Oxfordshire Safeguarding Children Board

Report title:	**OSCB Themes for learning and improvement 2017/18** **Report from Performance, audit and quality assurance (PAQA) subgroup**
Report Summary:	This is the learning and improvement report of the PAQA subgroup. The purpose is to highlight common themes for learning and improvement to support vulnerable children and young people in Oxfordshire. The OSCB applies the quadrant developed in the south-east region to frame its analysis: 1. Quantitative 2. Qualitative 3. Practitioner views 4. Family, children and young people's views The following sources are used: safeguarding self-assessments, school audits, single and multi-agency audits, participation work with children and young people, annual reports and serious case reviews practitioner feedback, performance data.
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Section 1: Executive summary

1. Introduction

This is the learning and improvement report of the PAQA subgroup. The purpose is to highlight common themes for learning and improvement to support vulnerable children and young people in Oxfordshire. The OSCB applies the quadrant developed in the south-east region to frame its analysis:

5. Quantitative
6. Qualitative
7. Practitioner views
8. Family, children and young people's views

The following sources are used: safeguarding self-assessments, school audits, single and multi-agency audits, participation work with children and young people, annual reports and serious case reviews practitioner feedback, performance data.

This executive summary provides a precis for each section.

2.1 Quantitative themes in summary

- The safeguarding system is (increasingly) under pressure
- Early Help assessments have increased significantly from 458 recorded last year to 1255 by end of year in 20017/18
- MASH enquires have increased. The timeliness of enquiries managed by the Multi-agency safeguarding hub (MASH) was below the target of 75% at 45% at year end
- The number of troubled families worked rose from 1549 last year to 2398 and is on track
- 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)
- Only 50% of fathers are attending children protection conferences regarding their children
- 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)
- The number of children placed out of county and not in neighbouring authorities also continued to rise – from 118 to 155 or 17.5% to 22.5% of the looked after population.
- 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%.
- The percentage of children referrals to CAMHS who are seen within 12 weeks was below the target of 75% at 56% at year end
- Attendance at A&E for self-harm of children who are 12-17 has increased from 542 in 2016-17 to 660 in 2017-18 – a rise of 22%.
- At 31 March – 499 children were recorded as receiving elective home education in Oxfordshire. There is evidence of links between safeguarding risk and safeguarding in education issues: attendance, exclusions, elective home education, attainment and achievement of pupils with SEND

2.2 What this means in terms of learning and improvement.

- Continuing to improve Early Help is a priority. The target to increase the Early Help assessments to 2,100 (an average of 175 per month) is supported
- Ensuring that Early Help assessments identify, name and tackle neglect is essential to reduce its impact on child protection plans (65% are due to neglect).
- The Think Family and Think Father message remains significant
- The poor achievement of children with SEN and other vulnerable groups should remain a priority
- The submission and collation of data from schools regarding the use of part-time tables is a priority to be able to drive change and keep children safe
- Strategic leadership and effort is required across the partnership to set and achieve targets for children missing from education i.e. exclusions, attendance, not on roll and part-time timetables. These children are at a greater safeguarding risk as they are not in school
- The use of hospital beds for children in mental health crisis because there is no suitable alternative is a regional safeguarding risk
- The cohort of children worked with by the Kingfisher Team and the Youth Justice Service demonstrate the complexity of need and wide range of vulnerabilities
- 5 priorities remain at the forefront of safeguarding work: mental health; domestic abuse; alcohol and drug abuse; exploitation and housing.

3.1 Qualitative themes in summary

Neglect is a repeated theme. Some of the issues resonate with learning from Child J, Baby L and Child Q

- Mental health, domestic abuse and substance misuse are a backdrop to neglect
- The work force needs to 'think family' and consider dads as a protective factor for children

Domestic abuse is a repeated theme due to audits covered. Some of the issues resonate with learning from Child J and Baby L and mean that further work should be done

- The circulation of indecent images of children by abusive intimate partners
- History of domestic abuse within the family home where there is peer on peer abuse
- Understanding the pathway for children and young people and the use of MARAC
- Ensuring that professionals are trained to deal with domestic abuse and discuss healthy relationships

Vulnerable adolescents and exploitation is a challenge. This resonates with Children A-F, Child J and current themes in the Kingfisher team

- The complexity involved in working across the services with children who present challenging behaviours that can be a risk to the public and themselves whilst being vulnerable
- Lack of protective behaviours: children and young people's limited ability to recognise they need help, to understand consent and what constitutes abuse
- The difficulties in finding appropriate resources for children who are at risk of exploitation in particular drug exploitation

School is pivotal in ensuring resilience. This resonates with Children A-F, Child J and current themes in the Kingfisher team

- School attendance is a critical factor to support well-being and safety of the child
- School data on attendance is critical in having a good overview of safeguarding risk
- Record-keeping is key to good information sharing and having a long view of the child
- Transitions between schools and school / college are points of vulnerability and planning should be in place for vulnerable children

Health and 'not being brought'

- Children not being brought to appointments should be identified early
- There could be greater knowledge of what a specific disability means and how this might impact on safeguarding
- Normalising and misinterpreting behaviour linked to special educational needs

3.2 What this means in terms of learning and improvement.

- Think Family.
- Use tools of the safeguarding trade earlier.
- Engage children and families in statutory safeguarding processes – with a focus on fathers and male care givers and capturing the voice of the child
- Take 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.
- Use chronologies to support joined up work. Keep up-to-date and shared.
- When there is a concern about neglect and children are not being brought to appointments levels of concern should be escalated
- Need for greater understanding of online and social media abuse coupled with knowing how to talk about what constitutes abuse, healthy relationships and consent

4.1 Practitioner views

There are concerns about:

- Threshold awareness by the workforce in general and in particular at the level of early help
- Safeguarding front-door effectiveness and the need for better co-ordination of the routes for referral and assessment between early help and the multi-agency safeguarding hub
- Complexity of cases not only within the children's safeguarding arena but also in relation to adults in those children's lives
- The need for stable, appropriate and secure housing
- Supporting vulnerable adolescents to develop protective behaviours
- Young people exploited in crime-related activity: response and provision
- Placement Sufficiency for children in care and children with acute mental health problems
- Young people's domestic abuse pathway: knowledge and application

- Links between safeguarding risk and safeguarding in education.
- Young people's mental health and self-harm: increasing risks and long waiting times for CAMHs

4.2 What this means in terms of learning and improvement.

Priorities should include:

- Improving the workforce's understanding of thresholds and early help
- Addressing neglect and raising awareness amongst the workforce
- Developing a strategic response to criminal exploitation and raising awareness amongst the workforce
- Developing programmes of protective behaviour
- Raising awareness regionally regarding placements
- Improving the work on domestic abuse and the young person's pathway to support
- Continued scrutiny of the front door to safeguarding to ensure the right kind of referrals, a prompt response and appropriate feedback
- Recognising and supporting the children's workforce who are operating in a system that is full to capacity

5.1 Parental views

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

5.2 Children and young people's views

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

6. Recommended actions for 2018/19 from the summary of themes

1. **Priorities for the business plan** for 2018/19 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 and especially criminal exploitation and mental health.
2. **Training priorities** e.g. need to establish the multi-agency domestic abuse training and neglect training (see 4.2 above)
3. **Learning events** to ensure that improvement themes cover thresholds and chronologies when working with neglect; awareness raising of child exploitation, working with families and children with respect to domestic abuse; working with adolescents on healthy relationships
4. **Audit work** to ensure that improvement is consistent and learning is robust. The voice of children and young people should continue to be involved in audit work.

Section 2: Full Report

2.1 Quantitative themes and findings

Introduction

This section aims to summarise the quantitative information available to the OSCB from datasets as well as the impact assessment. It provides facts and figures and a summary of findings.

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 2017/18, 1255 Early Help Assessments were completed which was significantly more than the 458 recorded in 2016/17. Continuing to improve Early Help is a key priority of the Children's Trust going forward and a target to increase this figure to 2,100 (an average of 175 per month) has been set for the coming year.

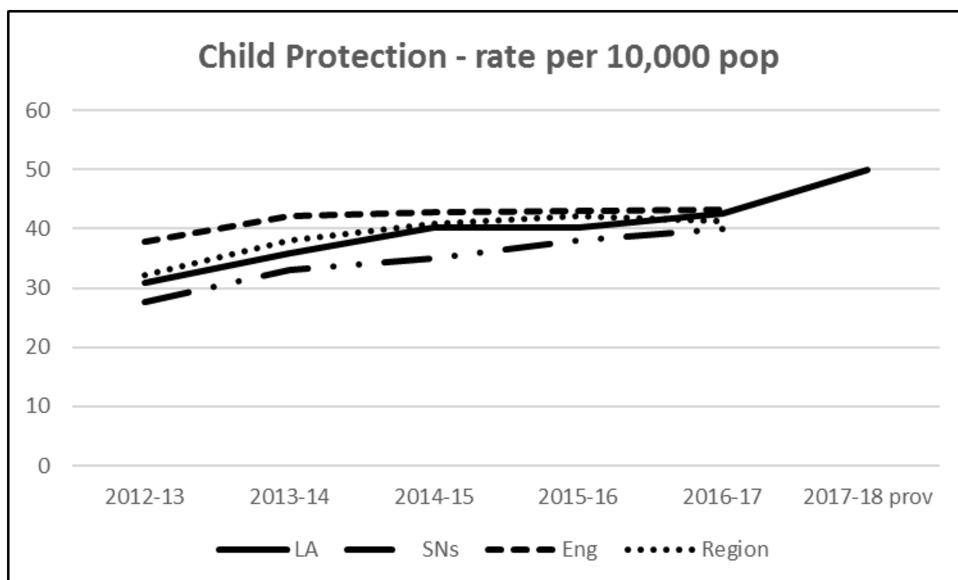
The number of troubled families worked with rose from 1549 in 2016/17 to 2398 in 2017/18 and remains on target.

Increasing levels of activity in child protection planning:
The number of children on a child protection plan rose to 730 at the end of March 2018 compared with 607 at the end of 2016/17 and 569 at the end of 2015/16. This is a rise of 28% over the 2-year period.

The rate of growth 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 likely to rise above the national average. The increase has been due to both more children becoming the subject of plans and fewer children ceasing. The increase in children becoming the subject of a plan is despite a 5% decrease in the number of child protection investigations; as more children were taken to case conference and then to a plan.

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 61/2017) but lower than our figure for last year which was 67%.

Social care assessments in Oxfordshire that identify neglect are much more likely to result in a child protection plan for neglect than elsewhere in the country. This raises questions about how we identify, name and tackle neglect earlier in the child's journey.



Graph 1: Child protection rates per 10,000 population

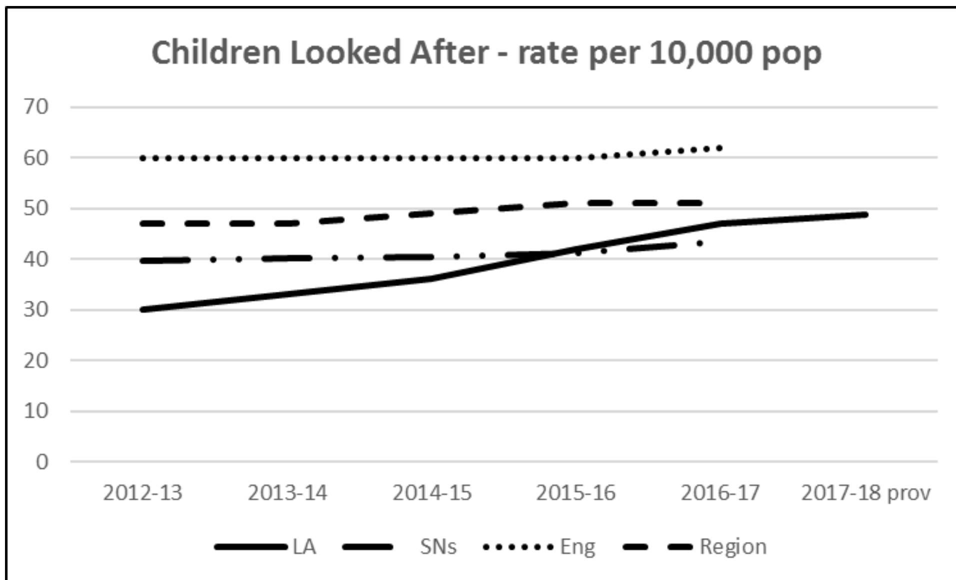
Referrals to Children's and Adolescent Mental Health Service: (CAMHS)
The percentage of children referrals to CAMHS who are seen within 12 weeks continues to be a cause for concern. At the end of the year this was only 56% compared with a target of 75%. The service continues to face high levels of demand.

Attendance at A&E for self-harm of children who are 12-17.
Alongside this we continue to collect and report the number of A&E attendances for self-harm of children who are 12-17. This has risen from 542 in 2016-17 to 660 in 2017-18 – a rise of 22%.

Disabled Children:
At the end of March there were 13 disabled children with a child protection plan compared to 16 last year.

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 6% in the year from 667 at the end of 16/17 to 691 at the end of March 2018. During the year the target was adjusted to be 700 based on the latest comparative figures and the realigned budget.

Safeguarding partners want to ensure that where children and young people are looked after, those who are most risk are closest to home. However, with the continuing rise in the number of looked after children, the number of children placed out of county and not in neighbouring authorities also continued to rise – from 118 to 155 or 17.5% to 22.5% of the looked after population. Some of the out of county placements are positive – at the end of December; 15 of these children were placed with family and friends and another 8 placed for adoption. Additionally, two thirds of the people placed out of county are in foster placements, with 41 children in residential placements.



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

Children at risk of sexual exploitation:

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 239 CSE screening tools completed in 2017-18 compared with 236 CSE screening tools in 2016-17 compared and 223 in 15/16. The number of boys identified as victims has increased. The number of children worked with who have additional learning needs are reported to be 70% of the cohort. The Team has also reported concerns regarding interwoven problems of drug exploitation alongside child sexual exploitation which is had led to a new focus on criminal exploitation and the development of work to address this.

In 2017, Thames Valley Police recorded a total of 106 victims of child sexual exploitation in Oxfordshire, almost 40% below that in 2016 (170) with the greatest reduction in Oxford (21 in 2017 compared with 94 in 2016).

Over 40% (44%) of victims recorded in the four years between 2014 and 2017 were in Oxford city and a further 26% were in Cherwell.

Children missing from home:

The number of children who have gone missing from home has fallen in the last year from 798 to 773 or from 2105 incidents of children going missing to 1913. The number who went missing 3 or more times was 149 or 19.3%. This compares with 18.5% last year.

Children involved in crime:

In 2017/18 the number of *child victims* of crime in Oxfordshire rose 3.6% from 2189 in 2016/17. Analysis on the timing of crimes revealed that 31% took place during the school day.

The numbers of domestic crimes involving children also rose from 1780 in 2016/17 to 1804 in 2017/18 – a rise of 1.3%. On the positive side – the numbers of domestic incidents involving children was 6.1% lower than last year and there has also been a 28% reduction in the numbers of child perpetrators of crime over the year.

Children missing from education:
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 as well as 34 pupils who were permanently excluded from their school. With the latter – there is a statutory obligation to provide alternative provision within 6 days but this had only been achieved for 24% of these children. 499 children were recorded as receiving elective home education in Oxfordshire.

Allegations made against adults working with children.
In the academic year 2016/17 there was a 41% increase in recorded allegations to 234. A substantial proportion were low level cases, requiring advice. The largest percentage of allegations originated from schools (in both the maintained and independent sector) although referrals came from a wide variety of voluntary and statutory organisations.

The highest category of referrals are allegations about physical abuse, totalling 108 referrals. Referrals of inappropriate behaviour have increased (to 55), these in the main relate to breaches of policies and procedures, for example code of conducts, safeguarding policies, social media policy etc.

Safeguarding in transport
A total of 275 complaints of a safeguarding nature were received by the OCC Transport Quality Safeguarding team in the last academic year, which is a positive sign that children and families know that they can escalate concerns. These are against drivers and personal assistants that hold an OCC badge. 94% of Oxfordshire taxi drivers are now trained in safeguarding.

Children and young people involved with Oxfordshire Youth Justice Service:
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. Figures for 17/18 are not available until May 2018.

The proportion of children receiving a custodial sentence dropped to 4.0% in 2017/18 from 4.3% in 2016/17 and 7.1% in 2015/16. The proportion of children receiving remand to custody increased to 16% in 2017/18 from 6.3% in 2016/17 and from 5.2% in 2015/16

Children who are privately fostered:
At the end of March 2018, the local authority was aware of 12 children living in a privately foster placement compared to 50 children at the end of March 2017 and 43 at 31 March 2016.

Mapping of vulnerable children 2016/17:
In the year the OSCB quality assurance group looked at the overview of activity across agencies at a ward level and published data on the use of social care; health and police services at ward level and school attendance by school partnerships.

There are clear geographical overlaps e.g. areas of higher incidences of domestic violence notifications tend to have higher levels of social care referrals, and more children are victims of crime. These are also linked to levels of deprivation, with areas with higher deprivation having higher levels of activity. There is less of an overlap with referrals to the CAMHS service. Additional work was carried out on children as victims of crime and a quarter of all victims were of school age; and the crime was during the school day in term time.

Oxford City and Cherwell have higher prevalence rates than Oxfordshire as a whole; the Vale is in line with the county average and South and West Oxfordshire have lower prevalence rates. All 4 wards in Banbury have particularly high rates as do Blackbird Leys, Barton and Northfield Brook in Oxford City. This has led to the development of Community Impact Zones in Banbury and Oxford.

Targets tracking the safeguarding system

The OSCB monitors and scrutinises performance data following up any measures which are off target. Over the last 12 months these have been:

- Children's safeguarding - increasing volumes of activity
- Multi-agency safeguarding hub (MASH) timeliness of enquiries - below the target of 75% at 45%
- Fathers attendance at child protection conferences - only 50% of fathers were attending conferences regarding their children.
- Child and Adolescent Mental Health Services waiting times for children - below the target of 75% in 12 weeks
- Children's attendance at A&E increasing

PAQA has escalated the following safeguarding concerns to the board:

1. The poor achievement of children with SEN and other vulnerable groups
2. The need for more data from schools regarding the use of part-time tables
3. The concern that targets should be set for children missing from education i.e. exclusions, attendance, not on roll and part-time timetables.
4. The use of hospital beds for children in mental health crisis because there is no suitable alternative

Pressures on the safeguarding system

Oxfordshire faces three key pressures on its system: **rising demand**, **diminishing resources** and staffing shortfalls as well as **difficulties with staff recruitment** and retention. An in-depth look at how these are being addressed through an impact assessment conducted by the children and adult's boards in 2017/18 would indicate several common approaches to keeping children safe. These include demand management and early intervention strategies, continuing to refine multi-agency approaches and the need to 'think family'.

Partners recognise the need to manage risk and pressures and regularly review them. 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.

Section 2.2 Qualitative

Introduction

This section summarises the qualitative information available to the OSCB. The sources of information include multi-agency and single agency audits, safeguarding self-assessments agency and school audits which have been reported to PAQA as well as serious case reviews. This section aims to draw out themes and learning points.

Multi-Agency Audits:

Four multi-agency audits covered the issues of neglect, domestic abuse, children with a disability and 'Education, health and Care Plans[1]' for children and young people with learning difficulties or disabilities (aged 0 to 25). The audits concerned a small percentage of the hundreds of children and families supported through the safeguarding partnership but there are some common themes for joint working which can be drawn out.

The themes were selected by the quality assurance group from issues arising in recent OSCB case reviews: Child Q, Child K, Child C[2], Child A and Child B. Audits tended to look in-depth at up to six different cases tracking them from the perspective of the different agencies and families involved as far as possible.

Key strengths and learning points are recorded, general points feed into training and overarching developmental work, and individual services take away their own actions. Overall the findings from audits were positive and considerable good practice was evidenced in relation to decision making, ensuring a wide perspective of underlying causes, the quality of information sharing, the voice of the child, good use of tools, a strong focus on other siblings and a whole family approach.

There was good evidence of strong multi-agency working across key partners in very complex and challenging circumstances for the children and families involved. Child protection planning was seen to be effective and achieving results although could have been instigated earlier in some cases. Learning points from the audits are summarised at appendix B

Summary of themes and findings from each of the audits

The neglect audit confirmed the complexity of family life for children in this situation. Domestic abuse was an overwhelming theme throughout the audit and mental health and substance misuse were evident in 67% of cases.

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[1] Education, Health and Care Plans (EHCP) were introduced in September 2014 in accordance with the Children and Families Act and replace Statements of SEN.
'The purpose of an EHC plan is to make special educational provision to meet the special educational needs of the child or young person, to secure the best possible outcomes for them across education, health and social care and, as they get older, prepare them for adulthood.' SEN and Disabilities Code of Practice, January 2015

[2] Child C Review was a partnership review

The domestic abuse audit revealed that a history of domestic abuse within the home and sexual violence was a common feature. The circulation of indecent images of children involved by abusive intimate partners also featured highly. Disappointingly it indicated that referrals to MARAC[3] for children and young people are not happening as a matter of course. Children and young people's ability to recognise they needed help, their understanding of consent and precisely what constitutes abuse were found to be lacking in a number of cases.

The audit on cases for disabled children picked up on several issues. The first resonated with case review findings that children not being brought to appointments should be identified early and noted in this way rather than 'not attending'. The second resonated with the SCR for Child A and Child B in that, where the child is non-verbal, greater consideration should be given to means of communication and that colleagues should seek to understand what a specific disability means and how this might impact on safeguarding. To this end the need for more active engagement and communication with GPs was identified. Finally, it confirmed that school is pivotal in ensuring resilience and identifying key issues and changes early. School attendance was highlighted as a critical factor to support opportunity, well-being, safety and in achieving positive outcomes including for very young children.

The audit on cases for children who had education, health and care plans showed that the quality of these plans could be better especially in terms of health and social care information and also where a child was transitioning form one setting to another. There was some lack of knowledge by professionals on what was required which impacted on quality, timeliness and reassurance that protective factors were sufficiently in place.

The views of families and children were sought in the first three audits and can be summarised as them (families) needing to be clearer about why agencies were involved in their lives; valuing the role of an advocate in meetings and lacking an understanding of process. With respect to domestic abuse they did not feel informed about plans and 'pathways' for support. With respect to disabled children some said that they relied on their parents to forward their views and opinions, which has implications where circumstances might make this more difficult.

Single Agency Audits:

Agencies reported back to OSCB in 2017/18 on their internal safeguarding practice. Comprehensive submissions were received and often scrutinised a specific area of work e.g. hospital maternity services or police investigation of domestic incidents or OH NHS FT dental services. Findings were positive and improvements were noted with planned actions. There were lots of examples good joint working and strong adherence to safeguarding standards.

Positive examples of improved safeguarding work from these audit reports can be found in section 5. Below is a selection of learning themes only.

[3] MARAC is a 'Multi-agency risk assessment conference. It is a multi-agency meeting which domestic abuse victims who have been identified as at high risk of serious harm or homicide are referred to in order to ensure that the victim stays safe.

Youth Justice Service, Oxfordshire County Council
The audit work highlighted the difficulties in finding appropriate resources for children who are at risk of drug exploitation. It confirmed the complexity involved in working across the services with children who presenting behaviours that are a risk to the public and themselves whist being vulnerable. It also cautioned that there is a lack of understanding from partners regarding the role and nature of the youth justice system which is not a preventative service.

Children's social care, Oxfordshire County Council
This service had undertaken a range of different audits which captured a lot of good practice. Areas for improvement were cited as consistently involving fathers; better capturing the voice of the child by ensuring that they are seen alone as well as ensuring that they are up-to-date and shared.

Schools safeguarding team, Oxfordshire County Council
An overview of audits showed that in general school record keeping could be better and include more outcomes for children and that multi-agency work could be improved by liaising more with other professionals. Schools reported the frustrations of not being included in strategy meetings when referrals are made to MASH about children in their settings as well as being unable to receive information attend meetings during holiday periods.

Education and learning, Oxfordshire County Council
Whilst acknowledging that circumstances are challenging and families may prefer not to engage the audits showed that more effort should be made to obtain the views of families and vulnerable learners when planning their education.

Oxford Health NHS FT
This service had undertaken a number of different audits which generated a lot of learning. A key point was to consistently 'Think Family' e.g. the importance of keeping children in mind where the adults have mental health problems and there are often very challenging family situations. Audits indicated the high prevalence of domestic abuse and neglect in the families that mental health clinicians are working with.

Oxford University Hospitals NHS FT:
Several services areas were audited for safeguarding standards. Learning included the need to use the OSCB safeguarding tools to aid identification and recording information. Practitioners could make more use of tools to identify levels of need and to track neglectful parenting.

Community Rehabilitation Company (CRC)
This service highlighted the need for better understanding from the workforce when working with young adult male service users.

Thames Valley Police
An audit on domestic incidents showed that there is improved recording the voice of the child at the scene of the domestic abuse incident. However, audits showed more room for improvement – it had occurred in less than 50% of all reported incidents.

Safeguarding self-assessment:

The self-assessment provided assurance on the overall safeguarding frameworks within partner agencies. A few areas were highlighted as amber and these were attributed to potential risks arising from the introduction of GDPR; increased caution when assessing risk as well as organisational change. Some concerns were raise about board member effectiveness and the need to ensure challenge, improvements and impact.

Serious Case Reviews:

The OSCB has worked on four serious case reviews since the last report to PAQA.
Since 2013 twelve serious case reviews and three learning reviews have been worked on. They concern nineteen children. The children fall into two main age groups; pre-school and secondary school age children – just over 50% are older children aged between thirteen and eighteen which is in part due to the completion of the A-F review. It is worth noting that seven of the twelve cases concern children who are pre-school or just in the first year at school. In addition, 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 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)

Section 2.3 Involvement of Practitioners

This section aims to summarise the views of the practitioner in Oxfordshire.

The sources of information include safeguarding subgroups, reporting from Independent Reviewing Officers and Child Protection Chairs, Children's Services Practice Week feedback, practitioner listening events, serious case reviews, audits and training and learning events, and workshops attended by the voluntary, community and faith sector.

Safeguarding themes regarding practice and process

Many issues relate to frontline practice in the safeguarding system from early help through to more complex support and show pressure points for actions and change.

Awareness of thresholds, in particular, for early help but across the whole spectrum of need still needs to be greater and properly applied.

There is a need for better co-ordination of the routes for referral and assessment between early help (LCSS[4]) and immediate safeguarding concerns to the multi-agency safeguarding hub (MASH) including Police domestic abuse referrals to MASH.

Capacity is a problem in a system under pressure: both in terms of rising caseloads and the coverage of administrative functions. Professional time is being spent on administrative functions for social care staff in particular because of reduced capacity in support staff.

Complexity of cases dealt with by professionals not only within the children's safeguarding arena but also in relation to adults in those children's lives is presenting challenges.

Finally, the need for assurance that families whose first language is not English are supported fully to engage in the safeguarding process and the appropriateness of interpretation for children through a family member has emerged as a theme for frontline practice.

Safeguarding themes raised by practitioners

The following relate to themes observed by practitioners in the safeguarding system as they support children and families. They are reassuringly reflective of those throughout this learning and improvement framework.
Supporting vulnerable adolescents to develop protective behaviours. The complexity of working with children presenting behaviours that are a risk to the public and themselves whilst being vulnerable and the tenacity required to support children with complex issues

Young people exploited in crime-related activity. The difficulties for practitioners in finding appropriate resources for children who are at risk. The need for better screening of need, referral routes and provision before children become identified as 'offenders'.

[4] Locality and Community support service

Placement Sufficiency. The lack of availability of placements for some groups of vulnerable children and young people e.g. children in care and children with acute mental health needs as well as the lack of quality of some of this provision e.g. secure estate or therapeutic placements.

Young people's domestic abuse pathway. Awareness and use of the pathway needs to be improved across the partnership. Multi-agency training is needed not just on domestic abuse but on understanding consent and healthy relationships.

Links between safeguarding risk and safeguarding in education. Attendance, exclusions, elective home education, attainment and achievement of pupils with SEND have all been raised as concerns.

Young people's mental health and self-harm. Ensuring consistency of approach across the county and accessing care in a timely way for children.

Housing themes. The lack of appropriate housing for vulnerable young people and families is a consistent concern and when location of school is not taken into account when children are taken into care, which can increase instability at an already vulnerable time.

Safeguarding themes from the voluntary sector leads

The two key safeguarding concerns communicated by the sector concern the funding environment and the anxiety of carrying risk. An increasing number of local charities with skills and a track record of making a difference for children and young people state that they are at risk in the current funding environment. Organisations have also stated their concern that, despite the establishment of the Locality and Community Support Service (LCSS), they feel that they are holding a growing number of increasingly complex cases. These are children who fall just below rising statutory thresholds and/or who can't access specialist services because of lengthy waiting lists.

Safeguarding themes through the OSCB training

OSCB trainers meet over 2000 members of the children's workforce each year. They provide anecdotal feedback to the OSCB. This year they have heard delegates raise the issue of increasing mental health issues in adolescents and long waiting times; drug exploitation; unaccompanied minors within the education system who have difficulty with the English language.

Section 2.4 Views of Young People, Parents and Carers

This section aims to summarise views of young people, parents and carers. The sources of information include young people forums; audit work, children in care council and Oxme.info the county council's website for young people.

Parents: 3 simple messages

1. Communication, communication, communication
   - ✓ Clear, honest, straightforward language needed.
   - ✓ Jargon, 'service speak' and paperwork is disempowering and bewildering
   - ✓ Connect and click with workers is central "you've got to let them in"
   - ✓ Responsive communication – i.e. returning calls, texting is favoured
   - ✓ Out of hours assistance - access at pinch points – evenings and weekends
   - ✓ Accessibility of information, plain English, interpreters etc

2. Don't leave help and support until crisis point

3. Sharing and co-ordination of information between agencies
   - ✓ Co-ordination between services and agencies is vital
   - ✓ They want an effective service – they don't care who runs it
   - ✓ People with SEN / disabilities have to battle their corner and fight for services

Children: simple messages

Don't like

- Telling my story over and over
- Breaches of confidentiality
- Having to wait until crisis for a service (and things getting worse)
- Poor communication: professional not coming good on offers of help and actions, slow in replying
- Abrupt change of social worker is difficult; some change is acceptable, importance of managed endings
- Being labelled and judged as troubled child / naughty child. Behaviours are communication and staff must seek to understand and learn from behaviours "*look behind the behaviours"*
- Not knowing who to go for help and in what situations. Children normalise abuse experience.

Do like

- Get in early *"make a difference as early as possible*".
- Relationships have got to work to build trust and progress "*click and connect*"
- Show you care / "*get to know me as a person not just a case or a set of problems"*
- Children and young people want to be informed and involved "*listen to me*" – increase views being reflected in plans and decisions
- personal 1-2-1 advice
- small things matter and show you care

Voice Of Oxfordshire Youth (VOXY): recent messages on safeguarding themes

- Lack of mental health support for young people
- Lack of youth clubs – seen as an important source of advice and guidance
- Needs to be more of awareness for teens about drugs and alcohol
- Bullying is a big deal and young people reporting lack of effective action in schools
- Fabricated and induced illnesses is an emerging concern

Homophobic, bi-sexual, transgender bullying – recent messages

- Importance of creating safe spaces for LGBT+ youth and how much this is valued by young people.
- Empowerment of knowing 'I'm okay, I'm normal too'
- Value of knowing how to support the LGBTQ+ people in their school
- Significance of understanding the LGBT history

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

In 2017-18 over 90,000 visitors accessed more than 175,000 pages on the oxme.info website. Children's Rights (33%) were a key concern this year alongside opportunities and finding a job (16%). Other key concerns among our site visitors include bullying with our content around anti-bullying week and the galleries from the poster competition (run jointly with the OSCB) proving popular both on the website and on our social media presences. Other popular content includes an internet safety page on sexting, activities for young people with disabilities and work experience.

YiPpEe – message for improvement in the university hospitals

YiPpEe is the Oxford University Hospitals FT's Public Partnership Group for children and young people. They were involved in the National Children and Young People's Inpatient and Day Case Survey (see section 5 for more details). Following this work the Trust has identified three areas for improvement in partnership with YiPpEe:

1. reducing avoidable noise on children's wards at night
2. improving the information provided on discharge
3. involving children and young people more in decisions about the care and treatment they receive

Summary of compliments and children's statutory social care complaints

Poor communication continues to be the top theme from complaints[5], closely followed by staff attitude. One prevalent theme from complaints this year is recording errors and the accuracy of assessments. The service continues to receive complaints that conference minutes and reports are sent out late.

73 formal compliments were received about Children's Services. The compliments praise the child focused work taking place which has been described as creative, insightful, reliable, professional, diligent and competent.

[5] The County Council's Complaints Service received 107 (stage one) complaints about Children's Services last year. The majority (77%) of those complaints were made by parents or grandparents. 32% of complaints were about children on a Child Protection Plan. 23% were about Looked After children.

Section 3: Impact of work to improve safeguarding practice

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. Auditing of safeguarding work takes place annually and services demonstrate change and impact over time.

- Public Health, Oxfordshire County Council could demonstrate that the **services that they commission consider their safeguarding practice.** Feedback from a provider of substance misuse support was as follows, “It is intended that the (serious case review) learning points will be discussed at staff team meetings and to inform future training events for staff and partners agencies” they went on to state that they had “enhanced the package of care of service users with children on a child protection plan - which includes targeted parenting groups”;

- 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)

- 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.

- 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 Children’s **Safeguarding Consultation line** for staff to talk through safeguarding issues with Named Nurses has received positive feedback: good advice; better understanding of the safeguarding system and reassuring to practitioners. (Small sample audit Feb 17)

- 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.

- The Community Rehabilitation Company audits identified improved attendance at **Core Groups and timely responses** to requests for information from the Multi Agency Safeguarding hub.

- Since the last audit the CRC has introduced fortnightly Sentence Planning Meetings which provide **management oversight of safeguarding casework** and enable safeguarding risks to children and domestic abuse to be identified when working with offenders.

- Children’s social care, Oxfordshire County Council could identify positive themes across four audits: commitment of staff; good recording; joint working and assessment and plans.

- Schools and learning, Oxfordshire County Council. Following the audit work more information is being requested by this service with respect to the **vulnerability of the young person** being supported e.g. safeguarding risks in terms of CSE and prevent to ensure that **planning takes these safeguarding concerns in to consideration**

- Thames Valley Police could demonstrate **an increase in the recording of children's information** when attending domestic abuse incidents.

- Thames Valley Police reported that Cherwell & West Oxfordshire Local Police Authority had the highest number of crime reports with completed "**Voice of the child**" sections.

- 94% of **taxi drivers** are now trained in safeguarding which is a learning point form the serious case review on child exploitation

- In 2017 a local **taxi driver,** who had undertaken safeguarding 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.

- In 2017 Thames Valley Police and Oxford City Council's Community Safety Team led a test purchase operation on to test the awareness of **hotel staff** with respect to CSE. The Team were pleased to report a positive outcome for an establishment that had featured prominently in previous CSE investigations in particular Bullfinch.

- YiPpEe is the Oxford University Hospitals Foundation Trust's Public Partnership Group for children and young people. The group have been involved in a wide range of activities over 2017/18, which include:
  - delivering a seminar to **children's nursing students**, at Oxford Brookes University, on service user involvement.
  - investigating the main causes of noise at night on children's wards, in response to the Trust's results for the National Children and Young People's Inpatient and Day Case Survey 2016.
  - attending the '**The Big Youth Forum Meet Up'**, at Great Ormond Street Hospital for Children, where they had the opportunity to meet similar groups from across the country.
  - YiPpEe also has two members elected to represent children and young people on the Trust's Council of Governors. They have a set agenda item at all **Council meetings** to update Governors on the work YiPpEe are involved in.

- November 2017, results were published for National Children and Young People's Inpatient and Day Case Survey. This surveyed patients, and their parents/carers, between the ages of 15 days and 15 years old. Questionnaires were sent by the Trust to 1,250 patients, with 462 returned, giving a response rate of 37%. OUH had more questionnaires returned than any other NHS Trust that took part in the survey. The Trust performed better than most Trusts on fifteen questions including, patients being able to talk to staff without parents or carers present, parents having enough information to be involved in care decisions and overall patient experience.

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
GDPR	General Data Protection Regulation
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

Appendix A

JSNA data mapping

http://insight.oxfordshire.gov.uk/cms/joint-strategic-needs-assessment

Appendix B

What did we learn?

Working to tackle neglect

- Use ‘tools of the trade’ earlier. Find the Child Care Development Checklist on Practitioner Portal and use it.
- Ensure child protection procedures are followed rigorously for children who are already subject to a plan e.g. new bruises, new safeguarding concerns
- Make more use of professionals-only meetings, multi-agency chronologies, case mapping, deputy role for core groups.

Dealing with domestic abuse

- All cases concerning young people cases should be referred to MARAC regardless of assessed level of risk this means both victims and those perpetrating harmful behaviours
- Need for greater understanding amongst professionals of online and social media abuse: the circulation of indecent images of children involved by abusive intimate partners features highly
- Professionals sometimes report a lack of confidence in knowing what to share with parents
- Professionals responses are sometimes clouded by how children and young people define their own peer relationships

Working with disabled children

- Ensure practitioners keep a clear record of ‘was not brought’ episodes to identify any patters or gaps and work with partners to ensure this is collated
- Children not being brought to appointments should be escalated as a risk factor where there is a concern about neglect and needs to be cross-checked across different health professionals
- Raise awareness of the importance of understanding how a child’s impairments may impact on and contribute to their safeguarding vulnerability
- School is pivotal in ensuring resilience and identifying key issues and changes early

Completing the ‘Education, health and social care plans (EHCP)

- Need to ensure that protective factors are in place as young people transfer to college
- Transition points need careful planning of expected outcomes for the child
- Health colleagues to better understand what information is required for the EHCP to get the best possible plan in place for children