# CABINET – 13 OCTOBER 2020
# THE OXFORDSHIRE SAFEGUARDING CHILDREN'S BOARD ANNUAL REPORTS (INCLUDING BOARD, QUALITY ASSURANCE AND CASE REVIEW WORK)

**Report by the Independent Chair of the Oxfordshire Safeguarding Children Board**

## RECOMMENDATION

1. ***Cabinet is RECOMMENDED to note the reports.***

## Executive Summary

2. The Children and Social Work Act 2017 established collective responsibility of, and accountability for, local multi-agency safeguarding arrangements across chief officers in the county council, the NHS clinical commissioning group and the police.

3. These three 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)'.

4. The Oxfordshire Board 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, NHS 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.

5. 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. It also includes themes from two of the Board's multi-agency subgroups: the Case Review and Governance subgroup and The Performance, Audit and Quality Assurance subgroup.

6. The OSCB annual report is considered at Cabinet, the Health and Wellbeing Board and the full Council.

## Introduction

7. The OSCB Annual Report sets out the challenges of the ongoing demand on the system with neglect being a key feature; the need to keep children safe in

full-time education and the contextual safeguarding risks that exist for children outside of their home environment. The report acknowledges that, as ‘system issues’, they will need ‘system leaders’ e.g. political leaders, headteachers, senior managers to bring a collective focus on them to deliver change. The report provides context, examples of work and feedback from practitioners, children and families. The report also highlights a number of examples of good practice including the increase in support to families at an early stage; the multi-agency practice guides following case review and audits; the escalation of safeguarding issues to board level and the safeguarding training of approximately 10,000 local practitioners. It concludes that the partnership is strong and areas for improvement are known. Priorities are set out in terms of leadership, practice improvement and learning.

8. The priorities for safeguarding leaders are to ensure that the multi-agency safeguarding arrangements are effective through independent scrutiny; to develop work on common areas of housing with the adults board and contextual safeguarding with Barnardo’s; to communicate clear safeguarding messages to Oxfordshire’s’ community and to commend those who do an exceptional job with the safeguarding partnership.

9. The priorities in terms of practice improvement are keeping children safe from neglect; keeping children safe in education and keeping children safe from harm and exploitation outside the home (contextual safeguarding).

10. The priorities for learning and improvement are to check how well local agencies meet standards for safeguarding and to test that learning from our review work is embedded.

11. The Performance Audit and Quality Assurance subgroup scrutinizes the effectiveness of safeguarding practice. This annual report summarises the common themes for learning and improvement to support vulnerable children. It concludes that challenges for the safeguarding partnership are to not lose sight of the individual needs of children; to keep children safe from neglect and to take individual responsibility for our role in the safeguarding partnership. The report has evidence of high standards of partnership working and acknowledges the complex challenges faced by workers.

12. The Case Review and Governance Annual report outlines the framework in terms of Child Practice Safeguarding Reviews. It summarises the learning from all case reviews. It concludes that the findings are not dissimilar to those of the National Triennial Review of cases e.g. neglect, difficult family circumstances, the vulnerability of adolescents and the role of schools in keeping children safe. It provides links to the ten most common learning points and practice improvement guides and points out the role for system leaders to embed these changes.

## Financial and Staff Implications

13. The OSCB has a partnership budget which is agreed on an annual basis. The Annual report records spend for the last financial year.

## Equalities Implications

14. The OSCB considers the needs of the most vulnerable children in the county and ensures that organisations are co-ordinating services to meet their need.

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Background papers:
OSCB Annual Report
Case Review and Governance Subgroup Annual Report
Performance, Audit and Quality Assurance Subgroup Annual Report

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