encompass' system	To schools. They have been made aware of this domestic abuse notification via OSCB. The outcome has been improved uptake from 16% to 48% (May 2018 data). This is still not sufficient and remains a concern.
Pathway for support for LGBTQ children	To the Children's Trust. Outcomes have been that the health advisory group is developing a 'referral' pathway for children asking for help; school health nurses have done awareness training to better support children; OSCB training is coming online in 2018 for professionals who want to improve their practice when working with children.

Partnership working with Oxfordshire Safeguarding Adults Board	Community engagement
Joint work on transitions ✓ Co-production group 'Moving into Adulthood: Working Together' set up to develop a new approach to supporting young people with social care needs through transition. ✓ Draft proposals to develop a social care team which spans transition (from around 14ys to 25ys), improving information, promoting independence and providing a named social worker. ✓ The Joint Commissioning Team re-aligned, bringing together commissioning for children and adults of working age into a single team. ***Joint work on housing*** ✓ New housing representative on each safeguarding board ✓ New adults' protocol has been launched on 'Working with people who do not engage with services/or are deemed ineligible to receive services' across housing providers and test out how it works in practice. ✓ New network for Housing Provider Safeguarding Leads is being established to improve communication about issues and concerns e.g. referral routes; access to information; good communication and training ***Joint work on domestic abuse*** ✓ Audit on the 'referral pathway' for young people ✓ The 'referral pathway' for young people subject to domestic abuse has been revised and will be launched in 2018 ✓ New domestic abuse service model commissioned to start in 2018 ✓ Work on training strategy for domestic abuse to deliver in 2018 ***Joint work on training*** ✓ Joint oversight of shared thematic training ✓ 'Think Family' online course developed for adults and children	✓ VCS representation on all key subgroups and board with a plan for action in 2018 ✓ VCS partners joined the training pool ✓ OSCB safeguarding training to specialist groups ✓ OSCB regular input in to Children, Young People's Forum ✓ Self-assessment of safeguarding for local partners completed ✓ Template Safeguarding policy for local partners ✓ Safeguarding checklist for local partners ✓ 4 meetings with the Voice of Oxfordshire Youth group ✓ Children in Care Council and Voice of Oxfordshire Youth group part of OSCB recruitment processes ✓ Voice of Oxfordshire Youth group presented their main safeguarding concerns ✓ Voice of Oxfordshire Youth group asked OSCB to look at how well safeguarding partners work with perpetrators of sexual harm to prevent further abuse – this audit will be reported in 2018 ✓ 200 survey responses received from children in care aged 5 to 18 yrs – analysis processed in 2018

OSCB view of progress made in terms of leadership and governance

Points of progress:

OSCB partners have challenged one another robustly and escalated issues from the board to the Children's Trust, local partners as well as to national government – it has played an active role in the safeguarding system. There has been regular scrutiny of MASH and the early help system which is showing improvement as the data indicates. OSCB and OSAB have made good joint progress on common issues leading to better outcomes for children transitioning as well as improved safeguarding connectivity with housing providers. Good progress has been made with voluntary sector partners ensuring that safeguarding concerns such as 'managing increased risk' are understood as a real pressure for local partners.

Points for improvement:

OSCB and OSAB should keep a tight focus on the domestic abuse work, in particular training as well as a watching brief on modern slavery too in order to assess prevalence in Oxfordshire. The OSCB partners should continue to review the system and ensure responses to local safeguarding risks e.g. exploitation, domestic abuse multi agency training, referral pathway for transgender children. Partners should also escalate issues where the solution lies beyond the partnership e.g. children in elective home education, specialist residential children for children in care.

OSCB should continue the positive work together with the voluntary and community sector developing representation, increasing training opportunities and improving communication.

Aim 2. Priority 1.

To drive forward practice improvement

The priority to address neglect has been focused on increasing support to families at an early point. This means seeing it and naming it before it impacts on children. Currently 65% of children protection plans are due to neglect. The aim is to reduce this.

Progress on practice improvement	
Working in partnership Neglect portal on the OSCB website	✓ Guidance on identifying and naming neglect – knowing what it looks like and feels like for a child ✓ Development of neglect pathways ✓ Safeguarding tools and interventions for identifying and working with neglect including Childcare Development Checklist, 3 houses, Signs of Safety, Safety House and Wizards and Fairies ✓ Information so that all practitioners understand a child protection core group and what role they play ✓ Provision of named link workers within adult services to provide consultation and advice ✓ Online resources to help practitioners

Progress on practice improvement	
Seeing and naming neglect	✓ Multi-agency chronology template to help partners track and record working with families ✓ 'Community impact Zones' initiated in Oxford and Banbury to target higher risk areas ✓ 'Community around the school' pilot targeted at risk hot spots ✓ 2304 'no names' consultations from partners and schools to social care have been dealt with ✓ Development of multi-agency neglect training video to provide common approaches for identifying neglect, tips on how to identify and name neglect, approaches to working with neglect and development of common, shared language. ✓ Development of 2-day multi-agency neglect training programme
Improving practice	✓ Multi-agency Neglect Strategy Group led by senior managers across partners ✓ Multi-agency Neglect Operational Group to deliver Neglect Action Plan ✓ Over 1000 multi-agency practitioners trained on the early help process: thresholds and referral forms ✓ Over 200 multi-agency practitioners at OSCB neglect conference ✓ Over 150 multi-agency practitioners at OSCB learning event on case reviews where early help and neglect was key ✓ OSCB 'Think Family' online course launched ✓ OSCB awareness of abuse and neglect online course launched – 791 trained ✓ Multi-agency audit on how well we work on cases of neglect ✓ More than 8,000 hits on neglect portal within first 9 months of launch ✓ Development of multi-agency Neglect Practitioner Forum to share best practice, identify issues of concern and drive forward practice improvement across services

Progress on practice improvement	
Measuring change in practice	✓ Local 'dashboard' on neglect which, for example, measures the proportion of early help assessments compare to referrals to social care for neglect ✓ A peer review of Oxfordshire practice is set up for 2018/19

OSCB view of progress made in terms of leadership and governance

Points of progress:

OSCB partners have driven forward the work on neglect setting up a strategy group, operational group as well as a practitioner forum to promote this work. The development of an online practitioner portal with over 8000 hits, the different learning events reaching over 2000 delegates as well as a performance framework to measure change in practice is commendable. The pilot on the multi-agency chronology work should further support this. It is really encouraging to see a major increasing in the number of early help assessments.

Points for improvement:

However, neglect is still the most common reason for children to be subject to child protection plans. At 65% this is higher than the national average. The groups working on neglect are clear there is more work to be done – a position which this has been endorsed by Ofsted report on children's services. The OSCB would like to see an increase in the number of early help assessments relating to neglect.

Neglect must remain a priority for the OSCB. It must be seen and named. Multi agency chronologies should be kept up-to-date and shared.

Aim 2. Priority 2.

To drive forward practice improvement

The priority to keep adolescents safe is wide ranging due to the complex needs of the most vulnerable. The aim has been to better understand concerns, train the work-force and work more effectively together.

Progress on practice improvement	
Working in partnership	✓ Kingfisher is a nationally recognised multi agency service that manages the riskiest sexual exploitation cases. It has worked with 554 children since 2014 ✓ Kingfisher has linked with voluntary agencies to ensure that children we are concerned about can get help quickly e.g. Donnington Doorstep's Step out project, Horizons, Safe!, Elmore, Oxford sexual abuse and rape crisis centre ✓ Two children's assessment homes and two 'move-on' homes opened in 2017 to ensure that children at most risk are kept closer to home ✓ The OSCB child sexual exploitation group has been expanded to consider wider exploitation issues ✓ Partners work on disability and education subgroups have made this work a priority ✓ Locality and Community managers chair multi-agency self-harm networks using risk assessments to screen high risk children and work out support ✓ Multi-agency complex case panel of senior officers and clinicians meeting to consider how best to support and 'unstick' complex cases ✓ Multi-agency entry to care panel to ensure that decisions are joined up and support is appropriate ✓ Horizons services within the Oxford Health NHS FT service have worked with local partners such as 'Safe!' ✓ Multi-agency work on suicide prevention strategy ✓ Multi-agency networks to assess and support most serious self-harm cases

Progress on practice improvement	
Protective actions	✓ Thames Valley Police issued 45 Child Abduction Warning Notices in 2017 ✓ Children who go missing are reviewed on a weekly basis and return interviews are monitored. There was a 93.8% completion rate at the end of Dec 2017 ✓ Thames Valley Police commended a local taxi driver for raising a safeguarding concern regarding a child that he was transporting which led to the eventual prosecution of the perpetrator ✓ Oxford Health NHS FT school health nursing team and the county council have worked together to raise awareness of LGBTQ inclusion ✓ South Oxfordshire and Vale of White Horse DC ran 'Chelsea's choice' for local schools ✓ Multi-agency audit initiated on how well we work with perpetrators to prevent harm ✓ Protective behaviours work with schools driven forward by Kingfisher Team for development in 2018 ✓ Year 3 & 4: safer together programme commissioned by Kingfisher. Pilot to run in 2018 ✓ Year 5: youth ambassador programme developed by Donnington Doorsteps Step Out project ✓ Year 7 & 8: pack being developed through schools, CAMHs, Kingfisher
Identifying exploitation	✓ Child sexual exploitation champions within services supporting colleagues ✓ Work to better identify male victims including a checklist on 'how you work with boys' ✓ Work to better safeguard disabled children and identify them as potential victims ✓ New locality panels being set up to identify those children going missing and at increased risk ✓ Child exploitation screening tool drafted ✓ Task group to design 'referral pathway for help' ✓ co-ordinate effective provision for exploited children and young people

Progress on practice improvement	
Improving practice	✓ Over 60 hotel workers at 'Say something if you see something conference' organised by TVP, Hotel Watch and Oxford City Council (3 conferences to date) ✓ Thames Valley Police and district council 'test purchasing' at hotels led to further safeguarding training and OSVDC OSCB training reviewed to ensure it is up-to-date ✓ 94% of taxi drivers completed safeguarding training and an increase in LADO and MASH reporting from this workforce ✓ Updated 'joint operating framework' for taxi licensing agreed across county partners for safer transport of vulnerable children ✓ 'Mind of my own' this new app has enabled 98 children to engage with workers on their care ✓ Multi-agency audit on how well we work with victims of domestic abuse ✓ Multi-agency audit on how well we work with children with disabilities who are vulnerable to exploitation
Keeping children safe in full time education	✓ Collation of data on attendance, exclusions, elective home education, attainment and achievement of pupils with special educational needs and disabilities ✓ Headteacher breakfast briefings to drive forward strategic change ✓ Keeping 'Safeguarding Children in Banbury' was funded by Cherwell DC and led by TVP in conjunction with the Banbury Headteachers group ✓ Development of multi-agency 'Team around the school' ✓ Local authority officer termly briefings with schools safeguarding leads ✓ Development of learning from case reviews for schools ✓ Two new posts within the county council to work with schools and help with school attendance

OSCB view of progress made in terms of practice improvement: Safeguarding adolescents

Points of progress

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 reassuring 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. They range from the strategic focus on keeping children safe in schools as an important step forward to suicide prevention strategies to safeguarding training for all taxi drivers e.g. 94% of Oxfordshire taxi drivers have been trained in safeguarding. In 2017 a local taxi driver, who had undertaken this training, was commended by Thames Valley Police for his actions in safeguarding a child who was at risk of significant harm from a dangerous individual. His actions ensured the child was kept safe and proved vital in ensuring the conviction of a predatory offender. This is a positive outcome for the safeguarding network in Oxfordshire, demonstrates increased awareness and reinforces the role of tax drivers in the safeguarding intelligence network.

Oxfordshire headteachers have regularly met with the county council, senior police colleagues and health colleagues to take action on keeping children safe in full time education – reducing exclusions and improving attendance. The 'Community around the school' approach has been initiated as a means to better work together.

Points for improvement

However, the safeguarding concerns presented by vulnerable adolescents are a serious challenge the local issue of child drug exploitation is a serious concern for the partnership. Serious case reviews and data re-enforce this message. The OSCB partners must keep the work to protect older children from harm as a priority with a clear focus on criminal exploitation and schools.

Aim 3:

To scrutinise and quality assure

Priorities have been to challenge improvements, take robust action following learning and to assess risk and capacity across the partnership

Progress on practice improvement:
The OSCB has a learning and improvement framework which sets out the ability to deliver the above priorities. It includes serious case review, audit work, self-assessment, impact assessment, learning events and training. This section summarises what partners have done and learnt.

Challenge improvements through serious case reviews:

Serious Case Reviews (SCRs) are undertaken when a child has died or been seriously harmed and due to abuse or neglect and there has been interagency involvement. They are commissioned by the Chair of the LSCB. They seek to draw out learning for agencies on how to work better together.
Over the last five years the OSCB has run 12 serious case reviews and 3 learning reviews which have involved 19 children. There are two main age groups; pre-school and secondary school aged children – just over 50% are older children aged between 13 and 18ys (this figure is influenced by the serious case review on child sexual exploitation). However, 7 of these cases concern children who are pre-school or just in the first year at school. Analysis shows that either the child, their siblings or parents have previously been known to children's services, either current at time of incident or historic.
Over the last year the OSCB has worked on four serious case reviews. Some of the emerging, repeated themes have been:

1. **Curiosity:** being curious about the family's past history, relationships and current circumstances in a way that moves beyond reliance on self-reported information
2. **Responding to physical abuse:** professionals identifying it, listening to children and following procedures to properly investigate
3. **The role of schools in keeping children safe:** understanding that school attendance is a critical factor to support opportunity, well-being and safety
4. **Professional understanding of the implications of elective home education:** actively knowing which agencies are in touch with the family and to what effect
5. **Taking a cumulative view when working with children:** not seeing events in a linear way but weighing up risks over time and keeping previous events in mind (using chronologies)
6. **Parental wellbeing:** mental health, substance misuse and domestic abuse are recurring themes
7. **Fragmented management of health needs:** ensuring effective communication across services for co-ordinated and consistent management of care
8. **Children's emotional wellbeing:** increasing evidence of self-harm by children aged 10 years & above
9. **Children's limited capacity to protect themselves** as they move into adolescence after experiencing a lack of consistent, supportive parenting in their early years (long lasting impact of neglect)
10. **Rethinking 'did not attend'** to **'was not brought'**

Challenge improvements through audits

Multi agency audits and single agency audits were reported every two months to highlight safeguarding themes, good practice and learning points. Four multi agency audits covered at least 20 cases from the perspective of all agencies involved. All this year's themes are reflected above in the learning points from case reviews. Additional food for thought for the workforce from audit work is:

- Think Family.
- Use safeguarding tools earlier (look on OSCB practitioner portal)
- Engage children and families in statutory safeguarding processes – with a focus on fathers and male care givers and capturing the voice of the child
- Use chronologies to support joined up work: keep them up to date and shared
- Reassess safeguarding risk when there is a concern about neglect and children are not being brought to appointments e.g. dentist, doctor, health visitor
- Develop your understanding of online and social media abuse and your ability to talk about what constitutes abuse, healthy relationships and consent

The joint audit on disabilities confirmed some of the vulnerabilities seen in data and case reviews, such as children not being brought to appointments. It also highlighted that professionals can be concerned about raising concerns regarding neglect because they are worried about spoiling their relationship with the family. It emphasised the importance of direct communication with the child.

The joint audit on domestic abuse confirmed some of the risks raised through case reviews and in addition it highlighted that professionals need more support to talk about and deal with consent and abuse, explicit images online and what constitutes a healthy relationship.

Some of the simplest but most important messages from audits come from families and children:

Parents and carers

1. *"Communication, communication, communication!"*
2. *"Don't leave help and support until crisis point"*
3. *We want "Good sharing and co-ordination of info between agencies"*

Children and young people's views on services

1. *Get in early "make a difference as early as possible".*
2. *Relationships have got to work to build trust and progress "click and connect"*
3. *Children and young people want to be informed and involved "listen to me" – increase views being reflected in plans and decisions*

Children and young people's challenges to the board

Issues of concern have been raised by the 'Voice of Oxfordshire Youth' group:

- Lack of mental health support for young people
- Lack of youth clubs – seen as an important source of advice and guidance
- Need for more awareness for teens about drugs and alcohol
- Need for more action on bullying in schools; it is a big deal
- Fabricated and induced illnesses is an emerging concern

These messages have informed OSCB business planning.

Robust action following learning: multi agency events

OSCB partners delivered a programme of multi agency learning events to over 400 local practitioners. Board members and local professionals planned the days, delivered presentations and led round table discussions. For example, the conference on neglect was attended by 156 delegates, with an additional 34 colleagues involved in delivering the conference, e.g. speaking, facilitating group discussions, manning information stands and/or assisting the OSCB business unit with setting up/ signing in on the day. The 3 events have challenged thinking and practice and opened up conversations and covered key themes for improvement.

This is what practitioners fed back to the OSCB:

1. Working with fathers: learning from the Child Q, Children A-F serious case reviews

"Excellent speakers who made me reflect and think about my practice".

"Absolutely brilliant. Today has been a conversation which is long overdue and we need more conferences like this more frequently to raise awareness and change practice".

2. Dealing with neglect: learning from the Child Q, Children A-F serious case reviews

"Understanding the impact of neglect on how a young person perceives themselves, how they may see the world and their value, will immensely influence my practice".

"Reminding all professionals to focus firmly on the child....., the importance of keeping explanations of concerns and expectations of parents simple and unambiguous and emphasising again the importance of multi-agency information sharing".

3. Ten most frequent learning points from case reviews, Children A-F, Child J, Child Q, Baby L, Child A and Child B serious case reviews

"I'm going to talk to my manager about how we might be able to share information better within different services, e.g. housing, benefits, this was a great learning opportunity – multi-agency chronologies are a great idea if used correctly – I will be taking to team meetings".

"it is important to communicate with other professionals, don't assume other agencies have it in hand, talk to my school team and put into practice at that level, the importance of linking in with other professionals"

Robust action following learning: OSCB multi agency safeguarding training

- 2040 multi-agency practitioners trained core safeguarding
- 417 multi-agency practitioners trained on early help assessments
- 451 multi-agency practitioners trained on mental health, child sexual exploitation, working with men and boys, drugs and alcohol and sexual abuse
- 38 multi-agency practitioners trained on female genital mutilation
- 697 early years multi-agency practitioners trained on safeguarding
- 3854 multi-agency practitioners trained on abuse and neglect; safeguarding and think family

The OSCB team of volunteer trainers was awarded a Certificate of Commendation from the NSPCC and BASPCAN this year. Here are five reasons why:

1. All trainers are local frontline local practitioners who deal with safeguarding issues in Oxfordshire on a daily basis and take time out of their day to deliver training e.g. from Thames Valley Police, the local hospital or early years settings.

2. The trainers are co-producers of the training – bringing their expert knowledge and responding to local concerns. They can bring real case studies and subject knowledge to the table.

3. The trainers co-deliver our core courses, which means that there will be trainers from two different agencies within the safeguarding partnership; this strengthens our local safeguarding network.

4. The trainers are an invaluable ear to the safeguarding network meeting the workforce over 100 times each year. They talk to the OSCB after training and we listen to their comments at the three development days.

5. Passion and commitment to training. Our training team is a positive and committed group of volunteers who are good at what they do. This feedback sums it up well,

"I have gained a better understanding of how safeguarding works in Oxfordshire and how to report concerns, trainers were brilliant – best safeguarding training I have ever attended, the training enabled me to understand my role in inter-agency working brilliantly and it was clear who I should contact around safeguarding issues in other agencies, trainers worked well as a team"

Assessing risk and capacity

All OSCB partner completed a comprehensive self-assessment of their provision against standards set out in section 11 of the children's act. This provided overall reassurance that the general frameworks are in place in organisations to keep children safe.

- 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

Partners also completed an impact assessment in the face of three key pressures on its system: rising demand, diminishing resources and staffing shortfalls as well as difficulties with staff recruitment and retention. Their impact assessment recommends

1. Further development of early help strategies and initiatives
2. Improving multi-agency working
3. Maintaining services and monitoring key issues: 5 priorities remain at the forefront of safeguarding work: mental health; domestic abuse; alcohol and drug abuse; exploitation and housing.

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

Priority: Challenge improvements

The multi-agency auditing of safeguarding work is valuable in testing change. The OSCB has seen some excellent examples of improved safeguarding work through regular quality assurance of services e.g.

- The National Probation Service could demonstrate that Oxfordshire staff have a good understanding and awareness of CSE, recognised in recent visits from the National Executive Director and the Chief Executive Officer of the NPS in the past 3 months.
- Oxford Health NHS FT were able to demonstrate that colleagues were using the guidance for responding to non-recent (historic) abuse citing an example which led to the prosecution of a perpetrator of historical abuse.
- Thames Valley Police could demonstrate an increase in the recording of children's information when attending domestic abuse incidents.
- The Community Rehabilitation Company identified improved attendance at Core Groups and timely responses to requests for information from the Multi Agency Safeguarding hub.
- 97% of dental staff had an excellent knowledge of safeguarding policies, procedure and guidelines when surveyed by Oxford Health NHS FT. (57 staff audited. 60% return rate. Jul 16)

OSCB should seek to develop more assurance in 2018 on neglect, safeguarding work with housing providers as well as work to scrutinise how well we work with young perpetrators (a theme chosen by young people in Oxfordshire).

Priority: Take robust action following learning.

The work on multi-agency training has been commended nationally this year. OSCB trainers are thanked for their time and effort to deliver high quality work. The statistics delivered by this group of volunteers is impressive and includes:

- 3854 multi-agency practitioners trained on abuse and neglect; safeguarding and think family
- 2040 multi-agency practitioners trained in core safeguarding
- 697 early years multi-agency practitioners trained on safeguarding

In 2018/19 multi-agency training will be developed to include domestic abuse, neglect as well as refresher courses for professionals who have undertaken a lot of safeguarding training and would benefit from a different type of learning. These should be a priority for the partnership to deliver in 2018/19.

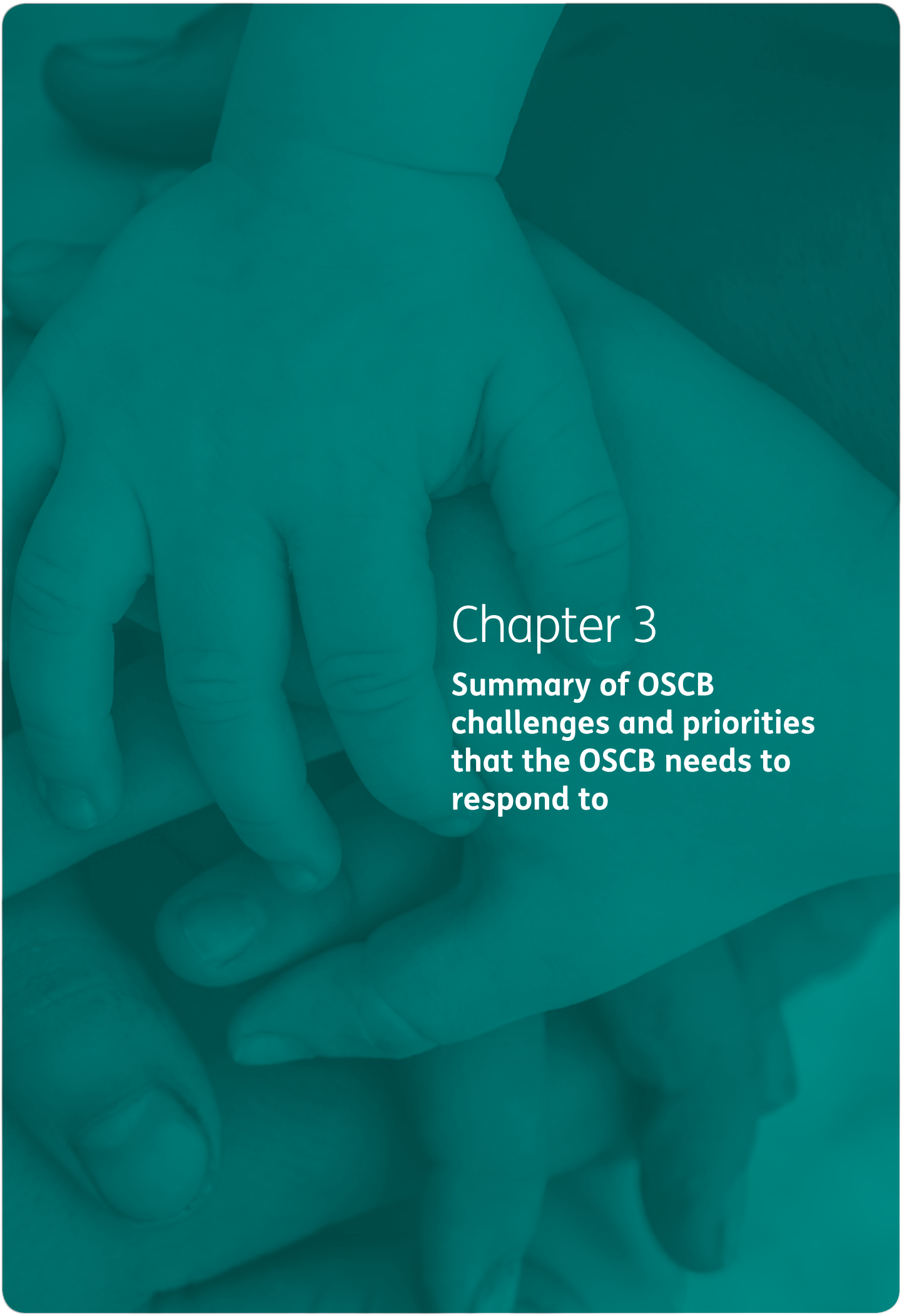
In 2018/19 multi-agency events will pick up on broader safeguarding issues for the workforce e.g. understanding criminal exploitation, multi-agency chronologies and the benefits of using them, talking about consent and healthy relationships and the additional vulnerabilities of disabled children.

Priority: Assessing risk and capacity.

The extensive work by OSCB and OSAB partners showed that they take safeguarding into account within their leadership arrangements and provision of services. Some good examples were given as to how safeguarding children is incorporated in to the daily provision of services:

- Children's Social Care developed an online portal for working with neglect
- Oxford City Council developed a Safe Haven Project for language students
- South and Vale District council put a 'Safe Place scheme' in place in Didcot and Wallingford
- West Oxfordshire District council set up safeguarding policy, procedure and specific 'Safe from Harm' pages on intranet
- Cherwell District Council introduced a safeguarding training programme for Councillors
- OUH NHST FT produced safeguarding leaflets and leaflets for parents to provide them with the information needed when a safeguarding concern has been raised
- Partnership work between the School Health Nursing Team (OH NHST FT) and Oxfordshire County Council on a number of initiatives to raise awareness of LGBTQ inclusion
- Public Health ran targeted focus groups on sexual health services, smoking cessation services and school health nursing to improve service delivery
- Thames Valley Police ran 'Hidden Harm: Open your eyes to abuse' 18-month campaign to raise awareness of hidden forms of abuse, initially focussing on Modern Slavery
- The Youth Justice Service improved work on the wider 'exploitation' of young people, e.g. focus within strategic plan, development of exploitation toolkit and educational resource
- The Fire and Rescue service in Oxfordshire is one of 6 pilot areas developing a national safe and well evaluation framework measuring the impact of safe and well in terms of positive outcomes for vulnerable people

OSCB wants to see the work on self-assessing safeguarding standards joined up with impact assessment in 2018.



Chapter 3

Summary of OSCB challenges and priorities that the OSCB needs to respond to

Oxfordshire Safeguarding Children Board

Summary of OSCB challenges and priorities that the OSCB needs to respond to

National drivers

- Implications of the new safeguarding partnership arrangements following the new Children and Social Work Act 2017
- Implications of reduced resources from Government
- Planned statutory changes to elective home education

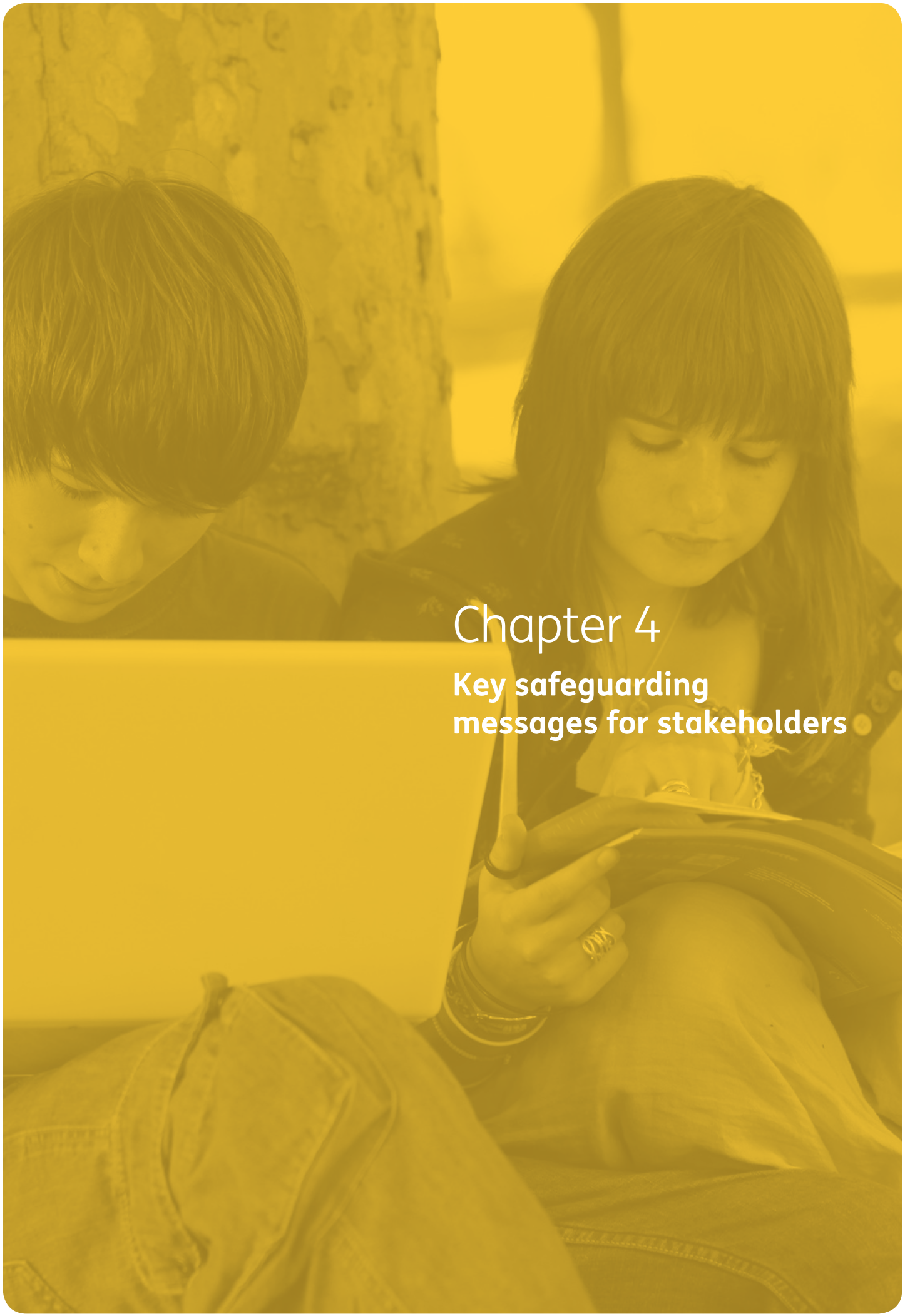
Local priorities for the OSCB and multi-agency work

- ensure that the early help process is improved and that partners in the safeguarding system understand early help, their role in it and the thresholds for statutory services
- ensure that partners know how to see and name neglect and understand the value of a multi-agency chronology when working with children
- improve multi-agency responses to safeguarding vulnerable adolescents from different forms of criminal exploitation and peer on peer abuse in particular those children with special educational needs
- maintain an emphasis on risks identified through 'safeguarding in education': attendance, exclusions, part-time timetables, elective home education, attainment and achievement of pupils with special educational needs and disabilities
- improve connections and communications with safeguarding leads in housing
- ensure that the workforce is competent, confident and capable and able to deal with:
- parental issues such as substance misuse, mental health problems and domestic abuse are addressed as part of this problem.
- adolescent issues of substance misuse, mental health, healthy relationships as well as online well-being.

Priorities for the Board business plan in 2018/19

(see annex D for detail)

1. Improving the effectiveness of the board; collaboration with Oxfordshire Safeguarding Adults Board and engagement with local community and voluntary organisations
2. Tackling neglect and safeguarding adolescents at risk of exploitation
3. Taking robust action following learning; to ensure continuous improvement and to assess risk and capacity across the partnership



Chapter 4

Key safeguarding messages for stakeholders

Our local community:

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

Heads and Governors of schools:

- Be informed. Know how to support pupils dealing with concerns like self-harm; radicalisation; sexting; sexual identity
- Check your pupil attendance and take action – know their 'whereabouts'. We know that children are safer in school
- Sign up for 'Encompass' the only means of receiving confidential notifications from the police about domestic abuse incidents that children have been involved in

The community, faith and voluntary sector:

- Your role in early help is important: we recognise that you are managing a lot of challenging work
- Use the new safeguarding policy template and checklist
- Carry out a safeguarding self-assessment

Children and young people:

- 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 you are concerned about how to get help quickly to support your emotional wellbeing and that you think 'unusual health seeking behaviour' is becoming a problem.

Children's workforce:

- Well done for doing a great job under pressure.
- We love hearing this kind of feedback about you: "She is very supportive, kind, thoughtful, considerate, caring and she always puts other people first, in general she's an amazing ...worker. But most of all she just wants the best for me."
- Please consider these learning points from recent case reviews:

1. **CURIOSITY:** being curious about the family's past history, relationships and current circumstances in a way that moves beyond reliance on self-reported information
2. **RESPONDING TO PHYSICAL ABUSE:** professionals identifying it, listening to children and following procedures to properly investigate
3. **THE ROLE OF SCHOOLS IN KEEPING CHILDREN SAFE:** understanding that school attendance is a critical factor to support opportunity, well-being and safety
4. **PROFESSIONAL UNDERSTANDING OF THE IMPLICATIONS OF ELECTIVE HOME EDUCATION:** actively knowing which agencies are in touch with the family and to what effect
5. **TAKING A CUMULATIVE VIEW WHEN WORKING WITH CHILDREN:** not seeing events in a linear way but weighing up risks over time and keeping previous events in mind (using chronologies)
6. **PARENTAL WELLBEING:** mental health, substance misuse and domestic abuse are recurring themes
7. **FRAGMENTED MANAGEMENT OF HEALTH NEEDS:** ensuring effective communication across services for co-ordinated and consistent management of care
8. **CHILDREN'S EMOTIONAL WELLBEING:** increasing evidence of self-harm by children aged 10 years & above
9. **CHILDREN'S LIMITED CAPACITY TO PROTECT THEMSELVES** as they move into adolescence after experiencing a lack of consistent, supportive parenting in their early years (long lasting impact of neglect)
10. **RETHINKING 'DID NOT ATTEND' TO 'WAS NOT BROUGHT'**

Senior managers and leaders:

- Engage with our priorities and lead your organisations in support of these
- Support the OSCB to escalate risks which sit outside of the local partnership e.g. lack of provision for looked after children and for children with acute mental health needs, elective home education
- 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

Annex A: Governance and accountability arrangements

How we work:

Throughout 2017/18 we have been a partnership set up under the Children Act 2004 to co-operate with each other to safeguard children and promote their welfare and have worked to the government guidance, Working Together 2015.

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 aim to do our job 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.

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.

Our multi-agency subgroups work to deliver the three aims of the board: effective leadership; practice improvement and checking that children are kept safe. See our business plan for details. The subgroups lead on safeguarding themes of child exploitation; disabled children, quality assurance, safeguarding procedures and safeguarding in education. We have three area-based groups which meet on a termly basis to bring together managers for updates on safeguarding work and to give feedback on any emerging safeguarding themes in their areas.

Who we work with and alongside

There are a number of other multi-agency board and partnerships in Oxfordshire that are working to improve the health and wellbeing of Oxfordshire residents and safeguard children, young people and adults with care and support needs who are vulnerable to abuse and neglect. They are:

i. **Oxfordshire Health and Wellbeing Board (HWB) and its associated partnership boards and joint management groups, one of which is the Children's Trust**

ii. **Safer Oxfordshire Partnership (SOP)**

iii. **Oxfordshire Community Safety Partnerships (CSPs)**

iv. **Oxfordshire Safeguarding Adults Board (OSAB)**

The Health and Wellbeing Board, Community Safety Partnerships and Safer Oxfordshire Partnership operate as strategic commissioning and delivery bodies. The two safeguarding boards are primarily scrutiny and challenge boards focusing specifically on safeguarding and effective partnership working to support this. These roles are distinctive but align well to provide a governance framework. The partnership protocol is on the OSCB website.

Health and wellbeing board. The Oxfordshire Health and Wellbeing Board (HWB) is a forum where key leaders from the health and care system work together to improve the health and wellbeing of the local population and reduce health inequalities. Each local authority is required to have a Health and Wellbeing Board under the Health and Social Care Act 2012.

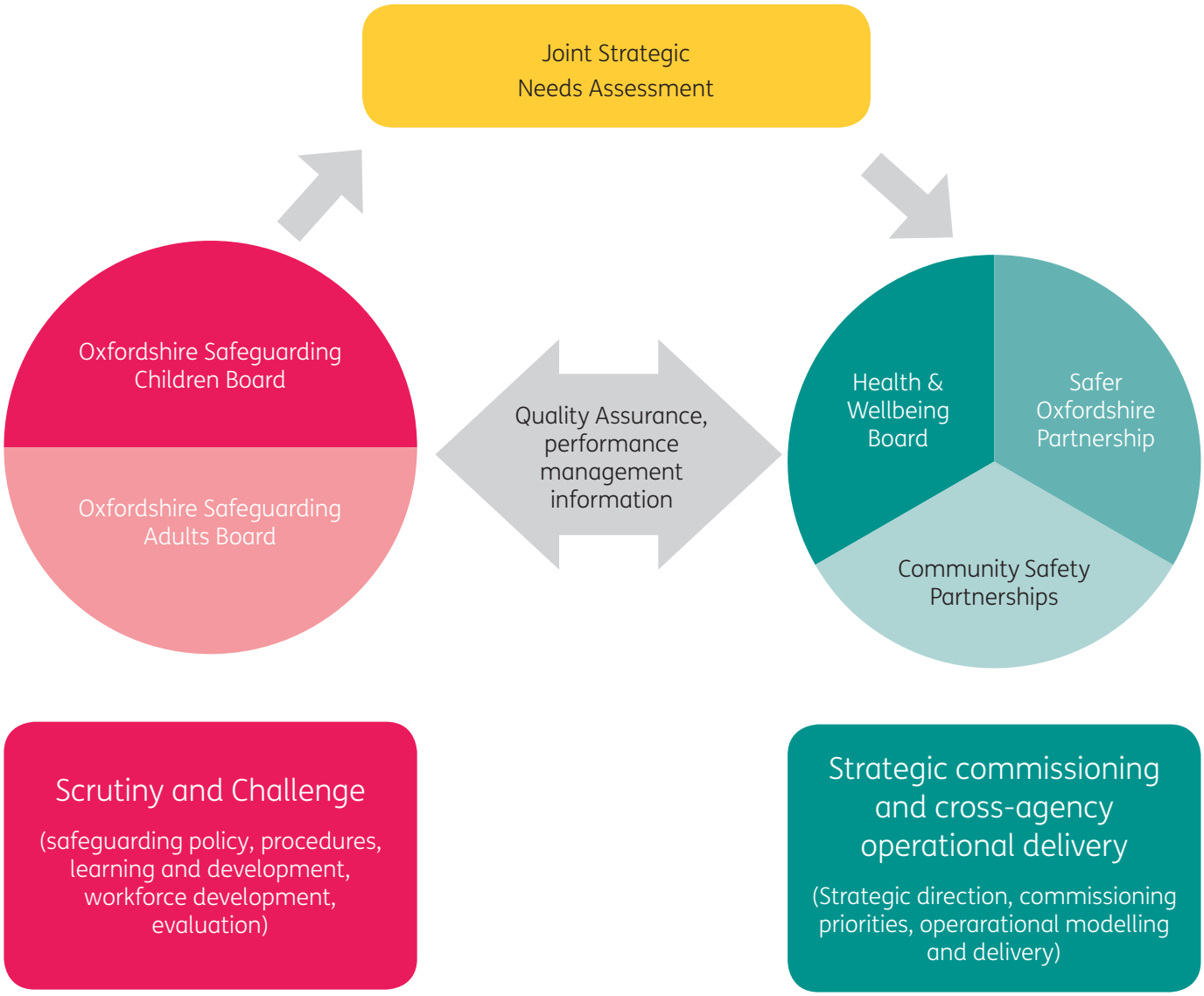
Children's Trust. The Children's Trust is responsible for developing and promoting integrated frontline delivery of services which serve to safeguard children. The partners work to plan services, find solutions and align resources as appropriate to deliver **Improvements.** The Trust produces a Children and Young People's Plan for Oxfordshire and recommends to the Health and Wellbeing Board where resources should be focused to deliver the Plan. The chairs of the Trust and Board are members of both groups.

The Safer Oxfordshire Partnership. This group aims to reduce crime and create safer communities in Oxfordshire and 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.

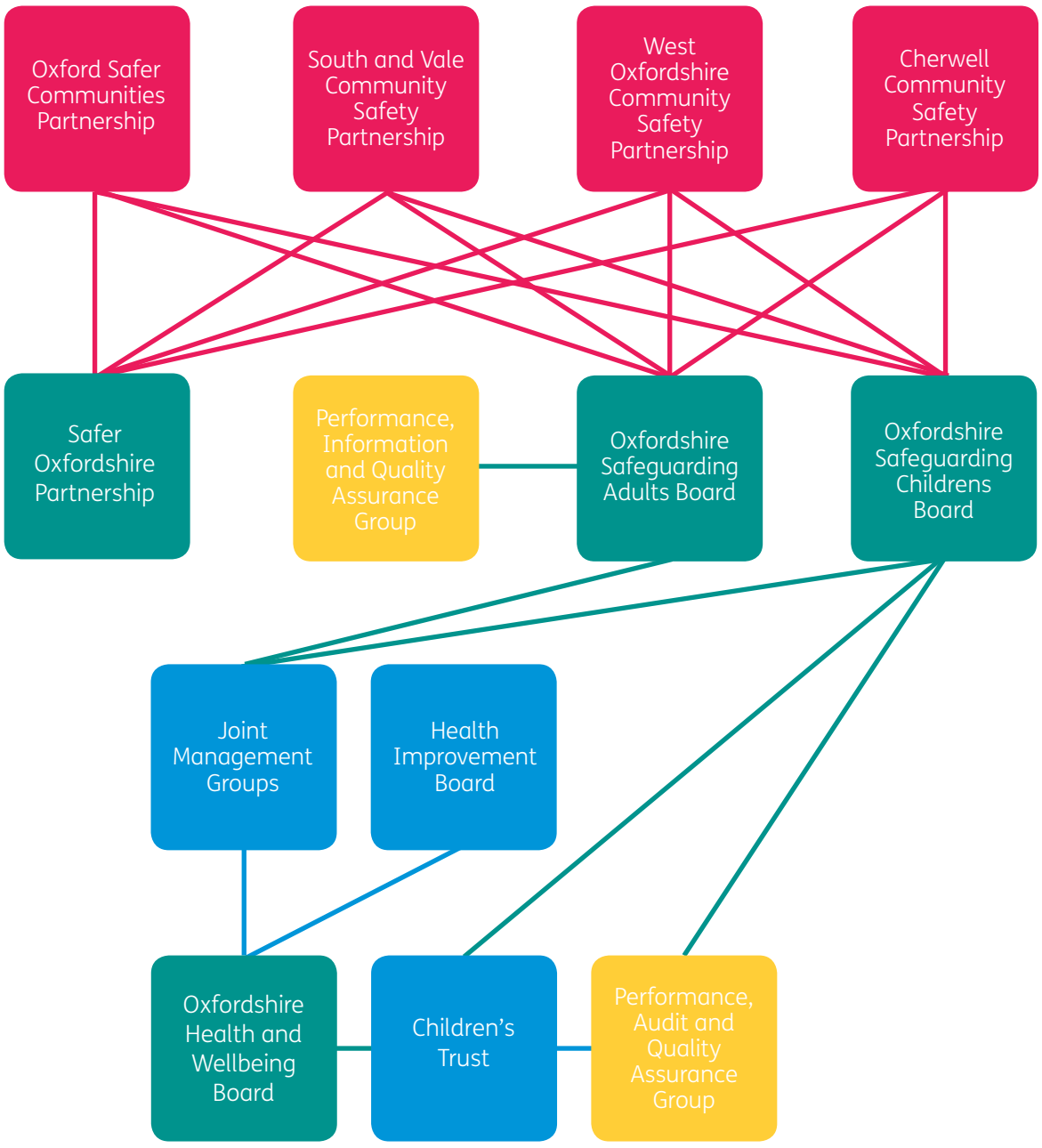
Community safety partnerships. These groups deliver projects that aim to cut crime and the fear of crime. Based in each district or city council area partners from the local authority, police, probation services, housing, fire and rescues services, the environment agency, the health sector and voluntary sector jointly tackle crime and safety issues. District colleagues are integral to the safeguarding work on child exploitation and engagement with the community and voluntary sector and safer transport.

The Oxfordshire Safeguarding Adult Board. This 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.

Oxfordshire Partnership Protocol Overview



Relationships



Annex B: OSCB Members

Who we are

The role of the County Council.
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 Hibbert-Biles and Councillor Harrod have fulfilled this role.

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.

Independent.
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 2017/18.

Health sector.
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.

The OSCB has a designated doctor and designated nurse. This is currently a stipulated requirement of boards as set out in Working Together 2015 (page 57 and page 69 para 9). Their function is to provide the board with direct access to the expertise of designated health professionals.

OSCB member agencies

- Independent Chair
- Oxfordshire County Council: children's services, youth justice services, adult services, fire and rescue services, legal &public health
- Oxford University Hospitals Foundation Trust
- Oxfordshire Clinical Commissioning Group
- Oxford Health NHS Foundation Trust
- NHS England Area Team
- West Oxfordshire District Council
- Cherwell District Council
- Oxford City Council
- South Oxfordshire and Vale of White Horse District Council
- Thames Valley Police
- Children and Family Courts Advisory and Support Service
- Community Rehabilitation Company
- National Probation Service
- Lay Members
- Representation from schools and colleges
- Representation from the voluntary sector
- Representation form the housing sector
- Representation from the military

Annex C: What happens when a child dies in Oxfordshire

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.. Deaths in children are always very distressing for parents, carers and clinical staff. Developing an overview of the confirmed causes of childhood deaths can lead in some instances to effective action in preventing future deaths. In accordance with the statutory guidance we review deaths of all children resident in Oxfordshire, identifying themes, modifiable factors and any issues that may affect the safety and welfare of children. In particular we aim to develop a more detailed understanding of the causes of death and where appropriate take forward recommendations made by the panel to influence strategic changes and practice.

In 2017-2018, 84 child deaths were reported to the Oxfordshire CDOP and were discussed with the Designated Doctor for child deaths. 34 of the child deaths reported were of children normally resident in Oxfordshire and 50 of the deaths were of children normally resident in other counties.

In 2017-2018 the Oxfordshire CDOP reviewed the deaths of 40 children who usually reside in Oxfordshire. These reviews included deaths that occurred in the year 2017-2018 and reviews that occurred before 2017-18, but had been carried over, due to alternative investigations which prevented completion of the CDOP process earlier. The outcomes of panel meetings are twofold: to identify the classification of death and modifiable factors.

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 2017-2018 the CDOP panel concluded that in 35% of cases reviewed there were modifiable factors. The following were identified that contributed to or caused the death.

Modifiable factors identified were:

- Co-sleeping
- Smoking
- Housing issues
- Infection guidelines/ sepsis guidelines not being followed
- Consanguinity

There are a number of established national campaigns around the issues that relate to modifiable factors, where that is the case, no specific recommendations have been made.

In 2017-2018 Oxfordshire contributed anonymised data to the following local and national campaigns:

- Co-sleeping
- Water safety
- Suicide prevention

In these areas no specific recommendations were made. Public health messages were shared, discussed and circulated. Oxfordshire also contributes anonymised data to research study requests (where appropriate) and to The Royal Society for The Prevention Of Accidents (ROSPA), so that they can collate a national picture. As a result of other identified modifiable factors, the following specific recommendations were made by the CDOP:

- When sepsis may be suspected the importance of sharing of information about baseline observations between episodes of care delivered by the out of hours service and GP services was highlighted. This has been incorporated into Sepsis training for GPs and out of hours services.
- Increased awareness of dangers of hot weather for infants – both from co-sleeping and open windows led to public health messages being circulated.

The Rapid Response Service

CDOP is advised of all child deaths and monitors the response when this involves an early response process (previously known as rapid response). In Oxfordshire, the early response service, coordinated by a team (Child Death Response 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 Child Death Team has an on-call rota to cover the service 24 hours a day, 7 days a week, including bank holidays. The 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 service is currently provided by the Chaplaincy team.

In collaboration with the Designated Doctor for Child Deaths (in working hours) and Acute Paediatricians (out of hours) the Child Death Team ensures that 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 Seesaw, in order to enhance the quality of care provided to all those whose work brings them into contact with bereaved families.

There have been several cases where there has been a delay in a family being able to view their child's body due to the complexity of processes needed at this time. This has caused distress to the family members. All relevant agencies are reviewing and updating their policies

The process ensures that the Child Death 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 Death chairs these early response meetings, ensuring that the principles underlying the early 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.

In 2017-2018 a total of 14 unexpected deaths of Oxfordshire children were reported to the Oxfordshire CDOP and Early Response Coordination team. For all Oxfordshire cases, an early response meeting was held. In all cases, the Coroner was informed of the child's death in a timely manner. A summary of the action taken by the Child Death Team have a target response time frame of two hours from the receipt of notification. This target has been reached in 100% of cases in 2017-2018.

Annex D:
OSCB priorities for 2018/19

Aim: Provide leadership for effective safeguarding practice	
PRIORITIES	**ACTIONS**
Improve board effectiveness	Develop the work of the Board to be more effective in light of the new Working Together guidance
Joint work with OSAB	Develop joint working on housing, domestic abuse, transitions and keep a watching brief on modern slavery
Engage local communities	Ensure that local voluntary and community organisations are better engaged in the partnership: training, communication and working together
Aim: drive forward practice improvement	
PRIORITIES	**ACTIONS**
Safeguard adolescents	Support multi-agency responses to safeguard vulnerable adolescents: • transitioning from children to adult services with OSAB • at risk of domestic abuse or peer abuse with OSAB • at risk of criminal exploitation • not in full time education
Address neglect	Support a co-ordinated and multi-agency response to neglect
Act following learning	Ensure the training workstream is well co-ordinated across the OSCB and OSAB and having an impact Ensure the learning and improvement comms. workstream reinforces safeguarding messages

Aim: ensure that children and young people are kept safe	
PRIORITIES	**ACTIONS**
Challenge improvements	Test how well learning is embedded in to practice through multi-agency audits which include the voices of children and families Check how well the integrated safeguarding arrangements effectively provide early help to families
Assess risk and capacity	Check the level of risk and impact on the safeguarding system through the annual partner self-assessments with OSAB

Annex E: Glossary

AILC	Association of Independent LSCB Chairs
BASPCAN	British Association for the Study and Prevention of Child Abuse and Neglect
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Service
CDOP	Child Death Overview Panel
CiCC	Children in care council
CRC	Community Rehabilitation Company
CSE	Child Sexual Exploitation
CSPs	Oxfordshire Community Safety Partnerships
EHA	Early Help Assessment
EIS	Early Intervention Service
FE	Further Education
HBT	Homosexual, bi-sexual and transgender
HMIP	Her Majesty's Inspectorate of Probation
HWB	Health and Wellbeing Partnership
LAC	Looked After Children
LADO	Local Authority Designated Officer
LCSS	Locality and Community Support Service
LGBTQ	Lesbian, gay, bi-sexual, transgender and queer
LIQA	Learning, Improvement and Quality Assurance (framework)
LSCB	Local Safeguarding Children Board
MAPPA	Multi-agency Public Protection Arrangements
MASH	Multi-Agency Safeguarding Hub
NPS	National Probation Service
NSPCC	National Society for the Prevention of Cruelty to Children
OCC	Oxfordshire County Council
OCCG	Oxfordshire Clinical Commissioning Group
OH NHS FT	Oxford Health NHS Foundation Trust
OSAB	Oxfordshire Safeguarding Adults Board
OSCB	Oxfordshire Safeguarding Children Board
OSVDC	Oxfordshire South and Vale District Councils
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
SFR	Statistical First Release
SOP	Safer Oxfordshire Partnership
SRE	Sex and relationships education
TVP	Thames Valley Police
VCS	Voluntary and Community Sector
VOXY	Voice of Oxfordshire's Youth

Annex F: Finance

2017/18 OSCB accounts

	Provisional budget 2017/18	Budget as at end Mar 2018
Funding streams		
Public Health	-31,625	-31,625
Foster carer training		-2,975
Contributions		
OCC Children, Education & Families	-196,610	-197,757
OCC Dedicated schools grant	-64,000	-64,000
Oxfordshire OCCG	-60,000	-60,000
Thames Valley Police	-21,000	-21,000
National Probation Service	-2,500	-2,500
CRC	-1,410	-1,410
Oxford City Council	-10,000	-10,000
Cherwell DC	-5,000	-5,000
South Oxfordshire DC	-5,000	-5,000
West Oxfordshire DC	-5,000	-5,000
Vale of White Horse DC	-5,000	-5,000
Cafcass	-500	-500
Public Health (see above)	0	0
Total income	**-407,645**	**-411,767**
Expenditure		
Independent Chair	39,000	35,266
Business unit	253,000	258,565
Comms: learning and improvement	12,000	12,027
Training & learning	66,000	66,014
Subgroups	10,000	9,087
All case reviews	40,000	28,021
Total	**420,000**	**408,981**