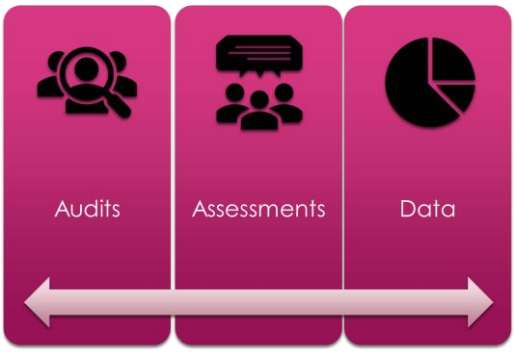
Annual report of the Performance, audit and quality assurance subgroup 2019/20

Introduction

PAQA takes a system-wide view on safeguarding work. This is done in three ways. (1) Audits: subgroup members audit their own services and how well they work with others to support children (2) Assessments: they self-assess their compliance with safeguarding standards and do an annual impact assessment. Views are drawn from both practitioners as well as families and children wherever possible. (3) The subgroup jointly reviews facts and figures through regular performance reports which look at the safeguarding system as broadly as possible.



Quality assurance audits on working together

Three multi-agency audits covered the issues of housing, mental health support to young people and work to address neglectful parenting. Findings were specific to each area of work but there are cross-cutting quality assurance themes reflected across the system:
(1) ensuring that all relevant professionals are involved at the right times in decisions to improve the wellbeing and safety of children e.g. involving the housing provider, school, health practitioner in core groups or professionals only meetings
(2) Partners value joint reflection on the progression of casework.

The findings from the neglect audit were important and worth sharing more broadly to practitioners:

- Each agency is a subject matter expert.
- Be clear about the impact of neglect in each child's life and not only as whole family
- Record this impact of neglect and share these findings
- A combined record of what it is like to walk in each child's shoes will focus our work.

Safeguarding audits within OSCB agencies

PAQA reviewed safeguarding audits from nine services. Collectively the audits showed that agencies are focussed on ensuring that they work well with others, they have good oversight of safeguarding and they understand where this has had an impact.

Auditing showed evidence of: improved safeguarding practice within Community Rehabilitation Company; work to support vulnerable young carers through Public health; work to keep vulnerable children in school by the county's Learner Engagement team; improved practice to better understanding of the needs of children with mental health problems by Oxford Health NHS FT as well as increased rigour when police are attending a domestic violence. These are just a few of many examples from all agencies.

Whilst highlighting much good practice auditing pointed to the need to: 'think family' but not to lose sight of individual children within families; improve how children's views are captured to inform decisions: work towards shared chronologies to better understand a child's

life. They provided a gentle reminder of building blocks for good practice: the need to better record, share information and remind staff of organisational safeguarding policies.

Impact assessment by OSCB agencies

Organisations identified the key financial and organisational pressures in relation to safeguarding children and their families and adults with care and support needs as: recruitment & retention as well as increasing demand for services. Partners identified the following safeguarding themes (1) support for clients who do not meet the threshold for social care support e.g. low-level neglect (2) information sharing, working agreements & communication (3) increase in volume and complexity of demand in relation to mental health, knife crime and exploitation in particular.

Self-assessment by OSCB agencies

Information provided assurance that board member agencies across Oxfordshire have policies and procedures in place to safeguard children and adults with care and support needs and are compliant with the standards. The majority of partners are committed to ensuring safeguarding practice is embedded into their daily work including training and ongoing reflection and support for staff for around safeguarding practices.

Practitioner Feedback

Over 1500 practitioners completed an online questionnaire for the OSCB. Over half of them were health colleagues. Of those surveyed 95% of staff have had training in the last three years. Feedback did highlight that they were not always signposted by their agency to the resources on the OSCB website. Consequently only a low proportion said that they had accessed the multi-agency tools – these are resources like the 'exploitation screening tool' or 'neglect toolkit for working with families'.

Practitioner responses are consistent with assurances given in agency returns regarding compliance with the standards on training and internal policies and procedures.

Children and young people's Views

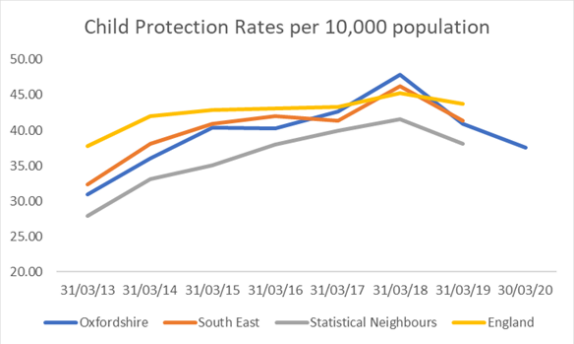
Where possible auditors have aimed to check how well young people are listened to. Mental health services and Youth justice services have consistently been able to show how they have listened. Public Health were able to demonstrate how voluntary sector providers have undertaken this e.g. Aquarius, worked with children to gain an explicit understanding of the isolation experienced by Young carers and developed a piece of work with the county council in response to this.

The local safeguarding data

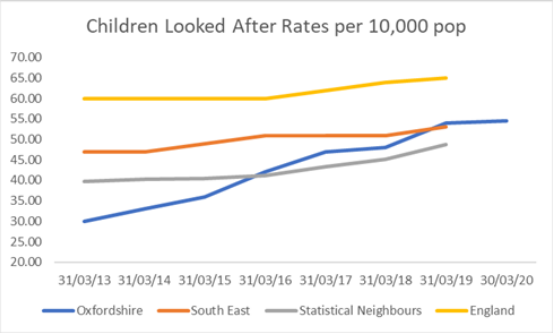
There is growing indication that work is being done to support families at an early point of need and that it is having an impact: 'early help assessments' for children have increased significantly (1862 against a target of 1500) and the number of 'troubled families' worked with has risen and stands at over 7000. However, early help data does not indicate that neglect is being identified early enough to prevent it being the main reason for children becoming subject to Child protection plans, as evidenced by Ofsted's Focused Visit to Oxfordshire in February 2020

The fall in child protection numbers seen both locally and nationally in 2018/19, continued in 2019/20 and figures at the end of March are more than 20% lower than 2 years ago. Neglect remains the main reason for being on a plan in Oxfordshire – over 60% at the end of March, compared with a latest national figure (March 2019) of 48%. The Focused Visit also noted "partnership attendance at initial and review child protection

conferences is too inconsistent and too many conferences are not quorate."



The number of children cared for by the local authority stabilised last year. In the coming year the authority is to implement the family safeguarding model which should help keep more families out of the care system.



The data raises concern about adverse childhood experiences and the potential for child exploitation e.g. 11% rise in the number of recorded children as victims of crime and a 14% rise in the numbers of domestic crimes involving children, the number of permanent exclusions from school is rising.

The percentage of children referrals to Child and Adolescent Mental Health Services who are seen within 12 weeks continues to be a cause for concern. At the end of the year this was only 40% compared with a target of 75%.

At the end of the year there was a noticeable effect from lockdown, with a near 40% drop in child protection investigations and children becoming the subject of a plan in the 5 weeks following lockdown compared to the 5 weeks before. This raises concerns both of vulnerable children being hidden from services and a significant increase in demand for services as lockdown is eased.

Escalated issues

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

(1) **Case conferences**. It is not standard practice for health, police and social care partners to all be present and contribute to decision making plus the recording of attendance is not always reliable. The Ofsted Focussed visit in 2020 picked up on this. PAQA acknowledges that the meeting co-ordination, timing and format needs to accommodate multiple people and this needs to be addressed as a partnership.

(2) **Safeguarding in education.** Setting and reporting of performance measures to be sure that children are being kept safe in and out of school has been challenging. Over the year the measures have become clearer, especially for children being excluded from school however the resulting statistics are not good. PAQA recognises the challenge of working towards targets which involve multiple individual settings as well as the importance of providing good alternatives to school provision in order to bring about change within the safeguarding system

(3) **Grades of disadvantaged school pupils**. These are not as good as the national average of children in similar circumstances and long-term reporting of this data has evidenced this. This item was escalated at year-end

(4) **Waiting times** for children wanting to access mental health services.

Impact

Over the course of the year PAQA has been pleased to see impact from its work. A few examples are: (1) 100% of schools signing up to receive notifications regarding domestic abuse incidents in children's homes from the police, through a system called Operation Encompass (2) Improvements in attendance at MASH cross-agency strategy meetings leading to earlier and co-ordinated decisions (3) CRC audits demonstrate an improvement in safeguarding practice from 45% 'sufficiency' in January 2019, to 85% in January 2020

Conclusions

The child population of Oxfordshire has grown by 7% in the last ten years and is estimated to stand at 143,400 young people aged under-18[1]. Alongside this growth there has been increased demand for services particularly towards the high end of the continuum of need. Within this context there are five messages:

1. **We must listen to and not lose sight of the individual needs of children** whilst remaining committed to a 'Think Family' approach. Audits have indicated that we could do this more consistently as sometimes their views are missing when we check.

2. **There are persistent and perpetual challenges for all those working to keep children safe.** The OSCB has a leadership role in helping practitioners learn how to identify and deal with neglect; in bringing together educational leaders to work on issues regarding exclusions and alternative provision with us to keep children safe in education; in ensuring earlier and timely access to mental health services.

3. **We need to focus on working well together whilst taking individual responsibility for our role in the safeguarding partnership.** Using multi-agency chronologies, sharing information, co-ordinating work and using our toolkits for identifying issues are themes for development.

4. **The partnership is committed to high standards and works well.** The examples in the self-assessments, the evidence in the audits and feedback points to a motivated workforce that want to make a difference and get it right for children in Oxfordshire.

5. **The workload is not straightforward**. Our work emphasises the complexity of need, the many safeguarding themes and the capacity of colleagues to deal with them makes it a challenging work environment.

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

1. Thames Valley Police
2. Childrens Social Care, OCC
3. Schools and Learning, OCC
4. Oxford Health NHS FT
5. Public Health, OCC
6. Youth Justice Service, OCC
7. National Probation Service
8. Community Rehabilitation Service (CRC)
9. Education Safeguarding Advisory Team
10. Oxford University Hospitals NHS FT

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