Oxfordshire Safeguarding Children Board

Annual Report

2018 - 2019

Contents

1. Foreword from the Chair

As the Independent Chair of Oxfordshire Safeguarding Children Board, it is my honour to provide a foreword to this the 2018-2019 Annual Report. I hope that you enjoy reading it and find it an informative and stimulating read about the Achievements, Challenges and Activities of the Board in the past year. We have responded to feedback from last year about the length of the report and have tried to make it a shorter, more concise and pithy report. I would like pay tribute to the hard-working team in the LSCB office who have worked so hard to pull this document together and who support me so impressively in my role as Chair.

I started my tenure as Chair of the Board in September 2018. It was very apparent to me from the start that I was joining a strong partnership with much to celebrate and build upon. Oxfordshire, like other areas, has challenges around demand on statutory services, criminal exploitation of children, the availability of specialist provision for children with complex needs and so on. However I head up a partnership that I am convinced is well sighted on these and other issues and committed to working together to address them. I continue to see little sign of complacency regarding performance and the issues that face us; instead I see a range of professionals and managers committed to continuous improvement.

This is the last report that will be written under the previous version of Working Together to Safeguard Children. The Department of Education issued new guidance last year (Working Together to Safeguard Children 2018) setting out a change in the way that Safeguarding Boards are governed. Boards were required to submit to the Department proposals for how they would comply with the new guidance by the end of June 2019. I am pleased to report that Oxfordshire submitted their proposals at the start of May. Our proposals built on the strong existing partnership but created a new Executive Group that is headed up the so-called “Big Three” of Oxfordshire County Council, Oxfordshire’s Clinical Commissioning Group and Thames Valley Police who have lead responsibility for the local safeguarding arrangements.

We are committed to the Annual Report being an impactful, not just one that is read and then gathers dust on a shelf or sits on an internet page slowly becoming out of date! So if the report raises questions for you, you strongly agree or disagree with any of the contents or wish to know anything more about any aspect of the report do get in touch with us to discuss it further. In the meantime thank you all for what you do week in and week out to safeguard the children and young people of Oxfordshire and I look forward to continuing to work with you in the coming year.

Richard Simpson
Independent Chair

2. Introduction

This annual report is a retrospective look at the work of OSCB for 2018/19. It will be the last Annual Report under the auspices of Working Together 2015. In May 2019 the OSCB will move to a new set of multi-agency safeguarding arrangements in line with Working Together 2018.

At present the OSCB Chair is required to publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. The report should provide a rigorous and transparent assessment of the performance and effectiveness of local services. It should identify areas of weakness; the causes of those weaknesses and the action being taken to address them as well as other proposals for action. Finally, it should include lessons from reviews undertaken within the reporting period.

3. Structure and Governance

3.1 Remit

The OSCB is a partnership set up under the Children Act 2004 to co-operate with each other to safeguard children and promote their welfare. Guidance is set out in Working Together. The Board's job is to make sure services are delivered, in the right way, at the right time, so that children are safe and we make a positive difference to the lives of them and their family. This is done in two ways:

1. Co-ordinating local work by:

- Developing robust policies and procedures.
- Participating in the planning of services for children in Oxfordshire.
- Communicating the need to safeguard and promote the welfare of children and explaining how this can be done.

2. Ensuring that local work is effective by:

- Monitoring what is done by partner agencies to safeguard and promote the welfare of children.
- Undertaking Serious Case Reviews and other multi-agency case reviews and sharing learning opportunities.
- Collecting and analysing information about child deaths.
- Publishing an annual report on the effectiveness of local arrangements to safeguard and promote the welfare of children in Oxfordshire.

3.3 Structures and strategic links

The board is not responsible or accountable for delivering child protection services but it does need to know how well the safeguarding system is working. The board's membership is set out in Appendix A. It has effective linkages to other strategic groups in Oxfordshire to ensure clear remit and cross partnership working. The board's structure (going forward) is set out in Appendix B and linkages are set out in C. The OSCB has a strong working relationship with the Safeguarding Adults Board with joint meetings twice a year. This year the two Boards have had the joint priorities of: housing; domestic abuse and transitions.

3.4 The OSCB Chair

The OSCB Independent Chair, Richard Simpson, was recruited following a commissioning process in 2018. This involved a series of interviews with board members and children. Richard is a senior manager with Barnardo's children's charity. This arrangement delivers additional independent scrutiny for the Board. As well as his personal experience and skill set, he brings with him the knowledge and support of Barnardo's.

3.5 Financial contributions

All board members contribute to the OSCB. The contributions for 2018/19 are attached at Appendix D.

3.6 Subgroups

The Board was supported by an Executive Group comprising the Independent Chair, strategic leads and subgroup chairs. The purpose of the sub-groups and key activity in the past year is outlined below:

Performance, Audit and Quality Assurance – reviews safeguarding data and intelligence to test the effectiveness of services including early help. The group has undertaken three multi agency safeguarding audits, ten audits of agency safeguarding practice and escalated issues on safeguarding in education, domestic abuse and sufficiency of placements for children with complex needs. See section 5.

Case Review and Governance – undertakes rapid reviews of serious incident notifications, oversees and supervises all serious case reviews and identify themes, actions and learning from serious incidents. The group has led on four serious case reviews, three partnership reviews and developed guides, four learning summaries and a series of ten learning points for practitioners in Oxfordshire. See section 6.

Training – commissions, monitors and oversees the delivery of training, hosted an annual conference and provided learning summaries and events from key themes that identified locally and nationally on behalf of the OSCB and the Oxfordshire Safeguarding Adults Board. The group has supported learning events on child drug exploitation for 100 delegates, multi-agency chronologies for children for 100 delegates as well as an annual conference for 150 delegates around contextual safeguarding. 5017 delegates have undertaken face to face safeguarding training and 6497 delegates have undertaken e-learning. The group also set in place the mechanism for charging for non-attendance at courses in 2019/20 to respond to a concerning level of last-minute non-attendance.

Child Exploitation – ensures a co-ordinated multi-agency approach is in place for all child exploitation concerns and emerging issues. The group has supported the development of a Child Exploitation screening tool as well as partnership arrangements for exploited and missing children across the county. This is developing a common understanding of the patterns and trends around missing and child exploitation risks within each local area, enabling the partnership to ensure that resources are directed appropriately. Other work has been undertaken to improve services when working with boys as victims as well as to better safeguard children with disabilities from exploitation.

Safeguarding in Education – ensures staff in pre-schools, schools, colleges and other education providers are aware of key safeguarding issues and are also able to escalate their concerns to the Board and Executive Group and influence the strategic development of services. The group has focused on the themes of keeping children safe in education, elective home education, promoting CAMHS guidance on self-harm for schools; analysing Ofsted safeguarding reports and school audit work. It has produced a termly newsletter for schools.

Procedures – ensures all practitioners and managers across the children's workforce have up-to-date guidance and procedures on all key safeguarding issues via the OSCB website. The group has updated procedures as a result of changes in legislation and guidance, in particular, Working Together 2018. Colleagues can refer to the online manual to see updates, which include working together on Information sharing, Female Genital Mutilation, Historical abuse.

Child Death Overview Panel – ensures local oversight of all child deaths in the area and ensures that lessons are learnt and action taken as appropriate to the circumstances and any themes are identified and addressed. The group has updated procedures as a result of changes in legislation and guidance, in Working Together 2018, in particular joining with Buckingham CDOP for themed meetings. Oxfordshire has a high number of deaths of children who are not Oxfordshire residents because it hosts the regional hospital and children's hospice. CDOP monitors the numbers and trends of these deaths and liaises with their local area to ensure all appropriate learning is gained.

Disabled Children – ensures the safeguarding needs of disabled children are addressed and high quality services are delivered to this group. The group has worked to improve the revised Childcare and Development checklist by refining key criteria which need to be addressed for disabled children's health and well-being, contributed to plans for the Oxfordshire approach to reviewing and learning from child deaths under the new Working Together guidance and considered the impact of the Intensive Support Team in safeguard those with challenging behaviour related to their mental health needs. The group has worked closely with the Exploitation group on the strategy aimed at reducing the vulnerability of children with additional needs to child sexual exploitation / child drug exploitation.

Health Advisory Group –brings together the lead health safeguarding practitioners and alerts the Board and Executive to key safeguarding gaps and concerns from the health sector. It also ensures that health professionals are aware of key safeguarding issues. The group has focused on the themes of drug exploitation, neglect and health professionals role in identifying it (including the concept of 'Was Not Brought' rather than 'Did Not Attend' appointments), gender identity, Adverse Childhood Experiences (ACEs), safeguarding issues and mental health (including concerns about lack of provision of in-patient beds), FGM and the Child Protection – Information System. The latter is a new project to link IT systems used in health and social services, to help staff share information securely on children who are looked after or on a child protection plan.

3.7 Listening to views of children and young people in Oxfordshire

The group, Voice of Oxfordshire Youth (VOXY), was part of the recruitment process for the OSCB independent chair in 2018/19. The group offers a helpful sounding board for the OSCB, which listens to its view and concerns. Last year VOXY told the OSCB that it was concerned about fabricated and induced illness. This led to a review of current cases by the OSCB designated doctor, with findings presented to the board as well as a review of inter-agency procedures confirming that they are fit for purpose. VOXY also said that they were concerned about the effectiveness of preventive work undertaken with young people they perceive to have started to demonstrate harmful behaviours. This led to a multi-agency audit and learning summary, which contributed to the OSCB's decision to run its annual conference on contextual safeguarding.

The OSCB was also keen to capture the views of children it comes in to contact with through serious case reviews. These are children who have been at risk of serious harm and neglect. Through meetings with reviewers they have told us that at times they 'felt like they were missing' or simply 'not seen' by professionals. They have also told us how small gestures of kindness made a big difference. This re-iterates the message from previous years that practitioners, across the system, should never underestimate the difference that they can make by 'being there', following-up and caring.

4. Priorities and Progress

4.1 Priorities for 2018/19

The OSCB had three aims: to provide leadership for effective safeguarding practice; to drive forward practice improvement and to challenge in order to ensure that children are kept safe. See Appendix E for the details.

4.2 Reporting on progress

Aim 1: Providing leadership for effective safeguarding practice.

Working Together 2018 set out the new statutory requirement for the leadership of safeguarding arrangements to be at chief executive level across health, police and the local authority. The OSCB has worked hard to ensure that the new arrangements will build on the existing collective approach to safeguarding children and young people and is set out in the multi-agency safeguarding arrangements.

The OSCB has worked jointly with the adults safeguarding board on Joint priorities. Domestic Abuse training is now up and running, workshops on the young people's pathway are in place and consultation has just completed on the next 5-year strategy. A Housing network has been set up for local providers, a multi-agency housing audit is underway and there is good board representation. Transitions work ensures that there is good cross-over between services and any concerns are quickly escalated.

In addition, reporting on modern slavery is reviewed to maintain a clear view on trends and any concerns arising regarding children – none have been reported as yet.

The voluntary and community sector held elections for representatives on the OSCB board and representatives from that sector are well-represented across the subgroups. The OSCB Chair has met and engaged with the Children and Young people's Forum. An action plan is ensuring good communication as well as visibility on the new OSCB website.

Aim 2: Driving forward practice improvement.

Safeguarding adolescents

The OSCB has supported the development of a Child Exploitation screening tool as well as partnership arrangements for exploited and missing children across the county. This is timely: whilst the number of children going missing has reduced those that went missing 3 or more times rose by 22% last year (from 149 to 168). The OSCB has challenged around the work with young people at risk of peer abuse. Audits have checked the effectiveness of joint working. Workshops have been run to raise awareness. Learning from the Child J serious case review with respect to mental health support for adolescents has been implemented by mental health services. The OSCB has worked with the Adults Board to improve communication and joint working on those children transitioning from children to adult services.

Tackling neglect

The OSCB has supported the development of the neglect practitioner portal which includes assessment tools to work with families, videos for practitioners, research and guidance on understanding and working with neglect. Partners have implemented a multi-agency training course on neglect and working with parents around emotional abuse. Colleagues have embedded the early help pathway - there were 1,378 in 2018/19 recorded early help assessments compared to 458 in 2016/17. Partners have checked how well we are involving fathers: data indicates that this could be better. Since July 2018 only 44% of fathers attended child protection conferences regarding their children.

Taking action from learning

5,017 delegates have undertaken **254** face to face safeguarding training events and

6,497 delegates have undertaken e-learning

They were 'Supporting LGBT children, young people and families' as well as 'Working with fathers and other male carers' course. This has increased the range of training and reinforced the 'Think Family' message that the OSCB promotes.

The OSCB has run three learning events on: (1) child drug exploitation as this theme has been raised by practitioners across the county e.g. Kingfisher Team, area safeguarding groups; (2) multi-agency chronologies as this is a repeated theme from serious case reviews and can help address neglect and (3) contextual safeguarding[1] as this has been of concern to practitioners across the county.

[1]Threats to the welfare of children can come from outside their families. These extra-familial threats might arise at school ... from within peer groups, or more widely from within the wider community and/or online. These threats can take a variety of different forms and children can be vulnerable to multiple threats, including: exploitation by criminal gangs and organised crime groups such as county lines; trafficking, online abuse; sexual exploitation and the influences of extremism leading to radicalisation.

5. Safeguarding Performance and Effectiveness

5.1 Quality assurance framework

The performance, audit and quality assurance subgroup reviews performance and effectiveness across the system. It draws on performance data, the annual impact assessment, safeguarding self-assessments, single and multi-agency audits, participation work with children and young people, serious case reviews and practitioner feedback.

5.2 Local safeguarding profile: performance data

Quantitative data provides a picture on ongoing rising demand. There is some indication that the early help work is beginning to increase and have impact. Early help assessments have increased significantly. In 2016/17 early help assessments made up 6% of all assessments compared to 18% last year. The number of troubled families worked with rose from 2698 last year to 4631.

The 2018 Ofsted inspection was positive about improvements made to the Multi-agency Safeguarding Hub (MASH) and these have subsequently been seen to show impacts. In 2017/18 45% of MASH enquiries were dealt with within the target timescale. In 2018/19 this improved to 98% of 'red' enquiries were completed on time and 75% of other enquiries.

After over 10 years of growth in child protection numbers (250 children in March 2009) the number reduced in the last year. The number of children on a child protection plan fell from 729 last year to 605 at the end of March 2018. Neglect is the most common reason for children to be subject to child protection plans (70%). This compares to the national average of 48%[2]. Neglect is not however the most common reason for children to be subject to an early help assessment.

The number of children looked after by the local authority rose by 13% from 690 last year to 780 at the end of March 2019 but remains lower than national average. This is an increasing trend. The biggest increase has been in younger children, who are presenting with increasingly complex needs and elevated risk profiles particularly autism, mental health issues and risk of exploitation.

Audit findings (children displaying harmful behaviours) and case reviews (Children A-F) show the impact of adverse childhood experiences. Quantitative data indicates that the number of child victims of crime rose by 30% (from 2313 to 3021) and the numbers of domestic crime involving children rose 55% (from 1840 to 2854).

From national and local serious case reviews (Children A-F and Child J) the OSCB has evidence of links between safeguarding risk and safeguarding in education issues: attendance, exclusions, elective home education, attainment and achievement of pupils with special educational needs and disabilities.

[2](SFR 2017/18).

Current year end statistics from 2018/19 indicate: 715 children were recorded as receiving elective home education and 413 pupils who were on a reduced timetable. Current statistics from the end of the second school term (i.e. Easter 2019) indicate 1448 pupils had received a fixed term exclusion and 55 pupils who were permanently excluded, of whom 19 received SEND support.

Data is showing us that children with additional needs make up a large proportion of the children worked with by the Kingfisher team, which specialises in supporting those children most at risk of child sexual exploitation. We know that this type of vulnerability often overlaps with drug exploitation and 50% of the caseload are known to have issues with drug and alcohol abuse. 40% were assessed as having mental health issues. Data also shows that the proportion of Oxfordshire's disadvantaged pupils aged 10-11 achieving the expected standard was below the England average at Key Stage 2 in 2018.

Local mental health services continue to face high levels of demand: in 2017/18 there were 566 child referrals into CAMHS each month, in 2018/19 this rose to 697. This has had an impact on the percentage of referrals to CAMHS who are seen within 12. At the end of the year this was only 34% compared with a target of 75%. The OSCB receives regular updates on this work and is assured that the urgent cases are seen promptly.

There are a higher than average numbers of young people remaining in their placement after 16 (84%) and a high percentage of 19-21-year olds in suitable accommodate (92%). The county council maintains contact with 93% 19-21 year old care leavers. 68% of the cohort are currently in employment, education or training.

5.3 Quality assurance: measuring performance and effectiveness

The OSCB takes a system-wide view on safeguarding work through an annual impact assessment and multi-agency auditing. These showed that the key financial and organisational pressures in relation to safeguarding children and their families were (1) recruitment and retention of staff and (2) increasing demand for services. They also pointed to (3) the need for partner agencies to fully understand their safeguarding duties within Working Together 2018, in particular key partner agencies, so that they can have sustained positive impact as well as (4) the benefits of sharing information and working well together as a long-term goal.

The OSCB gains further insight in to how well things are working at practitioner level through agencies' self-assessments and self-audits. Ten safeguarding audits from seven different agencies were reviewed. Collectively they showed that agencies are focussed on getting core safeguarding business right but that there is a determination to do better.

- Evidence of good practice. Thames Valley Police reported an increase in uptake of 'Operation Encompass' from .. to .... This system alerts schools if the child has been in the home when a domestic abuse incident has taken place in the family home the evening/ night before school.

- Evidence of quality assurance work. Children's Social Care audit stated, *"evidence found of multi-agency involvement including housing, education, LCSS, health. There is a strong sense of multi-agency collaboration on the case"*.

- Evidence of improved practice to deliver better outcomes. The Community Rehabilitation Company is setting up a permanent Risk and Safeguarding Practice Group to meet bi-monthly, to include practitioners, Unpaid Work staff and programme staff.

Whilst quality assurance work highlighted much good practice there were consistent themes for development at a practitioner level of the need for: good sharing of information, multi-agency chronologies and co-ordinated work.

5.5 Escalated issues

Quality assurance work raised some key concerns for the partnership over the last year which were escalated to the board. The first concerned domestic abuse: use of the 'young people's pathway'; use of MARAC; police recording of children's voice at domestic abuse incidents; sign up to Operation Encompass. The second was about safeguarding in education: setting and reporting of performance measures to be sure that children are being kept safe in and out of school. The third was about working together and case conferences: reliable reporting on attendance and contributing. Finally, the sufficiency of placements for children with complex mental health needs meaning there is a delay in discharging them when they come in to hospital.

6. Serious Case Reviews, Partnership Reviews, etc

6.1 National Child Safeguarding Practice Review Panel

In 2018 a revised version of Working Together was released along with Transitional Guidance, which applies until the new multi-agency safeguarding arrangements come in to place. The National Panel's[3] role and remit was outlined in this guidance along with expectations on safeguarding children boards.

The responsibility for overseeing this work lies with the Case Review and Governance (CRAG) Subgroup of OSCB. This includes the requirement to undertake a 'Rapid Review' as soon as a serious incident is reported to Ofsted and becomes known to the OSCB. The aim of the review is to enable the OSCB to gather the facts about the case and decide what steps we should take next, including whether to recommend to the independent chair to commission a review.

6.2 Cases considered for a review

The CRAG undertook three Rapid Reviews. In only one case were the criteria considered to have been met for a serious case review and the recommendation was also made by CRAG that the case raised issues which were complex and of national importance. Whilst the National Panel did not agree that the criteria had been met for a serious case review it has since commissioned its first National Review on adolescent risk and this same case will be examined in detail for that purpose.

The CRAG also undertook reviews of a further five cases, that were not notified to Ofsted as serious incidents but were of enough concern to local agencies that they were reviewed by the CRAG. Three of the cases resulted in Partnership Learning Reviews.

6.3 Ongoing reviews

The OSCB has worked on four serious case reviews, which were initiated before the start of the financial year. Of those four reviews: two have been signed off by the Board one is due for sign off and one has been completed as far as possible, whilst parallel processes are underway. The OSCB has worked on three partnership reviews all of which are ongoing and near completion

These reviews involve nine children, the majority of which are aged between 10-15 years, five are male and four are female. Two of these children are transgender.

[3]National Safeguarding Children Practice Review Panel

6.4 Safeguarding themes from reviews

Safeguarding themes covered by case reviews have been cross cutting – neglect plays a part in almost all cases. Broadly speaking additional themes have included: the impact of parental mental health on parenting and the well-being of children; severe emotional and physical abuse; engagement and attendance in education as well as children's emotional wellbeing as they explore their identity and, in doing so, may also become at risk of harm to themselves.

As mentioned, the CRAG considered 8 cases for a potential review this year. An emerging theme from these has been 'contextual safeguarding' e.g. children being vulnerable to abuse or exploitation from outside their families such as online abuse and child drug exploitation.

6.5 Learning from reviews

The learning from OSCB reviews is shared on the website. Each review has a series of recommendations and action plans.

One message that is mirrored in the impact assessments, the audits and our local reviews is to remember the value of good sharing of information, using multi-agency chronologies and co-ordinating work. See the Golden Rules of information sharing and the information on chronologies on the website.

Ten Learning points to strengthen working together in Oxfordshire

The OSCB has summarised the ten most frequent learning points from recent case reviews to share with practitioners. They should serve as a reminder of 'points to bear in mind' in the busy schedules of day-to-day work. There are many small changes that can be made to improve processes in a system. Ultimately the repeated messages are about how we, within the system, work.

1. **Understand the 'lived experience' of the child in the family:** use multi-agency chronologies to share information in a cumulative view to weigh up risks over time and keep previous events in mind. Make sure that children's comments are clearly recorded and understood – actual words used and not just the interpretation of them.

2. **Be curious:** be curious about the family's past history, relationships and current circumstances in a way that moves beyond reliance on self-reported information

3. **Respond to physical abuse:** identify it, listen to children and follow safeguarding processes thoroughly; children may sometimes be too afraid to speak or unable to verbalise what they are going through

4. **Consider the role of schools in keeping children safe:**

   - children are safest in full time education. Oxfordshire serious case reviews indicate that children on reduced time-tables, children absent from school and children educated at home are at increased risk. School attendance is a critical factor to support opportunity, well-being and safety

   - manage safeguarding records carefully and share them when children transfer schools

   - escalate concerns to safeguarding leads and follow up when your concerns persist

   - when the child is not in school be aware of the implications of elective home education; know which agencies are in touch with the family and to what effect

5. **Recognise the risks and impact of Parental wellbeing on the safety of the child:** mental health, substance misuse and domestic abuse are recurring themes. Don't minimise 'older' information and use it to inform your chronology

6. **Ensure effective communication across health services for co-ordinated and consistent management of care:** fragmented management of health needs can increase safeguarding risks

7. **Be mindful of children's emotional wellbeing:** there is increasing evidence of self-harm by children aged 10 years & above.

8. **Consider that children have a limited capacity to protect themselves as they move into adolescence:** more so for children who experience a lack of consistent, supportive parenting in their early years this can. Recognise that, as children explore their identity, they may be at risk of harm to themselves.

9. **Rethink 'did not attend'** to 'was not brought' and follow up to understand why the child was not brought

10. **Understand safeguarding risks that exist in the child's environment** – not just their family e.g. children being vulnerable to abuse or exploitation from outside their families such as online abuse, peer on peer abuse and child exploitation.

7. Strengths and Challenges

This report provides a rigorous assessment of the performance and effectiveness of local services. It identifies areas of strength and challenge as follows:

7.1 Strengths

The OSCB is a high functioning, high challenge Board with a strong reputation and a long-standing commitment to partnership working. The work to move smoothly to new multi-agency safeguarding arrangements is evidence of that. The OSCB training and learning programme continues to be an example of excellent practice with local practitioners volunteering their time to deliver learning to thousands of colleagues across Oxfordshire each year. The continued drive to address neglect through training, better resources and processes is positive and should continue. The indication that more early help assessments are taking place and that for the first time in ten years the number of children on child protection plans has not risen is a good indication of change.

7.2 Challenges

There is huge demand on the statutory system. The child population of Oxfordshire has grown by 7% in the last ten years and is estimated to stand at 143,400 young people aged under-18[4]. Alongside this growth there has been increased demand for services particularly towards the high end of the continuum of need. Our impact assessment tells us that local agencies are struggling from the financial pressures on resources and the capacity to retain staff to manage it.

Challenges exist in terms of practice improvement, leadership and joint working.

The key challenges for the Board partners in 2019/20 in terms of practice improvement are:

- **Neglect**

  This is an ongoing concern in Oxfordshire and a repeat factor in case reviews. OSCB partners remain committed to addressing it. Neglect is recorded as the main reason in 70% for child protection plans although it is not being picked up in a similar extent in early help assessments. Multi-agency participation and contribution to case conferences could be improved and the standard use of the multi-agency chronology still needs embedded. Data also indicates that fathers are present and contributing to only 44% of case conferences.

[4]Source ONS Mid Year Estimates for Oxfordshire for people aged 0-17 2007 & 2017

- **Safeguarding in (and out of) Education:**

  This issue frequently presents in case reviews and audit work. We know that children are safer in education. Work has just begun to agree targets and report data on part-time time tables, attendance, exclusions and also elective home education. We know that we need to improve understanding of education entitlement and provision to different partners in the system. OSCB partners are in the early stages of delivering change and improving practice.

- **Contextual safeguarding and child exploitation**

  This is an ongoing concern and the partnership arrangements need to be embedded. The partnership response needs to be agreed and implemented.

  Adolescents and risk: more adolescent children are subject to reviews, mental health concerns shown in increased referrals, peer on peer abuse not fully addressed through the young people's pathway

The key challenges for the Board in 2019/20 in terms of leadership and governance are:

- **Embedding the new arrangements and raising awareness of the board to local practitioners**

- **Independent scrutiny:** in the new safeguarding arrangements this will be a new piece of work to embed – need to ensure it picks up on escalated issues from 2018/19 such as domestic abuse

- **Voice of young people:** all audits and reviews point to good practice and the need to really improve this to know 'what it is like to be the child in this family'

The key challenges for the Board in 2019/20 in terms of joint work with the Safeguarding Adults Board are:

- **Domestic abuse:** to improve training for the workforce, better provision for people affected by domestic abuse and better joint working to support young people in abusive relationships

- **Housing:** to improve communication and joint working

- **Transitions:** to improve communication and joint working on those children transitioning from children to adult services

- The boards will also keep a watching brief on **Modern slavery** and **safeguarding training**

8. In conclusion

As we publish this annual report we are delighted to be launching our new multi-agency safeguarding arrangements on behalf of the children, young people and families in Oxfordshire.

The new statutory requirement is for the leadership of safeguarding arrangements to be at chief executive level across health, police and the local authority. We are fully committed to safeguarding children and promoting their welfare under these new arrangements. We are already setting out our priorities for the coming year.

Appendix A. OSCB membership

Independent Chair, Barnardo's

Oxfordshire County Council: children's services, youth justice services, adult services, fire and rescue services, legal &public health

Oxford University Hospitals Foundation Trust

Oxfordshire Clinical Commissioning Group

Oxford Health NHS Foundation Trust

NHS England Area Team

West Oxfordshire District Council

Cherwell District Council

Oxford City Council

South Oxfordshire and Vale of White Horse District Council

Thames Valley Police

Children and Family Courts Advisory and Support Service

Community Rehabilitation Company

National Probation Service

Lay Members

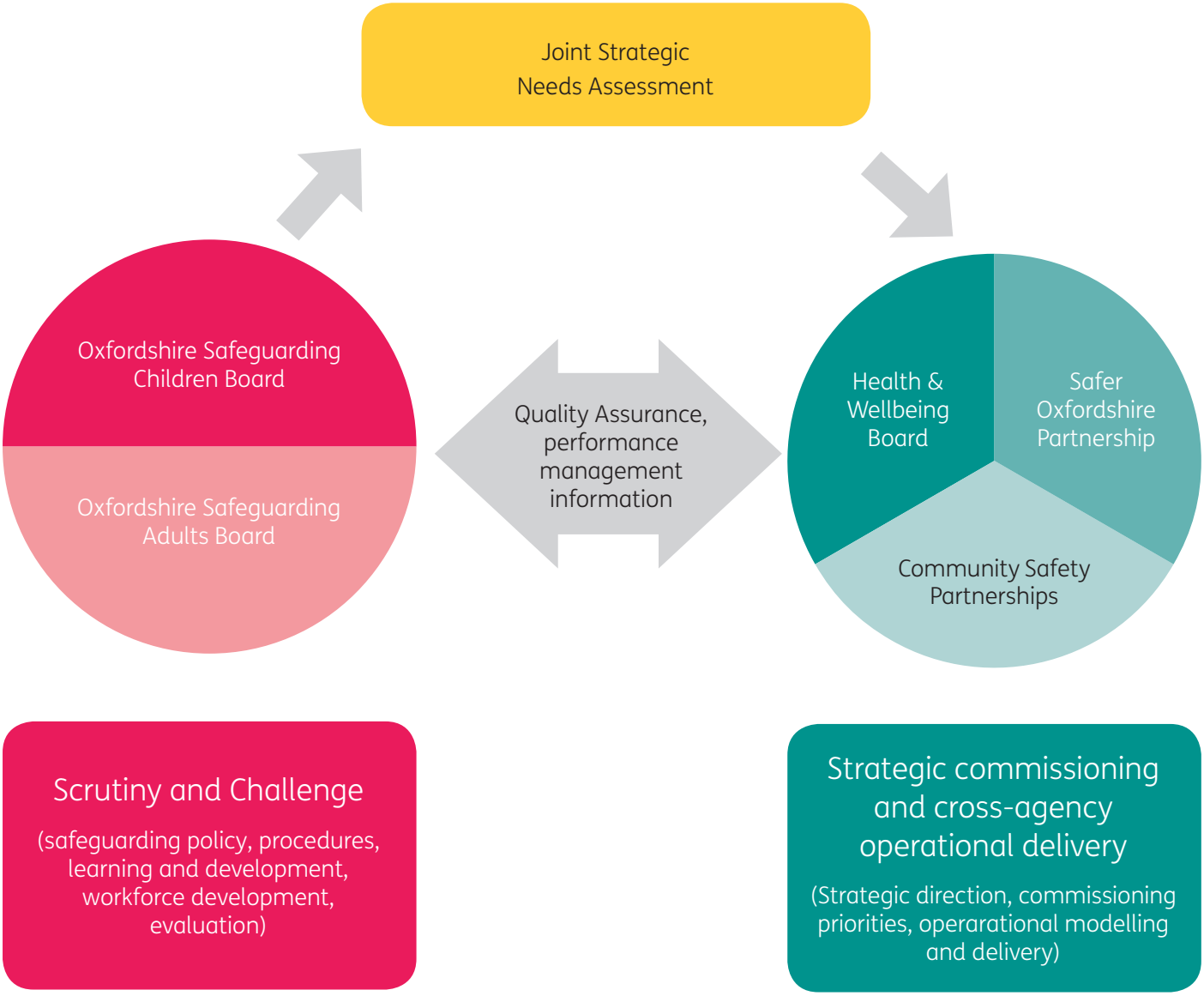
Representation from schools and colleges

Representation from the voluntary sector

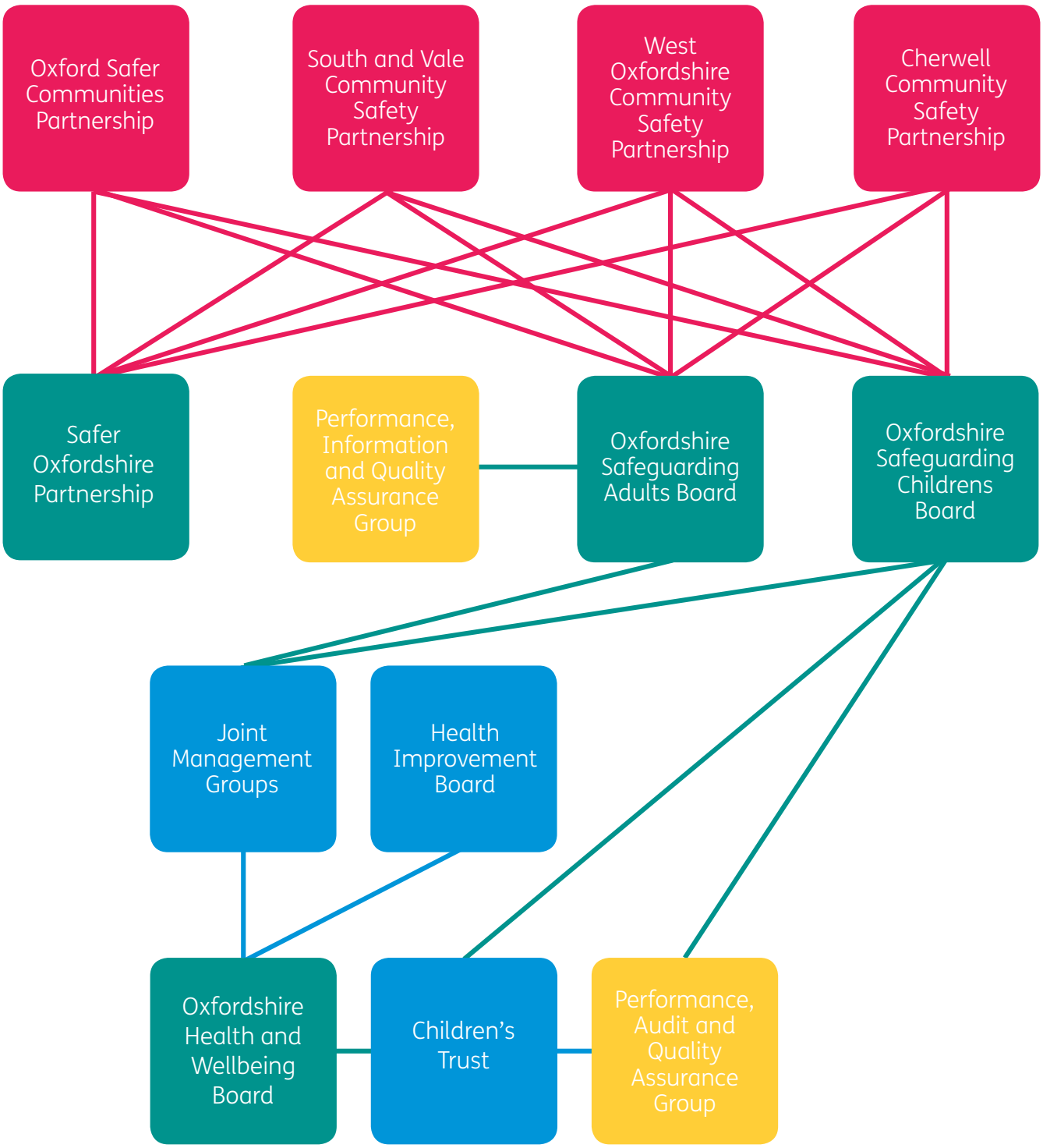
Representation form the housing sector

Representation from the military

Appendix B: OSCB structure diagram



Appendix C: Linkages to other strategic groups



Appendix D: Funding and expenditure in 2018/19

	Provisional budget 2018/19	End of year budget 2018/19
Funding streams		
Public Health	-£30,000.00	-£30,000.00
Income		
Foster carer training		-£3,825.00
Neglect training		-£2,200.00
Contributions		
OCC Children, Education & Families	-£196,610.00	-£199,000.00
OCC Dedicated schools grant	-£64,000.00	-£64,000.00
Oxfordshire OCCG	-£60,000.00	-£60,000.00
Thames Valley Police	-£21,000.00	-£21,000.00
National Probation Service	-£1,410.00	-£1,410.00
CRC	-£2,500.00	-£2,500.00
Oxford City Council	-£10,000.00	-£10,000.00
Cherwell DC	-£5,000.00	-£5,000.00
South Oxfordshire DC	-£5,000.00	-£5,000.00
West Oxfordshire DC	-£5,000.00	-£5,000.00
Vale of White Horse DC	-£5,000.00	-£5,000.00
Cafcass	-£500.00	-£500.00
Public Health (see above)	£0	£0
Total income	**-£406,020.00**	**-£414,435.00**
Expenditure		
Independent Chair	£39,000.00	£33,504.00
Business unit	£253,000.00	£253,908.00
Comms	£14,500.00	£14,970.00
Training & learning	£60,000.00	£60,094.00
Subgroups	£10,000.00	£10,129.00
All case reviews	£40,000.00	£37,868.00
Total	**£416,500.00**	**£410,473.00**

Appendix E: Board priorities in 2018/19

AIM: PROVIDE LEADERSHIP FOR EFFECTIVE SAFEGUARDING PRACTICE	
PRIORITIES	**ACTIONS**
Improve board effectiveness	Develop the work of the Board to be more effective in light of the new Working Together guidance
Joint work with OSAB	Develop joint working on housing, domestic abuse, transitions and keep a watching brief on modern slavery
Engage local communities	Ensure that local voluntary and community organisations are better engaged in the partnership: training, communication and working together
AIM: DRIVE FORWARD PRACTICE IMPROVEMENT	
PRIORITIES	**ACTIONS**
Safeguard adolescents	Support multi-agency responses to safeguard vulnerable adolescents: • transitioning from children to adult services with OSAB • at risk of domestic abuse or peer abuse with OSAB • at risk of criminal exploitation • not in full time education
Address neglect	Support a co-ordinated and multi-agency response to neglect
Act following learning	Ensure the training workstream is well co-ordinated across the OSCB and OSAB and having an impact Ensure the learning and improvement comms. workstream reinforces safeguarding messages
AIM: ENSURE THAT CHILDREN AND YOUNG PEOPLE ARE KEPT SAFE	
PRIORITIES	**ACTIONS**
Challenge improvements	Test how well learning is embedded in to practice through multi-agency audits which include the voices of children and families Check how well the integrated safeguarding arrangements effectively provide early help to families
Assess risk and capacity	Check the level of risk and impact on the safeguarding system through the annual partner self-assessments with OSAB

Appendix F: Glossary

ACE	Adverse childhood experiences
CAMHS	Child and Adolescent Mental Health Service
CDOP	Child Death Overview Panel
CRAC	Case Review & Governance
CRC	Community Rehabilitation Company
FGM	Female genital mutilation
LCSS	Locality and Community Support Service
LGBT	Lesbian, gay, bisexual, and transgender
LIQA	Learning, Improvement and Quality Assurance (framework)
LSCB	Local Safeguarding Children Board
MASH	Multi-Agency Safeguarding Hub
MARAC	Multi-Agency Risk Assessment Conference
OCC	Oxfordshire County Council
OCCG	Oxfordshire Clinical Commissioning Group
OFTSED	Office for Standards in Education, Children's Services and Skills
OSAB	Oxfordshire Safeguarding Adults Board
OSCB	Oxfordshire Safeguarding Children Board
SEND	Special educational needs and disability
SFR	Statistical First Release
SOP	Safer Oxfordshire Partnership
TVP	Thames Valley Police
VCS	Voluntary and Community Sector
VOXY	Voice of Oxfordshire's Youth

Oxfordshire Safeguarding Children Board

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