Oxfordshire Safeguarding Children Board

Performance, audit and quality assurance (PAQA) subgroup Annual Report for 2016/2017: Themes for learning and improvement

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1. Executive summary: themes for learning and improvement

Introduction

There are 141,800 young people aged under-18 in Oxfordshire *(mid-2015 estimates)*. This population has grown around 6% in the last ten years – mainly in urban areas such as Oxford, Didcot, Witney, Bicester, and Carterton.

The purpose of this annual report is to highlight common themes for learning and improvement to support these children. The following sources are used: safeguarding self-assessments, school audits, single and multi-agency audits, work with children and young people, annual reports and serious case reviews. The OSCB's framework for this work is based on:

1. Quantitative information
2. Qualitative information
3. Involvement of practitioners
4. Involvement of children, young people, parents & carers

The following pages provide detail against these four areas. A summary of these points is provided below:

Quantitative themes: what the facts and figures tell us

The 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.

Neglect is the most common reason for children to be subject to child protection plans (67%). This is higher than the national average where the proportion of children subject to child protection plans for reason of neglect is 45% and higher than last year. The OSCB should maintain its focus on addressing this form of abuse.

There has been a 14% increase of children in the care of the local authority to 675 children, whilst this is 27% lower than the national average, it is nevertheless impacting on local provision. Oxfordshire strives to keep children in placements close to the county but this increase has meant that the number of children having to live outside the county has increased from 77 to 118.

The OSCB should ensure that the appropriate mechanisms are in place to check that partnership working remains effective and strong in the light of the increased activity, pressure on budgets, and limited pool of workers and levels of organisational changes.

The OSCB should ensure that training and support is robust and that partners are engaged with it, as complexity of cases; expectations and activity levels all increase. As organisations and roles change,

more complex cases are held in universal services and more support and training is needed for these services.

Qualitative themes: most common learning points and emerging learning points

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

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

The audits have shown the complexity involved in working across the services with vulnerable children who present behaviours that are a risk, sometimes to the public, and often to themselves. In particular this linked to criminal exploitation in terms of drugs. They have also highlighted how straight talking; responding to the views of children; a 'think family' approach and strong connections between agencies can make a difference to the protective factors put in place for children.

Practitioners' themes:

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. They want to better understand key legislation; access sample policies and be clear on responsibilities in terms of leasing of buildings. They have expressed some anxiety as to what their role is with respect to early help and concern that they will not have the capacity to take on lead roles in managing Team around the Family processes

Practitioners in statutory agencies have told us that the increased capacity in the system is leading to a large workload and adding associated risks. They are finding it challenging to support high risk young people: children who self-harm and have mental health concerns. They state that they are finding it difficult to find appropriate resources for children who are at risk of drug exploitation. They have also told us of the complexity involved in working across services with children who presenting behaviours that are a risk to the public and themselves whilst being vulnerable.

Young People, Parents and Carers themes:

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

The message that the OSCB heard at the annual conference has been reiterated by young people. The impact of one person 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 (professional) can make a really massive difference*
- *regular consistent support*
- *one person is all it takes*
- *show you care*
- small things matter *"he (social worker) pops in for casual chats"*

Children don't necessarily know who they can go to for help. "*It didn't cross my mind who I could talk* to "*I didn't know who to go to*". The feedback once professionals were involved was positive, "I *didn't have to deal with it on my own*". Being listened to and acting on what's important to the child is vital. Showing you care is everything, "*get to know me as a person not just a case or a set of problems".* They clearly told us that as they become older 14, 15, 16 years then being very involved in decisions becomes even more important. They need to understand why social services are involved.

These themes aren't dissimilar for their parents and carers. Parents want to be told what was happening and why agencies are involved. Straight talk is helpful: '*It was about me so I should know'*

2. Themes and findings from case reviews, audits, complaints and engagement with young people

Section 2.1 Quantitative

Introduction

This section aims to summarise the quantitative information available to the OSCB from datasets; case reviews; audits and the Child Death Overview Panel. It provides facts and figures.

The Child's Journey:

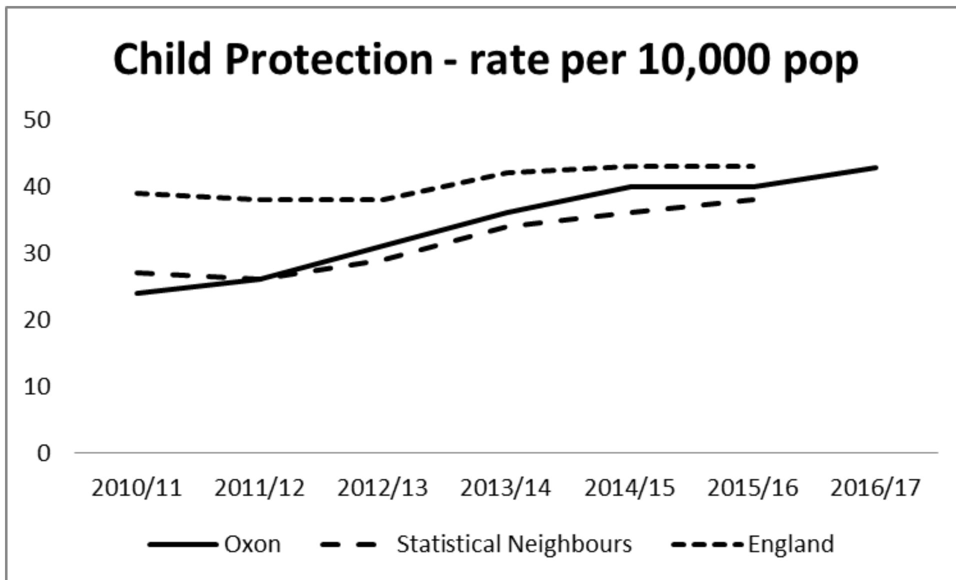
The performance data for last year can be summarised against the following steps in a child's journey through the safeguarding system:

Impact of changes to early intervention:

In 2016/17 Oxfordshire introduced the Early Help Assessment which replaced the Common Assessment Framework or CAF. In 2016/17 there were 458 recorded Early Help Assessments which is considerably less than recorded CAFs in the previous year. This is in part due to the uncertainty created with the restructure of Early Help Services and the introduction of new systems to record data. Improving Early Help is a key priority of the Children's Trust going forward and the safeguarding partnership would want to see these figures substantially increase in the coming year. The number of troubled families worked with rose to 1549 in 2016/17 and remains on target.

Increasing levels of activity in child protection planning:

The number of children on a child protection plan rose from 569 at the end of 2015/16 to 607 at the end of 2016/17. The rate of growth of children subject to child protection plans is higher than both the national average and the average of similar authorities such that at March 2011 we had 38% fewer children subject to a plan than the national average and are now in line with the national average. Our intention in the year was to reduce the numbers to 500 whereas in fact they rose to over 600.



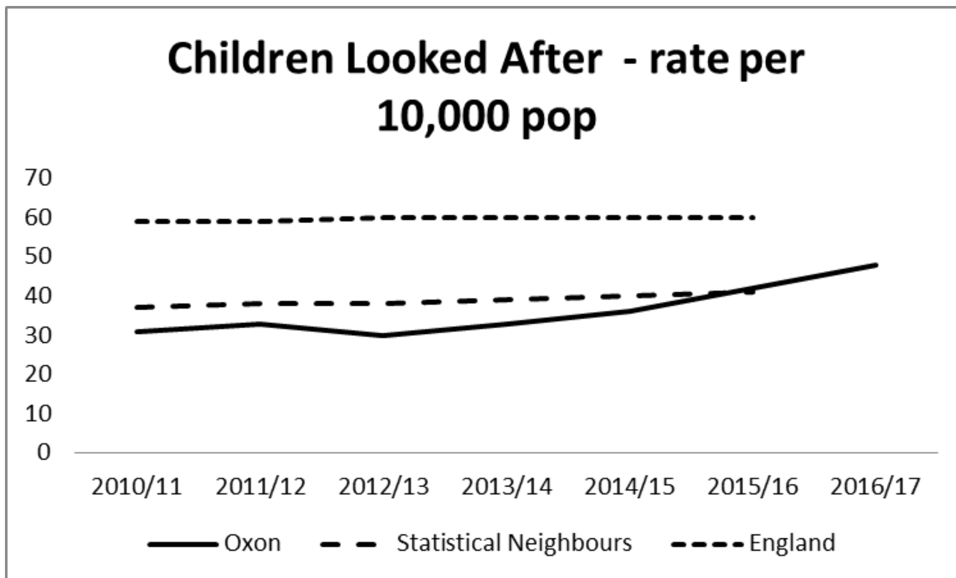
Graph 1: Child protection rates per 10,000 population

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

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

Increasing numbers of children in care and the impact on provision:
Children in care are those looked after by the local authority. This rose by 14% in the year from 592 to 675 whereas our target had been to maintain the current level. In March 2011 we had 47% fewer looked after children than the national average - we currently have 27% fewer.
A recent audit of cases by an independent consultant demonstrated that 36% of looked after children's cases reviewed could possibly have been prevented had an earlier intervention been made.

The Oxfordshire Safeguarding Partnership want to ensure that where children and young people are looked after, those who are most risk are closest to home. With the considerable increase in looked after children, the number of children placed out of county and not in neighbouring authorities has increased from 77 to 118.



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

Children at risk of sexual exploitation continue to be identified:
Multi-agency work to identify children and young people who may be at risk of child sexual exploitation (CSE) in Oxfordshire is coordinated by the Kingfisher Team. There were 236 CSE screening tools completed in 2016-17 compared with 223 in 15/16.

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

Children and young people who offend: increase in numbers involved with YJS
The young people who are involved with Oxfordshire Youth Justice Service (YJS) often present with complex needs requiring significant support both in and out of custody. 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 receiving remand to custody increased to 6.3% from 5.2% in 2015/16

Children who are privately fostered: increase in numbers reported

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

The implications of increased workloads on ensuring children are kept safe.
The annual "impact assessment" survey of partner agencies, conducted by the safeguarding children board and safeguarding adults board, concerning increased activity in the safeguarding system and resultant pressures included the following two recommendations. These were made in the light of increased workloads:

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

- Workforce Development and Support: The Boards need to be reassured that training and support is robust and that partners are engaged with it, as complexity of cases; expectations and activity levels all increase. As organisations and roles change, more complex cases are held in universal services and more support and training is needed for these services.

Serious Case Reviews:

Three new cases were brought to the attention of the OSCB for consideration of a serious case review in 2016/17. Of these referrals one serious case review was commissioned.
The OSCB has worked on five serious case reviews over the last year. Of those reviews: one was signed off in 2015/16 and two were signed off in 2016/17, one is active and one is complete as far as possible, whilst a police investigation is underway. Two of those five reviews were published in 2016/17.

Over the last five years eleven serious case reviews and two learning reviews have been commissioned. The reviews fall into two main age groups; pre-school and secondary school age children – just over 50% are older children aged between thirteen and eighteen. The majority of the reviews concern females. The proportion of pre-school children continues to highlight the need for effective universal service provision for young children; for example health visitors and early-years services such as Children's Centres.

Over the last year the themes covered by case reviews have been: the long-lasting impact of neglect; physical abuse; self-harm; child and parental emotional wellbeing; peer violence (domestic abuse) and parental substance misuse. The issue of neglect is a repeated theme in terms of the risks it presents to young children and the impact it continues to have as

they grow up. In Oxfordshire neglect is the most common reason for a child to be subject to a child protection plan.

Factors frequently identified across all cases include:

- Neglect: it is a repeated theme in terms of the risks it presents to young children and the impact it continues to have as they grow up
- 'Damaged and difficult' lives of young people and their capacity to protect themselves has also become a repeated theme in recent years.
- Substance misuse by the victim or parents
- Parents of victims where there have been a number of different partners
- Children who have a number of siblings by different fathers
- Majority children/young people were previously known to children's social care (either current at time of incident or historic)

Multi-Agency Audits:

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).

The purpose was to check how well agencies worked together on issues of domestic abuse, child sexual exploitation and 'Education, health and Care Plans' for children and young people with learning difficulties or disabilities (aged 0 to 25). In addition an audit was undertaken on the multi-agency usage of the child sexual exploitation screening tool – a sample of 178 screening tools was reviewed followed by an in-depth look at 20 completed tools. (This audit was reported in to the last annual report due to timings)

Single-Agency Audits:

Board member agencies reported back to OSCB in 2016/2017 on their internal safeguarding practice covering issues such as training, supervision, assessment of need and escalation of issues. The findings are summarised in the qualitative section.

The joint Safeguarding Self-assessment and Practitioner Questionnaires:

The 2016/7 **Safeguarding Self-assessment** return saw a 95% return rate. A total of 23 returns were received for analysis. Eight of which included practitioner questionnaires were. A peer review was held by OSCB in April 2017 to reinforce the OSCB's culture of challenge. Providers, commissioners and senior leads scrutinised and compared the results of their safeguarding self-assessments audits. Over twenty services attended.

School safeguarding reports, audits and risk assessments

The Safeguarding Board has a duty under section 10 and 11 of the Childrens Act to monitor Schools safeguarding arrangements. Section 175/157 of the Education Act 2002 introduced a duty on Local Authorities and governing bodies of maintained schools to ensure that they safeguard and promote the welfare of children. This is carried out through annual safeguarding reports to governors being completed and returned to the Designated Officers team by all Schools and Colleges irrespective of status (including Academies and Free-Schools) are obliged to comply with the Safeguarding Boards requests for information about safeguarding arrangements.
There was 97% compliance overall, including free schools, language schools, independent and state schools. All schools state that they are up to date with their generalist safeguarding training and comply with safe recruitment practices. They have reported that they need to ensure that they have enough colleagues trained at an advanced level to take the role as designated leads.

In addition to the annual report and those schools who self-audited, during the 2015/2016 academic year, the team has also undertaken a total of 80 audits in schools.

Early Years, Child-minder and 'out of school' Audits:
There was 100% compliance of all childcare settings (283) and childminders (285). Of the 90 out of school settings 50 submitted their audits. Safeguarding themes which are being picked up are: safer recruitment and safeguarding training needed as well as being clear on how / when to report concerns and share information with parents.

Designated Officer

The Designated Officer should be informed of all allegations against adults working with children and provide advice and guidance to ensure individual cases are resolved as quickly as possible. During the academic year 2013/14 there were a total of 138 recorded allegations; the following academic year (2014/15) there were 167 allegations and in the last academic year (2015/16) there were also 167 recorded allegations. There continues to be a proportion of allegations which are historical in nature but require but may concern individuals who continue to act in a position of trust with children. Roughly 50% of the referrals come from schools but in the last year referrals have increased from other settings both within the voluntary and statutory sector. Over 10% concern foster carers. Of all those allegations that were pursued there was a 100% positive outcome.

There has been an increase in allegations categorised as sexual abuse (33). There is a similar number of allegations (31) concerning inappropriate behaviours such as misuse of social media and breaches of codes of conduct.

Section 2.2 Qualitative

Introduction

This section summarises the qualitative information available to the OSCB. The sources of information include serious case reviews, multi-agency and single agency audits, safeguarding self-assessments agency and school audits, the Child Death Overview Panel and the Joint targeted area inspection. This section aims to draw out themes and learning points in particular.

Themes in common with other serious case reviews:

The OSCB has conducted a number of case reviews over the last five years and seeks to draw out common themes where possible. From the three recently published these are the ten most common learning points:

1. The importance of thinking carefully about the role of the **father** in the family system as well as communication with and involvement of fathers and male carers
2. The need for curiosity about the families past history, relationships and current circumstances that moves beyond reliance on **self-reported information**.
3. There are more challenges faced by professionals working with vulnerable families where **neglect** is an embedded issue.
4. The impact of the **parent's mental health** problems on the safety and wellbeing of the child.
5. Understanding of **substance misuse** and interventions, the changing levels of risk, and the impact on the child.
6. **Normalising and misinterpreting behaviour** - linked to Special Educational Needs.
7. Identifying the increased safeguarding **risks for children with learning disabilities** and Special Educational Needs.
8. Identification of physical abuse and **following safeguarding processes thoroughly.**
9. Multi-agency work must be well co-ordinated in order to **share planning** and to better understand what is happening to the child. Effective risk management requires **systematic planning** across the multi-agency partnership.
10. The **capacity of adolescents to protect themselves can be overestimated** and a tendency to view teenagers as adults rather than children can mean that proactive steps to protect them are not always taken.

Themes in common with the Tri-ennial review

The OSCB summary from the May 2016 triennial review of case reviews noted findings consistent with our own local quality assurance work and some have already been taken on

board locally, specifically following the Serious Case Reviews into Children A-F, Child J, Baby L and Child A and Child B. The following points are worth highlighting in particular.

For senior managers

- Coping with limited resources and increased activity and need for senior leaders to identify strategies to manage workloads and sustain acceptable levels through ongoing vigilance.
- Alongside this is the recommendation that there should be long term continuous approaches where maltreatment has been identified and a move away for single or episodic responses.
- Effective structures to be maintained through service change particularly in health and social care. Complexity of health structures noted and need for clear pathways and information sharing across transition points.

For practitioners and front line managers

- Step change required with how we understand and respond to domestic abuse and the need to move from incident based models to understanding the nature and impact of coercive control.
- Disabled children are particularly vulnerable where signs of abuse and neglect may be masked by, or misinterpreted as due to, underlying impairments.

Themes that have emerged for supported housing providers from case reviews

There have been two Serious Case Reviews in which there have been issues relating to supported housing. The issues have related to information sharing and communication as well as linking housing providers into child protection processes such as conferences and core groups.

Multi-Agency Audits:

Five multi-agency audits covered the issues of neglect, domestic abuse, and 'Education, health and Care Plans' for children and young people with learning difficulties or disabilities (aged 0 to 25) and child sexual exploitation. The audits concerning sexual exploitation were reported on in last year's report. The audits concerned a small percentage of the hundreds of children and families supported through the safeguarding partnership on a daily basis across Oxfordshire but there are some common themes for joint working can be drawn out:

Communication

- The importance of regular and effective communication between practitioner and children and their families came through strongly – cutting out repetition of 'your story': *Painful, I wanted to forget but I had to repeat'*

- Straight talk is helpful: '*It was about me so I should know*'

Communication in planning

- Parents want to be told what was happening and why agencies are involved
- Workers consistently bring their client's voice to planning meetings to inform work
- Planners need to check that the child's (*and not just parents'*) views have not only been captured and but responded to

Working with Young People

- Links between agencies working with complex young people needs to be strengthened
- Ensuring protective factors are in place for vulnerable children through change is essential e.g. when transferring to college. Whilst the destination may be unclear the provision required for them can be set out and ready
- Increased local expertise in working with young people and domestic abuse, particularly with young perpetrators would be beneficial

Effective approaches

- Plans for children work well when partners use 'tools of the trade' e.g. multi-agency chronologies , case mapping and when they share their expertise through 'professional only meetings' and by taking on the deputy role of for child protection 'core groups'
- Plans stay strong where there is a proactive response to new instances / incidents and they are properly followed up according to procedures

Multi-agency Working

- Managing change (transitions) for young people goes well when partners understand what is required of them e.g. succinct forward-looking reports for children with special educational needs for EHCP
- Long-term planning is effective when partners have strong links with one another and know how to contribute them e.g. recording and sharing health assessments to ensure health needs do not obscure neglect concerns over time

Single Agency Audits:

Seven agencies reported back to OSCB in 2016/17 on their internal safeguarding practice. Some agencies such as the county council provided information from different service areas such as public health, youth justice, children and education.

The audits have shown the complexity involved in working across the services with children who presenting behaviours that are a risk to the public and themselves whilst being vulnerable. They have also highlighted how a focus on 'thinking family' can make a difference to the protective factors put in place for children.

Audits undertaken by the Clinical Commissioning Group have led to 'Frequently asked safeguarding questions' for GPs. The audit undertaken by Thames Valley Police has led to a more rigorous reporting on children in the home during a domestic abuse incident. Oxford Health NHS FT audit has led to improvements in their electronic information system, which will enable enhanced data reporting in the future, for example numbers of referrals children's social care, number of court reports written etc. This should lead to a greater understanding of the safeguarding work undertaken by staff. It should also enable staff to be able to identify children linked to an adult they may be working with.

An example of positive practice highlighted through the audit included the safeguarding training run by Oxford University Hospitals NHS FT showed a really positive impact on health practitioners. A self-assessment taken three months after the training indicated that practitioner knowledge and confidence increased by 34%.The CRC has led a training programme to improved safeguarding awareness. They were able to report that 90% of staff located at their main Oxford site have been trained in Prevent, Safeguarding Level 1 and Safeguarding Level 2. The remaining 10% had training planned.

Safeguarding self-assessment:

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

Section 2.3 Involvement of Practitioners

This section aims to summarise the views of the practitioner in Oxfordshire. The sources of information include practitioner listening events, serious case reviews, audits and training and learning events, safeguarding groups and workshops attended by the voluntary, community and faith sector.

Children's Social Care Practice development week:

Children Social held a practice development week in 2016/17 which brought senior managers to the front line. The feedback from senior managers was just how well workers knew the families that they worked with - how they understood that the personal touch of a quick phone call /calling in made a difference to trusting relationships. The tenacity and dedication of practitioners were recognised as qualities in the work force that managers felt proud of.

Serious Case Reviews:

The serious case review published this year highlighted the complexity of situations that practitioners are dealing with on a daily basis. They also highlighted the challenges that systems can present to practitioners e.g. the difficulty that different information systems can place on co-working as information cannot assume to have been shared; the challenges of working across different geographical areas or locations where standard practices vary and assumptions can be made about what actions have been taken. There were examples of support from professionals even when they no longer had a direct role in supporting a young person. A great deal of learning has come from reviews, which has been shared through OSCB themed learning events.

Audits:

The safeguarding self-assessments included a practitioner questionnaire to gather the levels of awareness and impact on frontline staff working with children and young people. Although only a small number of agencies completed the questionnaires returns showed increased awareness of referral processes, how and where to raise concerns and good take up of safeguarding training.

Training

Over 9000 practitioners have completed face to face or online training. Satisfaction rates continue to be high for face to face courses. Delegates have told the OSCB that they would like more availability of course and a more accessible booking system which is something that will come in to shape in 2017/18. Trainers have fed back concerns from delegates:

expressing frustration at cuts to services; asking for greater clarity on how early help will work and what their responsibility is within this and stating anxiety on the perceived increase in self-harm by adolescents.

Learning events

A learning event and a conference have been run by the OSCB in 2016/17 covering safeguarding risks arising from social media, gaming and being on-line. The feedback showed that practitioners find this a difficult area to manage and do not wish to criminalise children and young people unnecessarily due to their ignorance. They valued the opportunity to discuss case studies. The same conference was then run through Thames Valley Police as a result of feedback from the event.
The annual conference concerned Identity and relationships. Presentations covered safeguarding risks that arise in relationships from being an adolescent; being LGBT; being autistic; being disabled or being more vulnerable to abuse. The presentations were wide-ranging and included recordings, films, short stories and a play written and produced by children from the Warriner School. It is apparent that this is an important theme for young people. Children's Social Care arranged a follow up event with the conference's key speaker as a result of the event.

Area Safeguarding Groups

These groups are chaired by Board members and attended by managers across the county. The area groups provide an accessible way for smaller local agencies and settings to be involved with the Board and keep up to date with local safeguarding themes and projects and national guidance and requirements. Locally identified issues included:

- Early help: the concern that agencies feel that they will not have the capacity to take on lead roles in managing Team around the Family processes
- Frustration that there were cuts and changes to service structures
- Increased capacity in the system leading to a large workload and its associated risks
- Supporting high risk young people: children who self-harm
- The difficulties in finding appropriate resources for children who are at risk of drug exploitation
- The complexity involved in working across the services with children who presenting behaviours that are a risk to the public and themselves whilst being vulnerable

The Voluntary, Community and Faith Sector (VCS)

The safeguarding self-assessment has led to providers saying that they want to know more about how the safeguarding system operates – importantly the new Local Community Support Service (LCSS) framework launched in March 2017. They want to better understand

key legislation; access sample policies and be clear on responsibilities in terms of leasing of buildings.

Work through the Chair and the VCS board members has highlighted the need for:

- Guidance and support to the sector including ‘How to do it’ guides, better induction training, ‘helpline’ style arrangements to assist those VCS organisations that are not as familiar with the system as more established and larger VCS bodies;
- Ensuring that safeguarding expectations are clearly set out in contractual specifications and that the resource allocated to provide the service(s) enables the sector to be compliant with expected safeguarding standards

Section 2.4 Involvement of Young People, Parents and Carers

This section aims to summarise the involvement of young people, parents and carers, and how this is fed back to the OSCB. The sources of information include young people forums; the ‘neglect pilot’ and sounding boards, children in care council and Oxme.info the county council’s website for young people.

Voice of the Child:

OUH NHS FT has the ’**yippee’** forum for young people and uses the ‘**Wellbeing Monkey’** to communicate issues to young people. Examples of good practice are: involvement in the interview process for a new paediatric rheumatology consultant. Contribution of feedback to the Children’s Survey Advisory Group at CQC Headquarters alongside professionals from the Trust.

OH NHS FT has an ‘**Article 12’** group, which articulate views on this provision. A recent survey of 27 children who were supported by the Phoenix Team found that the nurse gave 100% of them time to talk and 96% (26) felt that they were sufficiently involved in decisions about their care.

There were three specific pieces of work children and families participated in 2016 / 17 with the support of the County Council:

1. **Aloud: Views and voices from babies, children and young people experiencing Domestic Abuse.** Summer 2016
2. **Engagement exercise with parents and children experiencing Child Protection plans for Neglect.** Winter 2016 / 2017
3. **Children’s Voices on Coming into Care and Being in Care** - part of iMPOWER project Spring 2017

Sound bites have been pulled out for the OSCB. The feedback was to “*make a difference as early as possible*”. They reported that help feels overdue but positive when it happens and plenty of positives were reported. They encouraged professionals to “*look behind the behaviours*” and said that behaviours are communication. Some signs are being missed in children’s and young people’s experiences.

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

It was clear that the impact of one person can be incredible: they could be a teacher, a foster parent, social worker. Children said that we should never underestimate the positive impact a professional can have –

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

Children don't necessarily know who they can go to for help. "*It didn't cross my mind who I could talk* to "*I didn't know who to go to*". "(*when professionals were involved) I didn't have to deal with it on my own*". Being listened to and acting on what's important to the child is VITAL. Showing you care is everything: "*get to know me as a person not just a case or a set of problems"* And as they become older 14, 15, 16 years then being very involved in decisions becomes even more important. They need to understand why social services involved.

Children in Care Council:

The Children in Care Council (CiCC) are a productive and engaging forum for young people in Oxfordshire. Meetings are chaired and organised by the young people themselves, with support from the County Council. The new Care Leavers Forum (CLF) has been created by care leavers to support and deal with specific leaving care issues.

The reasons for young people going missing have been a regular theme discussed at the Children in Care Council (CiCC) over the last three years. The information is now frequently used in both missing and multi-agency risk assessments and management training to help practitioners think through the issues and will be annually updated to check whether new themes are emerging. Most critically, the young people were emphatic that a return interview should be undertaken by a trusted individual rather than someone independent. This should take place within the 72 hour window to maximise their readiness to open up.

They focused on children knowing their foster carers and key workers, feeling wanted, being able to air their views confidently and being properly prepared for independent living once they leave foster care. The following themes have emerged from our work with Looked After Children and Care Leavers as critical to improving outcomes for those at risk from going missing:

- CiCC held a meeting with Health Officials who said 'they didn't realise some of the issues care leavers face' lack of confidence in doing everyday task, such as calling a

doctors. CiCC and CLF will be working on self-esteem, confidence and possible mentoring. CiCC gave a new name to the LAC service 'the Phoenix team'.

- CiCC talked about bullying and stigma of being in care, comments were "crying made it worse", "crowds of people surrounding me, I retaliated", "people say things on Facebook that they won't say face to face", "reporting to schools was useless – made bullying worse", "some teachers deal with things really badly, pull us out of lessons", "many schools just don't deal with it", the designated teacher helped me deal with this... CiCC are working with the Anti bullying coordinator long term to deal with issues mentioned.

- 'I want to be treated the same as other children', 'Care isn't bad, it's the best thing that happened to me'

The Oxfordshire Pledge to its Children in Care and Care leavers was updated this year in response to specific concerns the CiCC had raised and to new Chairs of CiCC being elected into posts.

Two Pledge issues specific to safeguarding are:

- "We will offer training to our foster carers and residential workers on community and internet risks and creating adverts for new foster carer's.
- We will encourage all Looked After Children to share with their foster carers where they are going and who with. We want children and young people to feel confident to speak out when there is a problem and to know who to speak to".

One section of the Pledge deals with poor communication, tackling issues highlighted in the 2013 to 2016 Surveys of Looked after children and those leaving care. A 'good communication guidance' was created, which has been introduced to newly qualified social workers, put into health and social care modules and will be discussed in supervisions with social workers and personal advisors. *"need to feel I'm not alone", "just because I am doing well in life does not mean I am always ok", "I don't know how to make a complaint", I don't understand my entitlements". "Staff are great and understanding"*
"*They treat us like their own children and everything is fair and equal*" (foster child). Those who said they were depressed, sad or didn't feel safe were all followed up. Surveys, 5 to 25 yr olds, are being done again this year.

CiCC have developed a stronger relationship with Independent Reviewing Officers to tackle a number of issues raised in the Children in Care surveys to make being in care a 'better and more constructive experience' for Looked After Children and those leaving care. A new 'Intro Card' has been developed so children get to know their IRO's better: "You know everything about me; I know nothing about you."

Young people's concerns reflected on Oxfordshire's Website for young people, oxme.info

In 2016-17 nearly 50,000 visitors accessed more than 170,000 pages on the oxme.info website. Post-16 learning choices and the challenge of finding your first job or apprenticeship is the main concern that brings people to the site. With 28% of visitors checking 'Opportunities' pages, and a further 20% for checking the 'Earn' pages, representing almost half the site pages read this year. Interest in apprenticeships has increased, now representing 14% of pages accessed against 11% in 2015-16. Other key concerns among our site visitors include rights, bullying and sexual health and safety.

Anti-bullying content has proven especially popular this year, with over 5000 views of or searches for Oxfordshire's Anti-Bullying Week competition winners. This competition, organised jointly with the Oxfordshire Safeguarding Children Board, challenges individuals, schools and groups from across Oxfordshire to create anti-bullying materials such as posters, videos and songs.

Other popular pages on the site this year have been the page on emergency contraception, National Citizen Service content, pages about what age young people can legally work, and the page on sexual orientation (LGBTQ), where OXME has received comments from children and young people this year for the first time about transgender issues, such as this comment left in March of this year; I've recently come out as transgender but I'm not sure what to do next, could someone help me by pointing me in the right direction? Other commenters have spoken about their employment interests, changes to children's services this year, and asked practical questions about the availability of jobs and how to apply for them. New content on the site this year has included pages on periods, consent, sexting and pornography, created jointly with OSCB and Public Health.

Homo-phobic, bi-sexual, transgender bullying – views of young people

The online bullying survey (a free service to all schools) continues to be an effective way of consulting children and young people. It continues to show that, in line with national trends and previous local results, those young people who are "different" from the majority in terms of experience of a long-term illness or disability, race, religion, or sexuality are likely to experience increased frequency of bullying and "feeling unsafe". Of this group young people who identify as lesbian, gay, bisexual or transgender (LGBT) appear to be very vulnerable with 10% never feeling safe in the classroom (compared to 1% of those identifying as heterosexual) and experiencing increased rates of regular bullying.

Work by My Normal, as part of the strategy, has captured the voice of young LGBTQ+ young people and you can hear their views by visiting the link https://youtu.be/ZjhgOJgvN6k. Project Q, by The Warriner School, has also captured the coming out stories of young LGBT

young people to raise awareness about the impact of bullying on this group and they will shortly be performing at Stonewall's National Education For All Conference. http://www.thewarrinerschool.co.uk/projectq

Some quotes from young people in this year's survey about experience of LGBT students show a mixture of experience:

"A lot of students use the word 'gay' as an offensive word to ridicule other students"

"People only consider severe forms of discrimination to be bullying, but I think that the little things are always happening"

"This school takes bullying seriously, especially homophobic and transphobic bullying"

Summary of compliments and of children's statutory Social Care Complaints 2016/17

45 formal compliments were received about Children's Services (compared to 34 in the previous year). The compliments were encouraging and described the hard work and dedication of social workers. One area starting to see a steady stream of compliments is the REoC service which provides intervention to young people on the edge of care. The Kingfisher Team were also praised for support which was 'amazing and life changing'. A number of compliments were received on how well child protection conferences have been managed and how well chairs understood the challenges faced by families involved.

91 Stage One children's social care statutory complaints in comparison with 84 received in 2015-16. This is an 8% increase. Over a third of the complaints were about children looked after with 90% of those complaints coming from either parents or grandparents.

7 of the complaints received were directly from young people. This is a reduction in the 8 received last year. In 2017 the 'mind of my own' app is being launched to enable young people in contact with children's social to express their views and complain if necessary.

Poor communication continues to be the prevalent theme for complaints. This is followed closely by staff attitude and people tell us that they feel judged or have experienced discourtesy by a staff member – it is also understood that the attitude of another person is an individual perception and in children's social care difficult messages do have to be delivered.

3. Impact of work to date

Below are examples of 'positive impact' as reported to the Performance, audit and quality assurance subgroup following the scrutiny of safeguarding practice over the last 12 months.

1. Thames Valley Police were able to demonstrate improved safeguarding practice by police officers investigating **domestic abuse incidents**. The audit showed that training had led to the better collation of information by officers responding to a domestic abuse incident with respect to children in the home at the time. The information is then used by multi-agency partners to help inform any further action to be taken.

2. Children's Social Care audited the **child's voice in the planning of the care**. The audit had shown no improvement on the previous year where roughly 2/3 of cases showed the child's voice being represented within plans. The service has developed new ways of collating views of children including a new app called, 'My opinion matters' in order to ensure more children's plans are informed by their own views.

3. Children's Social Care ran a small scale audit on the **involvement of fathers in case planning and review** (following the Child Q serious case review). This showed that 70% of them effectively involved fathers. The service has subsequently made the views of parents, where there is a child protection plan, an area for development.

4. The **safeguarding training** run by OUH NHS FT showed a really **positive impact on** health practitioners. A self-assessment taken three months after the training indicated that practitioner **knowledge and confidence** increased by 34%.

5. 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.

6. Following an audit on documentation standards Oxford Health NHS FT has embedded the use of the Safeguarding form on the new Carenotes electronic system. This will enable **enhanced data reporting** in the future, **for example numbers of referrals children's social care, number of MARAC referrals, number of court reports written**. This should lead to a greater understanding of the safeguarding work undertaken by staff. It should also enable staff to be able to identify children linked to an adult they may be working with.

7. Following an audit on the Think Family approach to work, Oxford Health NHS FT has set up a quarterly network meeting for managers. This has led to **better communication between child and adult services**. A recent audit of Adult mental health teams provided good evidence that clinicians were considering the needs of the wider family, including children, in their assessments. Data around calls to the safeguarding children consultation line shows that **around 45% of contacts are from**

adult services, evidencing that clinicians who work with adults are considering the safeguarding needs of children. There are ongoing discussions around how to continue developing the Think family approach within the Trust.

8. As a result of feedback, information about management of allegations was fed back to locality coordinators who will consider training focussed at **GP** practice managers around allegation management.

9. **Communications between social care and GPs** has been a focus of work and the number of incidents reported to the CCG this year has decreased suggested improved direct links and clearer communication processes have been established.

10. **GP newsletters** are sent out weekly from the CCG and **safeguarding updates** are included regularly within these. Updates this year have included FGM information, updates on CSE support, updates on tools and resources available on the OSCB web site and links to learning from SCRs.

11. Numbers of **GPs trained** – There have been 3 well attended safeguarding training sessions involving 106 primary care team staff (including GPs, practice nurse and practice managers) and further session involving 41 safeguarding leads.

12. The **GP leads away day** covered Prevent, management of allegations in practice and safeguarding of disabled children and those with perplexing presentations.

13. **GP safeguarding leads meetings** occur monthly, providing 2 local meetings in each of the 6 GP clusters per year. A recent audit of their effectiveness provided feedback that they are found to be very helpful for peer support and as a form of safeguarding clinical supervision.

14. The National Probation Service's Public Protection Unit have received the national Child Safeguarding Training mandated by NPS and delivered in-house. **Learning from the child sexual exploitation case reviews has widened the skills set of officers**, in particular to be alert to 'relationships' with children under 18. The knowledge base of NPS staff was noted positively in the Joint Targeted Area Inspection in this respect.

15. The trafficking element of the child sexual exploitation cases, along with other adult trafficking / forced labour cases in Oxford has been a learning experience, and we have had input from the Oxford City Council staff involved in this area at our team practice meeting. The National Probation Service is now involved in **the multiagency approach to trafficking** which cuts across both child and adult safeguarding.

16. The HMIP Inspection noted the youth Justice Service's **practice innovation** with girls work and group work.

17. The YJS has **multiagency Case Formulation meetings** – where a case is considered allowing the time to be reflective. This includes joint cases with social care and is

considered an example of good practice by the agencies who attend and contribute(fCAMHS, Police, Social Care, Housing providers, YJS)

18. The YJB have recognised the work around **wider exploitation**. The local conference was successful, and an awareness of the issues of exploitation of young people through the use and dealing of illegal substances has been increased. As a result of this the YJS have developed a broader exploitation tool that encompasses all forms of exploitation.

19. The YJS Clinical supervision of sex offender cases with forensic CAHBS is having a positive impact. This provides bi-monthly clinical **oversight** of the cases were children are convicted of sexualised offences against others.

20. Safeguarding audits demonstrate that **Youth Justice Service staff have been trained** in assessing young people who sexually offend, safeguarding refreshers, SAVE (exploitation) a variety of mental health courses, resilience in the workplace, case formulation.

21. **Public Health** audited compliance to **quality and performance** indicators on the contracts, and found that all indicators were being monitored. This audit highlighted that, for all contracts where it was possible to monitor in the timescale, feedback on the service was gained from carers, parents and children, and staff receive regular feedback and supervision.

4. Recommended actions for 2017/18 from the summary of themes

To ensure that these themes are fed through in to:

1. **Priorities for the business plan** for 2017/18 to ensure that the issues of neglect and working with adolescents are addressed - the quantitative data is pointing to these areas as continued safeguarding concerns
2. **Training**
   - development of learning that covers the broader theme of criminal exploitation of adolescents – the qualitative audit work and analysis is highlighting this as an emerging theme and a concern for practitioners
   - ensuring that working with fathers is adequately covered in multi-agency training - qualitative learning from Baby L and also Child Q serious case reviews show that this has been a common theme
3. **Learning events**: issues for consideration should draw on the findings of the qualitative section in this report in particular the ten most common learning points from serious case reviews
4. **Audit work**: the board should ensure that the voice of children and young people are routinely involved in audit work. They have increased the quality of the learning and ensured that those using the services are represented in the monitoring of the services.

5. Glossary

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