

# PAPER

**BOD 121/2014**

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[This will be input by secretariat]

# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

# Board of Directors

**24 October 2014**

**Safeguarding Children and Adults**

**Annual Reports 2013/14**

**For: Information**

**Executive Summary**

Our Trust has a statutory duty to make arrangements to safeguard and promote the welfare of children under Section 11 of the Children Act 2004. We are a statutory member of five Local Safeguarding Children Boards (LSCBS) under section 13 of the Children Act 2004 including Oxfordshire, Buckinghamshire, Swindon, Wiltshire and BaNES, we also link with Milton Keynes.

The Care Bill which received royal assent in May 2014 will introduce statutory responsibilities for safeguarding adults for the first time, however in 2013/14 these responsibilities were enacted through multiagency partnership without statutory underpinning, Oxford Health FT is an active member of the Safeguarding Adults Boards in Oxfordshire and Buckinghamshire.

This report has been prepared:

1. **To provide the Board of Directors with an overview of the progress made to safeguard children and adults for the period 01/04/13 to 31/03/14 as outlined in the separate Safeguarding Annual Reports (appendices one and two).**
2. **To provide assurance that we comply with its statutory duties and CQC Outcome 7 Regulation 11 ‘Safeguarding people who use services from abuse’.**
3. **To give highlights for the Board from both Safeguarding Annual Reports to note and areas for development for 2014/15.**

Full details are outlined in full in the Annual Reports: Children Appendix 1 and Adults Appendix 2.

Key areas covered within the full reports are as follows:

* National Policy for Safeguarding including our response
* Safeguarding Governance Arrangements (children and adults)
* Partnership Working with Safeguarding Adults Boards and Local Authorities (Children and Adults)
* Serious Case Reviews and Partnership Reviews
* Think Family
* Implementation of Trust Training Strategy
* Implementation of Child Protection Supervision Arrangements.
* Safeguarding audit work (children and adults)
* Safer Recruitment
* Allegations management
* Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework – NHS Commissioning Board March 2013
* Key priorities for 2014/15

**Safeguarding children**

* **Tackling Child Sexual Exploitation Action Plan**

The Government published the ‘Tackling Child Sexual Exploitation Action Plan’ on 23 November 2011. This action plan brought together actions by the Government and a range of national and local partners to protect children from this largely hidden form of child abuse.

The action plan highlighted the need for effective links between child and adult services such as local authority social care, education and health services, the voluntary and community sector, local police and youth justice structures.

The actions in the plan were focused on ensuring that services respond to the particular needs of sexually exploited children and young people. The action plan refers particularly to the link between children going missing and being sexually exploited.

* **Savile Enquiry**

The Government commissioned an independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile. On 30 April 2013 Sir David Nicholson set an expectation that health organisations should review arrangements and practices relating to vulnerable people, particularly in relation to safeguarding, access to patients including that afforded to volunteers and celebrities and listening to and acting on patient concerns. Our Trust review is completed and the revised Trust Safeguarding Children policy 2013 now includes volunteers.

* **Dealing with Disclosures of Historical Sexual Abuse**

The Safeguarding team is currently working on new guidelines for staff dealing with disclosures of historical sexual abuse in conjunction with Thames Valley Police and Oxfordshire County Council. The group working on this includes representatives from Adult Mental Health Services and Psychological Services. In the wake of the Saville enquiry, this is a very important piece of work for the Trust accountability and as a guide to clinicians to ensure individual disclosures are risk assessed and information is shared appropriately if children remain at risk.

* **Partnership Working - children**

The Mandate from the Government to the NHS Commissioning Board (NHS CB) for April 2013 to March 2015 (published in November 2012) states:

***“We expect to see the NHS, working together with schools and children's social services, supporting and safeguarding vulnerable, looked-after and adopted children, through a more joined-up approach to addressing their needs.”[[1]](#footnote-1)***

**Multi Agency Safeguarding Hubs (MASH)**

The Trust is engaged in the introduction of the Multi-agency Safeguarding Hubs (MASH) as it is a key development in partnership working. The principles of a MASH Improving the way agencies work together to protect the vulnerable from harm, neglect and abuse.

Co-locating key safeguarding agencies enables:

* Better information sharing and decision making;
* Identification of risk at the earliest possible opportunity;
* Appropriate early and holistic interventions;
* A coordinated effective and timely response;
* Resulting in improved outcomes for children.

The Trust has been fully engaged with the setup of the MASH service in Oxfordshire and Buckinghamshire and provided support to the Swindon, Wilts and B&NES areas.The MASH for both Oxfordshire and Buckinghamshire commenced at the end of September 2014. The Oxfordshire Multi Agency Safeguarding Hub will support a co-located team and partnership working approach between the Children’s Social Care, Thames Valley Police, Oxford Health and Oxford University Hospitals. This will include the Trust provision of Named Nurses to support interagency working. This new initiative is an important priority for the Trust in 2014/15. In Buckinghamshire the Trust will be a virtual partner working with Children’s Social Care, Thames Valley Police and Buckinghamshire Health Trust to ensure information is shared and informs the decision making in the management of a case.

The need for robust Information security and information governance protocols is included in the MASH project plans. The Trust Caldecott Guardian is involved in this area of work to ensure health information governance requirements have been included.

* **Child Sexual Exploitation**

This has been the main area of work in 2013/14 in Oxfordshire. As a result of a joint investigation between the police and social care, Operation Bullfinch, nine men were charged and committed to trial at The Old Bailey. The case concluded in May 2013 and there were 59 guilty verdicts against seven of the men who received sentences totalling 95 years. There have been further arrests made in Banbury in the summer of 2014 and the trial for these men will be taking place in December 2014.

In response to this and in line with national guidance the Trust with other health providers have supported the implementation of Oxfordshire Safeguarding Children Board (OSCB) Child Sexual Exploitation Strategy.

Specific activities include:

* The Trust has been commissioned to provide a full-time health practitioner in Oxfordshire Multi-agency Child Sexual Exploitation team (Kingfisher Team) until 2015. The post is currently working with victims and those at risk of CSE offering health needs assessment and continued support for as long as they remain with the Kingfisher Team
* The Kingfisher Team has won three National Awards for their work with CSE in Oxfordshire; being recognised for working in an innovative way with extremely vulnerable young people
* The Looked after Children team specialist nurse also now attends the missing person’s panel on a monthly basis

Following the launch in October 2012 of the OSCB strategy and practitioner toolkit, training is ongoing in relation to child sexual exploitation (CSE); including use of CSE risk assessment tool and has been completed with Children Universal Services, school health nurses and CAMHs. The Child and Adolescent Harmful Behaviours Service is also providing training via OSCB training programme

**Highlights from the Safeguarding Adults Annual Report**

* **Systematic recording reporting of Adult Safeguarding particularly in community mental health teams**

There is a lack of assurance regarding the recording of safeguarding concerns reported to OCC through the SWIFT system; this is a social care electronic recording system within community Mental health Teams. An audit is being undertaken to examine safeguarding practice within these teams.

* **Reduction in the use of Restrictive practice**

Following the publication of National Guidance aimed at reducing to zero the use of restrictive practice within two years we have been improving our reporting and recording of restraint and seclusion, this has had an impact of reducing rates. We have reviewed our training and plan to run a new training programme for **P**ositive **E**ngagement **a**nd Caring Environments. This eliminates the use of certain restraint holds and positions which are highest risk. It also focusses on earlier engagement, interaction and prevetion.

* **Deprivation of Liberty Safeguards**

It is anticipated that in 2014/15 there will be an increase in applications and authorisations granted. This will reflect the Cheshire West Judgement of the Supreme Court in March 2014.Delays are being escalated to relevant Supervisory Bodies within the relevant Local Authorities.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Requests | Granted | Not Granted |
| Oxfordshire (mental Health wards) | 8 | 5 | 3 |
| Oxfordshire Community Hospitals | 19 | 13 | 6 |
| Buckinghamshire (mental health wards) | 25 | 21 | 4 |
| **Total** | 52 | 39 | 13 |

**Governance Structure**

Our OHFT Executive Safeguarding Lead for both children and young people and adults is the Director of Nursing and Clinical Standards. The safeguarding teams provide support across the organisation and link across our geography into local safeguarding boards.

The Safeguarding Children Service is led by the OHFT Lead Nurse Safeguarding Children, who is accountable to the Director of Nursing and Clinical Standards and works alongside the Trust Lead Doctor Safeguarding Children.

The Safeguarding Adults team is led by the Head of Nursing for Older Adult Mental Health who reports to the Director of Nursing and Clinical Standards. There is a team of two full time NHS safeguarding managers and four part time Social Care leaders.

Both safeguarding teams work collaboratively and report progress on their work plans, professional practice issues and partnership actions to the Trust Safeguarding Committee a sub -committee of the Safety Committee.

Policies are in place for both safeguarding children and young people and for safeguarding adults.

**Recommendation**

The Board is asked to note progress within the report and priorities we are addressing this year 2014/15.

**Lead Executive Director: Ros Alstead, Director of Nursing and Clinical Standards**

**Appendix 1**

**Safeguarding Children and Young People**

**Annual Report 2013/14**

1. **Introduction**

Oxford Health NHS Foundation Trust has a statutory duty to make arrangements to safeguard and promote the welfare of children under Section 11 of the Children Act 2004. The Trust is a statutory member of the Local Safeguarding Children Boards (LSCBS) under section 13 of the Children Act 2004.

**2. Purpose**

To provide the Trust Board with an overview of the progress against the safeguarding children priorities for period 01/04/13 to 31/03/14 as outlined in the Safeguarding Children action plan.

To provide assurance that the Trust is compliant with its statutory duties and CQC Outcome 7 Regulation 11 ‘Safeguarding people who use services from abuse.

To outline the safeguarding children priorities and areas for development for 2014/15.

Key areas covered within the report are as follows:

* National Context and Trust response.
* Safeguarding Children Governance Arrangements
* Partnership Working with LSCBs and Local Authorities
* Serious Case Reviews and Partnership Reviews.
* Think Family
* Implementation of Trust Training Strategy
* Implementation of Child Protection Supervision Arrangements.
* Safeguarding Children audit work
* Safer Recruitment
* Allegations management
* Key priorities for 2014/15

**3. National Context**

**3.1 Munro Review**

The Government response to the Munro review included a revision of the statutory guidance ‘Working Together’ which came into force on 15 April 2013. The new version is a single source document which streamlines previous guidance documents to clarify the responsibilities of professionals towards safeguarding children and strengthen the focus away from processes onto the needs of the child.

The role of Local Safeguarding Children Boards (LSCBs) is strengthened to provide more scrutiny and challenge, including assessing the effectiveness of the help being provided to children and families, including early help.

LSCBs should maintain a local learning and improvement framework which is shared across local organisations who work with children and families.

A new national panel of independent Serious Case Review (SCR) experts is to be established. The panel will provide advice to LSCBs about the application of SCR criteria and the requirement to publish reports.

**3.2 Ofsted and CQC Inspections of Safeguarding and Looked after Children services**

Under the current Inspection programme whereby Ofsted and CQC are both conducting inspections of safeguarding and looked after children services

A return to an integrated inspection model is out for consultation until 12th September 2014

The proposal includes the following Inspectorates:

• Office for Standards in Education, Children’s Services and Skills (Ofsted)

• Care Quality Commission (CQC)

• Her Majesty’s Inspectorate of Constabulary (HMIC)

• Her Majesty’s Inspectorate of Probation (HMI Prob)

• Her Majesty’s Inspectorate of Prisons (HMIP)

These inspections will focus on the effectiveness of local authorities’ and partners’ services for children who may be at risk of harm, including the effectiveness of early identification and early help and the effectiveness of the response of services to children looked after and care leavers. In addition, the inspectorates propose to conduct a joint inspection of the effectiveness of the Local Safeguarding Children Board (LSCB).

A new model of Ofsted Inspections commenced in September 2013. The Care Quality Commission (CQC) will continue to inspect safeguarding arrangements of health providers.

There is also a new national safeguarding children performance information framework in place. The framework is broken down into five themes, with national performance information items and approaches to local information for each.

The themes are:

* Outcomes for children and young people and their families
* Child protection activity (including early help)
* The quality and timeliness of decision making
* The quality of child protection plans
* Workforce

**3.3 Actions taken in Response to National Policy:**

* The Trust Child Protection and Safeguarding Children policy has been reviewed against Working Together 2013 and ratified by the Safety Committee.
* The Trust continues to work in partnership with local authorities and partner agencies and ensure the Trust is prepared to demonstrate effective and safe practice through the new Inspection framework.
* The Trust continues to work in partnership with other agencies and specifically in relation to both child protection and child in need cases where there is need for a service. There is also a national agenda to increase multi-agency working and integrated working models are being explored in Oxfordshire and the Trust is engaged in this work.
* The Trust is a statutory member of five LSCBs, and is represented on all LSCBs and relevant sub-groups. Work includes supporting delivery of business plans and priorities in line with national and local safeguarding priorities.
* There is also productive working with children’s social care at a local level this includes developing relationships with children’s social care and adult mental health services and joint training. As an example, a senior locality social worker is to attend Oxfordshire ‘Think Family to safeguard children meetings’. A visit is also planned for Oxfordshire Complex Needs Service in January 2015.

**3.4 Child Sexual Exploitation**

The Government published the ‘Tackling Child Sexual Exploitation Action Plan’ on 23 November 2011. This action plan brought together actions by the Government and a range of national and local partners to protect children from this largely hidden form of child abuse.

The action plan highlighted the need for effective links between child and adult services such as local authority social care, education and health services, the voluntary and community sector, local police and youth justice structures.

The actions in the plan were focused on ensuring that services respond to the particular needs of sexually exploited children and young people. The action plan refers particularly to the link between children going missing and being sexually exploited.

Further details about Trust actions are contained in Section 4

**3.5 Saville Enquiry**

The Government commissioned an Independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Saville. On 30 April 2013 Sir David Nicholson set an expectation that health organisations should review arrangements and practices relating to vulnerable people, particularly in relation to safeguarding, access to patients including that afforded to volunteers and celebrities and listening to and acting on patient concerns.

Trust review completed and following actions taken;

The revised Trust Safeguarding Children policy 2013 now includes volunteers.

The Trust Volunteer policy is in place. All volunteers are subject to pre-employment checks in accordance with Trust Policy. In addition the responsible manager must conduct a risk assessment to ascertain the nature of the volunteer work and any associated training required. It is explicit within the policy that all volunteers are required to participate in any necessary training required to carry out their voluntary work.

The Trust is currently awaiting the final report into Saville investigation that took place in Buckinghamshire and the actions identified from this enquiry for health services.

**3.6 Dealing with Disclosures of Historical Sexual Abuse**

The Safeguarding team is currently working on new guidelines for staff dealing with disclosures of historical sexual abuse in conjunction with Thames Valley Police and Oxfordshire County Council. The group working on this includes representatives from Adult Mental Health Services and Psychological Services.

In the wake of the Saville enquiry, this is a very important piece of work for the Trust accountability and as a guide to clinicians to ensure individual disclosures are risk assessed and information is shared appropriately if children remain at risk.

**Section 4 Partnership Working**

The Mandate from the Government to the NHS Commissioning Board (NHS CB) for April 2013 to March 2015 (published in November 2012) states:

***“We expect to see the NHS, working together with schools and children's social services, supporting and safeguarding vulnerable, looked-after and adopted children, through a more joined-up approach to addressing their needs***

**4.0 Multi Agency Safeguarding Hubs (MASH)**

The Trust is engaged in the introduction of the Multi-agency Safeguarding Hubs (MASH) as it is a key development in partnership working.

The principles of a MASH

Improving the way agencies work together to protect the vulnerable from harm, neglect and abuse.

Co-locating key safeguarding agencies enables:

* Better information sharing and decision making;
* Identification of risk at the earliest possible opportunity;
* Appropriate early and holistic interventions;
* A coordinated effective and timely response;
* Resulting in improved outcomes for children.

The Trust has been fully engaged with the set up of the MASH service in Oxfordshire and Buckinghamshire and provided support to the Swindon, Wilts and B&NES areas.

The MASH for both Oxfordshire and Buckinghamshire are due to commence at the end of September 2014.

The Oxfordshire Multi Agency Safeguarding Hub will support a co-located team and partnership working approach between the Children’s Social Care, Thames Valley Police, Oxford Health and Oxford University Hospitals. This will include the Trust provision of Named Nurses to support interagency working. This new initiative is an important priority for the Trust in 2014/15.

In Buckinghamshire the Trust will be a virtual partner working with Children’s Social Care, Thames Valley Police and Buckinghamshire Health Trust to ensure information is shared and informs the decision making in the management of a case.

The need for robust Information security and information governance protocols is included in the MASH project plans. The Trust Caldecott Guardian is involved in this area of work to ensure health information governance requirements have been included.

**4.1 Oxfordshire**

**Child Sexual Exploitation**

This has been the main area of work in 2013/14 in Oxfordshire.

As a result of a joint investigation between the police and social care, Operation Bullfinch. Nine men were charged and committed to trial at The Old Bailey. The case concluded in May 2013 and there were 59 guilty verdicts against seven of the men who received sentences totalling 95 years. There have been further arrests made in Banbury in the summer of 2014 and the trial for these men will be taking place in December 2014.

In response to this and in line with national guidance the Trust with other health providers have supported the implementation of Oxfordshire Safeguarding Children Board (OSCB) Child Sexual Exploitation Strategy.

Specific activities include:

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* The Kingfisher team has won three National Awards for their work with CSE in Oxfordshire, being recognised for working in an innovative way with extremely vulnerable young people
* The Looked after Children team specialist nurse also now attends the missing person’s panel on a monthly basis

Following the launch in October 2012 of the OSCB strategy and practitioner toolkit, training is ongoing in relation to child sexual exploitation (CSE); including use of CSE risk assessment tool and has been completed with Children Universal Services, school health nurses and CAMHs.

The Child and Adolescent Harmful Behaviours Service is also providing training via OSCB training programme.

The Trust is contributing to the Serious Case Review, in relation to the six child sexual exploitation cases, which will be published by Oxfordshire Safeguarding Children Board. The Trust is committed to meeting all the actions and has taken forward learning identified during the SCR process for trust services.

The Trust participated in ‘Child Sexual Exploitation: An Audit of Staff Knowledge and Training Needs’. This was commissioned by Thames Valley Area Team from Brookes University.

The final report was published in March 2014 and provides an overview of the audit evaluation, the four work streams undertaken and the main audit findings. This project took place during a period of unprecedented activity and development both nationally and locally around child sexual exploitation and many initiatives to address this serious and challenging issue were already being implemented across Thames Valley.

The report highlighted that given the responses to CSE overwhelmingly focus on dealing with the consequences after it has occurred, it is vital that agencies and professionals give greater focus on prevention which should be addressed in training and included in training strategies.

It outlines the progress that has already been made across Thames Valley to address the serious and challenging issues that are being faced both nationally and locally around child sexual exploitation.

The report concludes by making a number of recommendations for consideration by Health Education Thames Valley to support the on-going development of health care practice in this important area.

Good practice by health care staff is dependent on enhancing awareness of indicators of CSE; the use of a structured approach to the identification and assessment of risk; the ability to explore consent; an understanding of the impact of diversity; linking with multi-agency partners and specialist services and referring victims to services that support their physical and psychological needs.

The Trust are fully engaged with the recommendations’ from this report and the Safeguarding team have already reviewed the required levels of training as outlined in the Intercollegiate Guidance (RCPCH, 2010) to incorporate good practice and learning from case examples specific to health care contexts and utilising stories from some of the SCRs already published

Female Genital Mutilation (FGM)

Thames Valley Police have now made FGM one of their top priorities and FGM procedures and strategy are being reviewed and developed currently for the OSCB. The aim is to improve and develop the processes currently being utilised and make them more effective in promoting safeguarding and protecting the welfare of women and girls at risk.

A briefing paper was presented to the OSCB in March 2014 by Public Health that looked at the prevalence of FGM and current practice and procedures in place for responding. It also summarised the current National Guidelines on FGM and recommended that the OSCB formulate and implement a strategy to review procedures, training and communication with the wider community.

In response an initial interagency meeting was held between senior safeguarding leads for Children’s Social Care, Police and health and a steering group has been set up. The Designated Doctor is leading the Strategy group for health. Work completed so far by the Operational group includes a draft strategy for OSCB.

Immediate actions were identified to update the OSCB FGM procedures, in line with the London SCB supplementary FGM procedures and develop clear pathways for decision-making and referrals for women who have undergone FGM and where there is an identified risk to female children.

The Trust is fully engaged in this work and the aims for the group will form part of the working priorities for the Safeguarding team in the coming year:

* To develop and implement a strategy, share and gather information from work with local communities.
* Raise awareness amongst professionals and the general public, organise training, gather information about local support and resources, develop tool kit, develop local information sheets on FGM and local resources.
* The strategy group is initially for professionals. There will be an extended community consultation group, which would include community representatives.

The team will also ensure active engagement in FGM policy development in other LSCB areas including sharing learning from Oxfordshire.

**4.2 Buckinghamshire**

There have been a number of arrests made across Buckinghamshire for CSE with successful prosecution of 5 men in 2013. The Trust is fully engaged with multi-agency working to include support for the identified victims.

Other Trust actions include:

* Joint working in relation to CSE training and awareness raising including staff attendance at CSE conference
* Implementation of sexually harmful behaviour project for young people has been completed and positive feedback reported
* Department of Health evaluation of Trust Sexually Harmful Behaviours service published in September 2013
* Shared learning from the experience of CSE in Oxfordshire
* Active engagement by CAMHs service in multi-agency working to safeguard children at risk of sexual exploitation.

**4.3 Swindon**

The CQC completed an inspection of safeguarding and looked after children’s services in February 2014. This included CAMHs services and it was noted that CAMHs were delivering high quality support to a number of young people identified as being at high risk of CSE with case examples of the outreach service for children and adolescents (OSCA) team supporting this cohort of young people very effectively.

In addition was recognised as contributing to multi-agency risk management work.

Learning related to improved recording of referrals and ensuring reports are submitted to look after reviews.

Ofsted completed an Inspection of Swindon Borough Children’s Services between 11/03/14 and 02/04/14 and overall judgement was ‘requires improvement’. The Safeguarding Children Board was judged as ‘good’

**4.3 Wiltshire**

In 2012 the joint Inspection by Ofsted and CQC resulted in an inadequate judgement for children’s services. Statutory requirements were not met consistently and as a result Wiltshire Council received an improvement notice and an Improvement Board and plan were put in place. During 2013 the Trust worked with agencies to support implementation of the improvement plan

Following further inspection in 2013 by Ofsted, Wiltshire Council Children’s Services were judged as adequate. There was also a CQC Safeguarding and looked after children inspection in October 2013.

Improvements were noted and the CQC report notes examples of effective communication and co-operative working between CAMHS, social care and schools resulting in good, early support to children showing early indications of need or heightened risk. A CAMHS manager attends the Gateway panel which facilitates prompt identification of cases where early support may reduce levels of risk within families close to child protection thresholds.

Learning related to further improve working with adult mental health providers and improved recording of supervision and reports for Looked after Reviews.

**4.5 Bath & North East Somerset**

The CQC Inspection was completed in the week of 9th June 2014 with excellent feedback from the inspectors in relation to CAMHs Services. The report will include recommendations for services and full publication to follow.

All actions for the Trust are included in the SWB safeguarding children action plan.

**4.6 Multiagency Public Protection Forums**

**Multi-Agency Public Protection Arrangements (MAPPA).**

The Trust has adult mental health representatives engaged in Oxfordshire and Buckinghamshire Multi-Agency Public Protection Arrangements. The model of engagement of the Named Nurses with MAPPA has been reviewed and revised. They continue to review of Trust involvement with cases to inform the risk management and multi-agency working as part of the Trusts public protection role regarding high risk violent or sex offenders.

**Multi-Agency Risk Assessment Conferences (MARAC)**

The Multi-Agency Risk Assessment Conferences (MARAC) are forums for identification and risk management of high risk domestic abuse victims. In Oxfordshire the Named Nurses attend as Trust representatives alongside adult mental health representation. This is to ensure information sharing and risk management is in place for domestic abuse victims and their children.

In Swindon, Wiltshire and Bath and North East Somerset LSCB areas

Interface with other Named Nurses in Wiltshire ensures engagement with the Multi Agency Safeguarding Hub (MASH), Multi-Agency Public Protection Arrangements (MAPPA) and Multi-Agency Risk Assessment Conferences (MARAC) to ensure Trusts public protection role re high risk violent or sex offenders and high risk domestic abuse victims is maintained.

The Senior Named Nurse is a member of the Domestic Abuse Conference Call (DACC) Project Board/Scrutiny Panel, has a Wiltshire Council/Police Laptop available for use and is awaiting the start of this project in order to become fully involved in the process.

**4.7 National and Local Authority Area Child Protection and Child In Need Statistics as at 31 March 2011 and 31 March 2012 (latest data)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Number of children subject to a child protection plan  31 March 2011 | Number of children subject to a child protection plan  31 March 2012 | Number of children subject to a child protection plan  31 March 2013 | Number of Children in Need (throughout the year)  31 March 2011 | Number of Children in Need (throughout the year)  31 March 2012 | Number of Children in Need (throughout the year)  31 March 2013 |
| **England** | **42,700** | **42,850** | **43,100** | **735,500** | **739,300** | **736,100** |
| Oxfordshire | 332 | 364 | 430 | 5760 | 5711 |  |
| Bucks | 368 | 362 | 190 | 5961 | 5858 | 5305 |
| Swindon | 94 | 116 | 147 | 2794 | 1925 | 2077 |
| Wiltshire | 163 | 169 | 328 | 3390 | 3700 | 5089 |
| B&NES | 102 | 70 | 122 | 2127 | 2016 | 2247 |

**Key trends:**

* An increase in the number of children subject to CP plans in Oxfordshire, Swindon and Wiltshire.
* An increase in child in need cases in Wiltshire.
* It should be noted that the figures for Buckinghamshire were lower in the data for the financial year to 2013. Buckinghamshire are now reporting a 40% increase in referrals for the year to date.

**Section 5 - Trust Safeguarding Children Governance**

The statutory responsibilities of the Trust, as an NHS provider, have not changed under the Health and Social Care Bill (2012) and are outlined in the *Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework-* NHS Commissioning Board ‘(March 2013).

This reconfirms that health providers are required to demonstrate that they have safeguarding leadership and commitment at all levels of their organisation and that they are fully engaged and in support of local accountability and assurance structures, in particular via the Local Safeguarding Children Boards.

All health providers are required to have effective arrangements in place to safeguard vulnerable children and adults and to assure themselves, regulators and their commissioners that these are working.

The Trust is also required by Monitor to ensure compliance with health care standards. This includes the essential standard on safeguarding monitored by CQC, Outcome 7 Regulation 11 ‘Safeguarding people who use services from abuse’ The Trust is compliant with this standard.

**5.1 Safeguarding Accountability**

The Trust Board Safeguarding Lead is Ros Alstead, Director of Nursing and Clinical Standards.

The Trust Safeguarding Children Service is hosted by Children’s and Young Peoples Services and is provided across the organisation, to reflect the LSCB areas and the breadth and range of services provided by the Trust.

The Safeguarding Children Service is led by the Trust Lead Nurse Safeguarding Children, who is accountable to the Director of Nursing and Clinical Standards and by the Trust Lead Doctor Safeguarding Children. The Trust Leads work collaboratively and report to the Trust Safeguarding Committee.

**5.2 Safeguarding Children Team Staffing**

The safeguarding children service model has been reviewed in light of Trust wide service remodelling work and care pathways, to ensure the service delivered reflects the needs of care groups, locality and interagency working across the five LSCB areas in which the Trust provides services.

In addition the local context for safeguarding children has become more complex and partnership working with three LSCBs areas has increased in the last three years.

The team has been provided with additional resource to meet this growing demand.

* Trust Lead Nurse 0.91wte
* Trust Lead Doctor 1 session per week
* Senior Named Nurses Band 8a 2.11wte Oxfordshire and Buckinghamshire
* Named Nurses Band 4.2 WTE for Oxfordshire with a new dedicated 0.8WTE for Buckinghamshire
* Following additional resource from the Swindon, Wilts and B&NES LSCBs CCG a Senior Named Nurse 8a 1.0 WTE permanent post was recruited to and commenced in January 2014 to reflect the growing service needs of the area
* Named Doctor provision includes 3 additional roles with one session per week to cover Oxfordshire, Buckinghamshire, Swindon, Wiltshire and Bath/North East Somerset
* Admin support is currently under review to make sure there is the correct support to the team with the increase in the size of the team and complexity of the work needed

**5.3 Governance arrangements**

A bi-monthly Trust Safeguarding Committee chaired by the Director of Nursing and Clinical Standards is in place. This forum ensures robust governance of all safeguarding practice and activity across the organisation. Nominated senior divisional leads (both clinical and business support functions where appropriate) are required to evidence the contribution of their service area to ensuring that safeguarding children, young people and vulnerable adults is embedded in practice from front line practice to board.

Safeguarding Children and Vulnerable Adults Leads attend and report to this committee. This includes evidencing delivery against Serious Case Reviews, Section 11 Audits and assurance in relation to CQC Outcome 7. The group has in place reporting arrangements to the Safety Committee and Trust Board.

Safeguarding Children reporting is also in place via Divisional Performance meetings to the Trust Executive team.

Specific actions taken in 2013/14

* Section 11 Self- Assessment audits have been completed for 2013/14 and returned to LSCBs in Swindon & Wiltshire, B&NES, Bucks and Oxfordshire. There are no significant compliance concerns reported by the Trust in relation to statutory duties
* Safeguarding KPIs are now included in the contracts with clinical commissioning groups and the Trust will continue to be formally monitored on these in 2014/15
* The Trust Lead Nurse and Vulnerable Adult Lead have provided safeguarding input into service tenders in partnership with business and performance team

**5.4 Policies and procedures**

The Trust Safeguarding Children policy is in place and has been reviewed in line with the revised statutory guidance Working Together 2013.This policy outlines the roles and responsibilities of the Board and all staff and includes details of child protection supervision and training arrangements.

The safeguarding children guidelines for Urgent Care and Minor Injuries units have been revised and updated to reflect nation policy including child sexual exploitation.

A Safeguarding Children intranet page is in place to ensure increased access to safeguarding children key policies and guidance this is linked to the Patient Safety Button. The Patient Safety Button is highlighted and promoted to all staff groups during their mandatory Safeguarding children training, child protection supervision groups, safeguarding reviews and has been advertised on Trust staff announcements

**6 Serious Case Reviews (SCRs) and Partnership Reviews.**

**6.1 SCRs**

The Trust has established robust systems for completing Internal Management Reviews, implementing actions plans and sharing learning as part of SCRs when commissioned by an LSCB.

**Learning from published SCRS.**

**Oxfordshire**

One executive summary of an Oxfordshire case was published in December 2013 relating to the death of a child in 2010.

The key learning point in relation to the adult liaison mental health service.

Whilst there was a through mental health assessment completed by the liaison mental nurse which was of good quality and was formally communicated to the GP, there should be improved information sharing directly between adult mental health practitioners and health visitors working with parents to ensure that any potential impact on the child is considered.

Joint working between adult mental health and health visiting services has been further improved following the merger of CHO and OBMH in April 2011.This has improved information sharing across services in relation to parents with mental health issues which might impact on their ability to parent. The Think Family work continues to be taken forward by the safeguarding children team.

In addition as part of Oxford Health NHS Foundation Trust’s safeguarding children training strategy, working between the two services has been enhanced through integrated safeguarding children training and access to safeguarding advice and supervision.

**Buckinghamshire**

Two cases involving trust services were published by Buckinghamshire Safeguarding Children Board in 2013. Both related to the suicide of young people who had been known to CAMHs.

In response to the learning from these cases:

* The Trust has been actively working to improve the management of self harm presentations working with Buckinghamshire Health Care Trust and primary care.
* New escalation guidance for staff to ensure concerns are escalated to senior staff if response not received from other agencies

**Bath & North East Somerset**

One case following the suicide of a young person in 2012 was published and learning related to ensuring staff access domestic abuse training provided by LSCB interagency training programme.

**Current SCRs**

In 2013/14 there continued to be Serious Case Reviews commissioned by LSCBs. The Trust IMRs have been completed and submitted on time and actions plans taken forward in advance of publication to ensure learning is addressed.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Local Authority Area** | **2012** | **2013** | **2014** | **From 31/03/14** | **Other** |
| Oxfordshire | 1 | 3 | 1 | 1 | 2 SCRs /critical reviews pending |
| Buckinghamshire | 1 | 1 | 1 | 1 |  |
| B&NES | 1 | 0 | 0 | 0 |  |
| Swindon | 0 | 0 | 0 | 0 |  |
| Wiltshire | 0 | 0 | O | 0 | 2 partnership reviews |
| External LSCBs Somerset  East Sussex | 0 | 1  1 | 0  0 | 0 |  |

**6.2 Internal Review of Deaths of Young People**

The Service Director of the Children and Families Division commissioned an internal panel to review the deaths of patients by probable suicide either whilst in our care or soon after discharge since April 2010.

In addition the panel reviewed information about other possible suicides during this period from the Local Safeguarding Boards to see whether there are any links. Whilst this audit includes all known local cases the sample was nonetheless very small.

One of the emerging issues is that during the almost 4 years which the review spanned, awareness of potentially important factors (e.g. social media) has increased and is now more likely to be investigated. These factors may have been present in other cases but

may not have been seen as important or investigated at the time of the young person’s death.

The key findings were as follows:

1. **Keeping young people safe is everyone’s responsibility.**

Approximately half of young people who took their own lives did not have contact with any agencies at the time of their death with very few indications that they were at risk.

Keeping children safe is the responsibility of everyone who has contact with children and young people.

1. **Gate-keeper training in talking with young people**

In view of the above it is important to train those who have contact with young people to talk with them in a calm and empathic way about self-harm and suicidal ideation.

1. **Risk assessments**

Hanging is the most common cause of death among young people who have taken their own lives. Risk assessments within specialist CAMHS should routinely and directly inquire about thoughts, research (e.g. internet sites) plans or attempts at hanging.

1. **Safety advice**

Within specialist CAMHS the advice provided to young people who have attempted, are considering, or experimented with hanging or noose tying should be clarified. These are high risk behaviours and the potential seriousness of these should be directly discussed with the young person.

1. **Support times**

Most deaths occurred on Friday or Saturday afternoon/night. This suggests that if services are concerned about the safety of young people then contacting them at these times may be helpful.

Further actions to be taken by the panel.

* The findings of this audit should be shared widely with all agencies, voluntary organisations and within CAMHS to increase awareness about suicide within this age group.
* To hold a learning event to share the report’s findings.
* Findings of this are being shared with other LSCBs.

**6 Think Family**

A final report on key areas of work undertaken under the Think Family initiative. was presented to the March 2013 Safeguarding Committee.

The work plan was developed by the Think Family Steering Group and reflects the outcomes for the Ofsted/CQC thematic inspection in Oxfordshire (of joint working between children's and adult services) and links with the Families First (Bucks) and Thriving Families (Oxon) initiatives.

The key outcome measures were identified as:

• Improved recording of the children of patients on RiO

• improved information for young carers, families and staff

• increased referrals from Trust services to young carers support

• improved arrangements for families to visit wards

**Actions taken in 2013/14**

The Safeguarding Team take responsibility for the Think Family intranet site. Safeguarding team facilitate the quarterly meeting to support the team leads which is called “Think Family to Safeguard”,

Standard operating procedures have been developed and are now in use. This work will also inform the replacement EPR project and a Divisional Named Nurse is on the project group.

The Safeguarding Team will be involved in the re-audit of improved arrangements for families to visit wards in November 2014.

**7. Implementation of Safeguarding Children Training strategy 2013/14**

The Safeguarding team has updated the Safeguarding Children Training Strategy to reflect intercollegiate document 2014 and UK Core skills Training framework 2014 and these changes will commence 01.09.2014.

There are three levels of training for staff within the Trust. All Trust staff are required to undertake one or more of the levels of training. The core level of training required will be shown on the training matrix by staff group and on the individuals training record. The key changes in the new document relate to Level 3 safeguarding training and the number of hours staff are expected to complete.

The aim is to clearly separate what would be regarded as core training and what would be additional training without radically changing the training strategy in place which could cause confusion to staff.

**Actions planned for 2014/15:**

* Continue to develop bespoke training sessions for services to achieve additional Level three competencies and update training regularly to meet changes in National and Local guidance
* Monitor training compliance and ensure contractual targets achieved.
* The updated Safeguarding Children Training Strategy to reflect intercollegiate document 2014 and UK Core skills Training framework 2014 will be ratified by the Safeguarding Committee in 2014.

**8. Training Data**

Trust wide Safeguarding Children Training data as at 26/08/14

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Courses** | **Frequency** | **Duration** | **Sessions** | **Trained** | **% of Available Trained** | **Training Gap** |
|
| Safeguarding Children and Adults - Non Clinical - (eLearning) - 3 Yearly - OH | Three Yearly | eLearning | 604 | 541 | 90% | 62 |
| Safeguarding Children and Adults - Non Clinical - (eLearning) - Once (New Starters) | Once  \*\* | eLearning | 51 | 27 | 53% | 23 |
| Safeguarding Children Level 2 - (eLearning Or Classroom) 3 Yearly | Three Yearly | 2.5 Hours | 2517 | 2228 | 89% | 216 |
| Safeguarding Children Level 2 - (eLearning Or Classroom) Once | Once | 2.5 Hours | 1587 | 1485 | 94% | 87 |
| Safeguarding Children Level 3 - Trust Or Local Safeguarding Children Board | Three Yearly | 2.5 Hours | 1047 | 854 | 82% | 109 |
| **TOTAL** |  |  | **5806** | **5135** | **88%** | **497** |

\*\* This is for Trust induction and the data is being reviewed with Learning and Development team.

**9. Implementation of Child Protection Supervision arrangements.**

**9.1 Advice and consultation**

The Named Nurse and Doctor team work together as a team across all Directorates and services to provide advice and consultation to all staff on request Monday – Friday 9-5pm. Staff have access to Local Authority Emergency Duty social care teams for out of hours advice and Trust on call managers.

**9.2 New model for Consultations**

The Safeguarding Children team have set up a consultation line which will be piloted from September 2014 for 6 months and the use of it will then be evaluated.

There will be a single number for practitioners in Oxfordshire and Buckinghamshire to call and the staff will have a rota system to cover this. The purpose of this is to improve the response time when practitioners call a member of the Safeguarding team and streamline the work of the team.

**9.3 Activity Data**

All consultations are recorded by the named nurse or doctor; there was a period of staff changes in Q3 and Q4 of 2013 including administration.

There was an impact on the quality of data collection from consultation forms; therefore activity data may not reflect fully team activity during 2013/14.

|  |  |  |
| --- | --- | --- |
| Division | 01/04/12-31/03/13 | Number of consultations  01/04/13 -31/03/14 |
| Children and Families | 747 | 608 |
| Mental Health | 108 | 89 |
| Community | 15 | 10 |
| Specialised | 38 | 17 |
| Other | Not captured | 90 |
| **Total** | **908** | **814** |

**Actions taken**

A new database has been introduced in August 2014 which will improve robustness of data collection and include category of concern to further enable accuracy and trends for the team and to reflect organisational changes in the Divisions at individual service level.

The Safeguarding Children team have launched a new consultation line in September 2014 and it will be piloted for 6 months. There will be a single number for practitioners in Oxfordshire and Buckinghamshire to call and the staff will have a rota system to cover this. The purpose of this is to improve the response time when practitioners call a member of the Safeguarding team and streamline the work of the team. The pilot will be evaluated at the end of the 6 months

Further work has been undertaken to improve ease of access to the Safeguarding Children intranet pages for staff. Work has also taken place on the Trust Safeguarding Intranet pages to ensure they are clear for children and young people to access support

**Further actions planned for 2014/15**

* To refine data collection processes in order to inform services about their contact to the Safeguarding team and provide assurance for the Trust about safeguarding Practice. the use of data analysis to inform safeguarding service priorities for training and supervision
* The introduction of the new EHR system in 2015 will support the accurate recording of service level data

**9.4 Group Supervision**

The Named Nurses delivered a total of 98 child protection supervision groups. This includes Children’s Universal Services, Family Nurse Partnership, Oxfordshire PCAMHS and the Highfield Inpatient Unit, Complex needs Oxford/ Bucks, Clinical Nurse Specialist central area and Paediatric Continence services.

Evaluation of the supervision provided to Children’s Universal Services and FNP was completed in February – April 2013. This has provided evidence that practitioners place a high degree of value on their Child protection supervision sessions, and can evidence the impact on their safeguarding practice as a result of this.

Group child protection supervision is also undertaken for Oxfordshire and Buckinghamshire Addiction Services and the Complex Needs Service in Oxfordshire. Group child protection supervision for Buckinghamshire Complex Needs Service will commence in October 2014.

Group Safeguarding Supervision has now been introduced for all CAMHS staff across Swindon, Wiltshire and B&NES. An operational outline proposal was developed and been accepted and a final outline and matrix of all staff supervision is currently being written. This will be shared with Wiltshire CCG within compliance meetings once completed after 31st November 2014

In addition CAMHs have in place the following arrangements that provide an opportunity

to discuss cases with safeguarding as an agenda item:

* Through discussion at caseload or clinical supervision sessions
* At multi-disciplinary clinical meetings
* At CPA review meetings, that is the care planning process – all CAMHS patients are subject to CPA
* Through caseload audit – e.g. on in-patient wards matrons review records and care plans on regular audits for ‘Essential Standards’

The Named Nurses and Named Doctors receive their own Safeguarding Supervision via external supervisor and /or Trust Lead Nurse or Doctor. This is provided by the Designated Nurse and Designated Doctor in SWB.

**10. Safeguarding Children audit work.**

During 2013/14 the safeguarding service increased audit and supervision activity to support frontline staff and to provide assurance of safeguarding practice. This was reported to the Trust safeguarding committee and LSCBs through Section 11 audits and single agency audit reports.

**Audits completed:**

* Safeguarding Children Reviews have been undertaken this year with Integrated Therapy Services and the findings are currently being collated to be available in September 2014.
* Safeguarding Reviews within Community CAMHs teams: this was piloted in Salisbury CAMHs and will roll out across all Community CAMHs teams in Oxfordshire and Buckinghamshire for 2013/14.
* To date 15 teams audited out of 22 teams which equates to 78%. The safeguarding reviews enabled protective time for group discussion regarding key safeguarding issues and highlighted areas for development at an individual team and service level.
* Themes and action planning identified through service audits or training/supervision by Named Nurses are shared within Operational and Governance groups and reported to Safeguarding Committee.
* An audit is in progress to look at the quality of referrals to Social Care in SWB.
* The audit programme will continue in 2014/15.

**10.1 LSCB Multi – agency audit work**

**Oxfordshire**

The Trust participates in multi- agency case file audits as part of Oxfordshire Safeguarding Children Board (OSCB) Quality Assurance and Audit (QAA) programme.

An audit of use of the multi-agency risk assessment tool in three complex cases was completed. The learning points are currently being actioned and will be monitored.

Oxfordshire OSCB QAA audit is currently taking place to look at multi-agency working in cases with known mental health problems. The audit will be completed in September 2014.

**Buckinghamshire**

Planned audits to be undertaken by Buckinghamshire LSCB to look at the following:

* Transition Services and Support for Young People moving into Adulthood
* Sexual abuse in a neglect situation

**Swindon Wiltshire and BANES**

Case file audit work in Swindon has commenced and the Senior Named Nurse has joined the quality and audit sub-groups in Swindon

**11. Safer Recruitment**

The Disclosure and Barring Service (DBS) launched on the 1 December 2012 and merges the services previously provided by Criminal Records Bureau (CRB) and the Independent Safeguarding Authority (ISA).

The primary role of the Disclosure and Barring Service (DBS) is to help employers in England and Wales make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups including children.

**Trust actions:**

Enhanced DBS with barred list checks are mandatory for those roles that fall into the regulated activity categories as defined in the Safeguarding Vulnerable Groups Act, they form part of the wider pre-employment checking process which encompasses safer recruitment best practice and is monitored by the Recruitment team.

DBS checks are renewed on change of post and every three years where the employee has not changed post.

* Enhanced with barred list DBS checks are completed prior to appointment on all staff who will undertake roles that are defined as regulated activity, the DBS application process includes online access to expedite the recruitment process.
* For appointed candidates references are requested that cover at a minimum the last 5 years of employment, it is also a requirement that a minimum of 2 references are requested where a candidate may have worked in the same job for more than 5 years. The reference from the candidate’s current or most recent employer must be completed in the Trust’s safer recruitment template to ensure that a full character reference is obtained as well as confirmation of dates of employment.
* In 2013/14 OHFT conducted an audit to ensure all staff whose roles fell into the regulated activity categories including those in post for the last 12 months, had an up to date enhanced with barred list DBS check
* In line with safer recruitment guidelines the Trust reserves the right to carry out repeat checks on staff and carries out 3 yearly checks for staff who have roles fall into the regulated activity categories
* The Trust has a rolling programme to deliver safer recruitment training. To date a total of 330 managers, who are responsible for recruiting staff have been trained.
* The Trust has three staff within HR who have completed the NCLS Train the Trainer Programme.
* Managers/staff are also required to attend relevant safeguarding training levels 1 – 3 commensurate with their role.
* Interview panels consist of at least one manager who is trained in safer recruitment practices.
* All interviews conducted for roles that form part of the regulated activity group are required to ask a minimum of 3 safeguarding questions as well as competency based questions. The answers to these questions for each candidate are held on file for a period of 12 months.
* Candidates are asked at interview about any gaps in employment, vagueness in answers or numerous job changes that have been noted on their application form, these answers are noted and held on the job file for 12 months and permanently on the appointed candidate’s personal file.

**Further actions to be taken**:

New Trust recruitment policy will include additional statement in relation to the responsibility of all staff to inform the Trust if, at any time during their period of employment with the Trust, they are subject to any criminal record, cautions, warnings or bind over’s, or any changes to their existing DBS or clearance status.

Oxford Health are in the phase 5 release of the DBS linking directly to ESR which will allow the trust to receive automatic updates should there be a change in an employee’s criminal record where they are registered with the DBS update service.

**12. Allegations Management**

The Trust has a nominated allegations officer for handling allegations about children and vulnerable adults.

In 2013/14 there have been 5 allegations in relation to staff working with children that have been managed in line with LSCB and Trust Policy. These were reported to the Local Authority Designated Officer and reviewed by Service Managers.

**13. Safeguarding Children Action Plan**

The organisation develops and implements an annual Safeguarding Children action plan which captures key priorities for each LSCB area. This includes Section 11 statutory duties, CQC Outcome 7 assurance and learning from SCRs/SIRIs and Safeguarding Audits.

This will draw together all the key actions required for 2014/15 and progress will be monitored through Directorate Operational and Governance Groups and the Safeguarding Committee.

**Summary of Key Priorities for 2014 / 2015**

* Continue to work in partnership with local authorities and partner agencies and also ensure the Trust is prepared to demonstrate effective and safe practice through the new Inspection framework.
* To support the implementation and development of the MASH for all LSCBs
* To agree cross agency guidance for the management of disclosure of historical sexual abuse
* Ensure support and advice to frontline staff and managers is in place across each LSCB area
* To improve learning from incidents where safeguarding concerns are identified sharing the learning with services.
* Develop a robust pathway to share learning from SCRs Trust wide and ensure actions are followed up and completed.
* To continue to provide assurance of safeguarding children practice within the Trust to inform assurance for CQC compliance.
* To continue to review safeguarding children service model in light of any Trust wide service developments and care pathways, to ensure the service delivered reflects the needs of care groups, locality and interagency working across the five LSCB areas in which the Trust provides services.
* To continue to monitor training compliance and ensure contractual targets are achieved.
* To further develop data collection and analysis of Safeguarding Children team activity.
* To seek confirmation from HR all DBS standards have been met.
* To ensure robust service evaluation for 2014/15.

The Board is asked to note progress made last year and note this report.

**Safeguarding Children Team Staff Details**

**Trust Lead Nurse Safeguarding Children**

Julia Grant

**Trust Lead Doctor Safeguarding Children**

Nick Hindley

**Senior Named Nurses**

***Oxfordshire and Buckinghamshire***

Jill Berry

Jayne Harrison

Lisa Lord

***Swindon Wiltshire & B&NES***

Isobel Sanderson

**Named Nurses**

Liz Navrady-Wilson

Jo Lamb

Karen Marshall-Falland

Camel Cooney

**Named Doctors**

Dr. Madi Acharya / Named Doctor for Oxfordshire

Dr. Arabella Norman-Nott /Named Doctor for Buckinghamshire

Dr. Jan Cribb *I* Named Doctor for Swindon Wiltshire and B&NES

**Appendix 2**

**Annual Report Safeguarding Adults 2013/14**

1. **Introduction**

Oxford Health NHS Foundation Trust has a duty to make arrangements to safeguard and promote the welfare of vulnerable adults. The Protection of vulnerable adults is not yet on a statutory footing, however, the structure and commitment of the safeguarding boards mirrors that of the children’s safeguarding agenda. The Trust is a statutory member of the Local Safeguarding Boards and makes a financial contribution to the Oxfordshire and Buckinghamshire local Authorities to ensure the continued function of the Boards. Once the Care Bill is passed in the summer of 2014, the Safeguarding Adults Boards will be a statutory obligation.

1. **Purpose**

This is the third Safeguarding Adult’s Annual Report for Oxford Health NHS Foundation Trust and presents an overview of Trust’s activities in response to national and local priorities in Safeguarding Adults. The report provides evidence of compliance with CQC Outcome 7 Regulation 11 **‘**Safeguarding people who use services from abuse’.

1. **Safeguarding Adults Accountability Structure**

The Executive Board Safeguarding Leads are Ros Alstead Director of Nursing and Clinical Standards and Dr Clive Meux Medical Director.

The Safeguarding adults’ team who report to the Safeguarding Leads are:

* Deborah Humphrey: Head of Adult Safeguarding and Head of Nursing Older Adult Mental Health.
* Moira Gilroy: Senior Safeguarding Manager and practice lead Safeguarding Adults
* Julie Dale: Deputy Head of Social Care Mental health Division (Buckinghamshire County Council)
* Mary Moriarty: Safeguarding practitioner

Each of the 4 divisions have safeguarding leads and there is close working between the children and adult safeguarding teams.

A bi-monthly Trust Safeguarding Committee chaired by Director of Nursing and Clinical Standards is in place. This forum ensures robust governance of all safeguarding practice and activity across the organisation. Nominated senior divisional leads (both clinical and business support functions where appropriate) are required to evidence the contribution of their service area to ensure that safeguarding vulnerable adults is embedded in practice from front line practice to board. This includes evidencing delivery against Serious Case Review and CQC Outcome 7 action plans. The group has in place reporting arrangements to the Safety Committee and Board.

1. **Safeguarding Adults Inspections and CQC visits**

The CQC carries out four types of inspections; unannounced Mental Health Act visits to each ward (12-18 monthly), unannounced regulation inspections to any service or team (1-3 yearly), announced themed inspections of any service (ad hoc) and announced inspections of Childrens services (not just mental health).

* In 2013/14 the CQC completed one unannounced regulation inspection visit which focused on reviewing the mental health care for forensic inpatients at our Littlemore Mental Healthcare Centre in April 2013.
* In 2013/14, there were 18 unannounced Mental Health Act visits.
* There was a themed inspection of Community Treatment Orders.
* There was a routine announced inspection regarding assessment and admission in Buckinghamshire.

As a result of the inspections, themes have been identified and actions taken, which is reported by The Lead for Registration and Quality.

In relation to Safeguarding Adults, the key themes were about the staff ensuring they were promoting access to advocacy by including information in the relevant information pack and the promotion of patient involvement through the development of a Service User Involvement Strategy.

1. **Partnership Working**

5.1 The Trust representation at the Safeguarding Adult Boards has been clarified and there is attendance at the relevant sub groups. Feedback from the Boards is given to Divisional Directors and the Director of Nursing and Clinical Standards. Feedback also informs reporting of outcome 7 and updates. This work of the Safeguarding Adults team includes supporting delivery of plans from all Boards in line with national and local safeguarding priorities.

5.2 Examples of Partnership working during 2013/14:

* Contribution to Safeguarding Boards sub group
* Investigating with the Local Authorities external services where there have been concerns about the care and practice of vulnerable groups.
* Participation in Serious Case Reviews in Buckinghamshire and Oxfordshire
* Work with the CCGs and Local Authorities to establish safeguarding thresholds in relation to violence and aggression, pressure ulcer care and medication errors.
* Attendance at safeguarding strategy meetings
* Closer working relationships with the safeguarding children’s team

1. **SIRIs / Serious Case Reviews**

6.1 There have been a number of serious incidents requiring investigation (SIRIs) that have had safeguarding concerns. These have been reported following safeguarding adult procedures and investigated using the Trust’s root cause analysis processes. The issues included: patient on patient sexual abuse; quality of care on one of the older adult wards; and an inappropriate relationship between a member of staff and a patient.

6.2 There has been one serious case review (SCR) in Oxfordshire where the person was known to one of the CMHTs; this process is continuing into 2014/15. It is likely that there will be further SCRs in Oxfordshire. In Buckinghamshire there are 2 SCRs where the person has been known to the mental health teams. Both these SCRs are in progress and yet to be completed.

1. **Training**

Safeguarding Adults:

31st March 2014: 88% of phased target of 100%

Mental Capacity Act

31st March 2014: 101% of phased target of 85%

Prevent/Health WRAP

31st March 2014: No target for 2013/14.

89 members of staff have attended these Health WRAP sessions.

**Actions planned to ensure that the agreed level of training is completed:**

* There is a joint training package (safeguarding children and adults) being delivered which enables the required elements of training to be delivered within one session rather than requiring the staff to attend a second separate session. This is increasing the level of attendance at the sessions.
* Site specific training is being offered to suit the needs of teams that find it difficult to release staff or where staff have restrictions on their ability to travel.
* e-learning package is available for safeguarding adults.
* Monthly monitoring of training statistics by safeguarding team to identify if there are any problems.

1. **Safeguarding Adults Referrals**

Evidence of awareness of safeguarding adults issues is provided in the record of contacts between the clinical teams and the safeguarding adults team. During 2013/14:

* There has been a 43% increase in contacts from all services with the safeguarding adults team compared with 2012/13 (219 contacts in 2012/13 and 315 contacts in 2013/14).
* Specialised Services Division are recording all safeguarding adults reports made to the local authority through their safeguarding lead. This is the first year of collecting this data. In 2013/14 there were 48 safeguarding adults concerns reported to the relevant local authority (4% of all incidents reported through in the Division).

1. **Information Sharing**

9.1 In 2012/13 there were some issues related to timely information sharing with Oxfordshire County Council (OCC). These issues have now been resolved and there is clear communication between the Trust and OCC which enables issues to be resolved in a timely way.

9.2 Communication between the Trust and Buckinghamshire County Council about safeguarding matters is primarily managed through the Associate Head of Health Care. When she is absent there can be some issues in understanding the thresholds for reporting safeguarding issues and the processes to do this. Work is being undertaken to resolve this during 2014/15.

9.3 During 2013/14, there have been particular challenges with two patients who have histories of making false allegations against staff. Clinical teams have worked closely with Thames Valley Police and the OCC Safeguarding Team to formulate care plans for managing this alongside prompt local investigation. This has been successful in ensuring that the patients are demonstrably safe without the need for formal investigations under the Trust’s Disciplinary Policy.

1. **Observations/Audit**

**Observations**

10.1 All ward areas were observed by the Safeguarding Adults team during 2013/14. The Observations focused on the following areas:

General care

Patient/Visitor engagement

Patient Safety

10.2 Themes identified during the observations included:

* Nursing staff interacted well with patients as did therapy staff
* Staff were observed to work at the pace of the patients
* Responses to patients were prompt, appeared appropriate, effective and safe.
* Patients were offered choice and support with their care
* Infection control processes were implemented including signs reminding staff to wash their hands.

**Mental Capacity Act (MCA) Audit**

10.3 An audit of the Mental Capacity Act was completed for all wards.

The common themes are:

* Nurses are considering mental capacity but do not document this in line with the MCA.
* Nurses are continuing to look to other professionals to complete a mental capacity assessment even where the decision is related to a nursing intervention.
* Therapists and Doctors are more likely to document the assessment in line with the MCA, but this is not consistent or frequent.
* Social Workers consistently document their mental capacity assessments robustly in line with the MCA.
* There was evidence that patients are being asked whether they have a Lasting Power of attorney in place. This is a significant change from the outcomes of audits in previous years.
* There is evidence that staff are beginning to ask patients whether they have an Advance Decision to Refuse Treatment in place.

1. **Restraint**

The Board receives a quarterly report on the use of seclusion and restraint. The quarter 4 report for 2013/14 summarised the use of restraint for 2013/14. There were 1388 incidents reported of the use of restraint. There were 178 reports of seclusion.

The overall trend across the Trust compared with previous years shows a fluctuation within usual parameters, close to the lowest reported in recent years.

1. **Deprivation of Liberty Safeguards**

Data for 1 April 2013 – 31 March 2014

|  |  |  |  |
| --- | --- | --- | --- |
|  | Requests | Granted | Not Granted |
| Oxfordshire (mental Health wards) | 8 | 5 | 3 |
| Oxfordshire Community Hospitals | 19 | 13 | 6 |
| Bucks | 25 | 21 | 4 |
| **Total** | 52 | 39 | 13 |

This information demonstrates an awareness of the Mental Capacity Act and Deprivation of Liberty. The proportion of authorisations granted are in line with the national average.

It is anticipated that in 2014/15 there will be an increase in applications and authorisations granted. This will reflect the Cheshire West judgement of the Supreme Court in March 2014 which has provided a new test for deprivation of liberty.

1. **Key Priorities for 2014/15**

* To continue improving compliance with safeguarding, Mental Capacity Act and PMVA training and providing assurance through audit processes
* To develop quality audit to include patient views
* To continue to support front line staff and managers in safeguarding adults practice thorough the provision of safeguarding advice, supervision and training.
* To continue developing a robust system to ensure CQC Outcome 7 can be evidenced robustly
* To work with Divisions to provide assurance about safeguarding practice and to support appropriate and timely referrals to the relevant local authority safeguarding teams.
* **Development of the Multi-Agency Safeguarding Hub (MASH):** In both Buckinghamshire and Oxfordshire, each county is developing a MASH. The aim is to promote communication across partner agencies when a safeguarding adults concern is reported. We are working to ensure that the Trust is an integral part of each MASH to provide support and/or protection to service users where a safeguarding adults issue has been identified.

1. [↑](#footnote-ref-1)