OSCB
Oxfordshire
Safeguarding
Children Board

# Annual Report
## 2022/2023

## Foreword from the Senior Safeguarding Partners

Welcome to this Annual Report and thank you for your interest in the vitally important subjects of safeguarding and protecting our children. The report is published by Oxfordshire Safeguarding Board (OSCB) which includes the three statutory safeguarding partners (Oxfordshire County Council, Thames Valley Police and ICB (Integrated Care Board).

In our fourth year of reporting as senior safeguarding partners it has been rewarding to see progress across the system and to recognise and commend practitioners for some effective safeguarding work. The safeguarding message is becoming widespread in Oxfordshire; recently an electrician from a local firm contacted the MASH due to concerns he had about the children in a house in which he was working.

We are never complacent and are alert to the issues affecting children and try to  be responsive to meet those needs and keep children safe in Oxfordshire. Our agenda will encompass those on the Children and Young Peoples Plan led by the Children's Trust Board.

Similarly to last year, Early Help Assessments remain low whilst children Subject to a Child Protection Plan or becoming Children We Care for by the Local Authority continue to rise.

Two Child Safeguarding Practice Reviews (CSPRs) were commissioned this year and six Rapid Reviews of children were completed. Messages from these cases will be highlighted later in the report.






## Message from the OSCB Independent Chair

I am pleased to report the partnership remains strong. There have been changes to key members of the partnership and the new members are equally committed to the safeguarding agenda.

As highlighted by the Safeguarding Partners we can never become complacent and must continue to respond to emerging and existing safeguarding issues. This includes those issues that persist from the pandemic, notably concerns around adolescent mental health and school attendance – the OSCB is supportive of children being in school.

The cost-of-living crisis has adversely affected families and we are committed to working with partners to support those families and their children to thrive.

The constitution of the boards has been reviewed and signed off. There is new vision for the board.

In the spirit of joint working and better communication the OSCB and Adult Safeguarding Board (OSAB) partners will be having regular joint meetings to discuss some shared issues affecting both adults and children. I see this as a positive step and an example of how responsive we are as a partnership.

Derek Benson

Derek Benson,
OSCB Independent Chair

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# Introduction

The guidance, 'Working Together 2018' requires safeguarding partners to publish an annual report. The intention is to 'bring transparency for children, families and all practitioners about the activity undertaken' by the safeguarding partners.

This report sets out what we have done to achieve our shared vision and aims for children in Oxfordshire.

**Our vision**

**Working together to help children, young people, and families to thrive.**

**Our aims**

**We want to provide Oxfordshire's safeguarding partnership with:**

**1. Leadership and governance**

**2. Direction on improving practice**

**3. Scrutiny and quality assurance**

## Providing leadership for effective safeguarding practice

Martin Reeves
Chief Executive of
Oxfordshire County Council

Steve McManus
Interim Chief Executive
Buckinghamshire, Oxfordshire,
and Berkshire West Integrated
Care Board

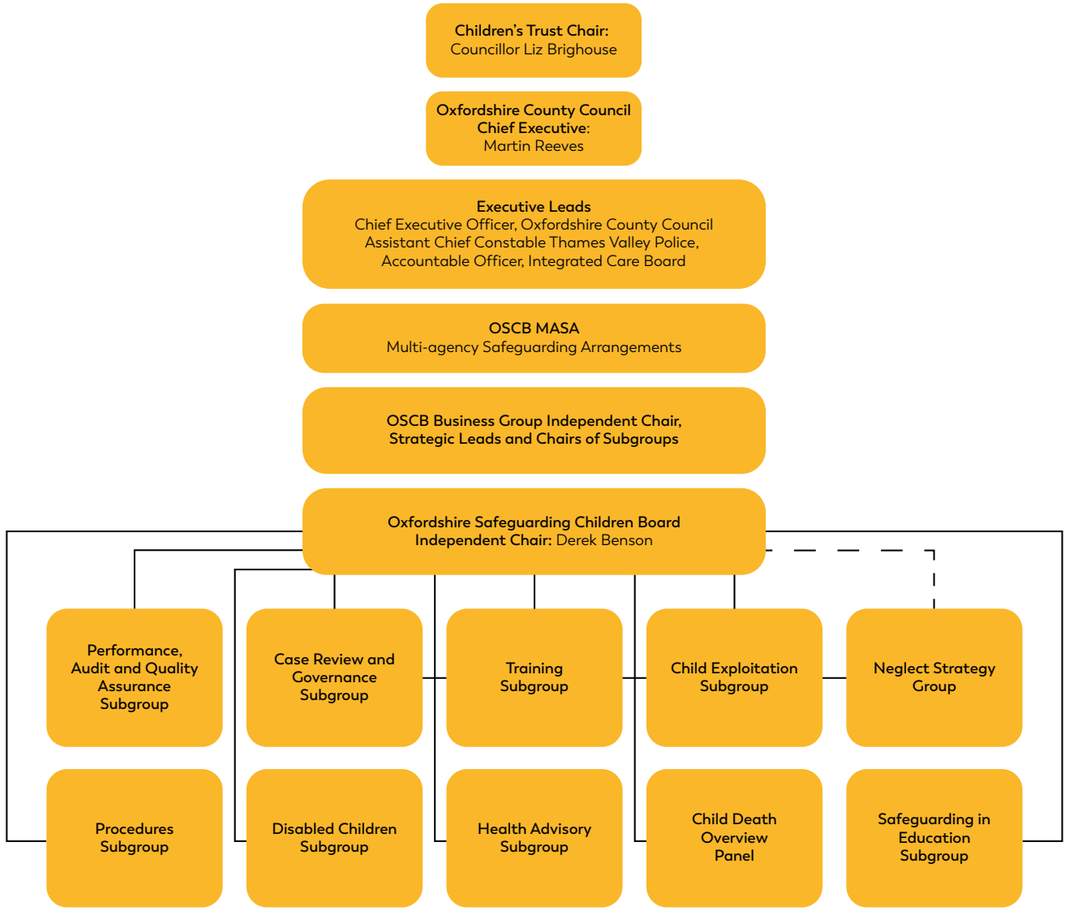
Jason Hogg
Chief Constable,
Thames Valley Police

The Executive Group is responsible for overseeing Oxfordshire's safeguarding arrangements.

The Oxfordshire Safeguarding Children Board brings together local organisations, which deliver services that affect families' and children's lives.

The board also includes independent community members and voluntary sector members.

## Structure Chart
## Oxfordshire Multi - Agency Safeguarding arrangements




Safeguarding work is driven by multi-agency subgroups. Each subgroup has a workplan which is reviewed every time it meets. Information on them, our membership, funding, and links to other partnerships are in links at the end of this report.

**Our partnership seeks assurance of safe practice by:**

- Providing oversight
- Identifying and escalating emerging issues
- Seeking resolutions
- Challenge and holding each other to account

## Update on the last 12 months

An audit of repeat Child Protection Plans highlighted the issue of neglect as being a key issue. The Neglect Strategy and assessment tools were revised and re-launched and a number of multi-agency learning events took place.

The exploitation of young people is a key national safeguarding issue and work has been completed in

Oxfordshire on working smarter with these young people, The Exploitation Screening tool has been revised and a series of learning events are planned about recognising potential exploitation of young people.

The board is live to safeguarding issues in other local authorities in case there are lessons or actions for us in Oxfordshire.

In response to the issues raised following the case of Child Q in Hackney - on behalf of the partnership, colleagues in Thames Valley Police (TVP) clarified the legal background to strip searches and completed a review of the numbers of children who had been strip searched on Oxfordshire over the last year. This will be subject to regular reporting and review.

An inquest into the sad death of  Awaab Ishak in December 2020 found his respiratory condition developed as a result of mould in the one bedroom flat in which he lived with his parents. As a response to this case - Oxfordshire homes have reviewed their safeguarding procedures and supported the OSCB to make representations to the government about the national housing crisis which is also impacting families in Oxfordshire.



## Children in Oxfordshire

**The Office for National Statistics (ONS) Population projection for 0–17-year-olds in Oxfordshire is currently 148,097.**

**What we know about different levels of support for children and families...**

### Early help in Oxfordshire

The Children's Trust has agreed a target to increase the number of strength and needs documents (early help assessments) to 5000 in 22/23.

Although the number rose by 27% in the year to 3599 it still fell short of the 5000 target. An additional 289 strength and needs forms were completed within the health visitor pilot completed by Oxford Health.

Partners have committed to improving the amount of early help offered to children and their families in the forthcoming year to:

a. List their 2022/23 early help targets

b. Identify their performance against these targets

c. Identify the barriers/challenges to achieving the target

d. What they are going to do differently

e. What the governance for early help reporting is?

f. Targets for 2023/24?

g. Actions to address the 3 priorities:

i. Early Help and Mental Health and Well-Being

ii. Early Help and 0–5-year-olds

iii. Early Help and SEND early intervention

## Contacts into the Multi-agency Safeguarding Hub

### Request for support through the Multi-agency Safeguarding Hub (MASH)

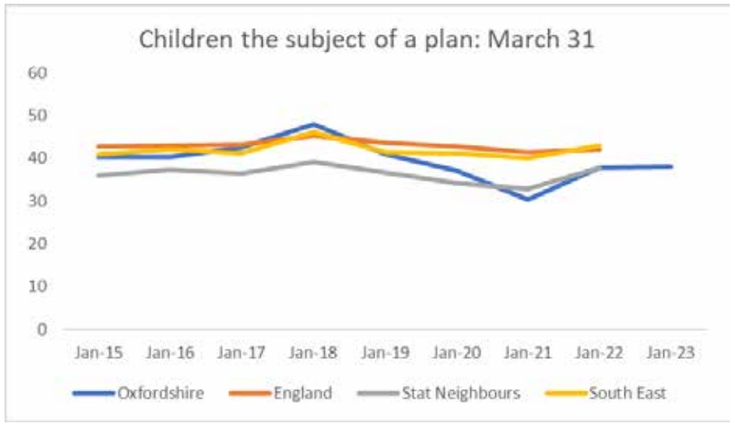
The Multi-Agency Safeguarding Hub (MASH) is the point of entry into Children's social care if there are significant concerns about the wellbeing of a child. It facilitates the sharing of information between services so risks to children can be identified at an early stage.

MASH is a partnership between Oxfordshire County Council, Thames Valley Police, The National Probation Service, NHS health services, South Central Ambulance Service and Drug and Alcohol Services.

MASH contacts rose by 35% in 20/21. In 21/22 they rose again, by 18%. In 22/23 they rose by 3%. The target set was based on the level of contacts pre Covid. Since then, not only have we had the Covid impacts, but also cost of living crisis that has increased potential need and associated concerns amongst other professionals. There is management oversight on all contacts at the first point of entry and during the decision-making process. All children presented cases in the MASH are RAG rated. All children at risk of significant harm are responded to immediately.

The expanded MASH Exploitation team is now live.

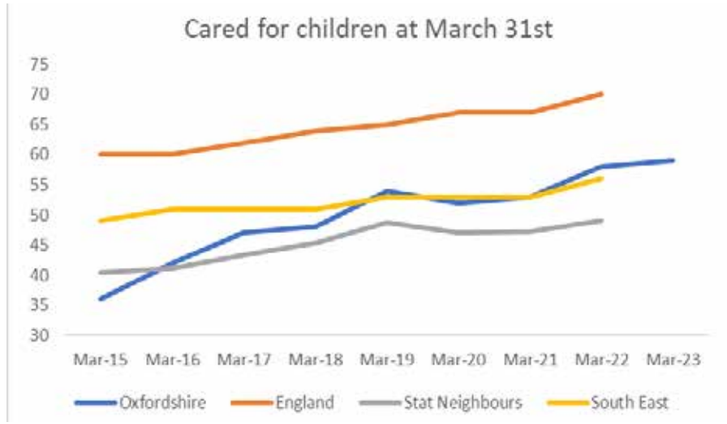
### Support through a child protection plan




475 last year to 567 children this year. This number is still lower than in 2019.



### Children we care for

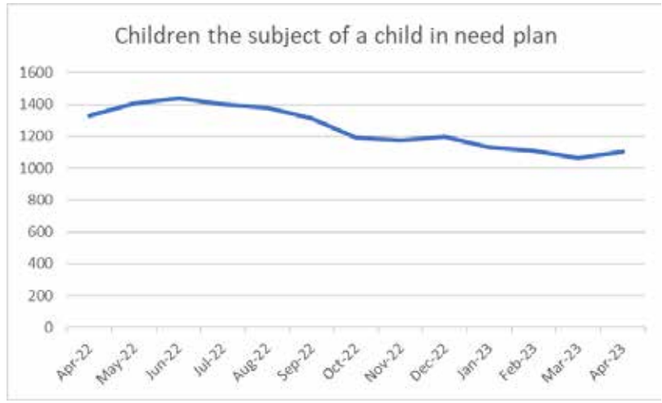



The number of cared for children rose in the year from 854 to 871. This was driven by an increase in unaccompanied asylum-seeking children (rising from 58 to 101) whilst the number of local children fell from 796 to 770. The number of children we care for is around 60 less than at the end of August and continues on a downward trend.. This increased check, challenge and support resulted in the number of children being cared for dropping in Q2 to 50, 74 in Q3 and 30 in Q4.

(Note there is no comparative data on child in need plans).

1104 children were the subject of a child in need plan at the end of March 2023 – down 17% on 12 months earlier. In the year there has been a focus on ensuring plans are closed in a timely manner and stepped down to early help or no support as appropriate.

### Support for Children in Need



## The effectiveness of safeguarding arrangements

Our partnership has 3 safeguarding issues which continue to be reviewed:


We need to support those families, who are not yet meeting all the needs of their children.

We need a system-wide approach to keeping children safe from harm outside their home & from child exploitation.

Local arrangements need to be properly understood and better used to keep children in full time education.

## Neglect of children in the family home

- The number of children subject to current and repeat child protection planning for neglect continues to be high.
- A significant amount of work has been completed by the partnership to revise and update the tools for assessing neglect and supporting families where neglect is a significant issue.

## Minimising risks to children outside the home

- A multi-agency Child Exploitation screening tool has been updated to assess children believed to be at risk of harm outside the home.
- Parents/carers are vital in safety planning to help protecting their child with the support of professionals.



## Children are often safer in school

- The number of children permanently excluded is a third of the 18/19 level, but the number of children suspended is rising 55% of primary school pupils and 33% of secondary school pupils who were suspended last year had special educational needs.

## Findings from Child Safeguarding Practice Reviews

In 2022/23 the OSCB has worked on 6 Rapid Reviews involving 17 children and commissioned 2 CSPRs in 22/23 involving 3 children.

**Two Children's Safeguarding Practice Reviews (CSPRs) (Previously known as Serious Case Reviews - SCRs) were commissioned.**

1. Child G was a young person cared for by the Local Authority who was sexually exploited when living in independent accommodation.

   A Report and Learning summary has been published on the OSCB website.

2. A review into a 2nd child will not be published on the OSCB website as agreed by the National Panel.

### What we know:

The repeat safeguarding themes identified in reviews last year are still current:

- More early help for families is needed.
- The recognition & impact of neglect on children.
- Exploitation of children outside the home.
- A child in school is a safer child.

However, there are new repeat factors from the more recent reviews:

- The impact on the family of historical intra familial sexual abuse.
- Placement sufficiency for young people.
- Access to services which support with children & young people with emotional health.





- See beyond the behaviours of the child – remembering that behaviour is communication.
- Embed the culture of early help and increase the number of early help assessments to divert children & families from statutory intervention.
- A child in school is usually a safer child – schools to be encouraged to hold a meeting with partners before excluding or permanently excluding a vulnerable child to see what can be done to keep them in school.
- The support offered to children Electively Home Educated (EHE) children is vital to ensure systems are place to support their education and wellbeing.
- Ensure rigorous commissioning and quality assurance of placements for the children we care for.
- Maintain oversight of how we record and share information – work is being completed by the OSCB on safe information sharing between partners & resolving disputes between professionals.
- Review access to mental health services for children & young people – especially CAMHS and Eating Disorder services.
- When completing assessments make sure all the other areas where the child have lived are contacted for information.
- Mobile families who move across boundaries can fall through the systems if communication is poor.

## The Multi-agency Safeguarding self-assessment

Oxfordshire's Safeguarding Self-Assessment requests and gathers information from board member agencies on the safeguarding arrangements made in line with Section 11 of the Children Act 2004, and standards developed by the Local Government Association for Adult Services.

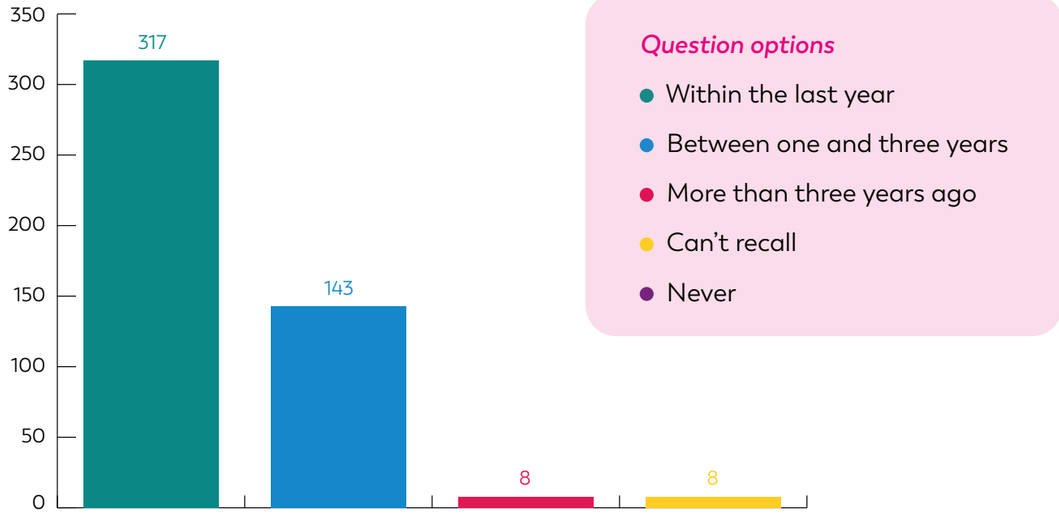
It provides agencies with the framework to measure and quality assure their safeguarding arrangements, and the opportunity to evidence the impact of policies and practice on children and adults in Oxfordshire, as follows:

- Partners were asked to show evidence to how safeguarding and promoting the wellbeing of children, young people and adults is prioritised within their organisation and provide evidence of how their organisation has been able to learn and improve your safeguarding practice
- We asked partners to measure the effectiveness of their safeguarding arrangements and joint working to protect the children, young people and adults with care and support needs
- We asked Partners to show evidence of good practice and areas for development within their organisation to support improvement / development plans
- Partners were asked to support the board in identify training needs and plan for the provision of training, and development of tools and resources to support practice

This report summarises what the self-assessment and peer review process tells us about the effectiveness of our safeguarding arrangements in Oxfordshire, and the effectiveness of joint working locally to protect children, young people and adults with care and support needs.


## Some of the headlines

*When did you last attend safeguarding training?*




*Your safeguarding practice*

| Do you know what to do when you have safeguarding concerns about a child or adult with care and support needs? | | |
|---|---|---|
| Yes (92.6%) | No (2.8%) | Partially (4.9%) |

| Do you have the opportunity to reflect on cases with a colleague/manager in a way that supports you in making safeguarding decisions? | | |
|---|---|---|
| Yes (73.2%) | No (10.1%) | Sometimes (16.7%) |

| How confident would you be to escalate issues if you felt that your safeguarding concerns were not being addressed | | | |
|---|---|---|---|
| Very confident (27.9%) | Confident (41.7%) | Slightly unsure (25.7%) | Very unsure (4.7%) |

## Findings from Child Death Overview Panel 2022-23

**WHO ARE WE?**

The CDOP Panel are a multiagency subgroup of the OSCB, who meet 4 times a year.

**WHAT WE DO?**

In accordance to statutory guidance, review the death of all children residents in Oxon.

**AIM:**

To take forward recommendations to influence strategic changes and practice and ultimately reduce the incidence of child deaths.

Deaths in children are always very distressing for parents, carers, and practtioners. Reviewing the confirmed causes of childhood deaths can lead to effective action in preventing future deaths, which is at the core of the process. A more detailed report is scrutinised by the Safeguarding Partnership Board annually. A report is also submitted to the NHS hosted National Child Mortality Database which contributes to analysis and learning. There are published thematic reports which are shared and used to influence national leaders.

### Summary

In 2022-2023 there were 38 notifications of a child dying in Oxfordshire area. It was noted that this is the second consecutive year with a slight rise, however the numbers remain too small for this to be statistically significant. 34% of notifications this year were about infants under 27 days old, this is a reduction on the previous year. There were 12 joint agency meetings for a family in which their child died suddenly. The Child Death Overview Panel met 4 times and reviewed 30 cases. 33% of those cases reviewed had 'modifiable factors', compared to the national figure of 39%. The most frequently seen modifiable factors were smoking in the household, unmet mental health issues for parents and co-sleeping.





### Learning and actions from the reviews completed in 2022-2023

Palliative care has remained a theme of learning within reviews throughout 2022-23. The value of early, proactive planning, involving both acute, community and palliative care teams has been clearly demonstrated however practice remains inconsistent. Pathways are being reviewed and learning is being fed back to wider teams through the strategic clinical network for NHS SE.

It has been recognised that in this review year there have been occasions in which delays in identification of serious illness have been noted. Viral illness developing into life threatening events, post operative complications and obscuring of symptoms (overshadowing) have all been explored within panel.

There were 28 recommendations from the reviews during 2022-23 relating to communication issues. It has been acknowledged by teams and practitioners that as demand has increased, pressures on staff have reduced the time available to construct comprehensive handovers and communication updates. Good multi-agency and multi-professional active communication is essential to holistic and well-coordinated care.

Services are committed to ensuring the ongoing care and safety of children. Members of CDOP have a forensic approach to the Panel's work ensuring that all possible learning is derived from each child's death, that trends are identified and acted upon as quickly as possible and that the voice of parents and carers, and, where possible, children and young people, is heard and responded to. Whilst there is always room for improved communication and information-sharing across and within services, agency representatives on the Panel are committed to taking all learning back to their colleagues.

As a result, service changes have been made in a timely manner and more collaborative and joint working has led to more effective and efficient sharing of resources across the local system.

## Embedding Learning and Improvement

The OSCB aims to improve practice through learning from reviews.
We keep in touch with practitioners and run online events.
We always aim to facilitate at least one annual conference as well as two large scale learning events.

### OSCB Learning Event: Follow up Learning Event on Child Exploitation

**Date: June 2022**

This was a follow up event to the first one held in January 2022.

a) Consolidating and concluding the 'time-limited' work streams.

b) Launching the framework for child exploitation/Safeguarding Adolescents for 2022-2025.

c) Launching the child exploitation/Safeguarding Adolescents Vision/Pledge/ Promise; and

d) Remembering Jacob.

### OSCB Learning Event: Violence Against Women and Girls

Sexual and physical violence, predominantly against women and girls, are recurring themes across local and national CSPR's.

Responding to domestic abuse has been highlighted as a challenge by the majority of agencies in this year's Self-Assessment returns.

The recent OFSTED review of sexual abuse in schools and colleges revealed how prevalent sexual harassment and online sexual abuse are for children and young people and the murders of Sarah Everard, Sabina Nessa, Biba Henry and Nicole Smallman have increased calls to collectively change the narrative and response to VAWG, to better safeguard women and girls and educate children and young people.

**Date: Feb 2023**

*This learning event was well received by attendees who commented on the dynamic and vibrant approach to sharing the information on a difficult topic.*



### OSCB Learning events: Trauma informed practice

**Background:** To increase awareness and understanding of the impact of trauma on children, young people, and their families.

**Date: November 2022**

The realisation that many families have experienced and/or are living with trauma and how workers can work more intuitively to help them work through it and support them to succeed.


## Learning through training

### Overview:

**301** training events in total

In 21/22 it was **289**

**6,210** practitioners attended virtual and face to face training

In 21/22 it was **5,072**

**11,826** practitioners completed online learning

In 21/22 it was **8,809**

### Practitioners have told us about OSCB training:

- *'I found the course delivered by 2 knowledgeable and experienced DSLs to be extremely helpful.'*
- *'Trainer from today was exceptional with inclusion of participants and great at time keeping.'*
- *'(the training) was engaging, interesting, and we had space to converse and ask all the questions needed.'*
- *'It was good to think about the more holistic approach to safeguarding, rather than just the usual process and procedure agenda'.*
- *'Details about the Chronology practice was very helpful and will support our setting in early identification of patterns and issues of any struggling families'.*
- *'I have made an action list to be included in our Safeguarding action plan for 2023 with notes from the training'.*



## OSCB Trainers are Volunteers:

- 77 volunteer safeguarding trainers (75 in 21/21)
- 10 new trainers completed our 'Train the Trainer' course this year (12 in 21/21)
- 2 development sessions were held for trainers to build their knowledge of OSCB Rapid Reviews and Child Safeguarding Practice Reviews, kinship care, update on neglect and the effect of pornography on young people (3 in 21/22)


For sharing your expertise for free.

*The trainers are an invaluable line of communication for the safeguarding network. They meet Oxfordshire's workforce over 100 times each year and feedback their views directly to us.*

## OSCB Trainers have told us:

- *'Having a multi-agency group of delegates means there are perspectives, experiences and knowledge from a broad range of practitioners. Partnering up with different trainers each time also offers an opportunity to learn about good practice and strengthen agency partnerships'*
- *'We don't have all the answers but the beauty of being part of the training pool is that when delivering to many professionals across many different settings, we find those answers together in a supportive and professional way'.*
- *'Being part of the Training Pool has been a two-way process for me, it has allowed me to share my experiences with other professionals from many different settings, which I hope has helped them to navigate their way through some difficult, challenging situations whilst at the same time, enabled me to learn from those professionals too'.*
- *'Developing, organising and delivering good quality, engaging training is what sets my soul on fire!'*
- *'Working alongside other professionals is awe inspiring as each sector shares a dimension of safeguarding I might not have considered'.*
- *'Every time I deliver a course, I learn something from the co-trainer and delegates'.*

## Evidence and Assurance

**The OSCB looks at the children's safeguarding system in different ways to check how well it is working.**

### ASSESSMENTS

Organisations check how well they comply with safeguarding standards and look at pressures on their services.

We reviewed 11 large services which support children in some way through a self-assessment and a peer review.

### AUDITS

We review how well organisations work with others to support children.

We reviewed children's experiences of support, where they were at risk of exploitation, where they had experienced substantial neglect.

### VIEWS

From practitioners, families and children: an important part of the jigsaw, these are included wherever possible.

Over 700 practitioners completed an online safeguarding questionnaire for the OSCB.

### DATA

We review facts and figures against local targets.

We review data on all safeguarding pressure points at all levels of the partnership on a bi-monthly basis.



## Annual Report 2022/23 Conclusions

**Strategic safeguarding partners need to take a lead on embedding the learning from 2022/23 in their organisations and across the system. This includes:**

- The common themes which will be taken forward by the partnership into next year are; Acknowledgment that the safeguarding agenda continues to expand, and the partnership remains committed to helping all children living in Oxfordshire to thrive and be safe
- It is important to read the back stories of families we are working with, including those who have moved across boundaries. The past will often inform the future
- Think creatively when working with families – do not be constricted by procedures
- We learn from audit and review and by professional challenge

Our local community: safeguarding is everyone's business.
Please report a concern if you are worried.

If you have a concern about a child, please call the Multi-Agency Safeguarding Hub (MASH) on **0345 050 7666** during office hours.

**Working together to help children, young people, and families thrive.**

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