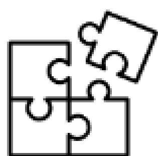
OSCB Oxfordshire Safeguarding Children Board

OSCB Performance, audit, and quality assurance (PAQA) subgroup.

Annual report 2021/22

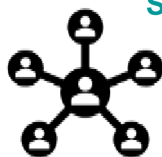


System-wide view on safeguarding work.

The subgroup[1] looks at the children's safeguarding system 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

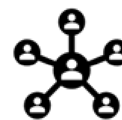
This report summarises the subgroup's view on how well our safeguarding system is working as one.



Safeguarding audits and assessments done by OSCB agencies

We reviewed safeguarding audits from 11 large services which come into contact with children. They considered how well safeguarding is included in their daily work. The audits showed:

→ rigour when **Thames Valley Police** are attending domestic violence incidents to ensure that they speak to children in the home and refer on to the Multi-agency Safeguarding Hub
→ Children's perspectives are well evidenced in **Children's Social Care** work, with feedback written 'to the child' where it is appropriate
→ when children frequently come into the **OUH NHS FT** Emergency Depts their needs are followed up and information is shared appropriately with other services
→ improvement in the way that health visitors at **OH NHS FT** analyse and record evidence of safeguarding risk for children and young people
→ Elective Home Education mediation through the county council's **Learner Engagement service** has resulted in more than 100 children being returned to a school roll, having previously been electively home educated
→ Successful delivery of a Parenting group by the **YJES** with carers of our Black and Mixed heritage children. It has provided peer-to-peer support for carers whose children are at risk of or being exploited
→ how the **NHS OCCG** is working with GPs to provide safeguarding advice and evening safeguarding sessions on current concerns



→ **Oxford City Council** has a system in place to identify themes and trends for additional training and communications for staff on safeguarding
→ **Cherwell District Council** has excellent examples of where safeguarding has been central to summer-time initiatives for children making safeguarding everyone's business
→ good practice and joint working by the **Probation Service** to safeguard children on the release of offenders. Following its reorganisation this year the Probation Service will be able to report more fully next year
→ 100% of schools completed the schools' annual safeguarding audit with 361 responses received. The **Education Safeguarding Advisory Team** School also completed 39 safeguarding advisory reviews.

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

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

All services identified areas for further improvement or challenge to ensure that children's safeguarding was at the forefront of their work.

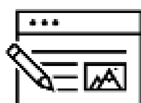
Auditing provided a reminder of building blocks for good practice: use of language that is non-blaming, clear and describes what is seen and understood; the need to better record, share information and remind staff of organisational safeguarding policies. Using multi-agency chronologies, sharing information, co-ordinating work and using OSCB toolkits for identifying issues are themes for improvement.

The subgroup has confidence that these services have good oversight of safeguarding and their auditing is to good effect.

Self-assessment by OSCB agencies

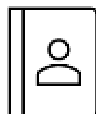
Information provided assurance that board member agencies across Oxfordshire take their safeguarding responsibilities seriously. They have policies and procedures in place to safeguard children and are compliant with the standards. Partners are committed to ensuring safeguarding practice is embedded into their daily work including training and ongoing reflection and support for staff around safeguarding practices. (A full separate report is provided to the OSCB).

Impact assessment by OSCB agencies



Organisations identified the key financial and organisational pressures in relation to safeguarding children and their families as (i) recruitment and retention (ii) demand and complexity (iii) mental ill health (iv) domestic abuse and violence against women and girls (v) exploitation

Quality assurance audits on working together

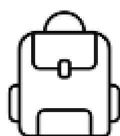


These are in-depth pieces of learning, drawing out detailed points of improvement and good practice. This report summarises some of the key points and safeguarding messages.

This year we reviewed children's experiences of support, where they were at risk of exploitation, where they had experienced substantial neglect and where they were subject to child protection planning.

Child exploitation is a strategic priority for safeguarding partners. This audit highlighted why as it showed just how challenging it is to deal with the criminal exploitation of children in a systematic way. Some quick learning points were that we should:

- help at an early point
- use the same multi-agency resources
- check that we have all the same information and not assume
- focus on the needs of individual children in a family as well as the family-as-a-whole, without over complicating the situation
- intra-familiar harm can make a child more vulnerable to harm from outside the home
- chase mental health support for this vulnerable group



Neglect is strategic priority for safeguarding partners. The messages on neglect remain consistent:

Be clear about the impact of neglect in each child's life and not only as whole family

- Record the impact of neglect and share these findings – decision making should be evidenced
- A combined record of what it is like to walk in each child's shoes will focus our work – use the multi-agency chronology

Interestingly there were some repeat messages across **both** audits for how we are working:

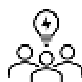
- Children's behaviours are not sufficiently linked to their lived experience and associated parenting issues.
- Language used to describe children's behaviours attributable to emotional harm and neglect is not yet consistently trauma informed.
- Children's behaviour as communication in and of itself is not yet consistently understood, or accepted, across the partnership.
- Queries or concerns about parental mental health or cognitive functioning need to be better understood at an earlier stage of involvement, to ensure that help for parents is known and accessible.

The practitioner survey on the **multi-agency chronology** (MAC) covered how well we use this resource to support children who are subject to child protection planning. It shows who is doing what and when and what the impact is on the wellbeing of the child.
The audit gave confidence that the MAC is '*good for reflection'* and that workers can '*see the child at the centre'* of what they are jointly doing.

We also learnt that it has been good for seeing a timeline of events, preparing for meetings, writing reports, and highlighting any ongoing issues across agencies.

The survey also highlighted points for improvement e.g., the MAC needs to be more user-friendly, more time should be given to completing it and that it should be more actively used in decision making.

Practitioner Feedback



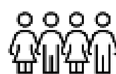
Over 700 practitioners completed an online safeguarding questionnaire for the OSCB. Of those surveyed 95% of staff have had training in the last three years. Like last year, feedback highlighted that a low proportion had accessed the multi-agency tools – these are resources like the 'exploitation screening tool' or 'neglect toolkit for working with families. This is a repeat message and one that the Board partners must act on.

We have heard how, "*Covid-19 has impacted on how we safeguard vulnerable people. This has been challenging, especially during periods of the Covid-19 restrictions with vulnerable residents not able to access face to face support services…*'

Anecdotal evidence reflects what we know from the data. We have been told that the, *"increase in complexity of cases and specific areas e.g., neglect, self-neglect, self-harm and adolescent mental health... Delays in discharge due to the lack of mental health placements or social care placements for adolescents"*

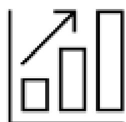
Feedback indicates a workforce operating at capacity with a high workload.

Children and young people's Views



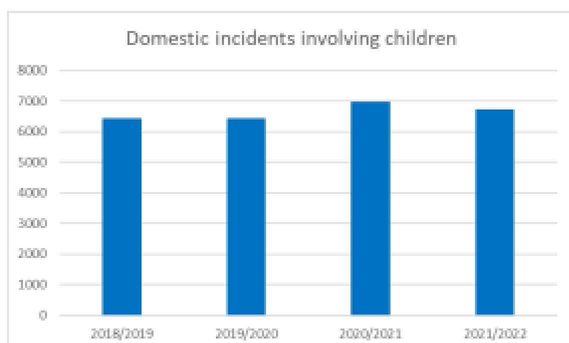
Where possible auditors have aimed to check how well young people are listened to.
OUH NHS FT could demonstrate changes on their children's hospital wards because of listening to feedback. Oxford City Council designed their Children and Young People's Strategy in partnership with children and young people. The NHS OCCG talked to young people about how to make it easier for them to access GPs and other health services.
Most services noted this as an area for continual improvement.

Local safeguarding data

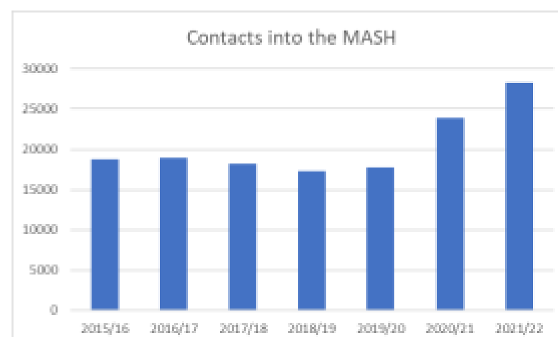


The child population of Oxfordshire has grown by 7.3% in the last ten years and is estimated to stand at 148,097 young people aged under-18[2]. Alongside this growth there has been increased demand for services particularly towards the high end of the continuum of need.

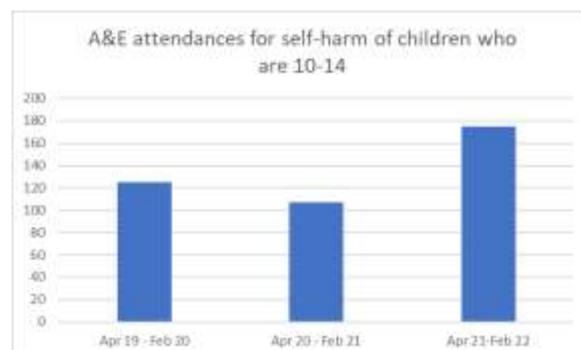
The number of domestic incidents involving children fell by 3.5% this year but remains 5% above the 2019/20 level. Despite this modest change some services, such as the MASH and A&E attendance saw a step change in activity as a result of Covid.
The number of children the subject of child protection plans and those who were cared for has risen in the year. Caseload pressures are reported across the partnership.



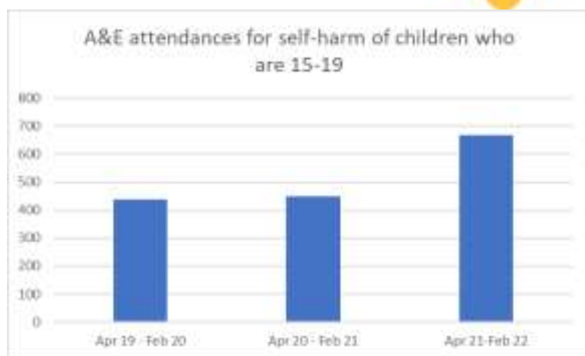
Across the system a clear message was put out that we were open for business and this appears to have stimulated demand. Contacts to the MASH are now 60% higher than pre Covid levels. Despite this rise there was no notable rise in referrals to social care, with most cases being signposted elsewhere. Only 20% of MASH contacts lead to a social care referral; and only 47% of social care assessments lead to a social care plan. In 2021/22 we completed 2938 early help assessments, but 6672 social care assessments meaning you are 2½ times more likely to be met with a statutory response. The Police receive more MASH contacts in Oxfordshire than in all the other Thames Valley MASHs combined. There is clear evidence of avoidable demand in the system.



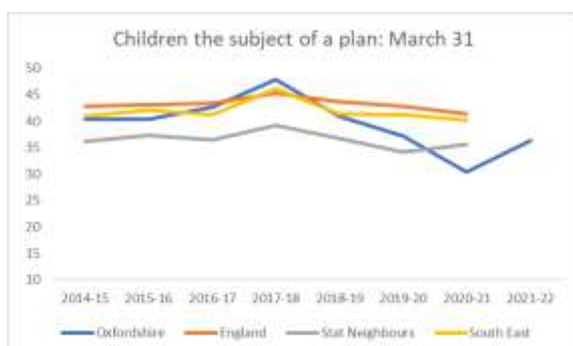
The latest data for A&E attendances for self-harm shows that attendances for 10–19-year-olds are 52% up on last year and 49% up on pre covid levels. Again, we need to ensure that appropriate help and support is provided as early as possible in the system. An audit is underway to see whether any earlier help would have reduced the likelihood of an A&E admission. It is pleasing to note that both the mean and the median waiting times for core CAMHS services dropped last year, though the service remains under significant pressure, with caseloads rising by 40% in the year.

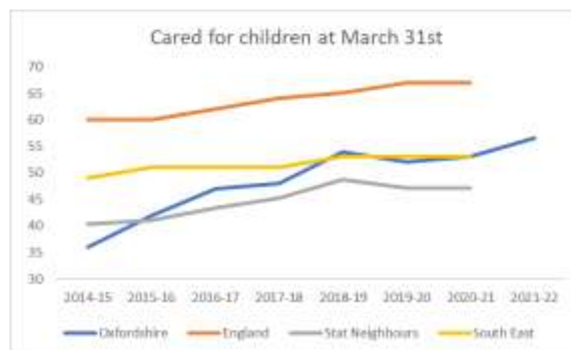


[2] Source ONS Mid-Year Estimates for Oxfordshire for people aged 0-17 2010 & 2020



Child protection numbers have risen in the year from 475 to 567. This has been driven by more children becoming the subject of a plan. The number is still comparable to similar areas and remains below the highpoint of 769 in July 2019. The number of cared for children has also risen. This is because we are housing more unaccompanied children under the national transfer scheme, but also because the number of children non unaccompanied children has grown. This year we saw an increase for the first time in 3 years of the number of children becoming cared for, but the figure of remains in line with previous years. However, the proportion of children who leave the cared for system continues to fall and has done for the 7 seven years. This seems to reflect a growing proportion of the cared for population being the subject of a care order (as opposed to being voluntarily looked after) and delays that have been reported in the court system. All of this is putting pressure on social care caseloads which are over all teams 16% higher than last year and in family solutions are 30% higher.

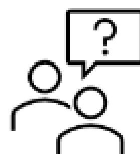




A key element in keeping children safe is keeping children in school. Covid significantly impacted on school attendance, but it is pleasing to see that there has been significant success in reducing exclusions which fell from 66 in terms 1 – 4 2019/20 (i.e., start of the school year to Easter) to 19 in 2021/22. Suspensions fell from 1741 to 846 in the same period. However, to term 4 (Easter) this year nearly 1 in 4 pupils were persistently absent. Persistent absence is highest for vulnerable groups:

- Children with a child protection plan (57.0%),
- child in need plan (53.5%) and
- Children with an EHCP (41.9%)

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



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:

(1) **Contacts into the Multi-agency Safeguarding Hub (MASH).** In 2021/22 the number of contacts into the MASH rose by 33% to 23,920; when just over 10% of children in Oxfordshire had a MASH contact.

(2) **Multi-agency help at an early stage of need is lower than local targets.**

You remain twice as likely to receive a social care assessment than an early help assessment in Oxfordshire.

(3) **Waiting times for children with mental health problems.** The average (mean) waiting time for core CAMHS services is 12% lower than 12 months ago, but the median is higher.

(4) **Increase in the number of children electively home educated**. This number has increased by over 30% to just over 900 children. Information has been put in to place to advise parents of the implications and work has been undertaken to identify the most vulnerable in this cohort.

(5) **The number of A&E attendances for self-harm are 56% higher than last year and 58% more than 2019.** (However, this has not led to an increase in actual hospital admissions which for self-harm (15-19) are 1% lower than 2 years ago).

(6) **Recruitment and retention** across the whole system. All safeguarding partners have noted this as a challenge in the current economic environment through the safeguarding self-assessment.

Impact

Over the course of the year PAQA has been pleased to see impact from its work. Its challenge has led to actions. We have seen improvements to the decision making for the care of the most vulnerable children through health, police, and social care partners consistent contribution.

As a result of this year's work there will be an additional focus on criminal exploitation across the system through the services' safeguarding audits. The schools' safeguarding audit will have an additional focus on neglect. Learning events will cover 'trauma-informed' approaches to working with children, violence against women and girls as well as criminal exploitation of children.

Conclusion

Oxfordshire's safeguarding partnership is committed to high standards.
The report indicates a motivated workforce that want to make a difference and get it right for children. It also indicates a workforce operating at capacity with a high workload.

The subgroup has also drawn out the points of improvement to help us work better as one system.

The subgroups view on the safeguarding system from this year's work is:

1. ***We need to work better as one system.***
   This is sometimes called, 'whole system cultural change'. It means that we all need to think about how we work together, based on what we have learnt.
   In our case it means nudging practitioners to use multi-agency chronologies, share information, co-ordinate work and use multi-agency toolkits for identifying issues.

2. ***Our current priorities for system change are right – we just need more traction on making change happen.***
   The OSCB has a leadership role in embedding learning.
   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. *We need to do more of this to make a difference.*

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

1. Childrens Social Care, Oxfordshire County Council
2. Community Rehabilitation Service (CRC)
3. Education Safeguarding Advisory Team
4. Learner Engagement Services, OCC
5. Probation Service
6. NHS Oxon Clinical Commissioning Group (NHS OCCG)
7. Oxford City Council in partnership with South Oxon and Vale of White Horse, West Oxfordshire, and Cherwell District Councils.
8. Oxford Health NHS FT (OH NHSFT)
9. Oxford University Hospitals NHSFT (OUH NHSFT)
10. Youth Justice & Exploitation Service, OCC
11. Thames Valley Police