

Division(s):

## CABINET - 20 NOVEMBER 2018

### THE OXFORDSHIRE SAFEGUARDING CHILDREN'S BOARD ANNUAL REPORT/THE PERFORMANCE AUDIT & QUALITY ASSURANCE ANNUAL REPORT AND THE CASE REVIEW & GOVERNANCE ANNUAL REPORT

#### Report by Director for Children's Services

#### Introduction

1. Richard Simpson (OSCB Independent Chair), Lara Patel (Deputy Director, Safeguarding, Children, Education and Families) and Tan Lea (Strategic Safeguarding Partnerships Manager, Children, Education and Families) will present a paper on **three** annual reports from the Oxfordshire Safeguarding Children Board. The reports concern an overview of safeguarding work; serious case reviews and quality assurance.

The Cabinet is requested to note these annual reports and provide any comments.

#### Background

2. Local Safeguarding Children Boards were set up under the Children Act 2004 to co-operate with each other in order to safeguard children and promote their welfare.
3. The Oxfordshire Safeguarding Children Board (OCSB) is led by an independent chair and includes representation from all six local authorities in Oxfordshire, as well as the National Probation service, the Community Rehabilitation Company, Police, Oxfordshire Clinical Commissioning Group, Oxford University Hospitals NHS Trust, Oxford Health NHS Foundation Trust, schools and Further Education colleges, the military, the voluntary sector and lay members.
4. The Board is funded through a partnership arrangement and meets 4 times per year. The Board is supported by a Business Unit located within Oxfordshire County Council. The board has two joint meetings with the Safeguarding Adults board per year. There are three area groups to ensure good communication lines to frontline practitioners.
5. The Board has a series of multi-agency subgroups, each of which produce an annual report. This paper includes annual reports produced by two the subgroups working on learning and improvement in safeguarding practice: the Case Review and Governance subgroup and The Performance, Audit and Quality Assurance subgroup.

## OSCB Annual Report

6. The key purpose of the **OSCB Annual Report** is to assess the impact of the Board's work in 2017/18 on:
  - service quality and effectiveness
  - safeguarding outcomes for children and young people in Oxfordshire.
7. The report evaluates performance against the priorities that are set out in the Business Plan for the year and against other statutory functions that the LSCB must undertake.
8. The report highlights lots of good examples of safeguarding work within the partnership. This included the successful conviction of a predatory offender through the actions of a taxi driver, who had undertaken local safeguarding training; the successful prosecution of a perpetrator of historical abuse through the use of multi-agency guidance for responding to non-recent (historic) abuse (example from OH NHS FT); identified improved attendance at Core Groups and timely responses to requests for information from the Multi Agency Safeguarding hub (example from Community Rehabilitation Company); increased recording of children's information when attending domestic abuse incident by Thames Valley Police; increased involvement of the hospital's young people's group (Yippee) in decision making meetings; new material and video to promote the work on neglect (Children's Social Care); self-assessment in 'Excellence when working with boys on CSE (Kingfisher) as well as the development of a new exploitation group to address broader issues of child exploitation (all OSCB partners).
9. In 2017/18 the OSCB delivered over 150 free safeguarding training and learning events plus online learning. The training reached over 9000 members of the Oxfordshire workforce:
  - ✓ 2040 multi-agency practitioners trained core safeguarding
  - ✓ 417 multi-agency practitioners trained on early help assessments
  - ✓ 451 multi-agency practitioners trained on mental health, child sexual exploitation, working with men and boys, drugs and alcohol and sexual abuse
  - ✓ 38 multi-agency practitioners trained on female genital mutilation
  - ✓ 697 early years multi-agency practitioners trained on safeguarding
  - ✓ 3854 multi-agency practitioners trained on abuse and neglect; safeguarding and think family
10. The OSCB delivered termly newsletters to over 4000 members of the workforce and e-bulletins to educational settings across the county. Learning and improvement events for approximately 150 delegates each time have covered:
  - Ten learning points from Oxfordshire case reviews
  - Fathers and male care givers
  - Working with neglect

## Performance, Audit and Quality Assurance Annual Report

11. The Performance Audit and Quality Assurance subgroup scrutinises the effectiveness of safeguarding practice. This annual report summarises the common themes for learning and improvement to support vulnerable children. They are drawn from safeguarding self-assessments, school audits, single and multi-agency audits, participation work with children and young people, annual reports and serious case reviews practitioner feedback, performance data.
12. The quantitative data shows that levels of activity continue to increase across the safeguarding system. The child protection partnership has three key pressures on its system: rising demand, diminishing resources and staffing shortfalls as well as difficulties with staff recruitment and retention. This is accompanied by an increasingly complex set of issues for vulnerable young people ranging from self-harm, to peer abuse to social media pressures. The OSCB sees evidence for better understanding of thresholds and improved safeguarding front-door effectiveness as well as the need for better co-ordination of the routes for referral and assessment between early help and the multi-agency safeguarding hub.
13. Qualitative evidence highlights the complexity of cases not only within the children's safeguarding arena but also in relation to adults in those children's lives; the need for stable, appropriate and secure housing and the benefit of supporting vulnerable adolescents to develop protective behaviours. Quality assurance work has raised concerns locally about the pathway of support for young people suffering domestic abuse; the response and provision for young people exploited in crime-related activity as well as concerns about mental health and self-harm amongst young people.
14. Practitioners and Board members have told the OSCB that they are concerned about availability of hospital beds for children with acute mental health needs; placements for children in the care of the local authority; the quality of provision in the Secure Estate and the limited access that the local authority has to support children who are in Elective Home Education. These matters, along with the pressures on the system, are being escalated.
15. Parents and children have given three simple messages (1) '*communication, communication, communication*' (2) don't leave help until we are at crisis point, "*make a difference as early as possible*". (3) please co-ordinate your efforts and share information appropriately. Children also said to show you care, "*get to know me as a person not just a case or a set of problems*". They want to be informed and involved "listen to me".

## Case Review and Governance Annual Report

16. The purpose of the group is to support the OSCB in fulfilling its statutory duty to undertake reviews of cases both where the criteria<sup>1</sup> are met and where they are not met in order to provide valuable information on joint working and areas for improvement. The group comprises members drawn from Thames Valley Police, the County Council's children's services and legal services, the OCCG Designated Doctor and Designated Nurse and a Head teacher representative.
17. Over the last year the OSCB has worked on four different serious case reviews which have concerned five children. One of the serious case reviews is associated with a Mental Health Homicide Review. No reviews have been published this year.
18. The themes covered by case reviews have been: the long-lasting impact of neglect; physical abuse; self-harm; child and parental emotional wellbeing; engagement and attendance in education. The issue of neglect is a repeated theme in terms of the risks it presents to young children and the impact it continues to have as they grow up. In Oxfordshire neglect is the most common reason for a child to be subject to a child protection plan. The OSCB has a Task and Finish Group to co-ordinate work to address neglect.
19. The ten most frequently recurring learning points have been:
- 1) **Curiosity:** being curious about the family's past history, relationships and current circumstances in a way that moves beyond reliance on self-reported information
  - 2) **Responding to physical abuse:** professionals identifying it, listening to children and following safeguarding processes thoroughly; children may sometimes be too afraid to speak or unable to verbalise what they are going through
  - 3) **The role of schools in keeping children safe:**
    - effective management of records and sharing them when children transfer schools; effective escalation of concerns.
    - children are safest in full time education. Oxfordshire serious case reviews indicate that children on part time time-tables, children absent from school and children educated at home are at increased risk. School attendance is a critical factor to support opportunity, well-being and safety
  - 4) **Professional understanding of the implications of elective home education:** actively knowing which agencies are in touch with the family and to what effect
  - 5) **Taking a cumulative view when working with children:** not seeing events in a linear way but weighing up risks over time and keeping previous events in mind (using chronologies)
  - 6) **Parental wellbeing:** mental health, substance misuse and domestic abuse are recurring themes. With respect to mental health colleagues need to

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<sup>1</sup> Working Together to Safeguard Children 2015

recognise the risks and impact on the safety of the child; don't minimise 'older' information

- 7) **Fragmented management of health needs:** ensuring effective communication across services for co-ordinated and consistent management of care
- 8) **Children's emotional wellbeing:** increasing evidence of self-harm by children aged 10 years & above
- 9) **Children's limited capacity to protect themselves:** as they move into adolescence after experiencing a lack of consistent, supportive parenting in their early years (long lasting impact of neglect)
- 10) **Rethinking 'did not attend' to 'was not brought'**

## **Financial and Staff Implications**

20. None noted

## **Equalities Implications**

21. None noted

## **RECOMMENDATION**

**22. Cabinet is** requested to note these annual reports and provide any comments.

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October 2018