Division(s): N/A

PERFORMANCE SCRUTINY COMMITTEE – 5 OCTOBER 2017

SAFEGUARDING CHILDREN IN OXFORDSHIRE

Report by Lara Patel Deputy Director Safeguarding, Tan Lea, Safeguarding Partnerships Manager, Children Education and Families Directorate

INTRODUCTION

1. Paul Burnett (Independent Chair, Oxfordshire Safeguarding Children Board), Lara Patel (Deputy Director, Safeguarding, Children, Education and Families) and Tan Lea (Strategic Safeguarding Partnerships Manager, Children, Education and Families) will present a paper on **three** annual reports from the Oxfordshire Safeguarding Children Board. The reports concern an overview of safeguarding work; serious case reviews and quality assurance.
2. The Performance Scrutiny Committee is requested to note these annual reports and provide any comments.

BACKGROUND

3. Local Safeguarding Children Boards were set up under the Children Act 2004 to co-operate with each other in order to safeguard children and promote their welfare.
4. The Oxfordshire Safeguarding Children Board (OCSB) is led by an independent chair and includes representation from all six local authorities in Oxfordshire, as well as the National Probation service, the Community Rehabilitation Company, Police, Oxfordshire Clinical Commissioning Group, Oxford University Hospitals NHS FT, Oxford Health NHS FT, schools and Further Education colleges, the military, the voluntary sector and lay members.

5. The Board is funded through a partnership arrangement and meets 4 times per year. The Board is supported by a Business Unit located within Oxfordshire County Council.

6. The Board is required to publish an annual report on the effectiveness of local arrangements to safeguard and promote the welfare of children in Oxfordshire.
7. The Board has a series of multi-agency subgroups, each of which produce an annual report. This paper also includes annual reports produced by two the subgroups working on learning and improvement in safeguarding practice: the the Case Review and Governance subgroup and The Performance, Audit and Quality Assurance subgroup.

8. The OSCB annual report will be considered at Cabinet, the Health and Wellbeing Board and the full Council.

PERFORMANCE ISSUES
The OSCB Annual Report

9. 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.

10. It evaluates performance against the priorities that are set out in the Business Plan for the year and against other statutory functions that the LSCB must undertake. The report highlights lots of good examples of partnership work ranging from a new CSE risk assessment tool to successful prosecutions against perpetrators of child sexual exploitation. Significant work has taken place to improve access to support for families and professionals including a new threshold of needs matrix and early help assessment. To support this all toolkits and resources were collated in preparation for an online portal. Serious case reviews have driven practice improvements which include full chronologies for children subject to child protection planning as well the development of procedures to ensure that professionals meet and consider cases without parents in an effort to ensure the of a case, when there is concern that it may be drifting.

11. In 2016/17 the OSCB delivered over 150 free safeguarding training and learning events plus online learning. The training reached over 9000 members of the Oxfordshire workforce. The OSCB delivered termly newsletters to over 4000 members of the multi-agency workforce and e-bulletins to educational settings across the county. Work has taken place to renew the set of online procedures to make them simpler and more accessible.

12. Learning and improvement events for approximately 150 delegates each time have covered:
    - Safeguarding risks online
    - Relationships and identity
    - Working with children with disability
    - Working with neglect

13. There are, however, areas for improvement. Quality assurance work highlights that partners must persist with addressing long term issues of neglect and better protect vulnerable adolescents at risk of exploitation. The workforce needs to know how to work effectively with families experiencing domestic abuse, parental mental health and drug and alcohol issues. Going forward partners need to keep a tight grip across the partnership on what is working well, where challenges are emerging and ensure targets are monitored for improvement.

14. The annual report directs the OSCB towards the following aims for 2017/18:

- Improving the effectiveness of the board; collaboration with Oxfordshire Safeguarding Adults Board (OSAB) and engagement with local communities including the voluntary and community sector
- Improving practice in 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

15. The annual report presents the following messages for multi-agency work going forward:

    - 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

The Performance Audit and Quality Assurance Annual Report

16. The Performance Audit and Quality Assurance subgroup scrutinises the effectiveness of safeguarding practice. This annual report summarises the common themes for learning and improvement to support vulnerable children. The following sources are used: section 11 audits, school audits, single and multi-agency audits, work with children and young people, annual reports and serious case reviews. The information is viewed through a quadrant of quantitative data; qualitative data; practitioner views, child and family views.

17. The quantitative data indicates that the child protection partnership should continue to be rigorous in scrutinising activity. The level of activity continues to increase. The rate of growth of children subject to child protection plans is higher than both the national average and the average of similar authorities. This is placing pressure on resources and agency structures.

18. Qualitative evidence from the three recently published case reviews the ten most common learning points are:

    i. The importance of thinking carefully about the role of the **father** in the family system as well as communication with and involvement of fathers and male carers
    ii. The need for curiosity about the families past history, relationships and current circumstances that moves beyond reliance on **self-reported information**.
    iii. There are more challenges faced by professionals working with vulnerable families where **neglect** is an embedded issue.
    iv. The impact of the **parent's mental health** problems on the safety and wellbeing of the child – in particular maternal mental health
    v. Understanding of **drugs / substance misuse** and interventions, the changing levels of risk, and the impact on the child.

vi. **Normalising and misinterpreting behaviour** - linked to Special Educational Needs.
vii. Identifying the increased safeguarding **risks for children with learning disabilities** and Special Educational Needs.
viii. Identification of physical abuse and **following safeguarding processes thoroughly.**
ix. 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.
x. 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. There is a complexity involved in working across services with **children who are presenting behaviours that are a risk to the public and themselves whilst being vulnerable**

19. Practitioners from the voluntary and community sector have said that they want to know more about how the safeguarding system operates – importantly the recently implemented Local Community Support Service (LCSS) framework. Practitioners in statutory agencies have told us that the increased capacity in the system is leading to a large workload and adding associated risks. They are finding it challenging to support high risk young people: children who self-harm and have mental health concerns.

20. Children and families have reminded the OSCB of the impact of one person can be incredible: they could be a teacher, a foster parent, social worker. Children have said that we should never underestimate the positive impact a professional can have –
    - *'one person is all it takes'*

The Case Review and Governance subgroup Annual Report

21. The purpose of the group is to support the OSCB in fulfilling its statutory duty to undertake reviews of cases both where the criteria[1] are met and where they are not met in order provide valuable information on joint working and areas for improvement. The group comprises members drawn from Thames Valley Police, the County Council's children's services and legal services, The Oxford Health NHS FT, the OCCG Designated Doctor and Designated Nurse and a Head teacher representative.

22. The OSCB has worked on five serious case reviews since the last report to the Board. Of those five reviews: three were published (one of which was signed off in 2015/6 and a further two in 2016/17), one is active and one has been completed as far as possible, whilst a police investigation is underway.

23. For each review a learning summary was produced highlighting key messages for practitioners and managers. The OSCB ran four learning events and an

[1] Working Together to Safeguard Children 2015

annual conference in 2017/18 covering a range of themes emerging from local serious case reviews and audits.

24. In May 2016 the triennial review of case reviews was published. This considered nearly 300 SCRs relating to incidents which occurred over three years to 31.03.14. Some of the key findings help provide broader context to the work in Oxfordshire:
    - There has been no change in the number of child deaths linked to maltreatment and if anything a reduction in all except the older adolescent group.
    - There has been an overall increase in SCRs and a steady increase in activity across the system.
    - Once a child is known to be in need of protection and a plan is in place, the system generally works well.
    - Only 12% had a CP plan in place at the time of their death or serious harm.
    - Pressure points are identified at 'step up' or 'step down' in care.
    - Fewer than half had current involvement with Childrens Social Care (CSC) and almost two thirds had at some point been involved with CSC.

NEXT STEPS

25. Learning and recommendations from these three annual reports is reflected in the OSCB Business Plan 2017/18, which is delivered through partnership work and monitored by the OSCB on a regular basis.

RECOMMENDATION

26. The Committee is requested to note the annual reports and provide any comments.

LEAD / CONTACT OFFICER

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