OSCB
Oxfordshire
Safeguarding
Children Board

Annual Report 2021-22

Foreword by the Senior Safeguarding Partners

We have the responsibility to work collectively and to drive forward improvements in our safeguarding system to ensure that children are safe as possible in Oxfordshire.

In our third year of reporting as senior safeguarding partners it has been rewarding to see progress across the system and to commend practitioners for some excellent safeguarding work.

However, local data tells us that children are 2 and half times more likely to have a statutory assessment than an early help assessment in Oxfordshire. Organisations in Oxfordshire need to increase early help work for families. We support the view that this needs to be led and resourced at a senior level in line with the Children and Young people's plan.

Local safeguarding practice reviews and quality assurance work point to where more could be done. Our message to local organisations is to ensure that they are doing everything they can to support our priorities of neglect, child exploitation and keeping children safe in school. For us to be effective against these serious safeguarding concerns, we need to work collectively.

We will maintain close oversight to make sure capacity issues and demand are known across the partnership so we can tackle them together as a whole system. We thank those people working locally, who make a positive difference to children and families' lives and recognise the commitment that they have to keeping children as safe as possible.

Independent commentary by the OSCB Independent Chair

The last year has presented partners with a range of safeguarding challenges, from adjusting to the latter stages of the pandemic to tackling persistent issues such as neglect, extra-familial harm and keeping our children safe in school. All this has had to be faced against a backdrop of increasing demand and worrying staffing pressures.

The Partnership in Oxfordshire has sought to work effectively together to meet the needs of its children and young people, carrying out important learning reviews and holding partners to account for their safeguarding responsibilities.

There is a robust safeguarding structure in the county, with a wide range of agencies and organisations involved. As well as the formal meeting programme I have sought to better understand the day-to-day realities of colleagues by having a series of 1:1 meetings both in-person and virtually. This has shown me at first hand their commitment and dedication to our young people.

We must remain vigilant to the safeguarding risks facing our communities and I am confident the OSCB and its partners are committed to that task.

Derek Benson

Contents

1. Introduction

We want to keep children in Oxfordshire as safe as possible by making sure everyone understands their roles and responsibilities regarding safeguarding through training, learning and local resources.

This report sets out what we have done to achieve our shared vision and aims for children in Oxfordshire.

Our vision

We want to keep children in Oxfordshire as safe as possible by making sure everyone understands their roles and responsibilities regarding safeguarding through training, learning and local resources.

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**

2. Providing leadership for effective safeguarding practice

Stephen Chandler
Chief Executive of Oxfordshire County Council

James Kent
Integrated Care System Lead, Buckinghamshire, Oxfordshire, and Berkshire West Clinical Commissioning Group

John Campbell
Chief Constable, Thames Valley Police

Oxfordshire's senior safeguarding partners.

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

Cherwell District Council North Oxfordshire
NHS Commissioning Board A special health authority
Oxfordshire County Council
OCVA Oxfordshire Community & Voluntary Action
NHS Oxford University Hospitals NHS Foundation Trust
Oxford City Council
NHS Oxford Health NHS Foundation Trust
Probation Service South Central
response
NHS South Central Ambulance Service NHS Foundation Trust
South Oxfordshire District Council
Thames Valley Police
Vale of White Horse District Council
West Oxfordshire District Council

The board includes independent community members and voluntary sector members also.

Safeguarding work is driven by multi-agency subgroups. You can find information on them, our membership, funding, and links to other partnerships in links at the end of this report.

Our partnership is not responsible or accountable for delivering child protection services, but we keep children as safe as possible because we:

- provide oversight
- identify and escalate emerging issues
- seek assurance
- challenge and hold each other to account

UPDATE ON THE LAST 12 MONTHS

- raised with the government the bigger safeguarding issues, which cannot be sorted locally. This included the availability of homes close to Oxfordshire for children who have a complex set of safeguarding needs and cannot live at home
- strong assessment of risk and capacity in the safeguarding system post-covid
- overseeing the learning from local and national reviews to improve practice
- allocating additional resources on child exploitation and neglect
- new guidance on information sharing by the police regarding taxi drivers
- commended 5 individuals for good safeguarding leadership from schools, the police force and the community and voluntary sector
- commended 3 groups of individuals, who worked well together on safeguarding initiatives

EFFECTIVENESS OF LEADERSHIP IN SUMMARY:

- ☑ strategic ownership of safeguarding by police, health and the county council
- ☑ good, frequent engagement of the partners bringing added value in terms of direction, decision making and connection
- ☑ need to ensure that the new Integrated Care Services for health is represented at the right level in the coming year

3. Children in Oxfordshire

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[1]. 26% of the school age population are from ethnic minority groups.

What we know about different levels of support for children and families

Early help In Oxfordshire ↑	2,938 assessments were completed. However early help in Oxfordshire is at lower levels than in similar counties
Request for support through the Multi-Agency Safeguarding Hub (MASH) ↑	23,920 contacts. An increase of 33 %. However, there was no notable rise in referrals to social care, with most families being directed to other support
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 ↑	776 last year to 846 children this year. This is due to us caring for more Oxfordshire children as well as unaccompanied children

This means that children are 2 and half times more likely to have a statutory assessment than an early help assessment in Oxfordshire. The safeguarding system needs to increase its early help work.

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

4. The effectiveness of safeguarding arrangements

Our partnership has 3 safeguarding issues where practice improvement is essential

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

TACKLING NEGLECT

What went well	Even better if
✓ improved focus demonstrated through a 'challenge event' which showed progress so far	● neglect was identified earlier before families reach a crisis point and need statutory help
✓ operational and strategic level work to support change in practice across our safeguarding partnership	● changes in practice are embedded across the whole system
✓ individual organisations taking responsibility for how they can make a difference	● practitioners and managers routinely used the tools and resources available
✓ audit of practice to identify gaps in the system	

CHILD EXPLOITATION WORK

What went well	Even better if
✓ hospital navigator system set up	● the shared vision and strategy are embedded
✓ targeted joint-working across the police, children's social care and the youth justice service to disrupt the criminal exploitation of children	● the screening tool and pathway are embedded
✓ review of screening tool to improve identification of children at risk of exploitation	● inter-agency data systems and information sharing are in place
✓ review of multi-agency groups tackling child exploitation to streamline work and improve practice	● disruption of criminals is targeted and effective
✓ audit of practice to identify gaps in the system	● all staff feel confident and have the skills to tackle child exploitation
	● need is identified at an early point and support is given

KEEPING CHILDREN SAFE IN SCHOOLS AND SETTINGS

What went well	Even better if
✓ exclusions of children from school have reduced. Looking at a 4-term timeframe they fell from 66 in 2019/20 to 19 in 2021/22	● we improve attendance at school for the most vulnerable groups as this has increased over the last 12 months
✓ suspensions fell from 1741 to 846 in the same period	● we could increase 'early help' work

EFFECTIVENESS OF DRIVING FORWARD PRACTICE IN SUMMARY:

- ☑ improvements made in all three priority areas
- ☑ limitations of progress also noted - a push is needed by all partners to keep these gains
- ☑ local leaders need to drive forward the cultural change and the system change for the safeguarding partnership to be more effective

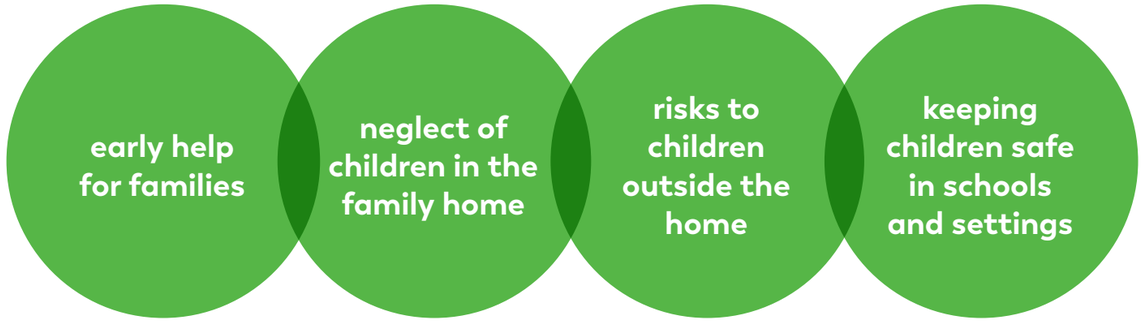
5. Findings from Child Safeguarding Practice Reviews

The OSCB has worked on 5 reviews for 6 children in 2021/22.

The Serious Case Review for Child R was published in December 2021. Child R was thirteen years and seven months old when she died in an out of county residential placement. She had previously been in foster care in Oxfordshire and had also been treated in an Oxfordshire in-patient psychiatric unit prior to moving to the residential home. She was part of a large sibling group, who had been supported by services for some time. Safeguarding concerns included neglect, physical harm and sexual harm. A Report and Learning summary are published on the OSCB website. The ten recommendations from the Child R serious case review published this year are a good reference point on what needs to improve in Oxfordshire's safeguarding system.

What we know

The repeat safeguarding themes identified in reviews last year are still current:



However, there are new repeat factors from the more recent reviews:

- **Child sexual abuse & Child sexual exploitation**
- **Sharing of intimate images on-line**
- **Children's emotional wellbeing & mental health**

Leadership and organisational culture impact on practice. The messages for system leaders are that we should:

- **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 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
- **Improve our use of language and our communication**

EFFECTIVENESS OF LEARNING FROM PRACTICE REVIEWS

- ☑ analysis is independent and constructive involving families and practitioners
- ☑ recommendations can be evidenced as changing systems and services
- ☑ new messages are coming through about how we support practitioners working with safeguarding issues such as child sexual abuse and online abuse

Findings from Child Death Overview Panel 2021-22

The OSCB has worked on 5 reviews for 6 children in 2021/22.

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 deaths of all children resident 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 clinical staff. 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 available.

Summary

In 2021-2022 there were 32 notifications of a child dying in our area – this is a slight increase from last year (23), 46% were under 27 days old. There were 7 joint agency response meetings for a family in which their child died suddenly. The Child Death Overview Panel met 4 times and reviewed 24 cases. 42% of those cases reviewed had 'modifiable factors', compared to the national figure of 37%.

Learning and actions from the reviews completed in 2021-2022:

- Co-sleeping, smoking by the primary carer and alcohol consumption pre-incident were factors identified, together and separately, as modifiable factors in 2021-22
- A new co-sleeping animation was developed and shared widely alongside the Berkshire West 'Lift the Baby' film
- Proactive end-of-life planning and timelier interprofessional communications, particularly between community care providers and acute teams has been recommended to teams as beneficial to improving more holistic care provision and coordinated, shared family support
- New symptoms or behaviours should be proactively followed up in children with complex needs to enable timely treatment changes and care reviews e.g. seizure activity
- Water safety advice to private landlords and to children is schools has been updated especially emphasising the risks of cold water and open water settings.

6. Embedding learning and improvement

'I have just taken part in the (Jacob CSPR Learning) session which was so powerful and beneficial', Probation Service

Really positive to be able to see how a SCR supported the development of services and communication links

The OSCB aims to improve practice through learning from reviews. We keep in touch with practitioners and run online events.

In 2021/22 a 'Big Day of Learning' included the Chair of the National Safeguarding Practice Review Panel as keynote speaker. Over 300 practitioners attended OSCB multi-agency learning events on:

- Improving our practice through learning from reviews
- The right support at the right time
- Introduction to the mental health pathway
- Reducing the Risk, The Domestic Abuse Act 2021
- Untouchable worlds, learning from the Child Safeguarding Practice Review for Jacob
- Updated learning from the CSPR for Jacob

Learning has led to improved ways for us to work together:

Thresholds of Needs Matrix. This provides advice on 'what to do and when' to ensure that children and families get the right support at the right time.

...an updated **Joint Operating Framework for Taxi Licensing** providing a single set of minimum standards for agencies with responsibilities for transporting children

...review of the **multi-agency chronology** to improve the way that we work and understand 'what it means to be a child in the family' that we are supporting

Partners ran campaigns on concerns such as safer sleeping:

- LIFT THE BABY – for safer sleeping
- Lullaby Trust safer sleeping advice
- NHS Oxfordshire CCG unsafe sleeping for babies

The OSCB online procedures manual was updated

- FGM learning resource developed
- Joint activity pathway for children and adult services when supporting parents with mental health problems
- Protocol for management of bruising in pre-mobile babies/children

Learning through training

Summary

289 training events in total

5,072 practitioners attended virtual and face to face training

8,809 practitioners completed online learning

Practitioners have told us about OSCB training

"I described it as akin to quality supervision (a rare experience for many Designated Safeguarding Leads). A fantastic use of time and resource"

"This was by far the best Safeguarding course I have done. Great information sharing"

OSCB trainers are volunteers

75 volunteer safeguarding trainers

12 new trainers joined our 'virtual training team' this year

3 development sessions were held for trainers to build their knowledge of self-harm referrals and healthy strategies, domestic abuse and young people and case reviews

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.

OSCB trainers have told us...

'I enjoy it, it gives me lots of different perspectives, pushes me to keep up to date on research and knowledge, I generally enjoy passing that knowledge to others. People are nice, I find it more valuable in terms of my development then going to training sessions, trainer development days are a good space to get together with other professionals'

EFFECTIVENESS OF EMBEDDING LEARNING IN SUMMARY:

- ☑ learner gain is recorded & feedback shows how learning will be applied
- ☑ training is delivered by local volunteers, with pace so that learning is embedded through the local network
- ☑ multiple resources demonstrate how well partners share key messages

7. Evidence and Assurance

The OSCB looks at the children's safeguarding system in different ways to check how well it is working.

organisations check how well they comply with safeguarding standards and look at pressures on their services	we review how well organisations work with others to support children	from practitioners, families and children: an important part of the jigsaw, these are included wherever possible	we review facts and figures against local targets
we reviewed 11 large services which support children in some way through a self-assessment and a peer review	we reviewed children's experiences of support, where they were at risk of exploitation, where they had experienced substantial neglect	over 700 practitioners completed an online safeguarding questionnaire for the OSCB	we review data on all safeguarding pressure points at all levels of the partnership on a bi-monthly basis

Main areas of safeguarding concern in summary over the last 12 months

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

- Contacts into the Multi-Agency Safeguarding Hub (MASH). In 2020/21 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.
- 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.
- Waiting times for children with mental health problems.
- 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.
- 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).
- Recruitment and retention across the whole system alongside the impact of Covid. All safeguarding partners have noted this as a challenge in the current economic environment through the safeguarding self-assessment

EFFECTIVENESS OF QUALITY ASSURANCE:

- ☑ partners have a full picture of the safeguarding system for children across the local authorities, police and health including emerging issues e.g., concerns regarding mental health, self-harm, increases in home education
- ☑ progress is evidenced: use of new resources; escalation of issues to strategic safeguarding partners
- ☑ there are a number of repeat messages which need senior leaders to reflect upon to deliver change in particular in terms of neglect and child exploitation

Annual Report 2021/22 Conclusions

Strategic safeguarding partners need to take a lead on embedding the learning from 2021/22 in their organisations and across the system. This includes:

- 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 our priorities for neglect, child exploitation and keeping children safe in school – these need whole system change and should be everyone's business
- making sure capacity issues and demand 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

Appendix A: Key safeguarding messages for Oxfordshire stakeholders

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 MASH on **0345 050 7666** during office hours.

Children and young people:

✓ thank you for telling us what you think

- we are promoting the Children Care Council's Good Communication Guide that has been updated with the support of the Safeguarding Young Ambassador
- we know that:
  - family relationships matter to you and we should recognise that more when trying to support you
  - we need to listen better to what you are telling us about what you need and what you feel and that we then take action together that makes a difference
  - we should recognise when your behaviour is telling us something has happened to you
  - how we talk to you and how we write about you matters

Children's workforce:

✓ Thank you for doing a great job under pressure

✓ We have heard some great feedback about you, which has said that you "are committed to improving the experience of children and young people in Oxfordshire"

- Please consider these learning points from recent case reviews:

1. **Child sexual abuse.** We need to know how to recognise it, how to talk about it and how to address it with care. Children need to feel heard and feel safe
2. **Behaviours demonstrating a child's trauma** and their need for help when they are not telling us using words, in particular if they are non-verbal
3. **Thinking about how we talk 'to' and 'about' children.** Thinking through what words we use when we respond to children seeking help. Moving from "what is wrong with you" to "what has happened to you". This includes how we write about children
4. **The long-lasting impact of adverse childhood experiences** which play out as a child becomes an adolescent and then a young person. We need to recognise emotional abuse and emotional neglect and the role that child blame plays within this
5. **Safe sleeping.** Getting the message out there to all parents and carers, not just mums
6. **Working with fathers and male carers.** In the majority of reviews, where a child was harmed by an adult, the adult was a male and not enough was known or understood about that adult. Attention needs to be given to the whole family and all those who care for the children

Heads and Governors of schools:

✓ Good work has been done to keep children in education and to reduce exclusions

✓ More schools are providing 'early help' to pupils and their families. Two schools were recognised for their early help work this year – we would like to extend this to all schools in 2022/23. Tell us about your good work.

✓ Safeguarding partners do not underestimate the investment this takes in terms of time and commitment to all pupils and families

✓ 100% return of schools safeguarding assessments. Make sure that your safeguarding governors have seen this and signed it off.

- Check your pupil attendance and take action – know their 'whereabouts'. We know that children are safer in school
- Governors should ensure that they are focussed on attendance of children in their school and have identified a senior lead with responsibility for early help

The community, faith and voluntary sector:

- Your role in early help is important: we recognise that you are managing a lot of challenging work
- Make use of the bespoke OSCB safeguarding policy template and checklist
- Carry out a safeguarding self-assessment

Senior managers and leaders:

- ensure early help is led and resourced at a senior level in line with the Children and Young people's plan.
- ensure your organisation is doing everything it can to support our priorities for neglect, child exploitation and keeping children safe in school – these need whole system change and should be everyone's business
- make sure capacity issues and demand in your agency are known across the partnership so we can tackle them together as a whole system

Appendix B: Matrix of safeguarding concerns from quality assurance work

Review work · Quality assurance work · Data · Escalated issues

...that need regional and national attention	
Availability of homes close to Oxfordshire for children who have a complex set of safeguarding needs and cannot live at home	● ● ● ●
...that are about our systems and how we work together as a whole	
Cultural shift in helping families at an early stage collectively to tackle neglect in the family home	● ● ● ●
County-wide effort to deal with the exploitation of children outside of their home	● ● ● ●
Shorter waiting times for children who need help with mental health problems	● ● ● ●
Shared vision and connectivity with schools about keeping children safe	● ● ● ●
Recruitment and retention across the system is challenging and adding to service pressures post-covid	● ●
...that are about our practice	
Straight talking with families to identify and name neglect	● ● ● ●
Using the same resources to help families at an early stage e.g., early help assessment	● ●
Thinking about safeguarding all family members – parents, children, siblings – when you may have contact with just one family member	● ●
Better sharing of safeguarding information across different health information systems	● ●
...that are repeat themes	
Lower exam grades for the most disadvantaged children	● ● ● ●
Children being visible to others and kept safe in early years settings and education during the day	● ● ●
Complex range of safeguarding issues that children face	● ● ● ●
...that have come to the fore through the pandemic	
Importance of keeping sight of the most vulnerable children	● ●
Emerging issues of domestic abuse and mental health concerns following lockdowns	● ● ●
Increased demand on frontline services post lockdown	● ● ●

Appendix C: Links

...to the multi-agency safeguarding arrangements

...to more 'about us'

Appendix D: OSCB Budget

	End of year figures 2021/22
Funding streams	
Public Health	-£30,000.00
Income	
Foster carer training	-£3,400
Non-attending delegates	-£9,465
Platform fees	-£63
Contributions	
OCC Children, Education & Families	-£206,400
OCC Dedicated schools grant	-£64,000
NHS OCCG*	-£60,000
Thames Valley Police	-£21,000
National Probation Service*	-£1,410
CRC*	-£2,500
Oxford City Council	-£10,000
Cherwell DC	-£5,000
South Oxfordshire DC	-£5,000
West Oxfordshire DC	-£5,000
Vale of White Horse DC	-£5,000
Cafcass	£0
Public Health (see above)	£0
TOTAL INCOME	**-£428,238.00**
Expenditure	
Independent Chair	£26,700
Business unit	£274,107
L & I work	£9,104
Training & learning	£39,868
Subgroups	£8,261
All case reviews	£28,163
CSPR Action planning work	£22,172
Neglect work	£559
TOTAL	**£408,934**
Available reserves*	£73,975
Drawdown	£0
Add to reserves	£19,304
Reserves Balance	£93,279

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

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