



**OSCB**  
Oxfordshire  
Safeguarding  
Children Board

# Annual Report 2019/2020



# Contents

1. Foreword	3
2. Introduction	4
3. Structure and governance	5
4. Priorities and progress	7
5. Child Safeguarding Practice Reviews	12
6. Improving practice through training and learning	14
7. Strengths and challenges	16
<b>APPENDICES</b>	
Appendix A. OSCB membership	20
Appendix B: The OSCB's structure	20
Appendix C: The OSCB's linkages	20
Appendix D: The Oxfordshire Safeguarding Children Board budget	21
Appendix E: Matrix of safeguarding concerns	22

## 1. Foreword from the Chair

It is once more my pleasure to offer a foreword to the Annual Report of the Oxfordshire Safeguarding Children Board. It has been my honour and privilege to Chair the Board for the last two years and while I have informed the Partnership of my plan to step down in September 2020, I will leave with a real sense of sadness and regret. I have loved my time chairing the Board, have had the joy of leading a strong and progressive Partnership, met and worked with some truly inspirational people and seen much evidence of joined-up and effective safeguarding practice.

Once again, the Business Unit have put together an excellent Annual Report that details the work of the OSCB over the past twelve months. It really does give a very real insight and outline of the work, the achievements, the challenges and the areas that will require sustained work to improve and address. I sincerely hope that you enjoy reading the report and that you find it an informing read about the vital work of the OSCB.

This is the first Annual Report that we have put together since the publication and implementation of Working Together 2018 which placed the leadership of the Safeguarding of children with Oxfordshire County Council, the Clinical Commissioning Group and Thames Valley Police. I am pleased to report that I have seen these agencies and the chief officers of these agencies grasp the leadership challenge and commit themselves to working ever closer together to offer the very best safeguarding partnership and consequent practice.

At the time of writing, we are still in the midst of the Covid 19 situation. All agencies are agreed that it has been a significant challenge to continue to offer services through the crisis and lockdown, but it will be as much if not an even bigger challenge to manage as we come out of the situation. It is anticipated that there will be significant pent up demand and it is ever more important that we re-commit ourselves to working in partnership and viewing the protection and safeguarding of children as everyone's business.

As ever, we are committed to the Annual Report being an impactful report. So if the report raises questions for you or you want to strongly agree or disagree with some or all of it or you would like to know more, we would love to hear from you. I will close by thanking you all for your unstinting efforts to protect and safeguard children in Oxfordshire – we have significant challenges to address both now and in the future but if we continue to believe in the collective, partnership approach I am utterly confident we will meet and overcome these challenges.



Richard Simpson,  
OSCB Independent Chair



## 2. Introduction

This annual report looks at the work of OSCB partners in 2019/20. Over the last 12 months we have set up a **new way of working together** as 'safeguarding leaders' in Oxfordshire. This followed a change in the law and **guidance** which asked us to ensure that the police, the county council and the NHS clinical commissioning group are working more closely together to keep children safe. This new group provides leadership to the OSCB which still exists as a bigger partnership of all agencies delivering services to children. Our Independent Chair, Richard Simpson, has produced this report with the support of the Business Unit.

The aim of the report is to explain to you what we think are the most important strengths and challenges in the safeguarding partnership in Oxfordshire and to tell you what we have learnt about improving our services to keep children safer in future.

## 3. Structure and governance

### 3.1 Remit

The OSCB is a partnership set up to support local organisations to work together in a system where:

- Children are kept as safe as possible
- We (the local organisations) work to agree a shared vision for how to achieve improved outcomes for vulnerable children
- We challenge and hold one another to account
- There is early identification and analysis of new safeguarding issues and emerging threats
- Learning is shared so that local services for children and families can become more reflective and implement changes to practice
- Information is shared well and supports good decision making for children and families

### 3.2 Aims

The OSCB has three aims: to provide leadership for effective safeguarding practice; to drive forward practice improvement and to challenge in order to ensure that children are kept safe.

### 3.3 Structures and strategic links

The board is not responsible or accountable for delivering child protection services but it does need to know how well the safeguarding system is working.

The membership of the senior executive group and the board is set out in Appendix A. It has effective linkages to other strategic groups in Oxfordshire to ensure clear remit and cross partnership working. The board's structure (going forward) is set out in Appendix B and linkages are set out in Appendix C. The OSCB has a strong working relationship with the Safeguarding Adults Board with joint meetings twice a year. This year the two Boards have had the joint priorities of: housing, domestic abuse and transitions.

### 3.4 The OSCB Chair

The OSCB Independent Chair, Richard Simpson is from Barnardo's. Not only does he bring his independence – he has no links to any of our organisations – but he also brings the expertise and knowledge of a national charity with a long history of keeping children safe. We value his experience, perspective and his constant challenge to us to do the best for local children.

### 3.5 Funding

All board members contribute to the OSCB. The contributions for 2019/20 are attached at Appendix D.

### 3.6 How the OSCB works

The work of the OSCB is driven through a series of subgroups. The people on these groups are from organisations which deliver services to children in Oxfordshire. Each subgroup has a specific role. See Appendix B for details on what they do.

### 3.7 Listening to views of children and young people in Oxfordshire

This year groups such as 'Voice of Oxfordshire Youth', the 'Children in Care Council', 'Children Heard and Seen' and the 'Safer Together Youth Ambassadors' helped deliver the OSCB annual conference on 'Understanding my world'. They received lots of great feedback, *"The speakers, especially the young people were amazing, and I really liked that we had a young person sat with us on the table so that we had their opinion through the work that was being completed"*.

Children have helped us consider equality issues for transgender young people, they have prompted us to consider the diversity of the young people in Oxfordshire and have proposed that we look at safeguarding risks in relation to housing and homelessness.

Children who have been involved in the reviews done on safeguarding practice have talked to us. These children have been at risk of serious harm and neglect.

We know it is not easy for them and we listen carefully. They have told us how small gestures of kindness made a big difference – that individuals can always make a difference. They have told us that sometimes they felt 'missed' or that they simply didn't feel heard. This was one of the reasons we ran the conference on 'Understanding my world'.

Family members have stressed to us the need for communities, not just workers, to recognise if a child is in need of help. The message that 'safeguarding is everyone's business' is still current and everyone needs to know how to raise a concern.

Following each review we feed back to the children in person. If they are too young to talk to we write letters to read when they are older. In this way they can find out what we have learnt and will do differently as organisations in future.



## 4. Priorities and Progress

### 4.1 Priorities for 2019/20

The OSCB has three aims: to provide leadership for effective safeguarding practice; to drive forward practice improvement and to challenge in order to ensure that children are kept safe.

### 4.2 Reporting on progress against our three aims

#### AIM 1: PROVIDING LEADERSHIP FOR EFFECTIVE SAFEGUARDING PRACTICE.

We have set up a new way of working together in Oxfordshire which is going well. Follow the link to the ['About us'](#) page on the website to see how we work. We can already see good progress:

- Strong links to other partnerships, where joint work makes sense e.g. to the Adult's board to check how workers can access interpreting services when supporting minority groups on safeguarding matters
- Productive links to share knowledge e.g. work with the children's charity Barnardo's to draw on their expertise with respect to the safeguarding risks faced by transgender young people
- Partnership links with the voluntary and community sector to reflect their views e.g. input on training, the annual conference, web-design and our subgroups
- Links to those who support children. A scheme has been set up to thank some of those who make a difference to the lives of families in our community e.g.
  - workers from the police and social care, who have created ways to support children where criminals are trying to exploit them
  - a young person who made 'mindfulness bags' for vulnerable young people to help them get through the covid-19 lockdown

#### AIM 1 IN SUMMARY:

We have set up our arrangements to lead the safeguarding partnership. We now need to make sure they stay strong and ask for an independent opinion on how well we are doing.

## AIM 2: DRIVING FORWARD PRACTICE IMPROVEMENT IN NEGLECT, KEEPING CHILDREN SAFE IN EDUCATION AND CHILD EXPLOITATION.

Generally speaking these are 'system' issues, which means that a lot of organisations need to work on them to make a difference, they are not sorted easily and take time. Nevertheless, we can see progress.

Local organisations have developed resources for workers to promote healthy functioning families and to avoid neglectful childhoods. They can be found on the OSCB website. There are signs that there is more support for families at an early point of need. 'early help assessments' for children have increased significantly (1862 against a target of 1500). The number of 'troubled families' worked with has risen and stands at over 7000.

There is more monitoring and action to limit the number of school children being excluded, on 'part-time' timetables and for improving pupils' attendance at school. Partners understand that providing good alternatives to mainstream school provision is part of the solution and the OSCB makes the challenge to local organisations to work out how to do this.

The Child Exploitation 'screening tool' has been developed so that workers can identify those children most at risk from safeguarding risks like buying and selling drugs, being part of gangs or being exploited by criminals. Local organisations have set up network meetings so that they can plan how to best help those they are most worried about and panel meetings for those who most often go missing from home or from their schools. To be sure that we are on track the OSCB has begun an evaluation to check how well organisations are working together. The OSCB is also raising the concern that adolescents can get timely mental health support as we know that is often a problem for those being exploited by others.

### AIM 2 IN SUMMARY:

Driving forward practice improvement in neglect, keeping children safe in education and child exploitation are big challenges and have to stay on our 'to-do list.

## AIM 3: CHALLENGING TO ENSURE THAT CHILDREN ARE KEPT SAFE.

OSCB partners have made sure they understand the big picture with respect to keeping children safe in Oxfordshire. They do this all year long through a specific subgroup, which looks at how well our local services are supporting those children and families most in need. It is called the Performance, Audit and Quality Assurance subgroup.

The group has three tasks:

1. to look at performance data
2. to review what audits and assessments tell us – we call that 'quality assurance'
3. to let us know if there any safeguarding concerns that we need to deal with or organisations that need to be challenged – we call these 'escalated issues'

This is what we have found out:

### (1) LOOKING AT PERFORMANCE DATA: OXFORDSHIRE'S SAFEGUARDING FACTS AND FIGURES

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. However, data indicates that **neglect** is still not being addressed early enough to prevent it being the main reason for children becoming subject to Child protection plans – over 60% at the end of March, compared with a latest national figure (March 2019) of 48%.

There has been a fall in the **number of children looked after by the local authority**, who are supported through child protection planning both locally and nationally. At the end of March 2020, the number was 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 looked after** stabilised last year; stayed at a similar number to the previous year. In the coming year the authority is to implement the family safeguarding model which should help keep more families out of the looked after system.

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

The percentage of child **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%.

## (2) QUALITY ASSURANCE: WHAT AUDITS AND ASSESSMENTS HAVE TOLD US

### **Quality assurance audits on working together**

Multi-agency audits covered the issues of housing, mental health support to young people and work to address neglectful parenting. All organisations ran safeguarding audits. They were reassuring and gave many examples of improved practice by organisations. Some are:

- positive work to support vulnerable young carers by 'Aquarius' and the county's Public Health service
- increased rigour when police are attending a domestic violence incident to make sure that children in the home are safe and spoken to
- successful work between schools, the county's Learner Engagement team and families to keep children in school when this is the safest option for them

Auditing pointed to the need to think about the needs of the whole family but not lose sight of individual children when doing so. Also, that we should improve how children's views are captured to inform decisions. Finally, that we should use shared 'multi-agency chronologies' to better understand a child's life and avoid drift when trying to help families improve their home environment.

### **Self-assessment by OSCB organisations**

Information provided by board member organisations gave assurance that they have policies and procedures in place to safeguard children. Organisations were constructively challenged through a peer review. Organisations identified pressures as recruitment & retention as well as increasing demand for services.

They said that key safeguarding themes are (1) support for families 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.

## (3) ESCALATED ISSUES: WHAT WE HAVE BEEN MOST CONCERNED ABOUT

The most persistent issues that we have felt needed the full attention of all board members are:

- Case conferences. It has not been standard practice for workers from health, police and social care to be present and contribute to decision making at 'case conferences'. These are the meetings where the support to a child is reviewed and planned. Without everyone present work can drift
- Safeguarding in education. There has not been one shared vision across all partners in Oxfordshire with respect to keeping children safe in school e.g. limiting those excluded, improving those attending each day, ensuring full-time time-tables for all those who should be learning.
- 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
- Waiting times for children wanting to access mental health services
- There are not enough places for children to go and stay when they no longer need to be in hospital but their needs are too complex to come home

These issues are not just persistent but need time to sort so they will remain as safeguarding concerns in the coming year.

### **AIM 3 IN SUMMARY:**

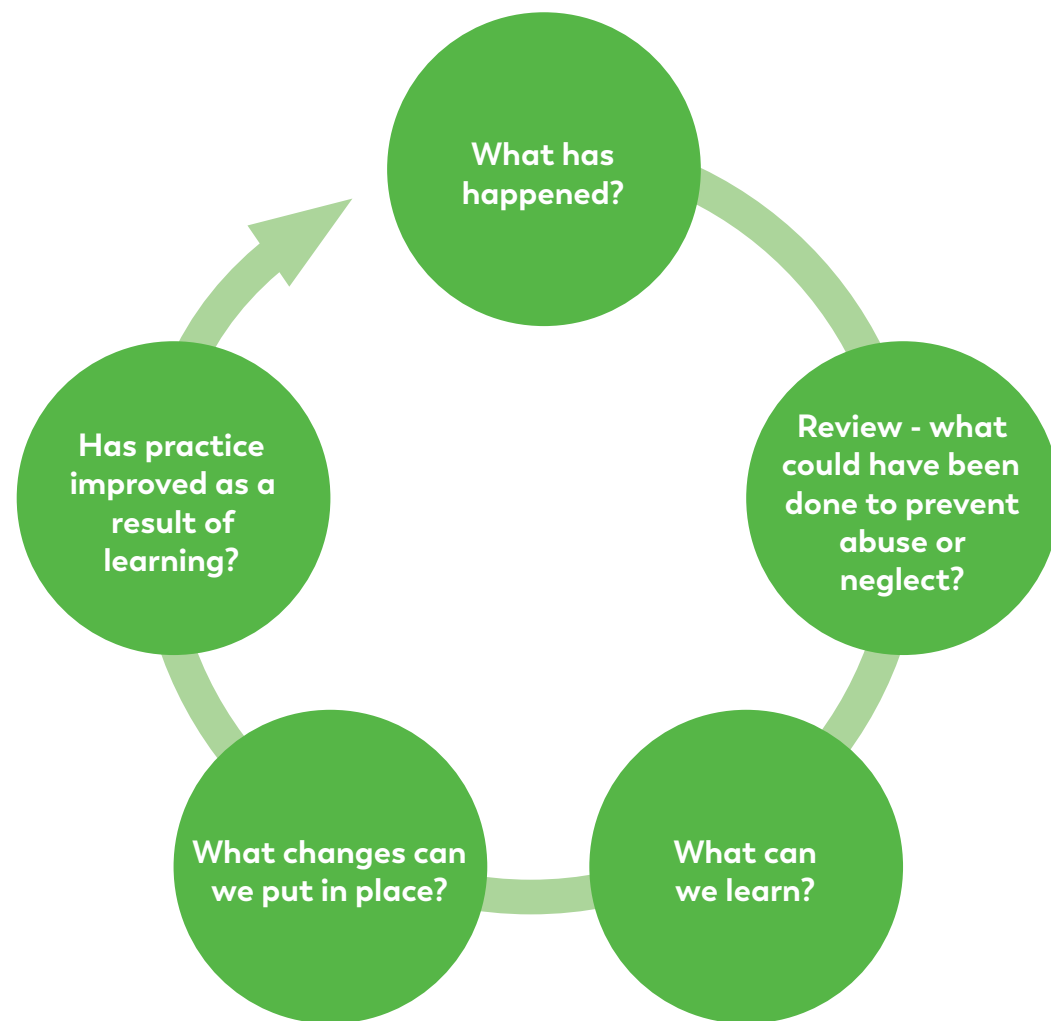
The OSCB have made sure they understand the 'big picture' with respect to keeping children well and are challenging in the right places. The matrix at Appendix E is an example of this 'big picture'.



## 5. Child Safeguarding Practice Reviews

### 5.1. Cases considered for review

This work is led by the Case Review and Governance subgroup - see section 2. The group drives the review, learn and improve functions of the board. Every time the local authority notifies Ofsted of a serious incident the subgroup will hold a Rapid Review of the circumstances. Five<sup>1</sup> Rapid Reviews concerning six children were held. The group considered that two of the five Rapid Review circumstances met the criteria for Child Safeguarding Practice Reviews and they have since been initiated.



### 5.2. Ongoing reviews

The OSCB has worked on ten reviews over the last year, which involved twelve children. A quarter of the reviews concerned children were aged under 5 years. The remaining children were aged between 10-15 years.

### 5.3. Safeguarding themes

Despite the small number of reviews the patterns and trends of maltreatment here do reflect national findings and trends:

- Responding to neglect and protecting children from its harmful effects is a perpetual and growing challenge for all those working to keep children safe
- Reviews frequently show difficult parental and family circumstances. Often there is not one single issue but a combination of different parental and environmental risk factors which built up over time including mental health, domestic abuse and drug and alcohol misuse
- The behaviour of vulnerable adolescents can detract from its underlying causes. Experiencing and perpetrating abuse are often closely related. Going missing is often a sign that there are other problems in their lives. Relationships are key to supporting adolescents. Most of the adolescents did not have good mental wellbeing
- Schools are key to noticing potential harm; to keeping children safe; to alerting other agencies for a child protection response and to challenging decisions. They do not always feel able to challenge decisions

### 5.4. Reviews published this year

In September 2019 the OSCB published a serious case review into the tragic death of a young boy, Child M, from injuries inflicted by his mother. Child M's mother pleaded guilty to causing his death by manslaughter on the grounds of diminished responsibility and was made the subject of an indefinite hospital order under the Mental Health Act.

A Mental Health Homicide Review into the care and treatment of the mother was commissioned by NHS England. Both independent reviews found that Child M's death could not have been predicted or prevented by professionals working with the family. More information and the learning from the review can be found on the OSCB website.

<sup>1</sup>This figure denotes serious incidents which occurred between 010419 and 310320

## 6. Improving practice through training and learning

The ten most common learning points from case reviews over the last year have been summarised in a poster for all to share. Learning documents have been produced, and are on the OSCB website on:

- Physical Abuse
- Parental Vulnerability
- Key points for strengthening working together in Oxfordshire poster
- Safeguarding Conversations / Supervision poster

At Appendix E we have attached a summary of safeguarding concerns which have come from case reviews and quality assurance work. These are things we want to improve our understanding of.

The OSCB has a wide-ranging training programme run by local practitioners free of charge. Their shared goal is to improve local practice and share local learning. Over the last year they have worked hard:

Thank you to all those workers in Oxfordshire who give their time, energy and experience to train their colleagues and strengthen our safeguarding partnership.

As well as the annual conference on the 'child's world' the OSCB has run workshops for hundreds of workers on:

- gangs and violence
- child exploitation
- multi-agency chronologies (time-lines)



**5,121** practitioners from across Oxfordshire attended **342** safeguarding courses. Of these **2414** were attending the **230** OSCB core courses.



The OSCB runs **3** core courses and a programme of specialist courses covering **5** themes: sexual behaviour, substance misuse, mental health, e-safety and working with fathers and other male carers.



OSCB courses are delivered by a team of over **80** volunteers drawn from a range of local voluntary and statutory organisations. They bring knowledge, experience and an insight into our partnership.



**4801** delegates completed online training. All core courses are now available on-line as well as specialist topics. Many have been updated and webinars are being developed in response to the impact of the Covid-19.



## 7. Strengths and Challenges

This report identifies areas of strength and challenge as follows:

### 7.1 Strengths

- ✓ The senior safeguarding partners have a high commitment to partnership working which is reflected across the broader board membership
- ✓ The OSCB is a well-functioning Board with a strong reputation
- ✓ The OSCB training and learning programme continues to be an example of excellent practice with local practitioners volunteering their time to deliver learning to thousands of colleagues across Oxfordshire each year
- ✓ The commitment of local practitioners to learn through review work
- ✓ The continued drive to address neglect through training, better resources and processes is positive and should continue
- ✓ The indication that more early help assessments are taking place and that the number of children on child protection plans has not risen is a good indication of change
- ✓ The nomination of workers across the safeguarding partnership for 'commendations' in safeguarding work
- ✓ The many examples of good practice in safeguarding work that see in audit work and assessment
- ✓ The involvement of children in case reviews and the life-letters written to help them understand our findings and learning



### 7.2 Challenges

- There is high demand on the statutory system, especially to help children, who need support from a range of services to help them
- Waiting times for children trying to get mental health support
- There are not enough places for children to go and stay when their needs are too complex for them to live at home
- The grades of disadvantaged school pupils are not as good as the national average of children in similar circumstances and long-term reporting of this data has evidenced this
- Our impact assessment tells us that local agencies are struggling from the financial pressures on resources and the capacity to retain staff to manage it
- We know that Covid-19 means that we need to be prepared to support children as lockdown restrictions ease and demand for help increases for vulnerable children and families

Challenges in terms of practice improvement remain the same. As 'system issues' they need leaders, headteachers, senior managers to maintain a collective focus on them.

- **Neglect:** We know that workers from police, health and social care all need to be part of decision making at 'case conferences'. Together they could make use of the 'multi-agency chronology' to better understand the family background, the sources of support and progress made in creating a safe home for their children
- **Safeguarding in (and out of) Education:** We know, as safeguarding leaders, that we need to develop a shared vision with all partners. This should include an improved understanding of education entitlement and provision. OSCB partners are in the early stages of delivering change and improving practice
- **Contextual safeguarding and child exploitation.** We know that the local arrangements need to be properly understood and better used. We also see increasing numbers of adolescent children who could benefit from more co-ordinated support for their mental health, emotional wellbeing and resilience

The OSCB will be taking these challenges forward into its business plan summarised on the next page.

**Priorities going forward:**

**LEADERSHIP AND GOVERNANCE**

We will make sure the plans for our safeguarding partnership are working well for us and our partners. This will include:

- Work with the adults' board to look at safeguarding risks in relation to housing and homelessness
- Work with Barnardo's to understand young people's experiences of significant harm beyond their families and keep them safe from it
- Work with Hampshire safeguarding partnership to get a second opinion on how well we are doing with our new set of arrangements led by the three partners of health, police and the county council
- Noting really good work and 'commending' those who do it
- Making sure we get our messages clear e.g. about listening to children at all times and that safeguarding is something we should all be doing

**IMPROVING PRACTICE**

Our learning says that we must focus on:

- Neglect
- Keeping children safe in and out of education
- Child exploitation

**SCRUTINY AND QUALITY ASSURANCE**

We will:

- Check how well organisations meet safeguarding standards and think about the needs of vulnerable children and families
- Learn from case reviews, audits and assessments
- Embed change





## Appendix A. OSCB membership

Independent Chair, Barnardo's

Oxfordshire County Council: children's services, youth justice services, adult services, fire and rescue services, legal & public health

NHS Oxfordshire Clinical Commissioning Group

Thames Valley Police

Oxford University Hospitals NHS Foundation Trust

Oxford Health NHS Foundation Trust

West Oxfordshire District Council

Cherwell District Council

Oxford City Council

South Oxfordshire and Vale of White Horse District Council

Children and Family Courts Advisory and Support Service

Community Rehabilitation Company

National Probation Service

Lay Members

Representation from schools and colleges

Representation from the voluntary sector

Representation from the housing sector

Representation from local judiciary

## Appendix B: The OSCB's structure

## Appendix C: The OSCB's linkages

## Appendix D: The Oxfordshire Safeguarding Children Board budget

	<b>Expenditure 2019/20</b>
<b>Funding streams</b>	
Public Health	-£30,000.00
<b>Income</b>	
Foster carer training	-£1,700.00
Non-attending delegates	-£16,150.00
Hosting of courses	-£1,687.00
<b>Contributions</b>	
OCC Children, Education & Families	-£201,100.00
OCC Dedicated schools grant	-£64,000.00
NHS Oxfordshire CCG*	-£60,000.00
Thames Valley Police	-£21,000.00
National Probation Service	-£1,410.00
CRC	-£2,500.00
Oxford City Council	-£10,000.00
Cherwell DC	-£5,000.00
South Oxfordshire DC	-£5,000.00
West Oxfordshire DC	-£5,000.00
Vale of White Horse DC	-£5,000.00
Cafcass	-£500.00
Public Health (see above)	£0.00
<b>TOTAL INCOME</b>	<b>-£430,047.00</b>
<b>Expenditure</b>	
Independent Chair	£32,714.00
Business unit	£272,438.00
L & I work	£17,087.00
Training & learning	£69,065.00
Subgroups	£10,672.00
All case reviews	£43,357.00
<b>TOTAL</b>	<b>£445,333.00</b>
Available reserves	£78,299.00
Drawdown	£15,286.00
Reserves Balance	£63,013.00

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



# Appendix E: Matrix of safeguarding concerns

● Audits ● Data ● Assessments ● Escalated issues ● Case reviews

## SAFEGUARDING CONCERNS

...that are about our systems and how we work together as a whole	
Shared vision across schools and partners to keeping children safe in school	● ● ● ●
Improve grades of disadvantaged school pupils in Oxfordshire to be as good as national averages	● ●
Managing demand for services especially in relation to mental health, knife crime and exploitation.	● ● ● ●
Being clear about when and how to use early help assessments to identify low-level neglect	● ● ●
Improve our waiting times for children wanting to access mental health services	● ●
Improve attendance at case conferences by all partners in person or online	● ● ● ●
... that are about our practice	
Making the right decision, at right time with the right people	● ● ●
Joint reflection by professionals on the progression of casework is valued	●
'Think family' but not losing sight of individual children within families	● ●
Capture children's views to inform decisions	● ●
Shared chronologies to better understand a child's life	● ●
Understand the 'lived experience' of the child in the family:	● ●
Curiosity about the family's past history and relationships	● ●
Good practice basics: better record, share information and use safeguarding policies	● ●
Rethinking did not attend to 'was not brought'	● ● ●
Follow best practice when responding to physical abuse	●

... that are repeat themes	
Respond quickly to neglect	● ● ●
Vulnerable adolescents: exploitation; difficult relationships; mental wellbeing; going missing	● ● ●
Children's limited capacity to protect themselves as they move into adolescence	● ● ●
Understanding safeguarding risks that exist in the child's environment	● ●
Schools are key to spotting potential harm; keeping children safe; alerting others	● ● ● ●
Parental well-being: mental health, domestic abuse and substance misuse	● ●
Focus on children's emotional wellbeing	● ● ●



**OSCB**

Oxfordshire  
Safeguarding  
Children Board

**[oscb@oxfordshire.gov.uk](mailto:oscb@oxfordshire.gov.uk)**  
**[www.oscb.org.uk](http://www.oscb.org.uk)**

Images used in this annual report are stock images