Divisions Affected - All

Cabinet – 18 October 2022

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 NHS clinical commissioning group and the 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 the Serious Case Review for Child R was published, three reviews were undertaken and 6 Rapid Reviews completed. Practical learning from these reviews informed the OSCB training programme for approximately 15,000 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:

- **Make sure that vulnerable children are seen.** Covid has taught us that any decision not to meet with a vulnerable family in person must be a shared one. The risk of not doing so must be central to that shared decision.
- **Embed the culture of early help** work across everyone working with children
- **Develop a clear understanding of trauma informed** practice across your services and adopt that approach to working with children
- **Develop and invest in plans to keep children close to home** by expanding local residential and foster care provision to meet children's needs.
- **Ensure rigorous commissioning and quality assurance** of placements for the children we care for
- **Maintain oversight of how we record and share information** about children. Set high standards.
- **Ensure greater understanding of the range of mental health and mental wellbeing support** opportunities for adolescents

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 priorities, the learning from case review work, 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 NHS Clinical Commissioning Group, Thames Valley Police and the National Probation Service. The budget contributions and expenditure is outlined in full detail in appendix B of the report.

    Comments checked by:

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Legal Implications

16. There are no legal implications for the Local Authority. Checked by: Sukdave Ghuman, Head of Legal Services & Deputy Monitoring Officer sukdave.ghuman@oxfordshire.gov.uk

    Sukdave Ghuman
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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

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