Oxfordshire Safeguarding Children Board (OSCB)

Annual Report 2023/2024

Foreword by Strategic Safeguarding Partners

We are pleased to present the annual safeguarding report for the Oxfordshire Safeguarding Children Board for 2023-24. The report is published by the three statutory partners (Oxfordshire County Council, Thames Valley Police and Berkshire Oxfordshire Buckinghamshire Integrated Care Board) who have a shared and equal duty to make the arrangements work together to safeguard and promote the welfare of all children at risk of abuse in Oxfordshire. They are responsible for putting in place effective arrangements to support the co-ordination, quality assurance and continual improvement of activity to safeguard children and young people. At the heart of this report is a commitment to transparency, accountability and above all the protection of the most vulnerable children, young people and families in Oxfordshire.

This annual report provides information and data on how our local safeguarding systems for safeguarding children is working. It provides an overview of learning from children's reviews and how we have embedded this learning into practice.

This report also sets out the achievements and the work that progressed despite unprecedented pressures on service and this progress is testament to the strength of relationships between practitioners and leaders. Building on this relationship will continue to be important and underpin the work we do. Ensuring the partnership work effectively, improving the way it shares information and the ongoing development of our government to maximise improvements across the system will be key in the future success of the partnership in safeguarding for 2024-2025.

Finally on behalf of the Oxfordshire Safeguarding Children Board, we would like to thank the partnership workforce for their dedication in safeguarding and for the positive different they make to the lives of children, families and communities.

This annual report was approved by MASA on …… In line with statutory requirements and best practice this annual report will be shared with:

- Child Safeguarding Practice Review Panel
- The What Works Centre for Children's Social Care
- The Police and Crime Commissioner
- The Health and Wellbeing Board
- Oxfordshire Safeguarding adult's board

Martin Reeves,
Chief Executive of
Oxfordshire County Council

Dr Nick Broughton,
Interim Chief Executive,
Integrated Care Board
Buckingham, Oxfordshire
and Berkshire West

Jason Hogg,
Chief Constable,
Thames Valley Police

Independent commentary by the OSCB Independent Chair/Scrutineer

This annual report has been informed by the safeguarding partners and scrutinised by me as Independent Chair. I was appointed as the new Independent Scrutineer/Chair for the safeguarding board in February 2024. I have held several senior leadership roles in the UK, including Director of Children Services and Executive Director of Social Work for a health and social care trust in Northern Ireland.
The aim of my work this year will be supporting the partnership with reviewing the effectiveness of the arrangements. Whilst I have started this post as chair, I will be moving into the scrutineer function as set out in statutory guidance of Working together to safeguard children 2023.

The role of the independent Scrutineer is to carry out the independent scrutiny functions as set out in Working Together to Safeguarding Children 2023. I will provide the critical challenge and appraisal of the multi-agency safeguarding partnership arrangements and will consider how effectively the arrangements are working for children and families as well as for practitioners.

I am currently developing a system of scrutiny to provide assurance, monitoring and challenge to the quality of work, to judge the effectiveness of the multi-agency arrangements to safeguard and promote the welfare of all children in Oxfordshire. My role will act as a constructive critical friend and be a key driver to promoting reflection for continuous improvement across the partnership. As the Independent Scrutineer I will consider how effectively the arrangements are working for children and families as well as for practitioners, and how well the safeguarding partners are providing leadership and will:

- Provide assurance in judging the effectiveness of servicesto protect children
- Assist when there is a disagreement between agencies
- Support the OSCB to be a learning organisation

Independent Scrutiny will be provided by a single individual, with a view to generating usable learning for system improvements and is independent from the statutory partners.

The Independent Scrutineer's role includes:

- Attending the MASA Executive Group, as well as other subgroups
- Reviewing and contributing to the Partnership's annual report
- Reviewing audits and performance data, including self-assessment audits
- Ensuring regular thematic peer reviews
- Determine the effectiveness of arrangements to identify and review serious child safeguarding cases
- Involvement in the escalation and conflict resolution process
- Have a direct line of sight to frontline practice including conversations/feedback with frontline practitioners
- Ensuring the voice of the child and service users is at the heart of all aspects of scrutiny by talking with and receiving direct feedback from children, young people and families to test the interconnectedness between performance, practice and the voice of the child, young person and family
- Embed scrutiny as a positive process with learning as its outcome

I will share my finding of this work in the next annual report in 2024/25.

Ian Sutherland

Contents

APPENDICES

1. Introduction

The guidance, 'Working together to Safeguard Children 2023' require 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.

We want to provide Oxfordshire's safeguarding partnership with.

1. Leadership and Governance
2. Direction on improving practice
3. Scrutineer and quality assurance

Our vision

We want to keep children in Oxfordshire as safe as possible by making sure everyone understands their roles and responsibilities regarding safeguarding through training, learning and local resources.

2. Providing leadership for effective safeguarding practice

The Executive Group set out in page 2 is responsible for overseeing Oxfordshire's safeguarding arrangements. The Lead Safeguarding Partners (LSP) as set out in Working Together named above will delegate the leadership for the partnership to the delegated safeguarding partners (DSP). We experienced changes in the Executive during this year as we had new appointments with the Local Authority, Health and Police. The workstreams have remained stable during this year with consistent sub chairs and members who have worked effectively together. The partnership continues to function using predominantly online meetings. However, there was a drive from the partnership to hold meetings in person during this year as partners felt it lends itself more to partnership working. The structure of the partnership has not changed for several years now and is currently being reviewed as part of the compliance work for Working together to Safeguard Children 2023.

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

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

Safeguarding work is driven by multi-agency subgroups. You can find information on the subgroups, membership on the OSCB website.

The partnership is accountable for delivering child protection services and we keep children as safe as possible because we.

- **Provide oversight**
- **Identify and escalate emerging issues**
- **Seek assurance**
- **Challenge and hold each other to account**

UPDATES ON THE LAST 12 MONTHS

- Review and updates of the operating principles for the Child Safeguard Practice Review subgroup have been made. The intention is to ensure a shared understanding of the threshold for serious incident notification and improve the discussion of learning across the safeguarding partners.
- A deep dive of children with complex needs with delayed discharge has been completed.
- Education Safeguarding Advisory Team – provided a comprehensive and rich report on S175/157 self-assessment returns from schools and colleges with 96% sign up. There has been a significant increase on the use of neglect self-assessment in schools compare to last year which has meant that children and their families receiving more targeted support for neglect
- The Seven Golden Rules to Information Sharing - was updated and circulated in the partnership it can be found here.
- Commendation letters were written to 25 multi-agency practitioners to recognise a piece of work that support improvement in the safeguarding system.

EFFECTIVENESS OF LEADERSHIP IN SUMMARY:

- Strategic ownership of safeguarding by health, local authority and police
- Strategic partners have recognised that the voice of children and their families will be an area of focus to strengthen within the partnership going forward
- Review of the structure of the partnership is planned to show evidence of impact and outcomes for children

3. Children in Oxfordshire

The safeguarding board regularly review data and performance figures. The partnership's ambition is to continually improve the join up of separate data sources to provide data that can identify vulnerable cohorts and directs resources to support them. This is a national challenge that it is hoped will be helped by the formation of a central government data strategy due to be published, in response to the 'Stable Homes, Built on Love' Government consultation Response.

Unless otherwise specified, data relates to the figures as at year end 31/3/2024

The child population of Oxfordshire stands at approximately 152,205. Whilst Oxfordshire has many strengths, it is essential to acknowledge that 10 out of 83 neighbourhoods in the county fall within the 20% most deprived areas in England. After housing costs, approximately 1/ 4 children in Oxfordshire live below the poverty line.

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

Early help In Oxfordshire

There were 4,409 strength and needs forms (EHAs) completed in the first 9 months of the year. Whilst this is below the target level of 7500 for the year it is higher than the number of social care assessments – This means that children are now more likely to be supported by an early help response. (Latest national figures show you are still 2.3 times more likely to be met with a social care than an early help response). This was an area of focus identified by the partnership during the previous year and demonstrates successful partnership working through a strengthened Early Help service.

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

In 23/24 the number of enquiries into MASH was 2% fewer than the previous 12 months. The MASH triages all contacts to Children's Social Care and Targeted Family Support at an early help level. There is assurance that children are receiving the right help at the right time and that the application for threshold is applied by the partnership.

Support through a child protection plan

As of 31st March 2024, there were 528 children made subject of a child protection plan.

Children we care for

There were 676 children we care for which is 127 less than 12 months ago and now in line with similar authorities.

We currently have 98 unaccompanied asylum-seeking children living in Oxfordshire.

Children's Health - The number of A&E attendances and hospital admissions for self- harm continues to reduce. A&E attendances are 14% lower than 12 months ago (650 for 10–19-year-olds) and hospital admissions (15-19) are 36% lower (125)

- There were 172 hospital attendances for children aged 10 - 14 yrs. This is 5% lower than the 182 in the previous 12 months.
- for 15–19-year-olds there were 478 attendances, 15% lower than the 562 in the previous 12 months
- the number of hospital admissions, 125, for self-harm (15-19) is 36% lower than the 194 in the previous 12 months. GPs receive summaries form Emergency Department in all cases. Self-harm data and themes are shared at the self-harm forum which is multi-agency in its representatives. Oxford University Hospital information is shared by the safeguarding liaison service with school health nurses and children social care for children on a child protection plan or open to Children We Care For.

The partnership has been focused on the timeliness of children being offered an initial health assessment. This has improved this year and increased to 71% in 23/24 (to January) and 100% for the last 3 months. This follows increased medical capacity and a focus on timely flow of information. Children placed outside of Oxfordshire continue to face long delays for both the initial health assessment and the review health assessment due to limited capacity in the receiving health team. Both issues have been escalated to the Corporate Parenting Panel, the Designated Nurse and through the ICB to NHS England.

4. Focused area for the partnership

Our partnership has 3 safeguarding issues where practice improvement is essential

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

TACKLING NEGLECT	
What went well	**Even better if**
• There is evidence that the application of Early Help (TAF Team Around the Family) and the first signs of emerging neglect and proactive stance have increased within the partnership • There is evidence of increase of tool usage to support families – Thrive, Home Conditions and participation in GCP2 for children in TAF, CIN (Child in Need) and CP (Child Protection) plans. • Collection of evidence base for impact of Neglect Strategy and evidence within actions plans • Achieving improved attendance across key cohorts (transfer from primary to secondary) and muti-agency understanding of reintegration timetables • Home Conditions Tool and other tools approved – currently in development a SEN my lived experience tool within a special school. Home condition use evidence in some contacts to MASH • GCP2 initiative with health visitors (funding by Public Health Grant) – currently in training phase • Piloting the use of GCP2 within Education in Oxfordshire	• Neglect continues to be identified earlier before families reach a crisis point and need statutory help • Continued increase for partners in support families with tools where neglect is a feature • Practitioners and managers routinely used the tools and resources available • Changes in practice are embedded across the whole system • Increase use of home condition tools from the partnership • Roll out of the GCP2 to all health visitors • Once piloting phase has been completed then delivery of the GCP2 in all schools across Oxfordshire

Child Exploitation work	
What went well	**Even better if**
• Children at risk in Oxfordshire (victim, suspect of offender) has increased overall by 3.18%. Reductions have been seen in Oxford City -11.2% and South and Vale -7.78 but Cherwell and West Oxfordshire have seen increase of 31.25% (672 to 882) and 5.66% (389 to 411) respectively. • There is now a multi-agency training package in place for exploitation in the partnership • More dates have been set for Trauma Awareness Training run through the Violence Reduction Unit • Effective multi-agency working has been highlighted in the partnership following the response of an increase in violence between two groups of children in an area of Oxford city. A group formed and key leads from across the partnership were identified to lead. • Prevention and engagement worked followed that resulted in a comprehensive partnership plan for every child with the support of the parents. This holistic piece of work has had a positive impact on the children, their families and the community. The learning from this work will be shared and formal recommendation for recognition will be completed.	• Further work on how we use data in the Child Exploitation Prevalence Report to inform and shape other sub-groups and the wider partnership • Disruption of criminals is targeted and effective • All practitioners to feel confident and have the skills to tackle and support child exploitation • Increase in partnership workforce to work in a trauma informed way to support victims • To ensure where good practice has been identified to look at opportunities to grow further in our work with children and families

KEEPING CHILDREN SAFE IN SCHOOLS AND SETTINGS

What went well	Even better if
• Exclusions continue to reduce from pre-covid levels (31 children last year) however, two thirds of exclusion are for children with special education needs • Progress update on Operation Encompass reporting to schools. The group were pleased to note that progress to address these issues have been made. TVP have ensured that all school contact details are correct and are in the process of training response officers. • Guidance has been written for schools on how to manage incidents of Child-on-Child harmful sexual behaviour. • This has been developed over a period of 12 months and has involved a multi-Agency working group consisting of colleagues from TVP, education, social care and the school nurse team. The impact is that schools and settings now have clear processes to support their decision making.	• A strategic education board has now been set up and work is being undertaken to address attendance in the partnership. Review of the Operation Encompass to ensure changes that have been made have had the right outcomes for children affected by domestic abuse. Review of this guidance to ensure we can see impact and experiences for children.

EFFECTIVENESS OF DRIVING FORWARD PRACTICE IN SUMMARY:

- Leaders will drive forward the cultural change for the safeguarding partnership to be more effective
- The partnership will strengthen the voice of children and front-line practitioners.

5. Findings from Child Safeguarding Practice Reviews

In 2023/2024 there was not any CSPR's publishes during this period. A thematic summary was published by the partnership and can be found here. This thematic review looked at intra-familiar sexual abuse, including siblings abuse, and highlights key practical issues found in Oxfordshire learning reviews. It links with national research and other learning reviews.

There were 6 key findings in this review which were.

1. Professional curiosity and unconscious or conscious bias "It was not seen"
2. Information sharing and working together to gain a full picture/history
3. The need for practitioners to be trauma aware when understanding Inter-generational patterns of abuse
4. Understanding individual children's worlds in their families and hearing their voice
5. Working with families to understand barriers and enablers
6. Impact of the covid-19 pandemic

We are planning to hold a conference in 2024 to ensure the learning from this thematic review and Child Sexual Abuse is shared wider across the partnership.

We had one serious incident notification in this period. The key findings learning from this review were raising awareness of risk factors for suicide in particular, children affected by parental suicide. The multiagency partners to ensure anniversary of important dates for families are considered in any intervention or assessments completed. The Child's voice was not always recorded in assessments and direct work. Notification to school health nurse for children that are elective home educated. Police intervention and national guidance – Thames Valley Police agree to review the system when Education refer matters to them so timely advice is sought. Finally, the multi-agency response to a change for a child to become electively education. The learning will be overseen by the multi-agency Child Safeguarding Practice Review Group in the following 6 months period.

What we know

The repeat safeguarding themes identified in reviews last year are still current and continue to be a priority for the partnership this year

- **The impact of trauma and cumulative harm**
- **Family engagement and consistent support**
- **Information sharing across the partnership**
- **Children with complex mental health/ emotional needs**
- **Parental mental health and parenting capacity**
- **Children not in school**

EFFECTIVENESS OF LEARNING FROM PRACTICE REVIEWS

The partnerships ambition is to improve collaboration of learning from Domestic Homicide and Adult Safeguarding Reviews into the children partnership. The aim is that the learning is shared across the system so that change can be embedded into front line practice.

Findings from Child Death Overview Panel 2023-24

Who Are We?

The CDOP panel are a multiagency group of the OSCB, who meet 5 times a year to review child deaths.

What We Do

In accordance with statutory guidance, review the deaths of all children resident in Oxfordshire

Aim

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

Deaths in children are always very distressing for parents, carers and clinical staff. Reviewing the confirmed causes of childhood death can lead to effective action in preventing future deaths, which is at the core of the process. The full report can be found here.

Summary

In 2023/24 Oxfordshire CDOP system received 32 notifications. The Designated Doctor for Child Death chaired 13 Joint Agency Response meetings (JAR's) for children in Oxfordshire in 2023/24. These are held in situations when a child died suddenly and unexpectedly, defined as a death or circumstances leading to death that were not predicted 24 hours previously. In all cases proactive support plans and a key worker identified for families, with feedback being reported through late case discussion meetings and multi-agency clinical Child Death Review Meetings (CDRMs).

The Oxfordshire CDOP panel met on five separate occasions in 2023/24 to review child deaths. The deaths of 38 children whose usual residence was in Oxfordshire. These reviews included deaths that occurred in previous years but had been carried over due to additional investigations or reviews which prevented completion of the CDOP process earlier (see table on next page).

Learning and actions from the reviews completed in 2023-2024:

- Interagency communication remains the most frequent theme arising from reviews. The value of early, proactive planning, involving acute, community and palliative care teams has been clearly demonstrated during the year with examples presented of excellent coordinated care.
- Bereavement support has been an area which families have fed back as being variable. This has been particularly challenging in situations where children have died out of area and initial follow up plans have been led by the out of area team. During the year work was undertaken to review and update details of the bereavement resources available to families. In the acute bereavement phase within Oxfordshire's main hospital and hospice sites leaflets are provided to families. Ensuring that these are shared with families whose bereavement began away from their home consistently requires improvement and will be an area of focus for 2024-2025.
- The role of the Keyworker in these situations has been identified as valuable. However, the depth of bereavement support skills and knowledge in non-health Keyworkers has been identified as undeveloped. Action is being taken by CDOP and its members to update Keyworker guidance and plan some more training in the coming year.
- Another key area of work, that is required in 2024-2025, in which the Keyworker plays a vital role is in ensuring the family experience and voice is heard within the review. Nationally this has been acknowledged as challenging. In responses a toolkit has been created to help involve bereaved parents in the review of their child's death. The toolkit provides a structured format for parents to ask questions, feedback to professionals, and learn the outcomes of Child Death Review meetings. The toolkit was developed jointly by bereaved parents and professionals during the research project 'Involving Parents and Staff in Learning from Child Deaths', funded by the National Institute of Health Research. It is recommended that the Oxfordshire area encourage the use of this tool in 2024-2025.
- The cultural support offer to families in the immediate bereavement phase has been identified by panel as limited for non-Christian faiths in the review year. The accessibility, for professionals, of specialist faith leaders has been restricted by limited key communication links being available. All services have agreed to review their local offer, to ensure it is equitable and meets the family needs. The CDOP Panel has agreed to keep cultural needs as an area of focus for reviews in the coming year.

6. Embedding learning and improvement

The OSCB aims to improve practice through learning from reviews. We keep in touch with practitioners and share learning summaries so that these can be taken related upon and considered for ongoing learning.

Learning has led to improved ways for us to work together:

- Revisions continue to be made to the **'Resolving Professional Concerns and Disagreements'** policy to ensure that it is easily accessible and for all partners.
- Updates are being made to the **'pre-birth guidance'** and **'self-harm and suicide guidance'** following reviews to ensure guidance was up to date. Further work is underway to review **'Children and families Moving cross Local Authority Boundaries/Management of transfer in case conferences**.

Summary

346
training events in total have been delivered

6,172
practitioners attended face to face training

11,338
completed e-Learning virtual and face to face training

Practitioners have told us about OSCB training...

Domestic Abuse: basic awareness - I thought this was an excellent training. It packed a lot into a tiny amount of time. The trainer was good: approachable, listened carefully, knowledgeable. The pace of the training was good, and the diagrams/models helpful and clear. I will be looking up some of the writers the trainer mentioned, and I will look up the 'power wheel' she has devised with input from users of services. I hope this feedback goes back to the trainer!

OSCB trainers are volunteers who deliver the partnerships training programme.

86 volunteer safeguarding trainers currently in core course training pool

30 trainers attended the trainer celebration event which was a face-to-face event. The guest speaker was Adrian Bethune, was an inspirational educator and spoke about looking after yourself whilst safeguarding others

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

OSCB trainers have told us...

'Working together as part of a multi-agency team to deliver the training was brilliant- it allowed us to pull together our knowledge and offer a holistic approach to safeguarding children where the concerns are exploitation'.

6. 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 17 large services which support children through a self-assessment and a peer review.

Audits – We reviewed how well organisations work with others to support children. We carried out a multi-agency audit into neglect and completed a deep dive for children with delayed discharge from hospital.

Views – From practitioners, families and children: an important part of the jigsaw, these are included where possible. Over 687 practitioners completed an online safeguarding questionnaire for the OSCB.

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

Main areas of safeguarding focus over the last 12 months are:

- A growing level of suspensions and at secondary schools
- Over 22,000 pupils (20% persistently absent for more than 10% last year)
- 1500 pupils missed more than 50% of schooling including 1:24 secondary pupils
- 88 children missing education currently
- 26 children subject to social care plan who are electively home educated

The Partnership, in response to the concerns have completed work to look at an attendance strategy to prevent further increases in the number of children absent from Education. Mental health continues to be a significant reason for low attendance across schools and work is being undertaken to look at a common approach to this and further resources to support schools in addressing this. Transport issues for children in special schools mean that some children's school attendance Is impacted. It was noted that not all schools use data effectively to track attendance and therefore further work has been identified to address this. The Safeguarding in Education subgroup are linked to the work of the strategic attendance review meetings which are in place and will take forward most of this work. The subgroup and partnership will review and support this work going forward.

Annual Report 2023/2024 -Conclusions

This year's report for 23/24 covers the activities undertaken by OSCB, including multi-agency reviews for children in the Oxfordshire area. The report demonstrates a high volume of work covered over the period, with areas of strengths and features of effective partnership working.

Going forward into 2024/25, the areas of focus will be on the compliance set out in the statutory guidance Working Together to Safeguard Children 2023. There will be a programme of activity carried out in the next financial year to ensure we review and make changes to the effectiveness of the arrangements in Oxfordshire. The priorities for the next year will remain unchanged from what was agreed in the previous year's (22/23) report. This will allow time for change and improvements to be embedded and to take effect and enable meaningful impact for children in Oxfordshire.

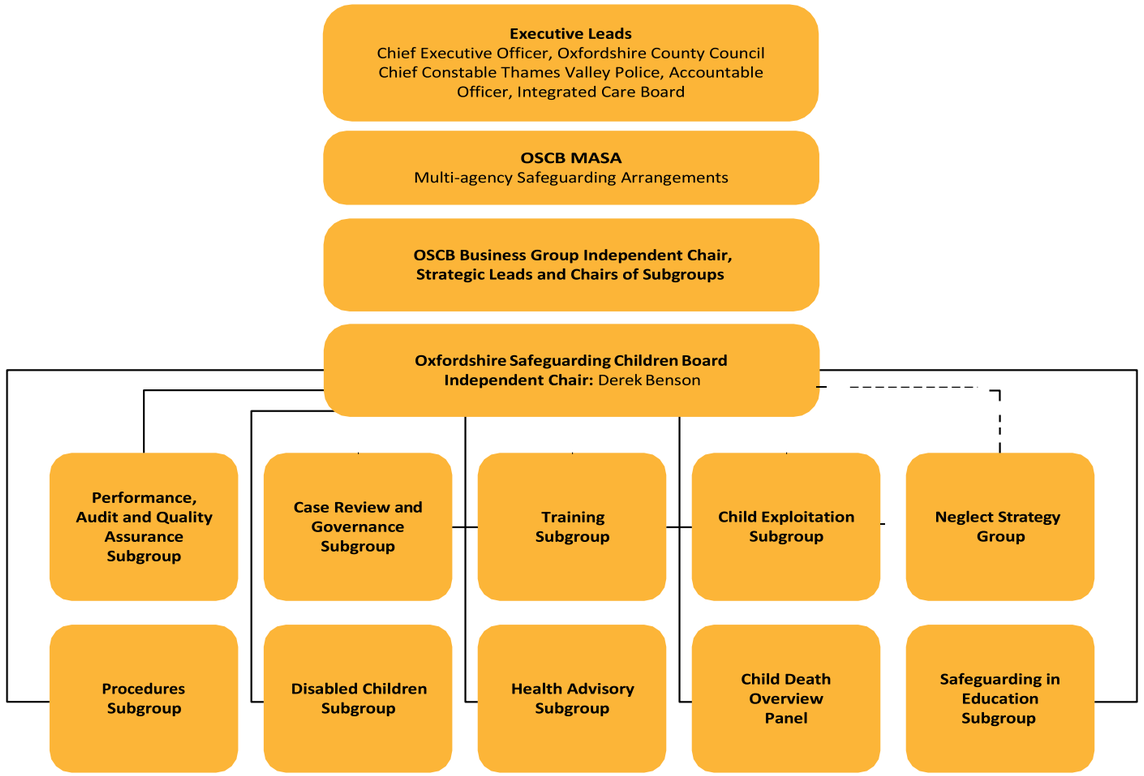
Senior leads in the partnership have agreed for a dedicated post in the business unit to lead on Engagement of young people and their families. This post is actively being recruited to and we can report in the next years report how this area of work has progressed. In addition, significant work is being undertaken on the OSCB website to ensure that documents, policies and guidance for the partnership is accessible for the partnership and reviewed at regular cycles.

Appendix A: OSCB Budget

	End of year figures 2023/24
Funding streams	
Public Health	-£30,000.00
Income	
Foster carer training	-£2,500
Non-attending delegates	-£9,500
Department of Education (Implementation of working together 2023)	-£47,300
Contributions	
OCC Children, Education & Families	-£208,000
OCC Dedicated schools grant	-£64,000
BOB ICB*	-£60,000
Thames Valley Police	-£21,000
National Probation Service*	-£1,410
CRC*	-£2,500
Oxford City Council	-£10,000
Cherwell DC	-£5,000
South Oxfordshire DC	-£5,000
West Oxfordshire DC	-£5,000
Vale of White Horse DC	-£5,000
TOTAL INCOME	**-£476,210.00**
Expenditure	
Independent Chair	£16,000
Business unit	£314, 107
L & I work	£5,546
Training & learning	£50,000
All case reviews	£26,160
TOTAL	**£411,813.00**
Available reserves*	£124,453
Drawdown	£64,397

* NHS Oxfordshire CCG also funds the Child Death Overview Process at a cost of £76,774 per annum

Appendix B: OSCB subgroup structure 2023/24



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.

OSCB
Oxfordshire
Safeguarding
Children Board

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Images used in this annual report are stock images