OXFORDSHIRE COUNTY COUNCIL

Cabinet
Tuesday, 17 October 2023

ADDENDA 2

6. Reports from Scrutiny Committees (TO FOLLOW) (Pages 1 - 46)

Cabinet will receive the following Scrutiny Reports:-

Oxfordshire Joint Health Overview and Scrutiny Committee on the Area SEND Inspection of the Local Area Partnership

Oxfordshire Joint Health Overview and Scrutiny Committee on Healthy Weight

Oxfordshire Joint Health Overview and Scrutiny Committee on Health and Wellbeing Strategy Update

People Overview & Scrutiny Committee on Local Area SEND Inspection

8. Local Area Partnership/SEND Ofsted Inspection (Pages 47 - 58)

Cabinet Member: SEND Improvement
Forward Plan Ref: 2023/261
Contact: Anne Coyle, Interim Director for Children's Services
Anne.coyle@oxfordshire.gov.uk

Report by Interim Director of Children's Services.

The Committee is RECOMMENDED to

a) Note the report of His Majesty's Chief Inspectorate;

b) Note the indicative action plan, development process and proposed governance

13. Budget & Business Planning Report - 2024/25 - 2026/27 (Pages 59 - 60)

Amendment to report

15. Oxfordshire Safeguarding Adults Board Annual Report 2022-23 (Pages 61 - 68)

Cabinet Member: Adult Social Care
Forward Plan Ref: 2023/128
Contact: Steven Turner, Strategic Partnerships Manager, Steven.Turner@oxfordshire.gov.uk

Report by Corporate Director for Adult Social Care (**CA15**).

To note the report and its conclusions.

16. Oxfordshire Safeguarding Children Board Annual Report 2022-23 **(TO FOLLOW)** (Pages 69 - 104)

Cabinet Member: Children, Education & Young People's Services
Forward Plan Ref: 2023/129
Contact: Laura Gajdus, Business Manager (OSCB), laura.gajdus@oxfordshire.gov.uk

Report by Corporate Director for Children's Services (**CA16**).

To note the report and its conclusions.

19. For information only: Cabinet Responses to Scrutiny Papers (Pages 105 - 114)

Water resources
Consultation and Engagement Strategy
EDI Action Plan
LGA Peer Review

Divisions Affected – All

CABINET

17 OCTOBER 2023

REPORT OF THE PEOPLE OVERVIEW & SCRUTINY COMMITTEE: Local Area SEND Inspection

Cllr Nigel Simpson
Chair of the People Overview & Scrutiny Committee
October 2023

RECOMMENDATION

1. The Cabinet is **RECOMMENDED** to **—**

   a) Agree to lead on developing a Local Area Partnership-level response to the recommendations contained within this report, and

   b) Agree that relevant officers will continue to update Scrutiny for 12 months on progress made against actions committed to in response to the recommendations, or until they are completed (if earlier).

REQUIREMENT TO RESPOND

2. In accordance with section 9FE of the Local Government Act 2000, the People Overview & Scrutiny Committee hereby requires that, within two months of the consideration of this report, the Cabinet publish a response to this report and its recommendations.

INTRODUCTION AND OVERVIEW

3. As the report of the Local Area Special Educational Needs and Disabilities (SEND) Inspection had not been published when the People Overview & Scrutiny Committee ('the Committee') met on 14 September 2023, the Committee resolved to convene an extraordinary meeting to consider it.

4. The Committee met on 2 October 2023 and invited the Interim Executive Director: People, Transformation, and Performance, Stephen Chandler, ('the Interim Executive Director') and the Interim Corporate Director: Children's Services, Anne Coyle, (the Interim Corporate Director') to attend to present the cover report which set out the indicative action plan development process and proposed governance arrangements and to answer the Committee's questions.

5. The Committee was grateful that the Leader of the Council, Cllr Liz Leffman, ('the Leader') as well as the newly-appointed Cabinet Members for Children, Education, and Young People's Services and for SEND Improvement, Cllr John Howson and Cllr Kate Gregory, also attended.

SUMMARY

6. During its meeting, the Committee heard from several parents and one young person about their experiences of SEND provision in Oxfordshire and the Committee was grateful to them for sharing their very moving experiences.

7. The Leader introduced the report by thanking the public speakers and by acknowledging that the Council had consistently let down parents over a long period of time and that the Council accepted the report in full. The Leader expected to see significant improvements in a very short period of time and was grateful to the Interim Executive Director and the Interim Corporate Director for their work on the Priority Action Plan ('the Plan') for the Local Area Partnership ('the LAP') which was due to be submitted by 27 October 2023.

8. The Committee recognised that the inspection was of the Local Area Partnership as an whole and the Priority Action Plan is the plan of the LAP as an whole. The Committee noted that the Joint Health Overview and Scrutiny Committee ('HOSC') had considered the report at its meeting on 21 September 2023 and that its questions focused on the partnership and on the health-related aspects of SEND provision. The Committee focused its questions more on education matters and on the Council's provision.

9. The Committee was pleased to hear an unequivocal acceptance of the report and the apologies made on the Council's behalf and of the resolve and commitment to rapid and systemic improvement. The Committee welcomed the ongoing openness to scrutiny of the Interim Executive Director and the Interim Corporate Director. At the same time, the Committee was conscious of the fact that the core leadership team is largely made up of interim appointments and that stability and continuity would be of benefit.

10. The Committee heard, and noted in the Ofsted report, that "[l]eaders openly acknowledge the urgent need for a 'reset' to repair the fractured relationships with parents and carers and other stakeholders." The Committee agreed that was essential. The Committee also heard a commitment to improving culture. The poor communication cited in the report had hindered the building of successful relationships and an element of restorative thinking and of building anew successful partnerships with families and with other stakeholders was key. This should include a commitment to co-production and a preparedness to engage with suggestions made by those who did not necessarily have an official relationship with the Council but did have positive contributions to make. Timely, clear, and charitable communication would be essential and the Committee was pleased to hear of the quality assurance work being undertaken in the area of responses to complaints.

11. The Committee considered that one factor was the difference between the strategic ambitions and the operational happenings and that one important element that would be helpful in improving the culture would be to conduct an audit of training available and to consider whether and where improvements were needed. One area that should be considered was whether the right training was provided by the right people in the right place, particularly in relation to neurodivergence.

12. One challenge of which the Committee was aware was the difficulties for small groups and organisations of providing support for those with SEND in the community. Many make a real difference but the limitations of funding are such that continued engagement is problematic. The Committee noted the existence of the Connected Communities Fund and called on the Council to consider how seed-funding could be appropriately paid out to groups to enable growth and sustainability.

13. The Committee commended the effectiveness of the outreach work undertaken by special schools in the county and considered it would be valuable were the Council to work with them to consider how best that work could be strengthened and extended.

14. The Committee discussed the situation with Education and Health Care Plan tribunals and explored if it would be appropriate to recommend that all applications for tribunals should be paused. The Committee was pleased to hear that a number of control measures had been put in place which should ensure that the number of tribunals should reduce markedly and that no such application would be undertaken without the agreement of at least the Deputy Director.

15. The Committee was keen to explore how it could best work with HOSC to scrutinise Children and Adults Mental Health Services ('CAMHS'), the challenges it was facing, and the resultant impact on children and families.

16. The Committee was very conscious that the report was a result of the inspection of the Local Area Partnership as an whole. That meant there was a challenge in identifying who was ultimately responsible for leading and holding to account. One of the challenges for the LAP would be to ensure that its leadership and responsibility was clear. The Committee observed that it was very important to build strong relationships with key partners across the LAP.

17. The Committee established that the Priority Action Plan would be shared with Cabinet before it was submitted to the Department for Education. The Committee emphasised that it was imperative that members of the Committee but also of the Council more widely were aware of the content of the Plan at the earliest opportunity to enable appropriate oversight and engagement. The Committee recognised, however, that there would be a fluidity and flexibility to the Plan up to the point of submission. The Committee also recognised that the Plan would be a high-level one but that there would be detailed tracking of the actions thereafter.

RECOMMENDATIONS

18. The summary of the discussion above sets out the particular themes the Committee drew out in its discussion and the areas for recommendations it sought to make. It provides the context for the recommendations as made by the Committee.

19. As stated in the report to Cabinet from HOSC, these recommendations of the People Overview and Scrutiny Committee are made jointly with HOSC and are addressed to the LAP as an whole. The Committee would welcome the same responses being provided to each Committee.

Recommendation 1: For Leadership over the Partnership and of Children and Young People's SEND provision to be explicitly set out and communicated clearly to families and all stakeholders; as well as clear measures of how leadership will be developed and demonstrated at all levels, and to demonstrate how new ways of working with stakeholders will put families at the heart of transformation.

Recommendation 2: To ensure good transparency around any action planning and the improvement journey for SEND provision for Children and Young People, and to develop explicit Key Performance Indicators for measuring the effectiveness of improvements that are open to scrutiny. The committee also recommends for more comprehensive action planning after the publication of the initial action plan requested by Ofsted, and for this action planning to be made fully transparent.

Recommendation 3: For the Leadership to adopt restorative thinking and practices with utmost urgency so as to reassure affected families, and for this thinking to be placed at the heart of any coproduction exercises to help families feel their voices are being heard as well as for the purposes of transparency.

Recommendation 4: To ensure adequate and timely co-production of action planning to improve SEND provision, and for the voices of Children and their families to be taken into account in tackling the systemic failings highlighted in the report. The committee also recommends that the Partnership considers timely allocation of seed funding for the development of co-production involving people with lived experience; and for joint commissioning of training and alternative provision across Oxfordshire, involving multi-agency stakeholders, the voluntary sector and families.

Recommendation 5: To continue to improve working collaboration amongst the Local Area Partnership so as to integrate support mechanisms and services as effectively as possible, and for rapid improvements to be demonstrated on clear and efficient information and patient-data sharing on Children with SEND.

Recommendation 6: For every effort to be made for children and young people with SEND to receive the support that is specifically tailored toward and appropriate to their own needs and experiences; and for those involved in providing support services to be aware of the additional/alternative services available which a child may also need a referral to. It is also recommended that improvements in one-to-one communications with families should be prioritised by Oxfordshire County Council, using the budget agreed by cabinet immediately following the Ofsted report.

Recommendation 7: To consider the use of digital resources for enablement, including at an individual level; and to ensure EHCPs are up to date and that they constitute living documents for families.

NEXT STEPS

20. The People Overview & Scrutiny Committee will review the published Cabinet response to this report and its recommendations at the meeting of the Committee after Cabinet's response in accordance with part 6.2, 13(f), of the Constitution of the Council.

21. The Committee will be considering the progress made against the Priority Action Plan, and SEND Improvement more widely, at subsequent Committee meetings during the coming year.

Contact Officer: Richard Doney, Scrutiny Officer
richard.doney@oxfordshire.gov.uk

Annex: Overview & Scrutiny recommendation response pro forma

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Annex - Overview & Scrutiny Recommendation Response Pro forma

Under section 9FE of the Local Government Act 2000, Overview and Scrutiny Committees must require the Cabinet or local authority to respond to a report or recommendations made thereto by an Overview and Scrutiny Committee. Such a response must be provided within two months from the date on which it is requested[1] and, if the report or recommendations in questions were published, the response also must be so.

This template provides a structure which respondents are encouraged to use. However, respondents are welcome to depart from the suggested structure provided the same information is included in a response. The usual way to publish a response is to include it in the agenda of a meeting of the body to which the report or recommendations were addressed.

Issue: Local Area SEND Inspection

Lead Cabinet Member(s): Cllr Liz Leffman, Leader of the Cllr John Howson, Cabinet Member for Children, Education and Young People's Services, and Cllr Tim Bearder, Cabinet Member for Adult Social Care

Date response requested:[2] 18 April 2023

Response to report:

Enter text here.

Response to recommendations:

Recommendation	Accepted, rejected or partially accepted	Proposed action (if different to that recommended) and indicative timescale (unless rejected)
To develop and introduce a Council wide staff retention strategy.		

[1] Date of the meeting at which report/recommendations were received
[2] Date of the meeting at which report/recommendations were received9

Annex - Overview & Scrutiny Recommendation Response Pro forma

To have a partnership approach to key worker housing with the District Councils, including exploring the potential for Section 106 funding.		

Divisions Affected – All

CABINET

17 October 2023

Local Area Partnership SEND Report 2023

Report of the Oxfordshire Joint Health Overview and Scrutiny Committee

RECOMMENDATION

1. The Cabinet is **RECOMMENDED** to **—**

   a) Agree to lead on developing a Local Area Partnership Level response to the recommendations contained within this report.

   b) Agree that the Leader; the Cabinet Member Children, Education and Young People's Services; the Cabinet Member for Special Educational Needs and Disabilities (SEND); and relevant officers will continue to update HOSC for 12 months on any progress made against these recommendations in light of some of the systemic failings highlighted in the Local Area Partnership SEND report published by Ofsted and the Care Quality Commission (CQC).

REQUIREMENT TO RESPOND

2. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must **respond in writing within 28 days of the request.**

INTRODUCTION AND OVERVIEW

3. The Joint Health and Overview Scrutiny Committee considered a report that was published by Ofsted and the CQC on Special Educational Needs and Disabilities (SEND) provision for children within Oxfordshire during its meeting on 21 September 2023.

4. The Committee would like to thank the Leader Cllr Liz Leffman; Cllr Liz Brighouse, the then Deputy Leader and Cabinet portfolio holder for Children, Education and Young People's Services; Stephen Chandler (Executive Director for People, Transformation, and Performance); Anne Coyle (interim Director for Children's Services); Rachel Corser (BOB ICB's Chief Nursing

Officer); and Daniel Leveson (BOB ICB Place Director for Oxfordshire) for attending and answering questions in relation to the report.

5. The Committee recognises the successes highlighted in the Ofsted/CQC report in relation to looked after children, disability services, early years, and SENDIASS; and notes the work involving the Oxfordshire Parent Carer Forum.

6. The Committee recognises the extent and depth of the Ofsted report, and feels that the appointment of a Cabinet Member with a specific SEND remit is an illustration that Oxfordshire County Council recognises the importance of tackling the failures highlighted by the report 'head on'; and that it plans to do so openly.

7. This report was also scrutinised by the People and Overview Scrutiny Committee, which has a constitutional remit over Children and Educational services, whilst HOSC scrutinised this in line with its remit over Health for all ages. The rationale behind HOSC's scrutiny of this Ofsted/CQC report (and on the broader aspect of Children's SEND provision more generally) is threefold:

   - HOSC has a constitutional remit over the Health of children, and this includes healthcare services provided to children.

   - The Local Area Partnership includes the BOB Integrated Care Board, which, as an NHS body, is a constitutionally-mandated subject of scrutiny for HOSC.

   - Children with SEND tend to experience a variety of challenges including; living with learning disabilities; having social and emotional wellbeing needs; as well as having difficulties with communication and interaction. Many children with SEND also have EHCPs; and can essentially be more are at risk of mental as well as physical health deterioration.

SUMMARY

8. As part of this item held on the 21 September 2023, the Committee heard from public speakers, which included parents of children with SEND who have expressed that they experienced challenges relating to their needs as well as in relation to the SEND services available. The Committee also heard from a spokesperson for Oxfordshire SEND Parent Action, who also expressed concerns around the experience of parents of children with SEND; and read out a list of actions which they had sent to the leader of the Council and that they wished to see implemented.

9. The Committee thanked the parents for speaking, and many of the members and officers present spoke about the powerful nature of these accounts. The Committee conveyed its apology for the system failures identified in the report.

10. The Committee Chair then initiated the item's discussion with a key overarching question of how the Leadership felt about the Ofsted/CQC report as well as how it planned to respond to the systemic failings highlighted by the Ofsted/CQC report. The Chair also enquired as to what reassurances the Committee could receive now, and on the publication of the action plan, to demonstrate that the co-production sought by families with lived experience will be at the heart of meaningful and timely improvements, and how trust will be rebuilt.

11. The Leadership of Oxfordshire County Council outlined a commitment to addressing the challenges and failings highlighted in the report. The Leader of the Council, Cllr Liz Leffman, stated that elected representatives had a responsibility to residents of the County to make sure that not only are they heard, but that they receive the services that they require, including in relation to SEND provision. The Leader also stated that whilst there were nationwide challenges with SEND provision, that does not take away the responsibility of the County Council to ensure that improvements to SEND services for children are made.

12. The Leadership of the Local Area Partnership also apologised over how affected families have had difficult experiences, and at how people have had difficulty in receiving good communication. It was cited that good leadership was key, particularly through ensuring good coordination with NHS partners also. It was noted that the cabinet had agreed an additional budget of £500,000 to immediately tackle communication failings. The BOB ICB Chief Nursing Officer also apologised and accepted that waiting lists for CAHMS were unacceptable. The Committee were assured that the NHS were planning to accelerate efforts to resolve the impact of an IT outage at Oxfordshire Health, and that they were looking at alterative support for children on waiting lists. The Chief Nursing Officer also highlighted the importance of good communication and openness.

13. It was also highlighted by the Executive director for People, Transformation and Performance that the CQC and Ofsted have asked the Local Area Partnership to produce a priority action plan within thirty working days of the publication of their report, and that the Partnership was committed to doing so as part of the action planning around this report's publication.

14. It was also emphasised to the Committee that since the publication of the report, the Local Area Partnership has agreed a series of workshops to produce the priority action plan; and that these workshops would include key stakeholders, initiating with the Parent and Carer Forum, which is independent from the local authority.

15. In regards to the role of leadership, the Committee was informed that the responsibility for the drafting of the action plan was jointly shared by BOB ICB's Chief Nursing Officer as well as by the Executive Director for People, Transformation and Performance. Additionally, the Parent and Carer Forum had worked on the Ofsted report and would be represented across the governance structures for the action plan.

OBSERVATIONS AND AREAS OF CONCERN:

16. This section highlights some key observations and concerns that the Committee has in relation to SEND provision for Children in Oxfordshire. Much of these concerns are centred around systemic failings that have been highlighted in the Ofsted/CQC report. These observations and areas of concern were also expressed during the formal meeting on 21 September 2023.

Importance and role of leadership: The Committee is seeking reassurances about clearly identifiable leaderships, and for a clearly identified single point of responsibility for EHCPs. The Committee also feels that reassurances of good leadership all the way down to the key points of contact across the system for the child and the family are crucial, and would like to see consideration of the development of SEND champions who have influence within their particular professional setting.

Confusion and information sharing: The Committee noted that the report highlighted that for most children, young people and their families who are affected by SEND, their experience can often be one of confusion. The Committee feels that it is imperative that we understand where this confusion is stemming from, particularly if this is due to a lack of clarity and clear availability of information on available services and how to access them. It needs to be ensured that children and their families are aware of the services available to them, and that they are aware of how to go about accessing these services, be they provided by Oxfordshire County Council, by schools, or by the NHS. The Committee also agrees with the report's emphasis that poor information-sharing could result in important knowledge of children, young people and their families not being connected across services efficiently and effectively. The Committee therefore wishes to see further improvements in how information is shared, and for it to be ensured that knowledge of children, young people and their families is connected across services more effectively and cohesively.

Waiting times: In light of the Ofsted/CQC report's reference to how childrens' and young peoples' needs are not consistently identified accurately or assessed in a timely and effective way right from the start, the Committee feels that there needs to be greater clarity on what measures will be taken to ensure swift diagnoses of SEND for Children who may be suspected of exhibiting this. Lengthy waiting times for help, which has also been highlighted in the report is also a significant issue which can result in further deterioration in the mental or physical health of Children with SEND as well as their families. The Committee wishes to see greater reductions in waiting times, and that it is pivotal for clear timeframes to be created for reducing any backlogs.

Listening to the voices of children and families: The Committee recognises that children and their families may feel frustrations that the views they express have not been listened to or taken into account. It is therefore crucial that people's voices are adequately taken into account

when designing as well as providing support services for children with SEND. Again, this is particularly important given that by not listening to the voices of affected children and their families, this can result in not merely a sense of hopelessness for such residents, but in greater deteriorations in their overall health and wellbeing. Additionally, it is crucial that any action planning or designing of improvements for SEND services takes lived experience into account so as to enable the services to be as personalised and effective as possible. The Committee also believes that there are inequalities implications if the voices of children and their families are not taken into account, as some children and their families may not be in a position to strongly advocate their experiences or case for support, and could, by implication, ultimately experience disproportionate disadvantages. Hence, the importance of listening to the voices of affected residents is relevant in two contexts. Firstly, this should be at the heart of any co-production exercises undertaken as part of action planning to improve children's SEND services overall. Secondly, affected children and their families should be listened to when providing specific services or support to them, so as to ensure personalisation of support as well as a stronger understanding of the specific kind of support that they require. Furthermore, the Committee was informed that the NHS was looking at the potential for the redesigning of pathways, and that this needed to be undertaken with staff across partners in the County and the University. On this matter, the Committee would expect co-production with families with lived experience to be at the heart of this work also.

Agency cohesion: The Committee understands that one area of improvement that was required, as highlighted by the Ofsted/CQC report, was that agencies within the Local Area Partnership work more cohesively overall to help achieve support for children at the right time. It is important that cohesion amongst agencies in the partnership is strengthened so as to ensure the smooth functioning of important aspects of SEND provision including; swifter diagnoses of SEND, support that is appropriate to a child, and good information-sharing amongst the partnership. Therefore, the Committee wishes to see greater cohesion amongst member agencies, and for there to be clear and evident steps of how this is being pursued, as well as any positive outcomes of such increased cohesion. Additionally, reassurances are also required on a timely resolution of the impact of the IT outage during 2022 at Oxfordshire Health.

***Staff training*:** That staff should receive training that is adequate as well as timely is crucial for the efficacy of SEND services. The Committee is concerned about the statement in the report that within schools, staff are not always well supported to understand and meet the different needs of children and young people with SEND. If there any particular reasons as to why or how staff are not being sufficiently supported in this regard, then this needs to be looked into as an urgent matter. If there are any statutory obligations on training for staff, then these obligations should be met, and mechanisms should be erected by the Partnership to facilitate this. It is crucial that school staff (or any other staff involved in children's SEND provision for that matter) are supported and trained for early identification

and intervention of SEND; as this will also be conducive to avoiding any potential negative outcomes on the mental and physical health of affected children in the long-run.

17. As such, the Committee believes that there is a need for clear action planning, that is both short-term and long-term in nature, so as to tackle all of the systemic failings highlighted in the Ofsted/CQC report. It is also crucial to note that action planning should be as transparent, as co-produced, and as holistic and joined-up as possible; with adequate input from lived experience and affected residents and families. The report highlighted multiple failings, and if either of these failings are not adequately addressed and resolved, then this could lead to a domino effect that would impact on the efficacy of any of the other aspects of children's SEND provision.

RECOMMENDATIONS

18. Given that this Ofsted/CQC report relates to an area that sits within the remit of two Scrutiny Committees, the recommendations highlighted below are separated into two lists. The first list contains a series of overarching recommendations aimed at the Partnership as a whole, and have been jointly developed by both HOSC and the People Overview and Scrutiny Committee. For completeness, both the HOSC and People Overview and Scrutiny Committee have included copies of these recommendations in their reports. The same responses should be provided to both Committees on the list of overarching recommendations below. The second list contains a series of recommendations made specifically by HOSC, taking into consideration the specific remit of HOSC over health. The second list is therefore centred around more health-related themes and a response need only be made to HOSC.

Overarching Recommendations (issued by HOSC and People's Scrutiny Committee):

1. For Leadership over the Partnership and of Children and Young People's SEND provision to be explicitly set out and communicated clearly to families and all stakeholders; as well as clear measures of how leadership will be developed and demonstrated at all levels, and to demonstrate how new ways of working with stakeholders will put families at the heart of transformation.

2. To ensure good transparency around any action planning and the improvement journey for SEND provision for Children and Young People, and to develop explicit Key Performance Indicators for measuring the effectiveness of improvements that are open to scrutiny. The Committee also recommends for more comprehensive action planning after the publication of the initial action plan requested by Ofsted, and for this action planning to be made fully transparent.

3. For the Leadership to adopt restorative thinking and practices with utmost urgency so as to reassure affected families, and for this thinking to be

placed at the heart of any co-production exercises to help families feel their voices are being heard as well as for the purposes of transparency.

4. To ensure adequate and timely co-production of action planning to improve SEND provision, and for the voices of Children and their families to be taken into account in tackling the systemic failings highlighted in the report. The Committee also recommends that the Partnership considers timely allocation of seed funding for the development of co-production involving people with lived experience; and for joint commissioning of training and alternative provision across Oxfordshire, involving multi-agency stakeholders, the voluntary sector and families.

5. To continue to improve working collaboration amongst the Local Area Partnership so as to integrate support mechanisms and services as effectively as possible, and for rapid improvements to be demonstrated on clear and efficient information and patient-data sharing on children with SEND.

6. For every effort to be made for children and young people with SEND to receive the support that is specifically tailored toward and appropriate to their own needs and experiences; and for those involved in providing support services to be aware of the additional/alternative services available which a child may also need a referral to. It is also recommended that improvements in one-to-one communications with families should be prioritised by Oxfordshire County Council, using the budget agreed by cabinet immediately following the Ofsted report.

7. To consider the use of digital resources for enablement, including at an individual level; and to ensure EHCPs are up to date and that they constitute living documents for families.

HOSC Recommendations:

1. For SEND commissioning to be developed using the Ofsted report as a baseline, and to place person-centred mental and physical health of children and their families with SEND at the centre of decisions on how funding is spent to maximise social value. The Committee also recommends for the Local Area Partnership to map all funding sources available for, and to explore joint commissioning of services and training that could improve the overall health and wellbeing for children with SEND.

2. To ensure that there is clarity of information on any physical or mental health services for children with SEND, so as to reduce the risk of confusion and lack of awareness of such services amongst parents, carers or families of children who require support for their mental or physical health.

3. To exercise learning from how other Counties and Systems have provided well-coordinated and effective SEND provision; particularly where

measures have been adopted to specifically reduce the tendency for poor mental or physical health amongst affected Children and Young People.

4. To ensure that staff involved in Health, Care, Education, and any relevant Voluntary Sector organisations are sufficiently trained and aware of children that may be neuro-divergent, have a learning difficulty or a disability (SEND); and for such staff to be adequately aware of the support and resources available, and the processes for referring such children for any relevant mental or physical health services that they might require.

5. For HOSC to continue to follow this item and to evaluate the impact of any changes or improvements made, with specific insights into the following; the Partnership's Action Plan as requested by HMCI; the overall measures taken to address the concerns raised by the Ofsted/CQC inspection; the progress made by CAMHS in reducing waiting times for treatment of children with SEND who require mental health support; and on how the NHS is working to increase the overall acquisition and availability of data on SEND childrens' mental health from key mental health providers.

NB The following recommendation was also made by the Committee, but specifically relates to NHS services. It is included for information and no response is required by Cabinet concerning it.

6. To work on reducing waiting times for CAMHS services for children with SEND who may show signs of worsening mental health, and to recognise and provide support to such children and their families whilst they are awaiting treatment.

FURTHER CONSIDERATIONS

19. The Committee intends to maintain ongoing scrutiny of the action planning and improvements being made by the Local Area Partnership in order to address the systemic challenges with SEND provision for Children highlighted by the Ofsted/CQC report. The Committee would like to be updated with and to receive evidence of the measures taken as part of relevant action planning. Clear evidence will also be sought for effective co-production and for the measures taken to ensure input from affected residents and families.

LEGAL IMPLICATIONS

20. Under Part 6.2 (13) (a) of the Constitution Scrutiny has the following power: 'Once a Scrutiny Committee has completed its deliberations on any matter a formal report may be prepared on behalf of the Committee and when agreed by them the Proper Officer will normally refer it to the Cabinet for consideration.

21. Under Part 4.2 of the Constitution, the Cabinet Procedure Rules, s 2 (3) iv) the Cabinet will consider any reports from Scrutiny Committees.

22. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must **respond in writing within 28 days of the request.**

Anita Bradley
Director of Law and Governance

Annex: 1 Scrutiny Response Pro Forma

Background papers: None

Other Documents: None

Contact Officer: Dr Omid Nouri
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Tel: 07729081160

October 2023

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Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Where a joint health overview and scrutiny committee makes a report or recommendation to a responsible person (a relevant NHS body or a relevant health service provider[this can include the County Council]), the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

This template provides a structure which respondents are encouraged to use. However, respondents are welcome to depart from the suggested structure provided the same information is included in a response. The usual way to publish a response is to include it in the agenda of a meeting of the body to which the report or recommendations were addressed.

Issue: Local Area Partnership SEND Report Scrutiny Item

Lead Cabinet Member(s) or Responsible Person:
Cabinet Member Children, Education and Young People's Services (Cllr John Howson)
Cabinet Member for Special Educational Needs and Disabilities (Cllr Kate Gregory)

To respond on behalf of the Local Area Partnership (Excluding the recommendation on reducing waiting times for CAMHS which is aimed specifically at the ICB).

Deadline for response: Tuesday 14th November 2022

Response to report:

Enter text here.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Response to recommendations:

Recommendation	Accepted, rejected or partially accepted	Proposed action (if different to that recommended) and indicative timescale (unless rejected)
1. For Leadership over the Partnership and of Children and Young People's SEND provision to be explicitly set out and communicated clearly to families and all stakeholders; as well as clear measures of how leadership will be developed and demonstrated at all levels, and to demonstrate how new ways of working with stakeholders will put families at the heart of transformation. (Overarching; made by HOSC and People's Scrutiny Committee)		
2. To ensure good transparency around any action planning and the improvement journey for SEND provision for Children and Young People, and to develop explicit Key Performance Indicators for measuring		

the effectiveness of improvements that are open to scrutiny. The Committee also recommends for more comprehensive action planning after the publication of the initial action plan requested by Ofsted, and for this action planning to be made fully transparent. (Overarching; made by HOSC and People's Scrutiny Committee)		
3. For the Leadership to adopt restorative thinking and practices with utmost urgency so as to reassure affected families, and for this thinking to be placed at the heart of any co-production exercises to help families feel their voices are being heard as well as for the purposes of transparency. (Overarching; made by HOSC and People's Scrutiny Committee)		
4. To ensure adequate and timely co-production of action planning to improve SEND provision, and for the voices of Children and their families to be taken into account in tackling the systemic failings highlighted in the report. The Committee also recommends that the Partnership considers timely allocation of seed		

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

funding for the development of co-production involving people with lived experience; and for joint commissioning of training and alternative provision across Oxfordshire, involving multi-agency stakeholders, the voluntary sector and families. (Overarching; made by HOSC and People's Scrutiny Committee)		
5. To continue to improve working collaboration amongst the Local Area Partnership so as to integrate support mechanisms and services as effectively as possible, and for rapid improvements to be demonstrated on clear and efficient information and patient-data sharing on children with SEND. (Overarching; made by HOSC and People's Scrutiny Committee)		
6. For every effort to be made for children and young people with SEND to receive the support that is specifically tailored toward and appropriate to their own needs and experiences; and for those involved in providing support services to be aware of the additional/alternative services available which a child may also need a referral to. It is also		

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

recommended that improvements in one-to-one communications with families should be prioritised by Oxfordshire County Council, using the budget agreed by cabinet immediately following the Ofsted report. (Overarching; made by HOSC and People's Scrutiny Committee)		
7. To consider the use of digital resources for enablement, including at an individual level; and to ensure EHCPs are up to date and that they constitute living documents for families. (Overarching; made by HOSC and People's Scrutiny Committee)		
1. For SEND commissioning to be developed using the Ofsted report as a baseline, and to place person-centred mental and physical health of children and their families with SEND at the centre of decisions on how funding is spent to maximise social value. The Committee also recommends for the Local Area Partnership to map all funding sources available for, and to explore joint commissioning of services and training that could improve the overall		

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health and wellbeing for children with SEND. (HOSC Recommendation)		
2. To ensure that there is clarity of information on any physical or mental health services for children with SEND, so as to reduce the risk of confusion and lack of awareness of such services amongst parents, carers or families of children who require support for their mental or physical health. (HOSC Recommendation)		
3. To exercise learning from how other Counties and Systems have provided well-coordinated and effective SEND provision; particularly where measures have been adopted to specifically reduce the tendency for poor mental or physical health amongst affected Children and Young People. (HOSC Recommendation)		
4. To ensure that staff involved in Health, Care, Education, and any relevant Voluntary Sector organisations are sufficiently trained and aware of children that may be neuro-divergent, have a learning difficulty or a disability (SEND); and for such staff to be adequately aware of the		

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support and resources available, and the processes for referring such children for any relevant mental or physical health services that they might require. (HOSC Recommendation)		
5. For HOSC to continue to follow this item and to evaluate the impact of any changes or improvements made, with specific insights into the following; the Partnership's Action Plan as requested by HMCI; the overall measures taken to address the concerns raised by the Ofsted/CQC inspection; the progress made by CAMHS in reducing waiting times for treatment of children with SEND who require mental health support; and on how the NHS is working to increase the overall acquisition and availability of data on SEND childrens' mental health from key mental health providers. (HOSC Recommendation)		
6. To work on reducing waiting times for CAMHS services for children with SEND who may show signs of worsening mental health, and to recognise and provide support to such children and their families whilst		

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

they are awaiting treatment. (HOSC Recommendation for ICB)		

Divisions Affected – All

CABINET

17 October 2023

Health and Wellbeing Strategy Update

Report of the Oxfordshire Joint Health Overview and Scrutiny Committee

RECOMMENDATION

1. The Cabinet is **RECOMMENDED** to **—**

   a) Agree to respond to the recommendation contained within this report.

   b) Agree that the Leader; the Cabinet Member for Public Health and Inequalities; relevant Public Health officers; the BOB Integrated Care Board; and District Councils will continue to jointly update HOSC for 12 months on progress made against actions committed to in response to the recommendation highlighted in the body of this report; which emphasises the imperative for an explicit criteria for monitoring the strategy's deliverability, and for exploring the prospect of enabling input from disadvantaged groups as part of this process.

REQUIREMENT TO RESPOND

2. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must **respond in writing within 28 days of the request.**

INTRODUCTION AND OVERVIEW

3. The Joint Health and Overview Scrutiny Committee considered a report by the Director of Public Health on Updating the Health and Wellbeing Strategy for Oxfordshire during its meeting on 21 September 2023.

4. The Committee would like to thank the Leader Cllr Liz Leffman; the then Cabinet Member for Public Health and Inequalities (Michael Oconnor); David Munday (Public Health Consultant); the ICB Place Director for Oxfordshire (Daniel Leveson); and the Executive Director for Healthwatch Oxfordshire (Veronica Barry) for attending and answering questions in relation to the report.

5. The Committee would like to express that it recognises the immense work being invested into developing and updating the Health and Wellbeing Strategy, and thanks system partners for their overall contributions to this work.

6. The Committee understands that the report they received did not constitute the official strategy document per se, but that it contained an outline of the key steps and developments taken as part of updating the strategy.

7. This report was scrutinised by HOSC given that it has a constitutional remit over health and healthcare services as a whole. When commissioning this report on the health and wellbeing strategy update, some of the insights that the Committee sought to receive were as follows:

   - The extent to which public consultation is at the heart of the work on updating the strategy.
   - Whether there is any new information on relevant public health patterns that would be used to inform any changes to the strategy.
   - How effective partnership working has been around coordinating and implementing the Health and Wellbeing Strategy thus far.
   - How the strategy particularly aims to target and support health and wellbeing amongst marginalised or deprived communities.
   - The extent to which there is synergy between the Health and Wellbeing Strategy and the Integrated Care Strategy.
   - Details of any criteria that may be adopted to assess the effectiveness of the strategy's design or delivery.
   - How the strategy will continue to work on promoting healthy living habits overall, and its interaction with other County-wide Public Health initiatives, including the work on promoting healthy weight.

SUMMARY

8. During this item held on the 21 September 2023, the Committee Chair outlined that the purpose of this scrutiny item was to examine the work undertaken by key actors and partners within the Oxfordshire system to update the strategy, and explained to the Committee that the report that has been received is not the official strategy document, but that it provides an outline of the work being invested into updating the strategy.

9. The Chair also urged for the Committee to have site of a draft of the strategy document prior to its ratification at the health and wellbeing board in December this year; so as to allow for an opportunity for scrutiny to provide feedback on the draft.

10. The Leader of the Council explained that the strategy is a product of a joint production of multiple system partners; including the ICB, the County Council, the District Councils, and Healthwatch Oxfordshire. In essence, this was a system strategy as opposed to being an Oxfordshire County Council strategy. The Leader outlined that the focus of the strategy was not on the nature of clinical services, but on the wider comprehensive building blocks of health, as well as how these building blocks play out at the level of Place. It was also emphasised to the Committee that the aim of the strategy was to focus on a few key set of priorities as opposed to everything and anything that related to health; and that the ultimate objective was to provide equity across the board.

11. The lead Oxfordshire County Council Public Health Consultant working on the strategy also explained the following points to the committee:

- That a lot has changed since the publication of the previous Health and Wellbeing Strategy; including the occurrence of the Covid-19 pandemic, which has had a significant impact on public health overall; as well as the cost-of-living crisis, which has also emerged since the previous version of the strategy, with significant implications on health and wellbeing.

- The way the strategy is formulated is that it is an objective plan, built out of the Joint Strategic Needs Assessment (JSNA).

- The Strategy also draws in the voices and experiences of residents and how they feel about the priorities around Health and Wellbeing.

- The BOB Integrated Care System's strategy also informs the wider Health and Wellbeing Strategy for Oxfordshire.

KEY POINTS OF OBSERVATION:

12. This section highlights some key observations and points that the Committee has in relation to the Health and Wellbeing Strategy and the work underway to update this. Much of these concerns are centred around ensuring clear coordination between system partners around the strategy, as well as ensuring effective transparency, delivery, and input from disadvantaged communities. These key points of observation were also expressed during the formal meeting on 21 September.

Cost-of-living crisis: The Committee noted that the report referred to the cost-of-living crisis. This crisis has clearly had an impact on families and households within Oxfordshire, and has at times significantly reduced the purchasing power of not only deprived communities, but also of ostensibly middle-income households. The cost of living can have a negative effect on the overall health and wellbeing of residents. Difficulties in affording healthy foods may occasionally render households being unable to have particularly healthy balanced diets. It is also the case that the financial

pressures of this crisis has, and can continue to have, strong ramifications on residents' mental health. The Committee therefore urges for stronger understanding and clarity, within the system as a whole, as to how the cost of living is impacting on the overall health and wellbeing of residents. It is pivotal that the work on updating the Health and Wellbeing strategy adequately takes this crisis into account, and explores avenues through which some of these associated challenges can be addressed in the long run.

Housing/Accommodation: The Committee notes that the report states that one of the building blocks of health is housing. It is evident that those individuals experiencing homelessness/rough sleeping, as well as those who may be living in unsuitable, overcrowded, or badly maintained accommodation, can experience challenges to both their physical as well as mental health and wellbeing. The Committee therefore urges that the role and importance of housing is thoroughly taken into account when updating the strategy, and that there is work with other partners within the county to help inform a stronger understanding of the role of housing, or to even explore avenues of support for residents whose health and wellbeing is undermined by poor experiences in housing. More work and coordination with Oxfordshire's District Councils is also key to ensuring that the overall aims of the Health and Wellbeing strategy trickle down to the local level of ensuring adequate and suitable housing.

Workforce recruitment and retention: The Committee understands that there have been recent challenges related to workforce recruitment and retention, which are not unique to Oxfordshire but are being experienced nationwide with respect to health and care services. Given that these workforce challenges are overarching in nature in that they could affect a multitude of services which can involve those contributing to what the strategy refers to the building blocks of health, it is crucial that these workforce challenges are adequately taken into account in the efforts to update this strategy. The priorities and aims of the strategy will only be met if there is sufficient resource to do so. A workforce that is adequate in number and that is also skilled should be considered a key ingredient for the implementation of the strategy's overall aims and objectives to improve health and wellbeing. It is also crucial that system partners work on promoting a culture and infrastructure for staff wellbeing.

Input from Disadvantaged Groups: The Committee believes that given that this is a system and county-wide strategy focusing on the building blocks of health, it is crucial that inclusivity is embedded in the strategy's development. On a fundamental note, what the report describes as the building blocks of health may be undermined if individuals do not have efficient access to healthcare services and support. Therefore, whilst this strategy may not be predominantly clinical in nature, it remains important for key partners to actively work on making information regarding the availability of services as explicit as possible, and for efforts to be made to reduce waiting times for services or treatments. That input from

disadvantaged groups should be fed into the strategy can be promoted in three ways:

1. There should be an explicit understanding of what the concept of disadvantaged groups implies; as in which specific population groups are experiencing the greatest disadvantage.

2. The known concerns and experiences of disadvantaged groups should be taken into account when developing and updating the strategy.

3. Disadvantaged groups should have an opportunity to provide direct input into the strategy inasmuch as possible; as well as into monitoring the deliverability and effectiveness of the strategy overall.

13. As such, the Committee believes that there is a need for clear coordination between system partners in developing as well as implementing the strategy and its principles. Transparency around the strategy's development and implementation is key, as well as the imperative to ensure input from residents; particularly those from disadvantaged communities.

RECOMMENDATION:

14. In light of having received a report on the strategy, as well as on the basis of the discussions had during the meeting on 21 September 2023, the Committee makes the following recommendation:

To ensure careful, effective, and coordinated efforts amongst system partners to develop an explicit criteria for monitoring the deliverability of the strategy; and to explore the prospect of enabling input/feedback from disadvantaged groups as part of this process.

FURTHER CONSIDERATIONS

15. The Committee intends to maintain ongoing scrutiny of the Health and Wellbeing Strategy, and would like to be able to have site of a draft version of the strategy document prior to its official publication. Moving forward, the Committee would like to be updated with, and to receive evidence of the measures taken as part of a delivery plan for the strategy, and of the effectiveness of its future deliverability.

LEGAL IMPLICATIONS

16. Under Part 6.2 (13) (a) of the Constitution Scrutiny has the following power: 'Once a Scrutiny Committee has completed its deliberations on any matter a formal report may be prepared on behalf of the Committee and when agreed by them the Proper Officer will normally refer it to the Cabinet for consideration.

17. Under Part 4.2 of the Constitution, the Cabinet Procedure Rules, s 2 (3) iv) the Cabinet will consider any reports from Scrutiny Committees.

18. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must **respond in writing within 28 days of the request.**

Anita Bradley
Director of Law and Governance

Annex:	None
Background papers:	None
Other Documents:	None
Contact Officer:	Dr Omid Nouri Scrutiny Officer (Health) omid.nouri@oxfordshire.gov.uk Tel: 07729081160

October 2023

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Where a joint health overview and scrutiny committee makes a report or recommendation to a responsible person (a relevant NHS body or a relevant health service provider[this can include the County Council]), the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

This template provides a structure which respondents are encouraged to use. However, respondents are welcome to depart from the suggested structure provided the same information is included in a response. The usual way to publish a response is to include it in the agenda of a meeting of the body to which the report or recommendations were addressed.

Issue: Health and Wellbeing Strategy Update Scrutiny Item

Lead Cabinet Member(s) or Responsible Person:
Leader of the Council and Chair of the Health and Wellbeing Board (Cllr Liz Leffman)
Cabinet Member for Public Health, Inequalities and Community Safety (Cllr Nathan Ley)

To respond on behalf of the System to the recommendation outlined below.

Deadline for response: Tuesday 14th November 2022

Response to report:

Enter text here.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Response to recommendations:

Recommendation	Accepted, rejected or partially accepted	Proposed action (if different to that recommended) and indicative timescale (unless rejected)
1. To ensure careful, effective, and coordinated efforts amongst system partners to develop an explicit criteria for monitoring the deliverability of the strategy; and to explore the prospect of enabling input/feedback from disadvantaged groups as part of this process.		

Divisions Affected – All

CABINET

17 October 2023

Oxfordshire Healthy Weight

Report of the Oxfordshire Joint Health Overview and Scrutiny Committee

RECOMMENDATION

1. The Cabinet is **RECOMMENDED** to **—**

   a) Agree to respond to the recommendations contained within this report.

   b) Agree that relevant officers will continue to update HOSC for 12 months on progress made against actions committed to in response to the recommendations, or until it is completed (if earlier).

REQUIREMENT TO RESPOND

2. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must **respond in writing within 28 days of the request.**

INTRODUCTION AND OVERVIEW

3. The Joint Health and Overview Scrutiny Committee considered a report by the Director of Public Health on Oxfordshire Healthy Weight during its meeting on 21 September 2023.

4. The Committee would like to thank the then Cabinet Member for Public Health and Inequalities (Michael Oconnor); David Munday and Derys Pragnell (Public Health Consultants), for attending and answering questions in relation to the report.

5. The Committee would like to express that it recognises the significant work being invested into promoting Healthy Weight throughout the County, and that it endorses this overall initiative to tackle excess weight..

6. This report was scrutinised by HOSC given that it has a constitutional remit over all aspects health as a whole; and this includes initiatives by the Council to promote healthy weight and to tackle excess weight within the County. When commissioning this report on Healthy Weight, some of the insights that the Committee sought to receive were as follows:

   - The extent to which the Covid-19 pandemic has resulted in increased excess weight amongst the population in Oxfordshire, and if so, whether there is a recovery from this trend.

   - How the work to promote Healthy Weight sits in the broader context of a preventative public health agenda, including in relation to Oxfordshire's Health and Wellbeing Strategy.

   - Details of any potential data relating to excess weight numbers, and if there are any identifiable patterns of excess weight and life expectancy that are Oxfordshire specific.

   - Details of what the underlying drivers and causes of excess weight might be, and whether these drivers are long-term or short-term in nature.

   - The extent to which co-production or co-delivery were at the heart of the work to tackling excess weight, as well as the degree to which a whole-systems approach is being adopted to tackle excess weight.

   - Whether there is a strong relationship between deprivation and excess weight, and how this relationship can be more thoroughly understood so as to create measures to address this.

   - Details of any potential challenges to tackling excess weight, including the degree to which residents might be receptive to the promotion of healthy living habits; whilst considering the factor of whether there is sufficient resource for all of this work.

SUMMARY

7. During this item held on the 21 September 2023, the Committee Chair outlined that the purpose of this scrutiny item was to examine the work undertaken to help promote Healthy Weight within the county; and that there will be a focus on the Whole Systems Approach to tackling excess weight.

8. The Chair also highlighted that the timing of this item is crucial given that excess weight affects many residents and families, and it is crucial for there to be plans in place to support residents living with excess weight as well as their families.

9. David Munday and Derys Pragnell (the two lead Public Health Consultants for the work on Healthy Weight) explained to the Committee that unhealthy

weight can often manifest within more disadvantaged communities, including some ethnic minority groups, within the County, and that the Whole Systems Approach aims to address this proclivity.

10. It was also explained to the Committee that the existing data on children and excess weight is stronger and more readily available as opposed to the data on adults, and that through utilising this data, one can observe that some areas manifest with more excess weight over a long period than others, with deprivation also being a key determinant of excess weight amongst children.

11. Nonetheless, the Public Health Consultants also stressed that the wider environment is also a factor in eliciting unhealthy weight, as opposed to deprivation per se. For instance, there are areas with a greater presence of fast-food outlets, which can create easily available unhealthy dietary options for families and children who reside in such areas.

12. The Committee were also informed that continuing to offer support to people who experience excess weight, alongside a prevention component is a crucial element of the Whole Systems Approach to healthy weight, and that particular services have been established for some ethnic groups as well as for men, whilst further considerations are being made for establishing more services to support women during pregnancy.

13. It was also emphasised to the Committee that the role of advertising of unhealthy products remains prevalent within Oxfordshire, and that much like other areas beyond the County, it was pivotal for this to be tackled. Residents that reside in areas with higher levels of excess weight are more likely to face exposure to such forms of unhealthy advertising, which could again relate to the presence of particular food outlets within these areas.

KEY POINTS OF OBSERVATION:

14. This section highlights some key observations and points that the Committee has in relation to the work on promoting Healthy Weight within Oxfordshire. Many of these observation points are centred around ensuring adequate support for residents in the context of the cost-of-living crisis and the associated challenges with affordability of healthier diets; identifying and providing support for population groups/communities that may struggle with healthy weight; the heavy presence of fast food outlets in certain localities, and exploring the role of licensing/planning in this regard; and the support being provided to families to promote healthy weight amongst children. The key points of observation outlined below were also expressed during the discussions.

Cost-of-living crisis: The Committee believes that the cost-of-living crisis has clearly had an impact on families and households within Oxfordshire. This crisis has rendered it harder for residents on lower incomes to afford to purchase foods that may contribute to having a healthy balanced diet overall. It is imperative that these financial strains are taken into account when tackling excess weight. There is a need for further clarity and

availability of support that residents can expect to receive to help achieve a healthy balanced diet in the context of a cost-of-living crisis. The Committee also feels that food banks need to be further supported in a manner that enables them to distribute more healthy foods for deprived communities and residents, particularly against a recent background of an increased reliance on food banks by households. It is also noteworthy that it is not only the purchasing power of deprived communities that has been drastically affected, but also that of ostensibly middle-income households. The Committee therefore urges for a stronger understanding and clarity, within the system as a whole, as to how the cost of living is impacting on weight and on healthy eating and the role of the market in this regard.

Ethnic groups and excess weight: The Committee understands that the report outlines that some ethnic groups are more likely to experience excess weight. It is therefore crucial that the system develops a stronger understanding of which ethnic groups tend to experience excess weight, as well as greater specificity of understanding on what the causes of this might be. If particular ethnic groups experience excess weight, then support should be provided to such groups in a way that takes cultural sensitivities into account, and in a manner that is receptive by particular population groups.

Advertising of products high in fats, sugars, salts (HFSS): The Committee recognises the role of advertising of unhealthy products, which remains prevalent within Oxfordshire. It has come to the Committee's attention that other areas beyond the County have implemented an array of measures to tackle the widespread availability and visibility of advertising for HFSS products. The Committee urges for Oxfordshire City and District Councils to learn from such initiatives implemented elsewhere to assess their efficacy, and to similarly adopt measures that have proven successful. It is particularly crucial that younger residents and children are not excessively exposed to such adverts. The Committee also understands that residents that reside in areas with higher levels of deprivation are more likely to face exposure to such forms of unhealthy advertising, which could be further exacerbated by the presence of particular food outlets within these areas.

Fast-food outlets and licensing: The Committee notes that the report states that areas of greatest socioeconomic deprivation have lower consumption of fruit and vegetables. The Committee urges for further investigations by the County Council into why this might be the case, and for exploring potential avenues of reversing this trend. The committee is also concerned regarding the dense presence of fast-food outlets in deprived areas throughout Oxfordshire, particularly in areas of consistently high excess weight and close to areas children congregate. A point of consideration might also be whether the heavy presence of fast-food outlets in deprived areas might also have some influence over the proclivity to have lower consumption rates of fruit and vegetables. In any case, the committee feels that the role of licensing/planning is crucial in this regard. Given the Council's emphasis on the wider environment surrounding

healthy living habits, considerations should be made for limiting the significant presence of fast-food outlets, particularly in areas close to schools which would require changes to policies and plans at District level. and to consider potentially working with District Councils on this.

Access to and awareness of support services: The Committee understands and notes that efforts are being made within the system to develop support services for residents living with excess weight. The Committee welcomes any initiative that aims to support residents with their weight, as this could be conducive to their overall physical and mental health. However, it is vital that individuals living with excess weight are aware of the support services available to them, and that there are clear and easy pathways of access for support. That support services should be transparent and easily accessible is important for two reasons:

- Families from disadvantaged or deprived communities may feel unable to communicate their experiences or concerns clearly, and a lack of transparency or complexities with referrals to or access for support can further add to these challenges.

- Some residents living with excess weight might suffer from low self-esteem or poor mental health, which can already render them to feel reluctant to seek support.

15. As such, the Committee believes that there is a need for a clear understanding of the root causes of excess weight, and for closer coordination between system partners, including the County Council, the NHS, as well as District Councils in further identifying trends in excess weight, and in developing measures to tackle some of the aforementioned challenges and concerns. Work to support ethnic minorities or vulnerable groups is also key, as well as thinking of how to address the degree to which residents, communities, and families may be receptive to messages around healthy weight and living habits.

RECOMMENDATIONS

16. In light of having received a report on Oxfordshire Healthy Weight, as well as on the basis of the discussions had during the meeting on 21 September 2023, the Committee makes the following recommendations:

1. *To ensure adequate and consistent support as part of secondary prevention for those living with excess weight; and to improve access to, as well as awareness of, support services that are available for residents living with excess weight.*

2. *To ensure effective support for ethnic groups that are more likely to develop excess weight, and to raise awareness amongst these groups of the support available to them.*

3. *To work on providing support to the parents, carers, or families of those living with excess weight, and to help provide them with the tools to help manage childrens' weight.*

4. *To explore avenues of support for residents who may struggle to afford healthy diets in the context of the cost-of-living crisis.*

5. *To ensure that consideration of the ill-effects of being underweight is also built into the language adopted, and the services being commissioned, as part of promoting Healthy Weight overall within the County.*

6. *In light of recent findings relating to the risks of excess weight medication (GLP-1 receptor agonists), it is recommended that the BOB Integrated Care Board review the availability of these medications and any associated risks; and to update the Committee on this.*

7. *To orchestrate a meeting with HOSC, to include senior Planning/Licensing officers, Chairs of Planning Committees of the District Councils, as well as the relevant Cabinet Member to discuss the planning and licensing around the presence of fast-food outlets in certain areas around the County and advertising of HFSS products.*

LEGAL IMPLICATIONS

17. Under Part 6.2 (13) (a) of the Constitution Scrutiny has the following power: 'Once a Scrutiny Committee has completed its deliberations on any matter a formal report may be prepared on behalf of the Committee and when agreed by them the Proper Officer will normally refer it to the Cabinet for consideration.

18. Under Part 4.2 of the Constitution, the Cabinet Procedure Rules, s 2 (3) iv) the Cabinet will consider any reports from Scrutiny Committees.

19. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must **respond in writing within 28 days of the request.**

Anita Bradley
Director of Law and Governance

Annex 1 – Scrutiny Response Pro Forma

Background papers: None

Other Documents: None

Contact Officer: Dr Omid Nouri

Scrutiny Officer (Health)
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Tel: 07729081160

October 2023

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Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Where a joint health overview and scrutiny committee makes a report or recommendation to a responsible person (a relevant NHS body or a relevant health service provider[this can include the County Council]), the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

This template provides a structure which respondents are encouraged to use. However, respondents are welcome to depart from the suggested structure provided the same information is included in a response. The usual way to publish a response is to include it in the agenda of a meeting of the body to which the report or recommendations were addressed.

Issue: Oxfordshire Healthy Weight Scrutiny Item

Lead Cabinet Member(s) or Responsible Person:
Cabinet Member for Public Health, Inequalities, and Community Safety (Cllr Nathan Ley)

For a response to be provided to all the recommendations outlined below (Excluding recommendation 6 which is aimed at the BOB Integrated Care Board)

Deadline for response: Tuesday 14th November 2022

Response to report:

Enter text here.

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

Response to recommendations:

Recommendation	Accepted, rejected or partially accepted	Proposed action (if different to that recommended) and indicative timescale (unless rejected)
1. To ensure adequate and consistent support as part of secondary prevention for those living with excess weight; and to improve access to, as well as awareness of, support services that are available for residents living with excess weight.		
2. To ensure effective support for ethnic groups that are more likely to develop excess weight, and to raise awareness amongst these groups of the support available to them.		
3. To work on providing support to the parents, carers, or families of those living with excess weight, and to help provide them with the tools to help manage childrens' weight.		
4. To explore avenues of support for residents who may struggle to afford		

Appendix 1: Health Overview & Scrutiny Recommendation Response Pro Forma

healthy diets in the context of the cost-of-living crisis.		
5. To ensure that consideration of the ill-effects of being underweight is also built into the language adopted, and the services being commissioned, as part of promoting Healthy Weight overall within the County.		
6. In light of recent findings relating to the risks of excess weight medication (GLP-1 receptor agonists), it is recommended that the BOB Integrated Care Board review the availability of these medications and any associated risks; and to update the Committee on this.		
7. To orchestrate a meeting with HOSC, to include senior Planning/Licensing officers, Chairs of Planning Committees of the District Councils, as well as the relevant Cabinet Member to discuss the planning and licensing around the presence of fast-food outlets in certain areas around the County and advertising of HFSS products.		

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Divisions Affected - All

Cabinet

October 2023

Area SEND inspection of Oxfordshire Local Area Partnership

Report by the Interim Corporate Director for Children's Services

RECOMMENDATION

1. **The Committee is RECOMMENDED to**

   (a) **NOTE the report of His Majesty's Chief Inspectorate;**
   (b) **NOTE the indicative action plan development process and proposed governance;**

Executive Summary

2. The County Council is jointly responsible with the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board (BOB ICB) for the planning and commissioning of services for children and young people with SEND in Oxfordshire.

3. There was an inspection by the Care Quality Commission (CQC) and the Office for Standards in Education (Ofsted) between 13 July 2023 and 21 July 2023. The report was published on 15 September 2023.

4. The inspection's outcome was that "There are widespread and/or systemic failings leading to significant concerns about the experiences and outcomes of children and young people with special educational needs and/or disabilities (SEND), which the local area partnership must address urgently".

5. The Council has unequivocally accepted the report as have partners.

6. Following publication of the report, His Majesty's Chief Inspector (HMCI) requires the local area partnership to prepare and submit a priority action plan (area SEND) to address the identified areas for priority action. Deadline for this submission is 27th October 2023.

7. The Priority Action Plan is being co-developed by the council and partners through 3 workshops, from 25th September to 3rd October. Discussion on progress took place with DFE representatives on October 6th.

Report

Priority Action Plan

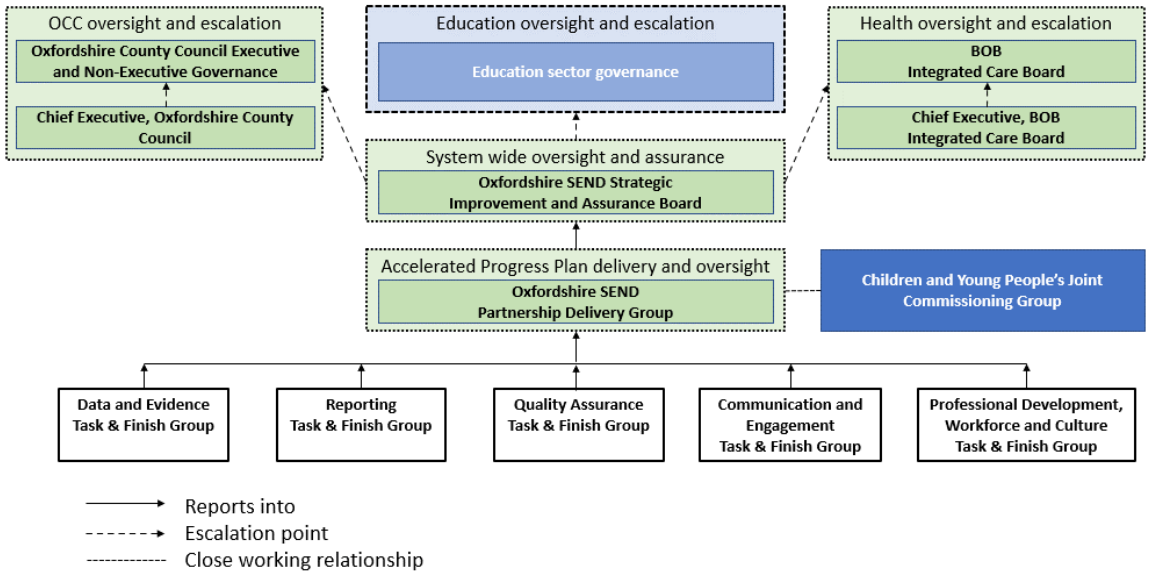
8. The Priority Action Plan (PAP) will be developed via 3x partner agency workshops. The first was held on Monday 25th September, with the others taking place on Thursday 28th September and Tuesday 3rd October. At these workshops, partners work together to develop an initial PAP, addressing the 5 priority actions and 4 areas for improvement identified in the inspection report. Workshop participants are comprised of the Oxfordshire SEND Partnership Delivery Group (see 13/14 below), Oxfordshire Parents Carers Forum, Headteachers and Academy Trust representatives, and members of the Education Commission. This ensures a collective partnership approach.

9. The draft PAP will be presented to the first meeting of the Oxfordshire SEND Strategic Improvement and Assurance Board (SIAB – see Governance and Monitoring below). This meeting will also ratify proposed governance arrangements and Terms of Reference for the SIAB.

10. The finalised PAP will be signed off by Martin Reeves (OCC, Chief Executive) and Nick Broughton (Chief Executive, BOB ICB).

Governance and Monitoring

11. Proposed governance arrangements are below:



N.B.: The above chart was originally presented to Health & Wellbeing Board on 5th October. Subsequent to this, the proposed Task & Finish groups have been amended. There are now 4 groups proposed, namely: Working Together, Journey of the Child, Preparation for Adulthood, and Leadership & Partnership.

12. As per its Terms of Reference, the Oxfordshire SEND Strategic Improvement and Assurance Board (SIAB) will meet monthly (with a review after 6 months) to provide strategic system and partnership leadership, assurance, and oversight of the areas of weakness identified in the inspection, across the local

area system in Oxfordshire for children and young people with special education needs and disabilities (SEND) and their families. It is proposed that the SIAB will have an independent chair.

13. The Board will provide oversight and assurance for the partnership delivery of the SEND Strategy, Action Plan, the Engagement and Participation Strategy and the SEND Communications and Engagement Strategies which contain additional and complementary work to the nine improvement priorities. The Independent Chair of the Board is accountable for reporting to the Department of Education and NHS England, progress against delivery of actions and outcomes within the Action Plan arising from the local area SEND inspection.

14. The Board will be supported by the Oxfordshire SEND Partnership Delivery Group (PDG) and, as necessary, any time limited Task and Finish Groups to respond to the areas of weakness. The SEND Partnership Delivery Group will take forward the co-ordination of partnership activity and monitor progress and impact of delivery in detail. It will liaise with OCC's Operational Groups who are responsible for local authority project delivery.

15. Membership of the SEND Partnership Delivery Group comprises staff from OCC, NHS Buckinghamshire, Oxfordshire & Berkshire West Integrated Care Board (BOB ICB), Oxford Health, Oxford University Hospitals, and Oxfordshire Parents Carers Forum. It will provide monthly assurance reports into the Board, and the SEND Strategic Improvement and Assurance Board Chair will meet with the Chair(s) of the SEND Partnership Delivery Group to ensure rapid tasking and clear accountability between the strategic and delivery assurance arrangements.

16. As per the Area SEND Inspections Framework, Ofsted and CQC will carry out a monitoring inspection around 18 months after the initial inspection. This will assess the extent to which the local area partners are taking effective action to address the areas for priority action set out in the inspection report, and the impact of actions on the weaknesses identified. These findings will be used to determine any further required intervention and/ or support (see Area SEND inspections: framework and handbook - GOV.UK (www.gov.uk).

Corporate Policies and Priorities

17. The report and its recommendations relate explicitly to the following priorities: tackle inequalities in Oxfordshire; prioritise the health and wellbeing of residents; create opportunities for children and young people to reach their full potential.

Financial Implications

18. Consideration of the action plan will include assessment of the financial implications involved.

Comments checked by:

Lorna Baxter,
Director of Finance, lorna.baxter@oxfordshire.gov.uk

Legal Implications

19. Consideration of the action plan will include assessment of any legal implications involved.

Comments checked by:

Anita Bradley,
Director of Law and Governance, anita.bradley@oxfordshire.gov.uk

Staff Implications

20. Consideration of the action plan will include assessment of any staffing implications involved.

Equality & Inclusion Implications

21. Consideration of the action plan will include assessment of any equality and inclusion implications involved.

Anne Coyle
Interim Corporate Director for Children's Services
September 2023

Annex: Area SEND inspection of Oxfordshire Local Area Partnership

Area SEND inspection of Oxfordshire Local Area Partnership

Inspection dates: 13 to 21 July 2013

Dates of previous inspection: 14 to 17 October 2019

Inspection outcome

There are widespread and/or systemic failings leading to significant concerns about the experiences and outcomes of children and young people with special educational needs and/or disabilities (SEND), which the local area partnership must address urgently.

A monitoring inspection will be carried out within approximately 18 months. The next full reinspection will be within approximately 3 years.

As a result of this inspection, HMCI requires the local area partnership to prepare and submit a priority action plan (area SEND) to address the identified areas for priority action.

Information about the local area partnership

Oxfordshire County Council and Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (ICB) are jointly responsible for the planning and commissioning of services for children and young people with SEND in Oxfordshire.

The commissioning of health services changed across England in 2022. In Oxfordshire, the responsibility for health services passed from Clinical Commissioning Group (CCG) to the Buckinghamshire, Oxfordshire and Berkshire West ICB on 1 July 2022. There have been more recent changes to some senior leadership posts in the local area partnership. These include the appointment of a new chief executive for the ICB and the recent appointment of an interim Director of Children's Services for Oxfordshire County Council, who has stepped up to this role since being in Oxfordshire since 2022.

Oxfordshire County Council commissions a range of alternative provision for children or young people, including for those who cannot attend school due to social, emotional, and mental health and medical needs, or for those who are at risk of or have been permanently excluded. Many of these places are commissioned at Meadowbrook College and the Oxfordshire Hospital School.

What is it like to be a child or young person with SEND in this area?

The experiences of children and young people in Oxfordshire depend on who they meet along their journey. If dedicated professionals recognise their needs early on, collaborate with others effectively and are then able to access the right support, they are one of the few whose needs are met. Sadly, this is too rare due to long-standing failings in local partnership arrangements. For most children, young people and their families, their experience is one of confusion and delay, alongside frustration that their presence and their voice are not listened to or valued. Consequently, many do not receive the right support or have their needs met effectively.

Conversely, children and young people who experience the pockets of stronger multi-agency working thrive. Where they encounter these dedicated practitioners, their quality of life is improved. As one young person commented, 'I now have a life worth living.' However, far too many children and young people are lost in the system. The processes that are intended to support them hinder them.

Children's and young people's needs are not consistently identified accurately or assessed in a timely and effective way right from the start. Where they are involved, early years settings, health visitors and school nurses do their best to identify and respond to emerging needs in babies, children and young people. However, there are lengthy waiting times for help and leaders have not acted effectively enough to ensure that appropriate support is available to mitigate the negative impact of excessive waiting times. While recent service changes are being implemented in some health teams, the impact of these changes are yet to be felt.

When families and professionals face an absence of early intervention, some feel the only way to get help is to secure support through an education, health and care (EHC) plan. Additionally, for those children and young people with an EHC plan, families too often report the need to intervene and advocate to secure provision in line with the plan for their child. This creates inequity in the system. Although the views of children, young people and their families are usually sought, they are not always listened to and acted on sufficiently well, for example when considering young people's views regarding how well their educational needs are being met.

Too many children and young people do not receive the right help until they are close to crisis point. This is hampered by the lack of cohesive communication systems between services across the partnership, which inhibits joined-up working. Poor information-sharing means that important knowledge of children, young people and their families is not connected across services efficiently and effectively.

In schools, staff are not always well supported to understand and meet the different needs of children and young people with SEND. Leaders know there is a lack of appropriate specialist settings and alternative provision (AP). This means that some children and young people are not able to get the right help quickly enough. At times, this contributes to the breakdown of placements, and leads to children and young people spending too much time out of school. Leaders recognise this and are planning a new

strategy to address these concerns.

Where children and young people receive support within specialist statutory teams, for example the Children's Disability Team, they receive timely assessment and appropriate advice to meet their needs. Here, practitioners effectively assess, review and support children and young people to achieve positive outcomes and experiences. For these children and young people, their transitions are well organised.

Children and young people who can access the right support and setting have their needs understood and met. This sets them up well for their future. For others, lengthy delays in finding the right setting to meet their needs means too many children and young people miss out on important learning and help for an extended time.

What is the area partnership doing that is effective?

- Recently appointed area leaders recognise the significant weaknesses of the current system and acknowledge the wide-ranging concerns found during the inspection.
- All agencies involved with looked after children with SEND have a sharp focus on working together to help them to achieve ambitious outcomes. This leads to effective monitoring and multi-agency work across the partnership for children living out of area. Their health, education and social care needs are prioritised. Consequently, their needs are better met and professionals work in partnership with parents and carers. Children are frequently seen by staff, including social workers, and their safety is prioritised.
- Early years practitioners get useful training and advice from the Early Years SEN Inclusion Team. They use the Early Years SEND toolkit to produce 'support and outcomes plans' that outline children's needs clearly. These plans guide practitioners to ensure that children work towards personalised outcomes one careful step at a time. This helps to prepare them for their next steps, if these are known and agreed.
- Where there is strong practitioner knowledge and expertise, children and young people benefit from cohesive, proactive planning for their needs. For example, families accessing the early help service benefit from plans that describe their needs well. The Learning Disabilities Child and Adolescent Mental Health Services team provides welcomed support and useful strategies to families and practitioners.
- The Oxfordshire Parent Carer Forum are committed to working with the local area partnership. They are well connected with training and workforce development initiatives and recently led on a well-received 'Moving into Adulthood' event alongside the partnership. Oxfordshire SENDIASS (SEND information advice and support service) is held in high regard by parents, carers and professionals. When they are able to access this, families receive helpful advice and training.
- Local area leaders acknowledge the lengthy waiting times for the neurodevelopmental conditions pathway. Children, young people and their families

are now being offered support while they are waiting for an appointment. Treatment and support are therefore moving towards a needs-led rather than diagnosis-led pathway.

- Many young people aged 18 to 25 who are known to adult social care receive effective assessment and intervention to meet their needs. Planning for transition is coordinated and avoids delays in meeting the needs of these young people into adulthood. This group receives professional support to participate in decision-making about their futures. Where professionals in further education settings know young people well, they help to support smooth transitions into young people's next steps.

What does the area partnership need to do better?

- Oxfordshire local area partnership has been characterised by frequent changes and interim arrangements in important roles within the SEND system. There is a disconnect between strategic thinking and operational practice which has contributed to a widespread lack of confidence in area leadership. This has negatively impacted the partnership's ability to undertake transformation and make sustainable change.
- Parent and carer confidence in the local area partnership to meet their children's needs is low. Around 2,000 parents and carers took time to share their views with inspectors. A tangible sense of helplessness runs through their descriptions of their lived experiences. These were typically about the years spent waiting or struggling to be heard to get support in education, health and care. Leaders openly acknowledge the urgent need for a 'reset' to repair the fractured relationships with parents and carers and other stakeholders.
- Agencies within the local area partnership do not work cohesively to ensure that children and young people get the right help at the right time. Although inspection activities supported multi-agency professionals to come together and understand more about children's and young people's needs, the absence of system-wide processes to support this collaboration on a day-to-day basis inhibits access to education, health and multi-agency services.
- The sufficiency of specialist provision is a significant area of concern. Too many children and young people are unable to access the education provision they need. Some wait for years. Despite their commitment to inclusion, some school leaders are unable to meet pupils' increasingly varied needs. This is due to a lack of suitable advice, guidance and support from specialists. Consequently, many school leaders and staff feel overwhelmed because they cannot support children and young people as well as they aspire to.
- Over time there has been little strategic oversight of AP. Area leaders do not know registered or unregistered providers well and relationships with commissioned providers have been notably weak. Area leaders, school leaders and AP leaders all have concerns about the effectiveness of the current system. Commissioning arrangements are unhelpful, and providers are concerned about delays in decision-making, including about transition arrangements.

- Many schools prioritise transition work. However, when there are delays to decision-making and naming suitable placements, this work is undone. Poor communication exacerbates this, adding to the feeling of helplessness expressed by many professionals, parents and carers. These delays impact planning and preparation for next steps.
- The timeliness of EHC plans has recently improved from the published 4% which are completed within the 20-week statutory time frame. EHC plans considered during the inspection rely heavily on education input. There is little inclusion of the contribution from health or social care. Internal quality assurance reviews are thorough and identify precisely where improvement is required. However, there has been no sharing of learning from this work. Therefore, this has not contributed to improving the quality of EHC plans. Frequently, EHC plans do not describe the child or young person accurately enough to ensure that their needs are met effectively, particularly at the point of transition.
- Co-production (a way of working where children, families and those that provide the services work together to create a decision or a service that works for them all) is undervalued across the partnership. Evidence indicates there is late-stage consultation rather than true co-production from the outset. Children's and young people's voices are not well heard or sought at the earliest opportunity. Parents and carers report communication both within and across the local area partnership as a significant challenge. They state that 'parents are the last to know', for example, if there are changes in professionals involved with the family.
- Children and young people with a high risk of admission for mental health concerns and/or placement breakdown are considered on the dynamic support register. All cases reviewed during the inspection demonstrated a lack of a multi-agency approach to meeting needs effectively.
- Commissioning does not always underpin the service provision needed in Oxfordshire. There is a lack of clarity in the planning and commissioning of services to meet the needs of children and young people. This leads to education and health services being unable to balance capacity and manifests in long waiting times for children and young people.
- Many service reviews and new projects are started. It is unclear if or when these are completed, or what the tangible outcomes are. As a result, parents and carers have lost faith in the area's ability to deliver on promises that have been made for impactful positive change. Leaders continue to work in a context where they are endeavouring to establish stability in key roles in the SEND system.

Areas for priority action

Responsible body	Areas for priority action
Oxfordshire County Council and NHS Buckinghamshire, Oxfordshire, and Berkshire West ICB	Leaders in the local authority, ICB and education, health and care providers should urgently prioritise systems to gather the views of children and young people with SEND effectively. Leaders should use these views to inform their strategic planning for, and evaluation of,

	SEND services that improve the outcomes and experiences of children and young people with SEND and their families.
Oxfordshire County Council and NHS Buckinghamshire, Oxfordshire, and Berkshire West ICB	Leaders in the local authority, ICB and education, health and care providers should develop communication systems across the partnership to improve the efficiency and quality of their information-gathering processes to ensure that children's and young people's needs are understood and met effectively through coordinated approaches.
Oxfordshire County Council and NHS Buckinghamshire, Oxfordshire, and Berkshire West ICB	Leaders across the partnership should establish rigorous processes to help ensure the improved timeliness and quality assurance of EHC plans. Leaders should use this learning to improve the quality of new and existing EHC plans.
Oxfordshire County Council and NHS Buckinghamshire, Oxfordshire, and Berkshire West ICB	Leaders across education, health and care should improve the commissioning of services to ensure that children, young people and their families receive sufficient support to better meet their needs and improve parental confidence in the SEND system.
Oxfordshire County Council and NHS Buckinghamshire, Oxfordshire, and Berkshire West ICB	Leaders, including education, health and care providers, should identify the steps that they will take to collectively monitor and measure the impact of their strategy and actions. These plans should be co-produced with and communicated clearly to children, young people and their families so that their experiences and outcomes improve.

Areas for improvement

Areas for improvement
The local area partnership should evaluate the quality and impact of services and joint working more effectively in order to inform improvements that lead to better outcomes and experiences for children and young people with SEND.
Leaders should improve their strategic approach to transition planning at all ages so that children and young people receive the right help and support they need to lead successful lives.
Leaders must continue to develop their oversight, strategy and commissioning arrangements of suitable alternative provision so that there is sufficient suitable provision that meets the needs of children and young people with SEND.
Leaders across the partnership should continue to address the long waiting times for children and young people requesting support from health services. The local area partnership should ensure that support is in place from health services for children and young people who are awaiting assessments.

Local area partnership details

Local Authority	Integrated Care Board
Oxfordshire County Council	NHS Buckinghamshire, Oxfordshire, and Berkshire West
Anne Coyle, Director of Children's Services	Nick Broughton, Chief Executive Officer
www.oxfordshire.gov.uk	www.bucksoxonberksw.icb.nhs.uk
County Hall New Road Oxford OX1 1ND	Buckinghamshire, Oxfordshire, Berkshire West ICB Sandford Gate Sandy Lane West Oxford OX4 6LB

Information about this inspection

This inspection was carried out at the request of the Secretary of State for Education under section 20(1)(a) of the Children Act 2004.

The inspection was led by one of His Majesty's Inspectors (HMI) from Ofsted, with a team of inspectors, including: one of His Majesty's Inspectors and an Ofsted Inspector from education and social care; a lead Children's Services Inspector from Care Quality Commission (CQC); and another Children's Services Inspector from the CQC.

Inspection team

Ofsted
Jo Petch, Ofsted HMI, lead inspector
Anna Gravelle, Ofsted HMI
Hilary MacDonald, Ofsted Inspector

Care Quality Commission
Lee Carey, CQC Lead inspector
Claire Mason, CQC Inspector

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Budget and Business Planning Report 2024/25 – 2026/27

Update to the section:

Dedicated Schools Grant (DSG) and High Needs Deficit

Paragraph 66

Dedicated Schools Grant

On 6 October 2023 the Department for Education (DfE) announced that the schools national funding formula that was published in July 2023 needs to be updated. This amendment is required to correct an error processing forecast pupil numbers, which means that the overall cost of the Core Schools Budget would have been 0.62% greater than the £59.6Bn funding available nationally for the Core Schools Budget. The additional £370m that would be needed nationally to fund additional costs resulting from error is not affordable within national funding for 2024/25.

Oxfordshire Schools' Dedicated School's Grant (DSG) was expected to increase by 3.12% to £503.9m in 2024/25, excluding growth funding. The impact of this correction is to reduce the provisional allocation by £4.6m to £499.3m (an increase of 2.19%). Behind the overall reduction the provisional Primary Unit of Funding has reduced from £5,067 to £5,022, and the Secondary Unit of Funding from £6,470 to £6,408.

Final DSG allocations for 2024/25 are expected to be notified in December 2023. Actual allocations for individual schools will re-calculated in December 2023, based on pupil data from the October 2023 census.

The 2024/25 high needs allocations (which fund provision for children with complex SEND) are unaffected, as are other funding streams outside the NFF, including the Teachers' Pay Additional Grant for 2023/24.

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Divisions Affected -

CABINET

17 OCTOBER 2023

OXFORDSHIRE SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2022-23

Report by KAREN FULLER

RECOMMENDATION

1. **The Cabinet is RECOMMENDED to**

   Cabinet are asked to note the contents of the report and its conclusions.

Executive Summary

2. The report summarises the work of the Oxfordshire Safeguarding Adults Board (OSAB) and its partners over the course of the year 2022-23. It is a requirement set out in the Care Act 2014 statutory guidance that the Local Authority receive a copy of the report and that they "will fully consider the contents of the report and how they can improve their contributions to both safeguarding throughout their own organisation and to the joint work of the Board" (Chapter 14, para 161).

3. The Report is not produced as a document but as a webpage. It is accessible via this link: Safeguarding Adults Board Reports - Oxfordshire Safeguarding Adults Board (osab.co.uk).

Background

4. Safeguarding Boards are required to share their annual reports with all statutory partners and those partners are expected to consider the report and its contents to decide how they can improve their contribution to both safeguarding throughout their own organisation and to the joint work of the Board *(S14.161, Care and Support Statutory Guidance).*

5. This report and the work of the Board will take on additional significance in light of the new Care Quality Commission Inspection regime, which will see the Local Authority inspected for the first time since Safeguarding Boards became a statutory requirement. Based on feedback received from the

inspection pilot areas, the Board will be asked for its view on the Local Authority and how they discharge their safeguarding function under The Care Act 2014.

Key Findings

Board work during 2022-23

6. Organisations have continued to see safeguarding as everybody's business and as a priority through many challenges (e.g. funding, recruitment, retention, sickness, reorganisations, industrial action, etc).

7. There has been an increase in safeguarding concerns across all types of abuse and neglect. This increase in concerns is replicated in other Local Authority areas across the country. There is no obvious reason behind this increase in concerns, but there is also a corresponding increase in the number of safeguarding (Section 42) enquiries that have taken place.

8. Despite challenging financial and workforce pressures and the against the continued backdrop of COVID, there is a narrowing gap between the life expectancy for people with a learning disability and the general population. The leading cause of death remains the same as for the general population.

9. The Making Safeguarding Personal approach has been championed throughout the year and there has been an improvement in the number of people who have defined what they wanted to happen as a result of the safeguarding work and who were satisfied with the work that was undertaken. This is excellent progress during a difficult year and demonstrates professionals are continuing to keep the person at the centre of their work with them, empowering them to make the decisions that are important to them and honouring that as much as they are able to whilst seeking to protect them.

10. The Board's annual frontline practitioner survey has indicated that there is still work to do to improve practitioner confidence with escalating concerns when there is a difference of opinion.

11. The Board's annual safeguarding self-assessment indicates that organisations continue to experience issues around recruitment, retention and resilience, which have been included in the impact assessment consistently since it was introduced.

12. As in previous years, Organisations also reported an increase in demand on their services. More people are presenting with multiple needs requiring the coordinated input of several organisations, which can be challenging for services.

13. There has been significant progress in the work of the Multi-Agency Risk Management (MARM) process, managed by the OSAB, since a dedicated Officer has been taken on to chair the meetings. Feedback from adults who are being discussed at the meeting has been positive, with some very positive

examples of adults changing the direction of their lives thanks to the hard work of those involved in the process.

14. Some of these have not been because of huge pieces of work carried out by individual organisations but from professionals attending the meetings, contributing to finding practical solutions (sometimes small things like sorting out a bus pass or helping complete application forms) that improve the persons' everyday lives and demonstrating their commitment to putting the person first.

15. Further information on the MARM process and the full summary report of its first year can be found here: Multi-Agency Risk Management (MARM) Framework - Oxfordshire Safeguarding Adults Board (osab.co.uk)

Board priorities for 2022-23 from the annual report (and mid-year current position)

16. The Board's Strategic Plan sets out its objectives for the next five years. This is reviewed annually to ensure that the priorities remain relevant and that new or emerging themes are incorporated, where necessary. Examples of key priorities are included below, but the full plan is available to read elsewhere on the Board's website OSAB Strategic Plan + Action Plan – 2023-27**.**

Ambition One: Working in Partnership

17. The Board is only effective if the partners around the table are working together to safeguard adults with care and support needs at risk of abuse and neglect. The Board will build upon the close working arrangements already in place to achieve the following:

1. The Board Members will work together as a partnership at all levels, looking to strengthen that relationship, empowering those working within our systems.
2. The Board and its partners will look for greater integration across the Adult and Children's Board, either at Full Board or at subgroup level. This does not have to mean combining the groups but reviewing Board processes and aligning the group agenda it may streamline some of the discussions.
3. All work will be done with the "so what?" question in mind. If work does not actively improve practice outcomes and is not linked to clear outcomes in the purpose of the work then it will not be taken forward.
4. The Board will work to improve the understanding of the roles and responsibilities of the organisations working with adults across Oxfordshire, what they offer, what are the thresholds for those services and what to do when there are professional differences of opinion about accessing services.

Ambition Two: Preventing Harm Occurring

18. It is always better to prevent harm occurring rather than responding once harm occurs. The Board will build upon the work that is already in place to achieve the following:

1. Improve the use of the Multi-Agency Risk Meeting (MARM) to assist providers who have cases that are not progressing, such as cases where there are lots of agency involvement but not necessarily a key lead, so that ideas and actions can be shared to improve outcomes. This requires a senior leadership ownership and active engagement to promote the process and hold their own and other organisations to account for its effectiveness.
2. Develop an overarching practice framework for the whole partnership, which includes restorative practice and trauma-informed working and clearly defines what these mean.
3. Develop an overarching commitment and strategy to tacking inequality and anti-discriminatory practice within safeguarding, and actively assess and respond to any identified issues.
4. Improve awareness of the safeguarding support available, the pathways and mechanisms e.g. how to trigger a statutory response before serious harm has occurred, amongst people most at risk and those supporting and working with them (perhaps using the Engagement Subgroup to do this?)

Ambition Three: Responding Swiftly when Harm Occurs

19. When organisations are alerted to abuse occurring, we are responsible as a system for responding swiftly and intervening as early as possible. The Board will build upon what is already in place to achieve the following:

1. Initiate a system-wide discussion on how we share information and intelligence in a way that reduces requests from information between partners (i.e. proactive information sharing), improving our intelligence and therefore the support we offer in an effort to reduce or remove the risks people are facing, where possible.
2. Adopting a collaborative problem-solving approach in the face of learning from MARMs, SARs, SI's and difficult or complex safeguarding events. This must come with an acknowledgement that decisions can be extremely complex with no clear right/wrong answer and we will not be able to protect everyone as well as we would want to.
3. Reviewing the Board's dataset to ensure that the Board is assured when an issue occurs that the system responds in a timely fashion and in line with Making Safeguarding Personal principles.

Ambition Four: Engaging Effectively with People at Risk

20. The Safeguarding Board and its partners should be engaging with those who are using services or have experience of the safeguarding process to better inform our work and improve how we react to incidents of safeguarding. The Board will work to achieve the following:

1. Hearing the voice of the adult at every meeting, whether it is a success story, a concern or just the experience of someone on the receiving end of our services
2. Consider an expert by experience at the Board or its subgroups or link into existing expert by experience panels run by partner agencies

3. Work closely with Advocacy organisations/providers to include the voice of those they work with are also heard at Board level
4. Review the strategic plan for 2024 onwards to co-create with people using our services the safeguarding priorities for the partnership

Financial Implications

21. N/A – The Local Authority is not being asked to commit any further financial resources towards the Board beyond what is currently committed.

Comments checked by: **James Thomas, Finance Business Partner**

Legal Implications

The Care Act 2014 requires Oxfordshire Safeguarding Adults Board (OSAB) to ensure that vulnerable adults are safe, and that agencies work together to promote their welfare. The Act sets out a legal framework for how local authorities and other organisations should protect adults at risk of abuse or neglect. The Board has a statutory duty to prepare an annual report on its findings of safeguarding arrangements in its area. There are no direct legal implications arising from the publication of the report.

Comments checked by: Anita Bradley Director of Law and Governance

Staff Implications

22. N/A – There are no additional staff resources being requested by way of this report for the work outlined in the Annual Report.

Equality & Inclusion Implications

23. N/A – there are no additional equality & inclusion implications.

Sustainability Implications

24. The Board have moved the majority of its work to a virtual environment, reducing travel congestion, and no longer prints any materials for Board meetings or training sessions, instead making these available electronically. It has also reduced printing & design costs by making more things, such as this annual report, plain text on the OSAB website.

Risk Management

25. The Board is made up of the partners who attend the meetings, supported by a small team in the Board Business Unit. If organisations do not continue to

provide the level of engagement with the work of the Board it is likely it would fail to meet its duties laid out in statute and its accompanying guidance. As the Local Authority is the organisation charged under The Care Act 2014 to ensure the Board is established and running well, this would represent a reputational risk. It is also likely any such failings would be highlighted under the new CQC inspection framework and in their resulting published report.

NAME	Karen Fuller, Corporate Director of Adult and Housing
Annex:	Annex 1 – One Page summary of the Report
	Full Report: Safeguarding Adults Board Reports - Oxfordshire Safeguarding Adults Board (osab.co.uk)
Contact Officer:	Steven Turner, Strategic Partnerships Manager, 01865 328993

[October 2023]

Annex 1 – one page summary of the report

Oxfordshire Safeguarding Adults Board Annual Report – 2022-23

6 Key Messages

1. Organisations have continued to see safeguarding as everybody's business and as a priority through many challenges (e.g. funding, recruitment, retention, sickness, reorganisations, industrial action, etc)
2. Safeguarding concerns have continued to rise (14% increase on 2021-22) as they have since 2018-19 (a 39% increase between these periods). This trend is in line with national and regional increases in concerns.
3. Safeguarding enquiries (those incidents deemed to meet the Care Act 2014 criteria for safeguarding) have also risen at a similar rate to last year and again in line with regional & national trends.
4. A person's own home remains the most likely place for them to experience abuse, with neglect remaining the most common type
5. Only 1% of people were unsatisfied with the outcome of the safeguarding work done to protect them
6. 80% of people deemed to lack capacity had an advocate (family, friend or impartial advocate)

5 Key Themes

1. Professional curiosity about a person's background or the veracity of self-reported information could be improved
2. Risk Assessments are often done in isolation without input from other agencies
3. Discussions about a person (e.g. in supervision) and the outcome/actions are not routinely recorded on the person's file
4. There is a lack of flexibility in our ways of working with people who professionals find complex or difficult to engage
5. Multi-agency/joint work is often seen as a last resort than an option for earlier intervention

4 Key Priorities for the Future

Working in Partnership

- Reviewing practical operational relationships with the OSCB and Safer Oxfordshire Partnership
- Improving understanding of the roles & responsibilities across organisations & the system

Preventing Harm Occurring

- Improve the knowledge and use of the MARM process to intervene early
- Develop overarching practice framework, including what trauma-informed work looks like

Responding Swiftly

- Adopt a collaborative problem-solving approach to learning from incidents
- Review the Board's dataset to ensure a swifter systemic response to issues

Engaging Effectively

- Bring Advocacy & 3rd Sector organisations into the Board's work to gather voices not currently heard at Board
- Involve experts by experience/service user voices in the work of the Board.

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Divisions Affected - All

Cabinet – 17 October 2023

Oxfordshire Safeguarding Children Board (OSCB) Annual Report

Report by Corporate Director of Children's Services

RECOMMENDATION

1. **Cabinet is RECOMMENDED to** note the annual report of the Oxfordshire Safeguarding Children Board senior safeguarding partners and to consider the key messages.

Executive Summary

2. This paper highlights findings from the Board's annual report on the effectiveness of local arrangements to safeguard and promote the welfare of children in Oxfordshire.

Background

3. Local multi-agency safeguarding arrangements are the collective responsibility of chief officers in the county council, the Integrated Care Board and Thames Valley Police.

4. These three senior safeguarding partners agree ways to co-ordinate their safeguarding services for children; act as a strategic leadership group in supporting and engaging others; and implement local and national learning including from serious child safeguarding incidents. They work with relevant partners through the Oxfordshire Safeguarding Children Board, under the leadership of an Independent Chair. The arrangement is referred to as the "Oxfordshire Safeguarding Children Board (OSCB)".

5. The report can be accessed in full on the OSCB website.

Key Issues

6. The OSCB Annual Report sets out the safeguarding challenges in Oxfordshire. The report shows the need to improve practice with respect to the themes of: (1) Neglect (2) Child exploitation and (3) Keeping children safe in education.

7. There are key messages for system leaders to bring a collective focus to:

"Ensuring early help is led and resourced at a senior level in line with the Children and Young People's plan"

"Ensuring organisations are doing everything they can to support safeguarding priorities of neglect, child exploitation and keeping children safe in school. This needs whole system change and should be everyone's business"

"Making sure capacity and demand issues in organisations are known across the partnership so we can tackle them together as a whole system. This includes issues of recruitment and retention of our highly valued workforce"

8. The Child Safeguarding Practice Review Annual report sets out what the safeguarding partnership can learn from the most serious and complex reviews.

9. Over the last year two Child Safeguarding Practice Reviews were commissioned and six Rapid Reviews completed. Practical learning from these reviews informed the OSCB training programme for local workers and volunteers. It also informed learning summaries, workshops and an online conference.

10. The strategic messages for system leaders from these reviews, are:

- The partnership took learning from repeat themes with moving from "What is wrong with you to what has happened to you "
- Recognise the importance of key adults in a child's life and involve them in any assessment made
- Avoiding using victim blaming language in reports referring to young people in any reporting
- The importance of understanding family dynamics including the history of the family and particularly in large families
- The importance of understanding the impact of historical intra familial sexual abuse
- Neglect was not recognised which led to significant harm of children
- More robust pre-birth assessment and planning is required
- Further understanding is required in neurodiversity and the impacts this has on parenting ability

11. The Performance Audit and Quality Assurance Annual report sets out what is understood about the effectiveness of safeguarding practice**.** The report has evidence of high standards of partnership working and acknowledges the complex challenges and pressures faced by workers over the pandemic. It summarises the common themes for learning and improvement to support vulnerable children. It concludes that:

12. **Our current priorities for system change are right – we just need more traction on making change happen.** This means helping practitioners learn how to identify early and deal with neglect; bringing together educational leaders to work on issues regarding exclusions and alternative provision to keep children safe in education; ensuring earlier and timely access to mental health and well-being services**.**

13. **We need to work better as one system.** We all need to think about how we work together based on what we have learnt. For example, reminding practitioners to use multi-agency chronologies, share information.

Corporate Policies and Priorities

14. The report outlines the Safeguarding Children Board's priorities, the learning from Child Safeguarding Practice Reviews, the outcomes of quality assurance work and the summarised findings with respect to the unexpected child deaths in Oxfordshire. The report supports the vision, values, objectives and strategic priorities in the County Council's Corporate Plan (see Corporate Plan).

Financial Implications

15. The Oxfordshire Safeguarding Children Board is funded by the local safeguarding partnership including the County Council, District Councils, the Integrated Care Boards, Thames Valley Police and the National Probation Service. The budget contributions and expenditure are outlined in full detail in appendix B of the report.

    Comments checked by:

Legal Implications

16. Working Together to Safeguard Children (2018) is a Department for Education (DfE) statutory guidance which 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. There are no direct legal implications arising from the publication of the Annual Report.

    Checked by: Anita Bradley Director of Law and Governance

Anne Coyle
Corporate Director of Children's Services

Annexes:

Annex 1: OSCB Annual Report
Annex 2: Child safeguarding practice review subgroup annual report
Annex 3: Performance, audit and quality assurance subgroup annual report

Contact Officer: Laura Gajdus. Business Manager - OSCB

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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

Contents

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

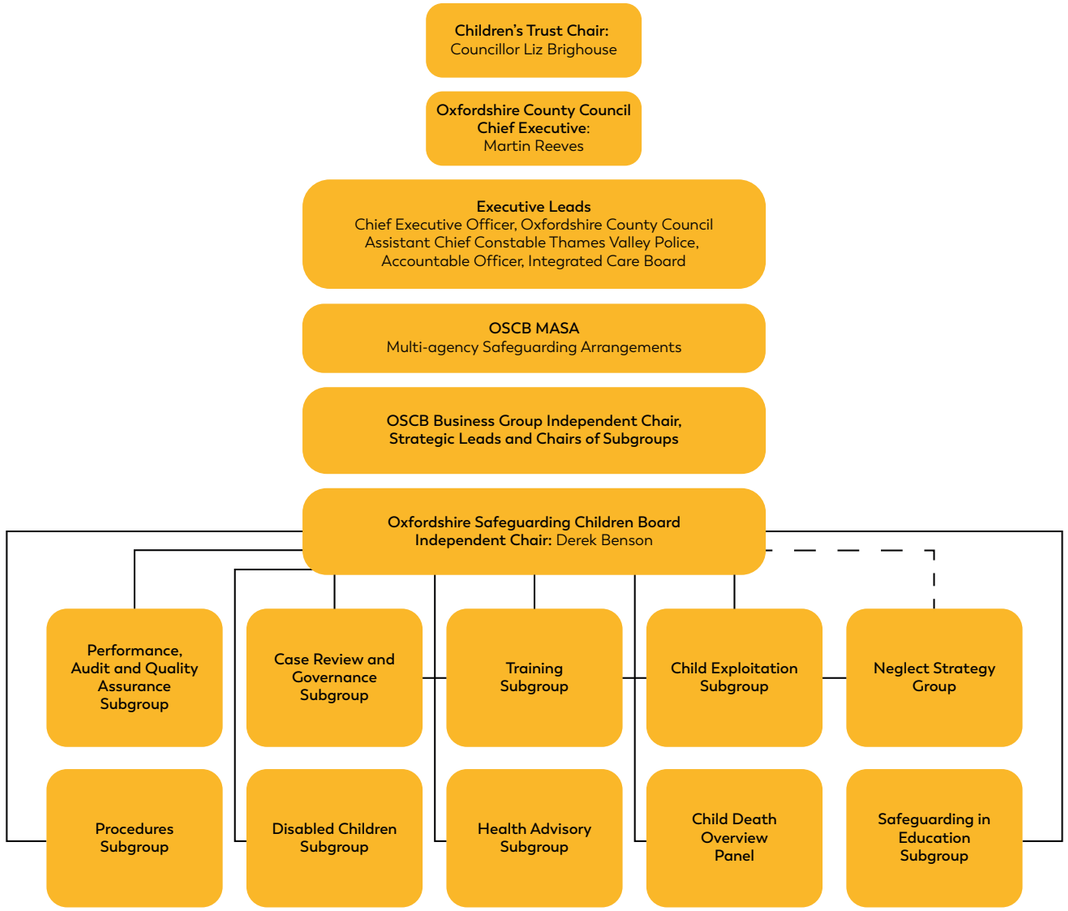
Jason Hogg
Chief Constable,
Thames Valley Police

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)

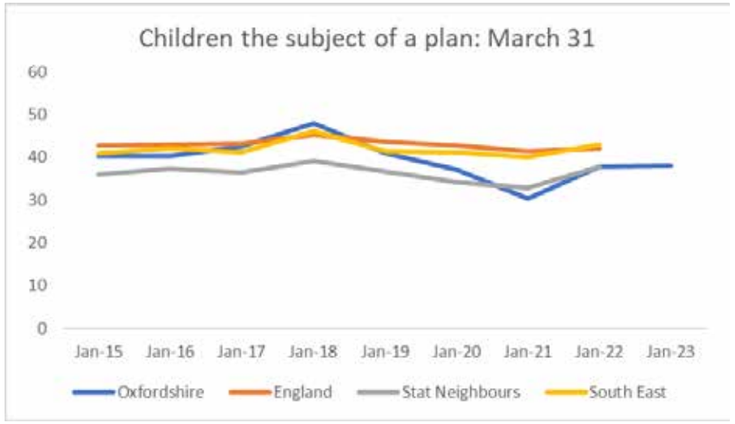
The Multi-Agency Safeguarding Hub (MASH) is the point of entry into Children's social care if there are significant concerns about the wellbeing of a child. It facilitates the sharing of information between services so risks to children can be identified at an early stage.

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.

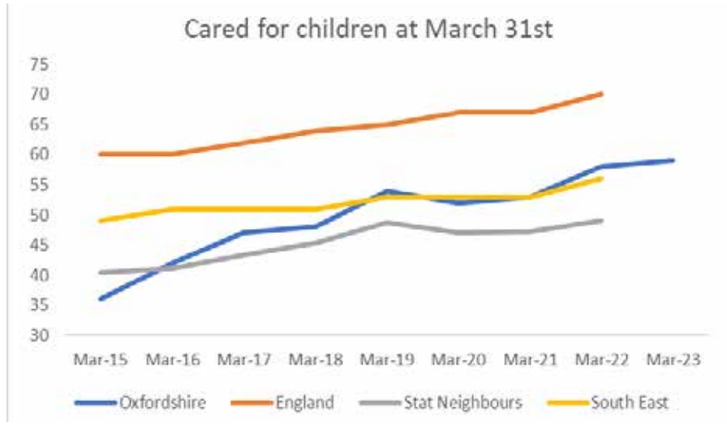
The expanded MASH Exploitation team is now live.

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

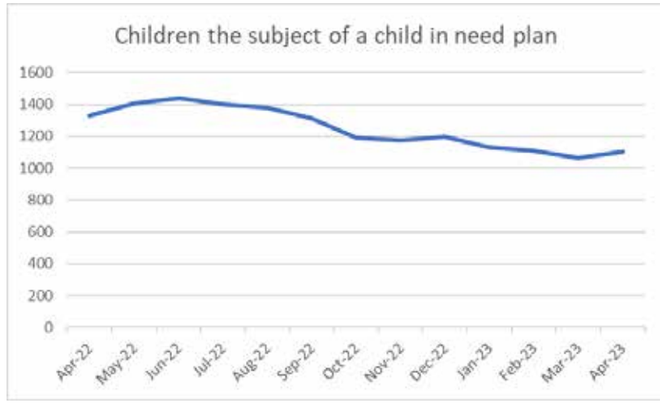


The number of cared for children rose in the year from 854 to 871. This was driven by an increase in unaccompanied asylum-seeking children (rising from 58 to 101) whilst the number of local children fell from 796 to 770. The number of children we care for is around 60 less than at the end of August and 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.

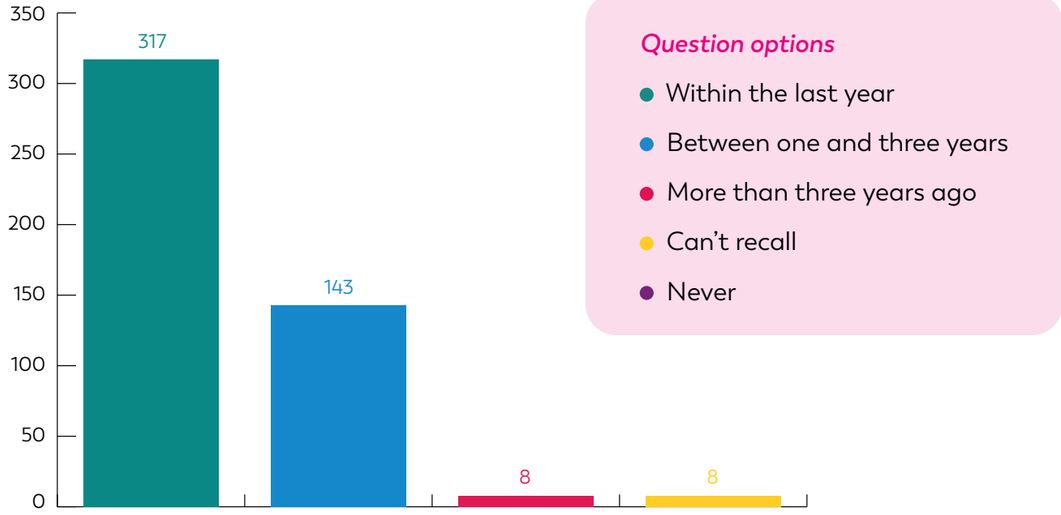
It provides agencies with the framework to measure and quality assure their safeguarding arrangements, and the opportunity to evidence the impact of policies and practice on children and adults in Oxfordshire, as follows:

- 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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Child Safeguarding Practice Review (CSPR) subgroup Annual Report 2022-23

Contents

Introduction

This is the 2022-23 annual report from the Chair of the Child Safeguarding Practice Review (CSPR) subgroup of the Oxfordshire Safeguarding Children Board (OSCB).

It covers information on all reviews considered and commissioned as well as any action taken over the last 12 months.

The CSPR subgroup

The purpose of the subgroup is to support the OSCB in fulfilling its legal duty to undertake reviews where the criteria[1] is met. It has the local duty to undertake reviews where learning could lead to improvements in practice. The aim is to help the OSCB learn from the most serious and complex situations and incidents.

The subgroup members come from:

- Thames Valley Police
- Oxfordshire County Council's children, Public Health, education and legal services
- The NHS through the Buckinghamshire, Oxfordshire, Berkshire Integrated Care Board, Oxford University Hospitals FT and Oxford Health NHS FT
- The local education community

National Context

The Department for Education's National Panel for Child Safeguarding Practice Reviews maintains national oversight of review work. Over the reporting period the National Panel for Child Safeguarding Practice Reviews has produced papers on the management of bruising in non-mobile infants, safeguarding children with disabilities and complex needs in residential setting an Annual Report for 2021- 22 as well as good practice examples of completing Rapid Reviews.

[1] Working Together to Safeguard Children (2018)

Serious Incidents

Serious incidents are referred for a Rapid Review in line with guidance in Working Together 2018. Appendix A explains how the Department for Education defines a serious incident.

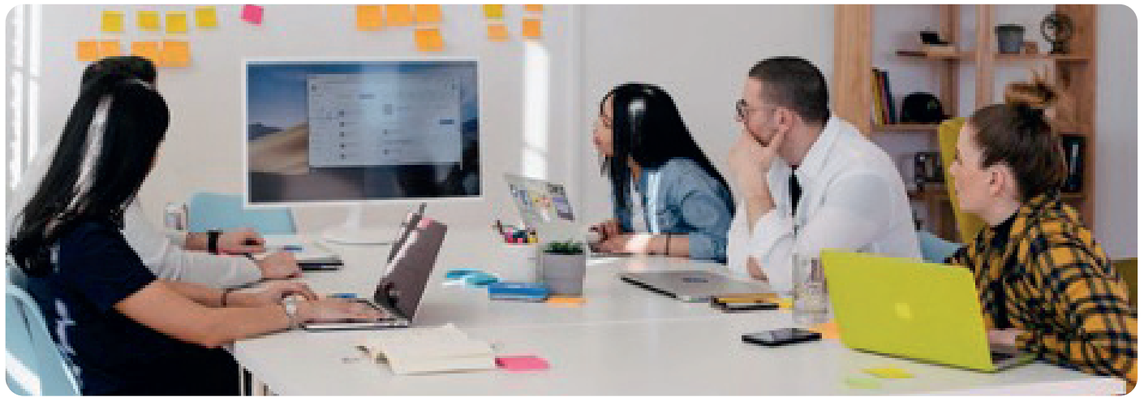
The CSPR subgroup also reviews cases referred by board members if they present concerns in how well agencies have worked together to safeguard children. This includes cases which may have met the (RTH) OUH Serious Incident Framework[2].

This year 6 serious incidents (where abuse and neglect was suspected)[3] were notified to Ofsted and 1 incident was referred for consideration. NB: Following the Rapid Reviews one of the incidents, concerning an infant death, was deemed to have no longer met the criteria. The thorough review removed suspicion of abuse and neglect. This is similar to last year, when there were 6 notifications and the preceding year when there were 9.

Rapid Review meetings held by the CSPR subgroup

The purpose of a Rapid Review is to decide if the criteria is met for a CSPR and if one is needed.

If work is already in place or there is no further learning to be gained, then it is not necessary to do a Rapid Review. These types of reviews are real-time and provide an insight as to how well the safeguarding system is operating now. Rapid Reviews concern current incidents. They guide us to current learning points.



[2] NHS England » Serious Incident framework

[3] There may be more serious incident notifications but the CSPR subgroup has only considered those, where abuse or neglect is suspected.

Analysis of Rapid Reviews

When a Rapid Review of a case takes place partners are very proactive in providing information held on the child and their family to ensure that as much information as possible is available to inform the review and ensure the child/ren are safeguarded.

	2022-2023
No. of agencies referring incidents for review	4
Rapid reviews held	6
Rapid reviews involving safeguarding partners outside Oxfordshire	3
CSPRs initiated following the Rapid Review	2

Of the six serious incidents reviewed this year 2 were non mobile infants.
Sadly 1 infant died – possibly as a result of parental rollover.
The remainder were all aged between 10 and 16 years.

Analysis of the seven Rapid Reviews held:

- Two of the Rapid Reviews concerned infants under the age of 1 year
- The next biggest group of children are aged 10-16 years
- One young person was aged 17 years and he was detained in an YOI at the time of the incident
- The largest ethnic group is white British
- The majority of children were subject to chronic harm and did not die but did impact significantly on their development and well-being
- The largest subcategory of serious harm has been by neglect followed by intra familial sexual abuse
- The Rapid Reviews have delivered high quality local learning
- Two Rapid Reviews recommended a CSPR be commissioned, and these have been completed

[4] Review in this context means Child Safeguarding Practice Review

Serious Incidents

Child A

- This review was signed off in September 2022.
- The review concerned a child who was seriously self-harming and at risk of suicide. She was accommodated in residential placements out of county.

Completed actions include:

- The development of the strengths and needs assessment for early help work.
- Communication with the National Panel, the Secretary of State and Oxfordshire MPs regarding placement sufficiency.
- The importance of good working relationships between professionals - keeping the child at the centre.

Delayed publication of CSPR Child G

- This review was signed off in July 2022. It concerned an adolescent who was sexually exploited whilst living in independent accommodation under the care of the local authority.
- Key pieces of work include the learning events run in November 2022 on trauma informed practice; trauma and parenting; understanding challenging behaviour and secondary trauma.
- Due to changing circumstances in Child G's life it was agreed to delay publication so they would be able to engage with the process.

Rapid Reviews (including key issues)

Case	Ofsted notified?	Decision type	CSPR meeting	Presenting issues
Child 1	Yes	Rapid Review	11 May 2022	Intra familial sexual abuse – adults and children
Child 2	Yes	Rapid Review	13 July 2022	SUDI possibly due to rollover by parent. Issues of homelessness, alcohol use, Domestic Abuse, insufficient pre-birth assessment
Child 3	Yes	Rapid Review	10 August 2022	Chronic neglect. Issues of early parenting concerns, cross border movement of parents, large family network
Child 4	Yes	Rapid Review	8 September 2022	Intra familial sexual abuse between siblings. Issues of family isolation, underpinned by parental profound religious beliefs, very large family network
Child 5	Yes	Rapid Review	October 2022	Chronic neglect compounded by the child sustaining serious injuries after falling 40 metres. Issues of previous parenting concerns, large family network, children being Electively Home Educated, families moving across borders
Child 6	Yes	Rapid Review	February 2023	Non mobile child sustained significant injuries. Issues of parental capacity, homelessness, insufficient pre-birth planning, 3 different men in the child's life by 8 weeks old, domestic abuse
Child 7	No	SIN due to incident in YOI	July 2022	Notification from a YOI to say an Oxfordshire child (along with 6 others) had been involved in a serious assault of another young person

Learning points this year

Rapid Reviews and cases for consideration concern existing incidents. They guide us to current learning points. Over the last 12 months the CSPR subgroup picked up on the following repeat themes for local safeguarding practitioners.

- Moving from "What is wrong with you to what has happened to you"
- Recognise the importance of key adults in a child's life and involve them
- Use non blaming words and language about a young person – they are always the victim
- It is important to understand family dynamics including the history of the family and particularly in large families
- The past can often inform the now
- It is important to understand the impact of historical intra familial sexual abuse
- Think creatively of ways to safeguard a young person – do not be bound by procedures
- Parents may physically chastise a child to manage their presenting behaviours. Whilst it is not illegal to hit a child/young person the impact of physical violent on the child should not be underestimated
- Neglect not being recognised and leading to significant harm of children
- More robust pre-birth assessment and planning is required
- Bereavement of key family members who could have supported parenting
- Understanding neurodiversity and how it may impact on parenting ability
- Knowing the right service to support a parent
- Understanding an assessing individual needs in large families

Reflections from partners

The focus of the OSCB continues to be inclusive with the partnership and remembering that safeguarding children is everyone's responsibility.

In contrast partners can feel 'done to' as opposed to taken along. Colleagues in Children's Services can feel the responsibility lies with them. None the less, the commitment of partners in Oxfordshire remains strong with a culture of professional challenge, openness, escalation (including the re-launch of Escalation policy now called Resolve) and learning.

Partners value the opportunity of working together to explore cases in depth and ensure that the learning from cases is disseminated throughout the partnership.

Reflections from independant reviewers

Jane Wiffin

- *It was a pleasure undertaking my LCSPR in Oxfordshire- Business Office very supportive.*
- *Good communication. well linked in with partner agencies. The review process was a little arduous - the consultation process with all having a slightly different view. Led to many changes.*
- *Professionals were open - lack of defensive willing to learn.*
- *Everyone took LCSPR process seriously. Committed time and effort.*

Sarah Holtom-Fawcett

- *Excellent business support from the team and paying particular thanks to CB. It really works as a reviewer to have a named support person and CB is super-efficient and very easy to work with.*
- *Able to hear and talk about the difficult things/barriers in agencies and across the partnership and commitment seen from practitioners and senior managers to make the changes to systems and strengthen practice where required*
- *Attention to detail in the draft reports from CRAG - at times there was perhaps a little too much debate over sentences / words in the report in meetings which could have been approached in a more efficient way with email feedback for consideration*
- *Good focus on ensuring family participation. In the Review regarding Sibling Sexual Abuse - I wonder if comment could be made regarding the timing of approaching families as wider learning for the National Panel when they expect certain timeframes. In many situations it is unrealistic to have a 6-month schedule for completion and expect the family to be able to contribute meaningfully when other processes may be ongoing or they family may not be in a psychological space to feel able to think about things*
- *I would also add that KB was a very skilled and experienced Business Manager - she was relational, authoritative when required and kept everyone to task in the Review process. Her knowledge about practice and systems in Oxfordshire across the partnership was impressive. It was clear to see how well respected she was by her Team / seniors and practitioners.*

Family Involvement

The OSCB always tries to involve family members and those who have cared for the children whose cases are being reviewed.

As highlighted by Sarah Holtam–Fawcett it is important to understand the impact of a serious incident affecting their child and to be led by their ability to process events. It is also important to be available to families should they have any queries.

Costs, timeframes, and process

Costs vary according to the type of review, its complexity, duration and the level of practitioner and family involvement.

They can range from approximately £8,000 to over £20,000.

Sharing Learning

The CPSR subgroup shares learning from each Rapid Review with safeguarding partners such as the Housing Forum and Safeguarding Trainers at regular intervals. Online learning events were run and follow up sessions.

For those registered with the OSCB booking system they can still be accessed as follows: OSCB.training@oxfordshire.gov.uk

Impact of reviews

OSCB Reviews keep recommendations to a minimum to ensure they are focused and have impact.

The following are examples of change as a direct result of recent reviews:

- ☑ Raising awareness of 'placement insufficiency' for children with the most complex set of needs through regional work.
- ☑ Improving the online system for 'multi-agency chronologies' (MAC) to build a full picture of what is happening in the life of a child /family who is subject to child protection planning, particularly for neglect.
- ☑ Improving the Thresholds of Needs Document to better capture family background information and make connections between mental health services and children's social care when they are determining what level of needs a child has.
- ☑ Development of a bruising protocol so that practitioners better know how to recognise signs of abuse in older children.
- ☑ Creation of a kit for schools to help them know 'who to call' and what help is available if they are worried that a child is at risk of exploitation.
- ☑ The revised tool for screening the risk of child exploitation will be launched in early Summer 2023.
- ☑ The Resolving Professional Issues between Professionals will be launched early Summer 2023.

Conclusion

This report evidences the commitment of members of the CSPR subgroup who aim to be dynamic and responsive and to unplanned incidents involving children.

This group meets monthly so that it can respond to urgent issues involving children living in Oxfordshire.

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Performance, audit, and quality assurance (PAQA) subgroup

Annual Report 2022-23

Page heading?

System-wide view on safeguarding work:
The subgroup[1] looks at how partners are managing children's safeguarding. This is done in different ways.

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

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

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

Data:
We review facts and figures against local targets.

[1] The list of Subgroup members is provided on the final page of this report.

Safeguarding audits and assessments done by OSCB agencies

In 2022/23 The group reviewed safeguarding audits from 12 large services which come into contact with children. They considered how well safeguarding is included in their daily work. The audits were presented by:

- Thames Valley Police
- Education
- Domestic Abuse Services
- Acute Health Services
- CAHMS
- A/E
- School Nursing service
- Health visiting Service
- Local Authority Children's Services
- Probation Service
- Local Authority Designated Officer (LADO)

(Some partners completed more than 1 audit on different themes).

Subjects of audits included:

Domestic Abuse

- The effects (both long and short term) for children living with Domestic Abuse
- How many domestic abuse incidents resulted in criminal prosecution
- The rise of child on parent Domestic abuse
- Domestic abuse in the digital world
- The normalising of domestic abuse among young people

Education

- Children Missing Education is increasing
- Children are safer when accessing education
- The significant increase of children being Electively Home Educated (EHE)
- When asked why they **decised??** to EHE their child parents site significant mental health and anxiety as a reason. However very few parents access specialist services such as CAHMS to support their child
- The number of exclusions/permanent exclusions of children and how they can be supported to access education

Health services

(i) Acute services

- The number of children/young people presenting to A/E having self-harmed
- The relationship with Think Family in supporting families

(ii) CAHMS

- Waiting time to access the service
- The significant increase in children presenting with eating disorders
- Resulting in delay in accessing the Eating Disorder services

(iii) School nursing Services

- Supporting children and young people who are struggling to manage in mainstream school
- Is the service compliant with their safeguarding procedures

(iv) Health visiting service

- Post visit notes/recordings
- Caseloads of Health Visitors
- Safeguarding issues

Police

- How information is collated and shared at Child Protection Conferences (CPCs)
- How incidents of Domestic Abuse are managed
- If police are compliant with national and local safeguarding children protocols

Children's Services

- Children Looked After (CLA)
- Increased numbers of children entering the care system (particularly older children)
- The impact of increased numbers of children on services provided including placements
- The care of unaccompanied asylum seeking children becoming CLA
- The quality of health assessments of CLA

Frontline teams

- There has been an increase in children becoming subject to Child Protection plans
- Children becoming subject to repeat child protection plans
- Recognising Neglect as a key issue in repeat Child Protection Plans

Local Authority Designated Officer (LADO)

- Increased scrutiny of adults in positions of trust working with children
- The type of allegations and how they are managed
- The link between children's and adults safeguarding

These are just a few of many examples from the services showing how safeguarding is part of their business-as-usual.

After every audit an action plan is developed which is monitored by the Members of the PAQA sub committee. Auditing can be an indication of safe practice in organisations working with children. It can also give a context of the work; good practice and work needed.

This year the chair commended a number of practitioners presenting their audit reports for the quality and detail given in their report. The subgroup has confidence that these services have good oversight of safeguarding and their auditing is to good effect.

Picture?

Self-assessment by OSCB agencies

Oxfordshire's Safeguarding Self-Assessment formally 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:

- Demonstrate how safeguarding and promoting the wellbeing of children, young people and adults is prioritised within your organisation and provide evidence of how your organisation has been able to learn and improve your safeguarding practice
- Measure the effectiveness of safeguarding arrangements and joint working to protect the children, young people and adults with care and support needs
- Identify good practice and areas for development within your organisation to support improvement / development plans for your organisation
- Enable the OSCB/OSAB to identify training needs and plan for the provision of training, and development of tools and resources to support practice

Picture?

Multi-agency Safeguarding self-assessment

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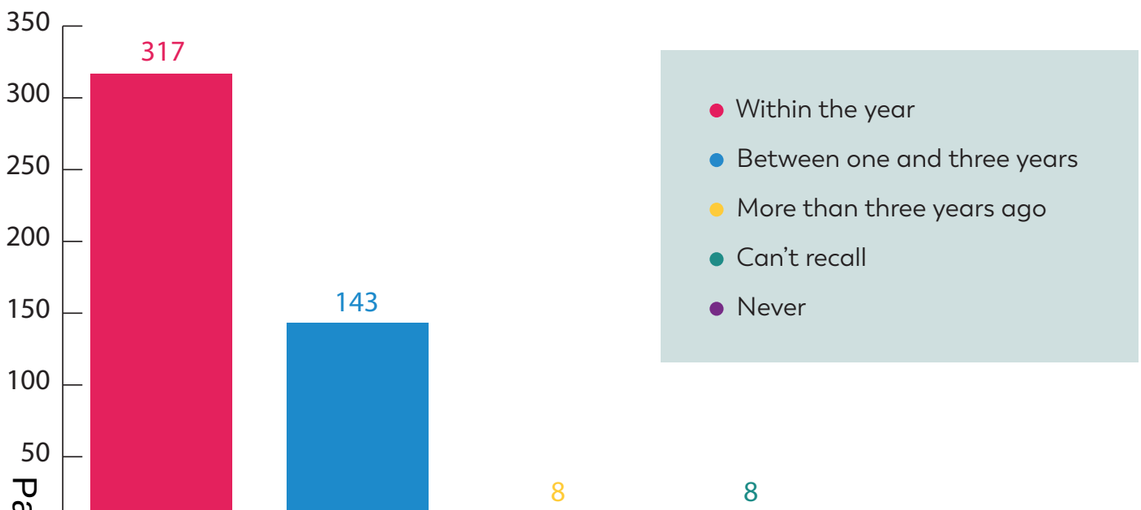
- Identify good practice and areas for development within your organisation to support improvement / development plans for your organisation
- Enable the OSCB/OSAB to identify training needs and plan for the provision of training, and development of tools and resources to support practice

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 yo felt that your safeguarding concerns were not being addressed			
Very confident (27.9%)	Confident (41.7%)	Slightly unsure (25.7%)	Very unsure (4.7%)

Quality assurance audits on working together

These are in-depth pieces of learning, drawing out detailed points of improvement and good practice. This report aims to highlight some of the findings from the different audits completed.

Child exploitation also known as **Contextual Safeguarding** is a key priority for safeguarding partners. It is characterised by children/young people

- Being criminally exploited
- Being sexually exploited
- Going missing
- At risk of radicalisation
- County lines
- Gang activity
- On line grooming/exploitation
- It can also involve child labour and/or child trafficking

This is the government's recognition of harm being caused to children outside the home - essentially by adults - but can include the involvement of children who are also being exploited and asked to involve their friends.

As well as protecting children/young people from exploitation the OSCB is keen to promote positive language when working with exploited children and to remember they are victims of crime. It is also important to involve the family when working to protect the child/young person.

In response issue to this the OSCB has:

- Revised the assessment and working tools for professionals working with exploited children
- Tightened the partnership procedures to recognise and divert children from further harm
- Confirmed the commitment for including parents in safety plans for their children

Neglect is strategic priority for safeguarding partners. During the last year several conferences have been held helping all staff and partners to recognise neglect.

A new set of tools to assess and support practitioners have been developed and are available on the OSCB website.

The council's internal procedures will be updated in June 2023 to reflect the new changes.

Your role as a practitioner

- Be clear about recognising neglect
- Understand the impact of neglect on a child
- Be clear about what you can do to help and support a child and family experiencing neglect

The Muliti-Agency Chronolgy (MAC)

The OSCB in response to practitioner survey on the multi-agency chronology (MAC) is currently working on a more user friendly and computer accessible system for more effective in gathering key information on a child/young person experiences.

OSCB Training

In response to the findings and themes from audits and practice reviews the OSCB training team reviews the training programme monthly to ensure key findings are covered.

In 22/23 Learing through training offered:

Overview

- 301 training events held in total
- 6,210 practitioners attended virtual and face to face training
- 11,826 practitioners completed online learning

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'.*

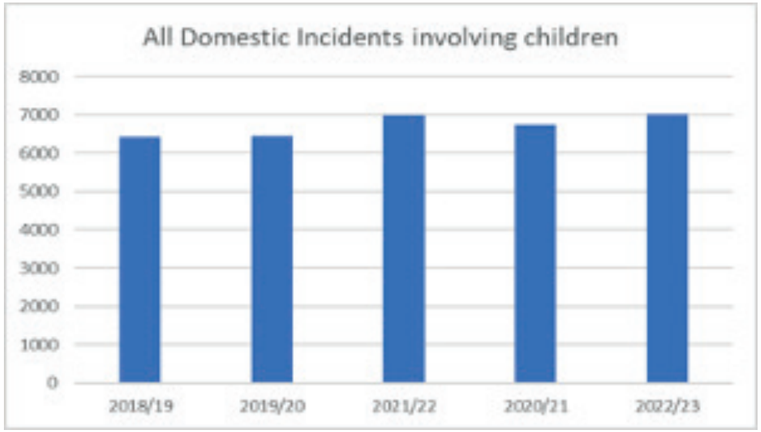
OSCB trainers are volunteers:

- **77** volunteer safeguarding trainers
- **10** new trainers completed our 'Train the Trainer' course this year
- **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

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

Trainers for sharing your expertise for free!!!

Heading??



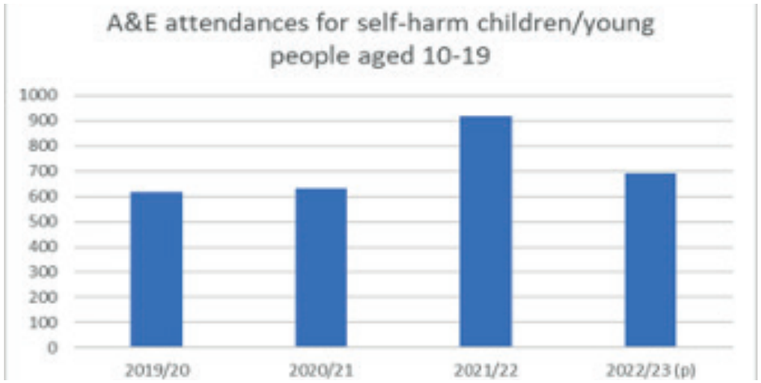
The TVP were being inspected at the time of this report and amongst other matters also focused on:

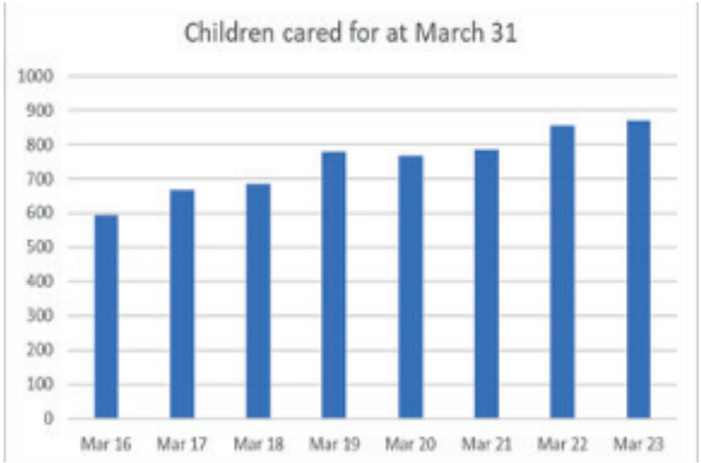
- Domestic abuse incidents with children involved/ linked
- Non-Domestic Abuse referrals to CSC

Contacts into the MASH

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 levels of anxiety across the partnership. There is no national data on contacts to social care, but we share data with other authorities in the Southeast. This shows the rate of contacts in 21/22 was 20% lower than the SE average rate. The MASH triages all contacts to Children's Social Care and Targeted Family Support at an early help level. There is management oversight on all contacts at the first point of contact, and during the decision-making process. All children presented cases in the MASH are RAG rated. All children at risk of significant harm are dealt with immediately.

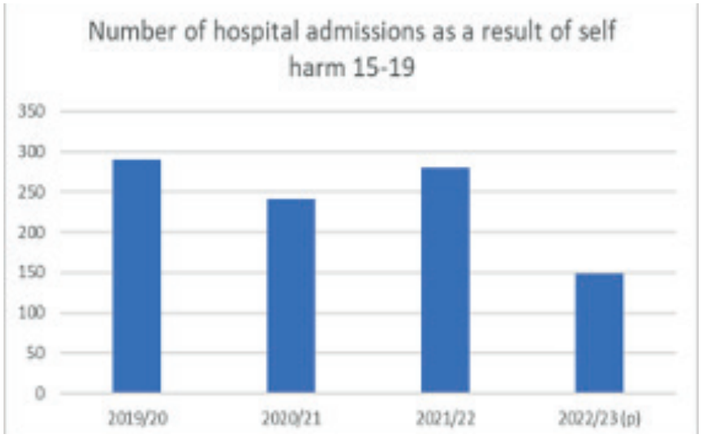
The expanded MASH Exploitation team is now live.

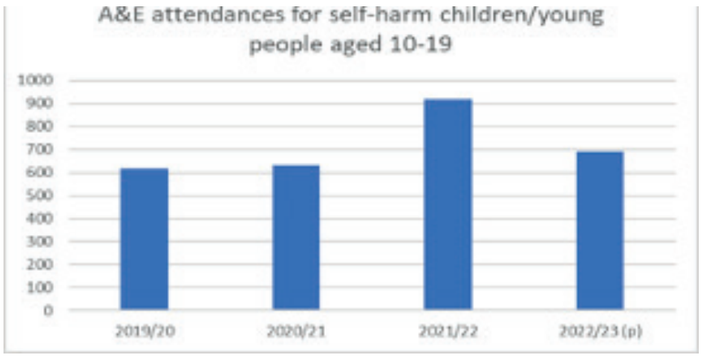




A key element in keeping children safe is keeping children in school.

We need to ensure school attendance remains a high priority for all agencies as a key measure of keeping children safe.





Whilst the timely delivery of initial health assessments (IHA) for Children we Care remains challenging, the situation has improved. This is largely due to a reduction in the number of children becoming looked after over the past 3 months. Oxford Health has increased its medical capacity by an additional initial health assessment each week. There are approximately 40 children waiting for their IHA with the predominant reasons being a delay in the required paperwork from Children's Social Care to be able to proceed and children placed outside of Oxfordshire facing long delays due to limited capacity in the receiving health team. Both issues have been escalated to the Corporate Parenting Panel and the Designated Nurse.

Repeated issues and ongoing concerns

PAQA's review of information leads to the escalation of some matters to the Board partners. The most persistent issues in the safeguarding system remain:

- Staff not being fully signed up to using the new screening tools for assessing neglect
- The increase in the number of EHE (Electively Home Educated) children – underpinned by the pause by the government for the proposal to introduce a register for children being EHE
- Exploitation – the new screening tool will be launched in the early Summer of 2023. It is hoped that partners will sign up to the new process
- Children being cared for continues to increase
- Children being supported by a Child Protection Plan continues to increase
- The partnership is still not meeting it's targets for completing early help assessments to deflect families away from statutory intervention
- The national housing crisis
- The delay in accessing CAMHS and/or Eating Disorder services for children
- The persistence of domestic abuse incidents harming children

OUH self-harm and mental health presentation monitoring continues. Presentations are lower over the year although there has been an increase in 8–12-year-olds attending ED. The three county self-harm forums are no longer taking place to monitor trends however, information is shared with the safeguarding in education team, CAMHS, SHNs and the BOB. It has been noted that there has been a spike in presentations following school holidays at the start of term. There has been a slight reduction in ED under 18s attending over quarter 4 (n=205), it is noted that the North of the county continue to have the higher level of presentations. The monitoring of admission rates for the under 18 attendances following self-harm noted an increase of 7% in Q4 to 24% indicating an increase in the acuity of presentations. Information is shared with primary care and children social care for open cases. The safeguarding liaison service shared information for 3083 attendances at the Emergency Department and Clinical Decision Unit, a reduction of 827 from quarter 2. The number of attendances for children aged has decreased for 22/23 and this is very positive.

Early help and assessments

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 are being asked for the children's trust meeting on 18th May 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:

- Early Help and Mental Health and Well-Being
- Early Help and 0–5-year-olds
- Early Help and SEND early intervention

Waiting times for CAHMS

In April CAMHS had a record number of referrals to our Single Point of Access with 751 compared to April 22 at 450. A large-scale project is underway to improve the Patient journey with SPA/Getting Help and Getting More Help.

Waiting times for NDC continues to be high however the team are offering a pre assessment offer (uptake is currently low). We are implementing the use of Sharon for both NDC families and for Getting Help /Getting More Help CAHMS services over the next 6 months. Sharon is an online peer and expert support system as well as developing a pre assessment offer for GH/GMH families who are waiting.

Increase in the number of children electively home educated

At the end of T4 (Easter 2023) 1180 children were electively home educated. This is an increase of 16% in the year and 65% on Easter 2019 (pre-Covid). Despite the increase the number of electively home educated children who were the subject of a social care plan fell to 6 this year from 15 last year and 25 at Easter 2019

Recruitment and retention

This continues to be a challenge across the whole partnership and work is being done to both recruit to posts ans.

This report summarises the subgroup's findings on how well our safeguarding system is working as one.

Also how the partnerships respond to emerging themes e.g young people attending local A/E departments following self harming

Oxfordshire's safeguarding partnership is committed to high standards.

We hope this report indicates the commitment from partners to keeping children safe and holding partners to account for their practice. The members of PAQA are dynamic and determined to improve partnerships to safeguard children.

List of agencies providing evidence on how well they work to address safeguarding themes:

- Children's Social Care, Oxfordshire County Council
- Community Rehabilitation Service (CRC)
- Education Safeguarding Advisory Team
- Learner Engagement Services, OCC
- Probation Service
- NHS Oxon Clinical Commissioning Group (NHS OCCG)
- Oxford City Council in partnership with South Oxon and Vale of White Horse, West Oxfordshire, and Cherwell District Councils.
- Oxford Health NHS FT (OH NHSFT)
- Oxford University Hospitals NHSFT (OUH NHSFT)
- Youth Justice & Exploitation Service, OCC
- Thames Valley Police

OSCB
Oxfordshire
Safeguarding
Children Board

oscb@oxfordshire.gov.uk
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Overview & Scrutiny Recommendation Response Pro forma

Under section 9FE of the Local Government Act 2000, Overview and Scrutiny Committees must require the Cabinet or local authority to respond to a report or recommendations made thereto by an Overview and Scrutiny Committee. Such a response must be provided within two months from the date on which it is requested[1] and, if the report or recommendations in questions were published, the response also must be so.

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Issue: Water Resources and the South East Regional Plan

Lead Cabinet Member(s): Cllr Pete Sudbury, Cabinet Member for Climate Change Delivery and Environment

Date response requested:[2] 21 March 2023

Response to report:

Enter text here.

Response to recommendations:

Recommendation	Accepted, rejected or partially accepted	Proposed action (if different to that recommended) and indicative timescale (unless rejected)
That the Council includes, as part of its consultation response, a statement setting out Oxfordshire County Council's vision in terms of a holistic approach to water management, highlighting our preference for solutions that are	Accepted	The final responses were sent with statements of the County Council's vision in terms of a holistic approach to water management as requested.

[1] Date of the meeting at which report/recommendations were received
[2] Date of the meeting at which report/recommendations were received9

based in nature and that recognise the reality of an increasingly water scarce environment and the need to adapt to this reality.		
That the Council ensures appropriate language is used in future responses to consultations and all Council documents, avoiding unclear and divisive words such as 'nonsense'.	Partially accepted	The final responses were sent with appropriate language, and this has been noted for future responses being prepared by us.
That the Council works with Thames Water to explore if more can be done to expedite water leakage repairs.	Accepted	The Council is seeking to work with Thames Water to explore if more can be done to expedite water leakage repairs.

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Issue: **Consultation and Engagement Strategy**

Lead Cabinet Member(s): Cllr Neil Fawcett, Cabinet Member for Community and Corporate Services

Date response requested: 19 September 2023

Response to report:

Recommendation	**Accepted, rejected or partially accepted**	**Proposed action (if different from that recommended) and indicative timescale (unless rejected)**
That on issues expected to be contentious political leaders should be accountable via Cabinet or single Cabinet member decision for the consultation and engagement strategy, rather than officers	Already actioned	Officers work very closely with portfolio holders on high-profile consultation and engagement exercises to ensure that cabinet members have oversight of and are accountable for the strategy. For some issues which have significant public interest or which are expected to be contentious, such as the recent engagement exercise on OUFC's response to the council's strategic priorities, the strategy is taken to a public meeting of Cabinet for approval.

That at its next annual refresh of the Communications and Engagement action plan the Council strengthens its road-map for how it will leverage its partnerships to increase the breadth of engagement by including (but not limited to) a) Creating SMART targets for partnership working b) Committing to undertake engagement processes which are representative by design	Partially accepted	The council already undertakes some representative engagement activity, such as the annual residents' survey. Further representative exercises will be commissioned where appropriate. For budget consultation and engagement exercises, the council has for a number of years used a range of participatory and representative methods to increase the breadth of engagement, from deliberative discussion days and representative surveys to market stall events, large scale public debates and open online feedback forms. Deliberative techniques are also used to engage children and young people, such as our full-day sounding board events. The consultation and engagement team work closely with partners on a range of activity. However, as part of the next annual refresh of the action plan, we will look to strengthen targets around partnership working.
That the Council develop an outline business case for launching Let's Talk Oxfordshire in app form.	Rejected	Let's Talk Oxfordshire is run on third party proprietary software, which means the council is not in a position to develop the software itself. While we can suggest this as a potential future development to the company who owns the software (EngagementHQ), we are not able to directly commission an app version.

		Let's Talk Oxfordshire is already available in a mobile-friendly format, which we believe offers the same functionality as an app. We therefore feel that app version would not offer additional benefit or value over and above the current mobile format.

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Overview & Scrutiny Recommendation Response Pro forma

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Issue: **EDI Strategy and Action Plan**

Lead Cabinet Member(s): Cllr Nathan Ley, Cabinet Member for Public Health, Inequalities and Community Safety; Cllr Neil Fawcett, Cabinet Member for Community and Corporate Services.

Date response requested: 19 September 2023

Response to report:
Cabinet would like to thank Performance Overview and Scrutiny Committee members for their observations regarding the EDI strategy and action plan.

A question was raised about the council's participation in Stonewall. We currently participate in the Stonewall workplace scheme as we believe it provides us with valuable benchmarking data and the opportunity to learn from a wide range of organisations across different sectors.

However, as a participant in the scheme, we are under absolutely no obligation to support the campaigns or policy positions of Stonewall and have our own equalities, diversity and inclusion framework and action plan.

We do regularly review the wide range of employment accreditation schemes on the market and we will continue to monitor the schemes available and the benefits they offer.

Response to recommendations:

Recommendation	**Accepted, rejected or partially accepted**	**Proposed action (if different from that recommended) and indicative timescale (unless rejected)**
That the Council, as part of its response to this recommendation, provides an appraisal of the Council's relationship with Stonewall and the justification for continued involvement with it.	Accepted	Appraisal provided in the response

Overview & Scrutiny Recommendation Response Pro forma

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Issue: **LGA Peer Review on Communications (six month update)**

Lead Cabinet Member(s): Cllr Neil Fawcett, Cabinet Member for Community and Corporate Services

Date response requested: 19 September 2023

Response to report:
Cabinet would like to thank Performance Overview and Scrutiny Committee members for their observations regarding the update on the LGA Peer Review response. With regard to Observation 2, which relates to the council's website, the digital content team - who are responsible for updating the website - moved from IT Services to the Communications, Marketing and Engagement team as of July 2023. This is part of a programme of work to redevelop the website and increase its capability as a communications vehicle as well as a transactional tool.

Response to recommendations:

Recommendation	**Accepted, rejected or partially accepted**	**Proposed action (if different from that recommended) and indicative timescale (unless rejected)**
That the Deputy Leader is invited to participate in the fortnightly meetings between the Leader and Director of Communications	Rejected	It is not felt necessary for the Deputy Leader to attend these fortnightly meetings as the administration is a single political group, the Liberal Democrat

		Green Alliance. During the multi-group alliance, regular meetings were held between the Director of Communications and the portfolio holder for corporate services, who was a representative of the second political group in the alliance.