**Safeguarding Children and Young People**

**Annual Report 2015/16**

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**Executive summary**

Safeguarding children is a complex and challenging area of work. The aim of the safeguarding children team is to provide high quality advice, training and support to practitioners across Oxford Health NHS Foundation Trust, to enable them to keep children safe during the course of their work.

In all geographical areas covered by Trust services, safeguarding activity has increased over the past year. Across Oxfordshire, Buckinghamshire, Swindon, Wiltshire Bath and North-East Somerset there were 1517 children subject to a Child protection plan at 31.03.2015. In addition 26,216 children across the region were subject to a Child in Need plan at some point throughout the year.

Audit work over the year has evidenced that practitioners are working with increased complexity and risk in their caseloads. This is within a context in which many partner agencies are facing budgetary pressures and cuts to frontline services. Hence, it is more important than ever that the Trust is assured that safeguarding practice across services is robust.

This report outlines key areas of work in order to provide assurance to the Trust Board.

Areas of excellence in safeguarding children work in the previous year include the following areas:

**Trust wide CQC Inspection September 2015 - feedback on Safeguarding**

Safeguarding children was rated as good.

The inspection identified that systems were in place to keep children and young people safeguarded from abuse. Staff were knowledgeable about the trust’s safeguarding processes and were clear about their responsibilities. They were able to explain their role in the recognition and prevention of child abuse and knew how to report abuse in line with safeguarding procedures.

Staff reported that they were supported through and valued the safeguarding consultation line and this model was highlighted as good practice. An area of development was recording safeguarding supervision via the learning and development portal.

**Historical Sexual Abuse guidance**- this has been developed in conjunction with senior colleagues from Thames Valley police and Childrens Social Care , in order to provide guidance to practitioners when patients disclose abuse that happened in their childhood. This has been a significant area of work over the previous year, and was developed in response to the large increase in consultations relating to this issue.

**Child Sexual Exploitation**- the Joint Targeted Area Inspection in March 2016 in Oxfordshire noted that investment in safeguarding leadership by health providers, and the development of collaborative work between agencies had led to the provision of high quality health services for children at risk of CSE. This includes School nursing, the Kingfisher specialist nurse, CAHBs and the Horizon service.

**Neglect-** this area remains a priority in all of the LSCB areas**.** The safeguarding children team is actively involved in work in Oxfordshire to develop a neglect pathway for staff. Buckinghamshire is to be part of the NSPCC pilot for the graded care profile. Training is to be rolled out end of 2016.

**Female Genital Mutilation-** the team has been involved in developing a standard operating procedure to provide guidance for staff across the Trust. This is in line with national reporting requirements and LSCB procedures. In addition, a health visitor within the trust has secured funding through a national award to develop an app to provide information for staff and clients. The team has shared the excellent work undertaken in Oxfordshire with the Bucks Safeguarding Children Board and this has informed the development of the FGM pathway in Bucks.

**Consultation line service**- this is now an established service which is well used by staff. There were 1644 calls during 2015/2016. 41% of these were from the adult services, indicating that staff are considering the needs of the wider family in their work and utilising a Think family approach. A recent survey, detailed in the report, evidenced that staff valued the service received via the consultation line, and 89% felt the advice received had a positive impact on a child.

**Section 11-** Oxfordshire- At the peer review of the Oxfordshire safeguarding children board section 11 audit the Trust were rated blue in all areas - exceeds expectations.

**Other areas of work-** the team has been involved with 5 serious case reviews,1 homicide review and 2 domestic homicide reviews. They have delivered 57 level 2 & 3 safeguarding children training sessions, 11 CSE workshops and 4 supporting disclosures of historical child sexual abuse workshops. The team has also facilitated 170 safeguarding children supervision sessions, undertaken 9 Trust audits and 8 local safeguarding children board audits. In addition, 11 staff have been supported to write a report for court, and 5 staff who have been called to give evidence at court have been supported by a Named Nurse.

**Priority areas for development for 2016/17:**

**Lampard recommendations, Goddard- Independent Inquiry into Child Sexual Abuse (IICSA) and Bradbury recommendations -**

**Lampard recommendations-** in response to Kate Lampard’s report into *Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile[[1]](#footnote-1)* the Trust were required to provide evidence against 14 recommendations to Monitor[[2]](#footnote-2) in June 2015. Recommendations include assurance that safeguarding resources, structures and processes (including training programmes) are robust and operate as effectively as possible. An action plan is in place and includes a review of policies and procedures in relation to volunteer and visits by celebrities’/VIPs. Some of the recommendations are also reflected in evidence collated in preparation for a visit by the IICSA.

**Independent Inquiry into Child Sexual Abuse (IICSA)** - is an inquiry which has been commissioned as a result of high profile cases of child sexual abuse by celebrities and within institutions and is led by Honourable Lowell Goddard. Visits to statutory organisations such as the NHS will be part of the inquiry. As a Trust we will be required to provide evidence that as an organisation we are responding to current and non-recent disclosures of child sexual abuse and effective safeguarding governance arrangements are in place. Verita[[3]](#footnote-3) have produced a checklist for organisations to identify compliance and areas of development and this has been completed. The majority of areas are rag rated as green; two areas are rated amber these are providing level 6 training for executive leadership and the KPI for safeguarding children training set by commissioners is 95%, the training of eligible staff is currently 89%. A plan is in place to address both areas.

**Bradbury**- an independent investigation into governance arrangements in the paediatric haematology and oncology service at Cambridge University Hospitals NHS Foundation Trust after the Paediatrician Myles Bradbury abused children under his care, resulted in several recommendations. Some of these were only applicable for Cambridge, but some relevant for the Trust. These include reviewing the chaperone policy, being able to identify those with unusual working patterns, ensuring that expectations of staff behaviour are captured within policies and training.

In 2016/2017 the safeguarding children and adult team along with other services across the Trust will work together to ensure that recommendations from Lampard and Bradbury are considered and implemented as appropriate and preparation for a possible visit by the IICSA is completed. Actions will be monitored via the safeguarding committee.

**Safeguarding children supervision-** this continues to be a key area of work. The team recognises that whilst all teams currently receiving safeguarding supervision value this service, there is currently an inequity of provision across the Trust. Hence a proposal paper has been written which recommends offering supervision to CAMHs teams in Oxfordshire and Buckinghamshire in addition to current provision to teams in Swindon, Wiltshire and Bath & North East Somerset ( B&NES) . This recognises the high levels of risk and complexity held by those teams. Further work is required to establish these groups, whilst maintaining a level of supervision to universal services that meets requirements.

**Multi-Agency Public Protection Arrangements (MAPPA) and Multi-Agency Risk Assessment Conferences (MARAC) in relation to high risk domestic abuse across the Trust-** The Trust has robust arrangements in place in Oxfordshire to ensure appropriate representation at these meetings, similar arrangements have not historically been in place in SWB or Buckinghamshire. Progress has been made in this area; a named nurse has received training to access systems in Buckinghamshire and initial discussions have happened in SWB to consider how information could be shared. However, further work is required to ensure Trust arrangements are established.

**Domestic Abuse-** in response to an Oxfordshire serious case review (SCR), the Trust Domestic abuse guidance and Designated MARAC Officer (DMO) guidance have been reviewed and updated by the safeguarding children team. Senior level agreement about strategic leadership of domestic abuse is required in order to take this work forward in line with the SCR .

**Think Family-**The safeguarding children and adult teams are reviewing the terms of reference and roles and responsibilities of the Think Family champions. This is in relation to understanding different roles within adult teams such as carers and safeguarding leads and how these relate to each other and ensure a consistent approach across the Trust.

**Safeguarding Form on CareNotes-** A safeguarding children form is available for staff on CareNotes to record safeguarding information in one place and allow audit and reporting from this information. Work is to continue to embed use of the form across the Trust.

**Jayne Harrison and Lisa Lord- July 2016**

1. **Introduction**

The 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 statutory responsibilities of the Trust, as an NHS provider are outlined in the *Safeguarding Vulnerable People in the Reformed NHS - Accountability and Assurance Framework.[[4]](#footnote-4)*

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.

The Trust is a member of the five Local Safeguarding Children Boards (LSCBs) in Oxfordshire, Buckinghamshire, Swindon, Wiltshire and B&NES as the Trust provides services in these areas. It 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.

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 the CQC Regulation 13 ‘Safeguarding service users from abuse and improper treatment’ The Trust is compliant with this regulation.

**2. Purpose**

To provide the Trust Board with an overview of the progress against the safeguarding children priorities for period 01/04/15 to 31/03/16 as outlined in the Safeguarding Children action plan.

To provide assurance that the Trust is compliant with its statutory duties and CQC Regulation 13 ‘Safeguarding service users from abuse and improper treatment’.

An annual report for the SWB area has also been produced for CCG commissioners and is append iced and provides more details of work in that geographical area.

To outline the safeguarding children priorities and areas for development for 2016/17

Key areas covered within the report are as follows:

* Safeguarding Children Accountability and Governance Arrangements
* National Context and Trust response
* Inspections
* 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 2016/17

1. **Safeguarding Accountability**

The Trust Board Safeguarding Lead is the 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 Nurses Safeguarding Children, who are 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.

Following retirement of the previous post holder in July 2015 the Trust lead nurse role was covered by the three Senior Named Nurses. From January 2016 the Lead Nurse role has been filled by two previous Senior Named Nurses on an interim basis until 30th September 2016.

The Lead Nurses are line managed by the Head of Nursing of the Children and Young People Directorate.

**3.1 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 five LSCB areas continues to increase. The team is organised geographically with named nurse leads for each LSCB area.

* Trust Lead Nurse 8b 1.2 WTE (interim arrangement until 30th September 2016)
* Trust Lead Doctor 1 session per week
* Senior Named Nurses Band 8a 1.7 WTE Oxfordshire and Buckinghamshire
* Named Nurses Band 7 3.7 WTE for Oxfordshire with a dedicated 0.8WTE for Buckinghamshire
* Senior Named Nurse 8a 1.0 WTE Swindon, Wilts and B&NES
* Named Doctor provision includes three additional roles with one session per week to cover Oxfordshire, Buckinghamshire, Swindon, Wiltshire and Bath/North East Somerset (Oxfordshire and Buckinghamshire Named Doctor posts currently vacant)
* Admin support Band 4 0.6 WTE

**Action for 2016/17**

To recruit a Named Doctor to cover both Oxfordshire and Buckinghamshire and use the time made available by combining two areas for a Named Doctor for safeguarding adults.

**3.2 Governance arrangements**

A quarterly Trust Safeguarding Committee chaired by the Director of Nursing and Clinical Standards is in place. This group ensures robust governance of all safeguarding practice and activity across the organisation. Nominated senior directorate 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 group. This includes evidencing delivery against Serious Case Reviews, Section 11 audits and assurance in relation to CQC Regulation 13. The group has in place reporting arrangements to the Quality- Safety Sub-Committee and Trust Quality Committee.

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

**4. National Policy Context & Trust Response**

**4.1 Working Together to Safeguard Children 2015**

Following consultation the government updated and revised the statutory guidance Working Together to Safeguard Children, the revision was published in March 2015. The revisions include changes to:

* The referral of allegations against those who work with children.
* Notifiable incidents involving the care of a child; a section on Notifiable Incidents has been added.
* The definition of serious harm for the purposes of serious case reviews.

The Trust Safeguarding Children policy has been revised against Working Together 2015 and was been ratified by the Safety Committee on the 4th November 2015.

All safeguarding children procedures and training have been updated in line with the revised Working Together guidance.

**4.2 The Children’s Safeguarding Performance Information Framework[[5]](#footnote-5)**

The national safeguarding children performance information framework was introduced in January 2015. This describes key nationally collected data that can help those involved in child protection at both the local and national levels understand the health of the child protection system.

The Safeguarding children team provide quarterly data to Bucks Safeguarding Children Board (BSCB) in line with this framework. Other LSCBs are yet to request this data. Processes have been developed to allow this data to be made available if required.

**4.3 The Children and Families Act 2014 / Care Act 2014**

The emphasis in both Acts is on outcome focused, person-centred practice when considering assessment, planning and support as well as coproduction and multi-agency approaches to planning and commissioning.

Part 3 of the Children and Families Act transforms the system for disabled children and young people and those with SEN, so that services consistently support the best outcomes for them. The reforms create a system from birth to 25 through the development of coordinated assessment and single Education, Health And Care Plans; improving cooperation between all services responsible for providing education, health or social care; and giving parents and young people greater choice and control over their support.

Key areas of work include facilitate building relationships with young carers and adult services.

**Action for 2016/17**

Multi-agency arrangements will be inspected from April 2016 by Ofsted and CQC and the CYP directorate will continue to work with partners to prepare for these inspections.

**4.4 Savile Enquiry**

The report by Sir David Nicholson in April 2013 called for review of 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. Following on from this review the Government commissioned an independent oversight of NHS and Department of Health investigations into matters relating to Jimmy Savile, and this led to a lessons learned report which was published in February 2015 by barrister Kate Lampard.

The report included 14 recommendations for the NHS, Department of health and wider government. A call for information was made by Kate Lampard regarding changes that had been put in place by health organisations and a response was sent by the Director of Nursing and Clinical Standards on 15th June 2015. The Trust review has been completed and the following actions relating to the safeguarding team have been taken:

* The Trust Safeguarding Children policy now includes volunteers
* Safeguarding training for staff and volunteers is in place and updated every three years.
* Governance arrangements are in place which allow regular safeguarding briefings to the Trust quality committee, Trust board and operational and governance meetings.
* The safeguarding children team provide safeguarding advice, support via a consultation line and supervision to staff.
* Information / resources about safeguarding children are available via the consultation line and the safeguarding children area on the Trust intranet.
* Guidance available for staff on joint working with Oxford Health NHS Foundation Trust and other agencies with regard to disclosure of historical child sexual abuse.
* Completion of Verita[[6]](#footnote-6) checklist for the [[7]](#footnote-7)Independent Inquiry into Child Sexual Abuse (IICSA) was submitted to Oxfordshire CCG May 2016.

**Actions for 2016/17**

A Savile challenge event is planned by Buckinghamshire Safeguarding Children Board (BSCB) for July 2016.

Further work is required by the Trust in relation to overall co-ordination and management of volunteers

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

As a response to increased numbers of consultations from staff in relation to historic disclosures, guidance for staff on joint working with Oxford Health NHS Foundation Trust and other agencies with regard to disclosure of historical child sexual abuse has been available to staff since October 2015.

The guidelines are to support clinicians to ensure individual disclosures are risk assessed and information is shared appropriately if children remain at risk. Leaflets for staff and clients have also been developed to support taking forward a disclosure, these are available via the safeguarding children webpage, training and cascaded through directorate and team meetings

The work was presented at the Health Visitor conference in May 2016.

Six workshops were offered in Buckinghamshire and Oxfordshire between Jan-March 2016. . The workshops were mainly for adult services, but also helpful for staff in the Children and Young People directorate for historical disclosures made by parents/carers or children. The workshops were directed at safeguarding leads/team managers/supervisors/locality team leaders to cascade information to teams and were delivered by Trust lead nurse safeguarding children alongside Thames Valley Police and adult mental health colleagues.

32 staff from Psychological Services and Healthy Minds attended in Bucks.

10 staff from Complex Needs Service, AMHTs, CAMHs attended in Bucks.

23 staff from Psychological Services and Talking Space attended in Oxfordshire.

8 staff from Health Visiting, Early Intervention Service, Older adults and AMHT attended in Oxfordshire.

The guidance has also been shared with Local safeguarding children boards and with Local Safeguarding Adult boards in Oxfordshire and Buckinghamshire.

**Actions for 2016/17**

To share guidance with local safeguarding children and adult boards in Swindon, Wiltshire and B&NES. Complete a thematic review of consultations received in regard to disclosures of child sexual abuse before and after guidance was available.

To publish an article in regard to the development of the guidance in the journal *Child Abuse Review.*

**4.6 Female Genital Mutilation**

**Multi-agency statutory guidance on female genital mutilation (HM Government, April 2016)**

There is new guidance from HM Government which replaces guidance from 2014. The guidance provides information, strategic guidance and advice and support to front-line practitioners.

<http://ohftintranet.oxfordhealth.nhs.uk/PatientSafety/Safeguarding%20children%20documents/Female%20Genital%20Mutilation%20(FGM)/National%20guidance,reports,research,reviews,audits/HM%20Gov%20Multi_Agency_Statutory_Guidance_on_FGM%20April%202016.pdf>

The Trust’s processes in regard to how staff fulfil their mandatory reporting duty and how to document assessments, care plans and information sharing have been updated to reflect these changes.

 

A significant change to practice in regard to supporting women and girls who have experienced FGM, is the Trust’s mandatory obligation to report patient identifiable information to the Dept. of Health regarding prevalence of FGM. If FGM is identified then this information needs to be shared with DoH, consent to share this information should be obtained from the woman and they have the option of opting out.

Each LSCB area has been working on local implementation of FGM policies and procedures.

Thames Valley Police has made FGM one of their top priorities and FGM procedures and strategy have been reviewed and developed for the Oxfordshire Safeguarding Children Board (OSCB). The aim is to continue 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.

The Trust is fully engaged in this work and will continue to form part of the working priorities for the Safeguarding team in the coming year.

The OSCB FGM procedures and pathways have been used to support the development of standard operating procedures for Oxfordshire and the whole trust.

A Safeguarding Named Nurse attends the Oxfordshire FGM no names meeting monthly. This meeting supports a multiagency risk assessment of the needs of women and girls who have been cut or are at risk of being cut. Safeguarding decisions and criminal proceedings are discussed as part of that meeting.

A special interest group has been established to support the development of awareness, and practice guidance to staff across universal services in regard to FGM.

A Buckinghamshire safeguarding children board (BSCB) FGM challenge event was attended by safeguarding team staff in November 2015.

A named nurse is part of the BSCB FGM working group which convened in February 2016, to ensure active engagement in FGM policy development and allow learning to be shared from Oxfordshire.

**Action for 2016/2017**

To provide workshops to adult mental health and CAMHS teams who work in areas where there is high prevalence of population from countries where FGM is practiced. These will be delivered by November 2016.

**4.7** **National and Local Authority Area Child Protection and Child In Need Statistics as at 31 March 2013, 2014 and 2015**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Number of children subject to a child protection plan  31 March 2013 | Number of children subject to a child protection plan  31 March 2014 | Number of children subject to a child protection plan  31 March 2015 | Number of Children in Need (throughout the year)  31 March 2013 | Number of Children in Need (throughout the year)  31 March 2014 | Number of Children in Need (throughout the year)  31 March 2015 |
| **England** | **43,100** | **48,300** | **49,700** | **736,100** | **781,200** | **781,700** |
| Oxfordshire | 430 | 504 | 569 | 6125 | 6320 | 6719 |
| Bucks | 190 | 242 | 332 | 5305 | 6007 | 7445 |
| Swindon | 147 | 214 | 213 | 2077 | 2656 | 3746 |
| Wiltshire | 328 | 396 | 403 | 5089 | 5239 | 6130 |
| B&NES | 122 | 79 | 99 | 2247 | 2169 | 2176 |

**Key trends:**

In line with national figures, there has been an increase in the number of children subject to CP plans in Oxfordshire, Buckinghamshire, B&NEs and Wiltshire. There has been an increase in child in need cases in Oxfordshire, Buckinghamshire, Swindon, Wiltshire and B&NEs.

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, for example the Multi Agency Safeguarding Hubs (see below) and Single point of Access for social care/CAMHs.

**5. Inspections**

**5.1 Trust wide CQC inspection 28th September- 2nd October 2015**

The safeguarding team worked together with the Trust IC5 taskforce to develop a plan in preparation for this inspection.

Safeguarding was rated as good and the safeguarding consultation line was reported by staff as being supportive and the model was identified by the CQC inspectors as good practice.

Feedback relating directly to safeguarding is as follows:

* Across all services the trust staff were good at recognising safeguarding and reporting incidents.
* Teams learnt from incidents and there was shared learning across services, through regular ‘briefing notes’.
* The structure of team meetings included safeguarding and committees which provide the board with assurance, were well embedded.
* Staff understood the trust’s safeguarding policies and procedures and safeguarding training was mandatory.
* There were good links with safeguarding leads within the trust and information available in areas to offer support and advice.
* The trust was represented on the local safeguarding local authority boards.
* Staff to record supervision and safeguarding supervision.

There was no specific required action and the team will continue with areas for development as planned and share good practice.

**5.2 Oxfordshire Joint Targeted Area Inspection (JTAI) in relation to Child Sexual Exploitation (CSE) and Missing Children (Ofsted, CQC, Her Majesty’s Inspectorate of Constabulary (HMIC) and Her Majesty’s Inspectorate of Probation (HMIP) March 2016)**

A multi-agency thematic inspection which included an inspection of the social care front door (MASH and assessment teams) and a deep dive inspection of Child Sexual Exploitation and Missing Children cases was completed in March 2016.

Audits of 7 chosen cases were completed and did not flag any major issues of concern for trust services, all cases met expectations and we were pleased to note that there are 2 cases with excellent practice that exceed expectations.

Inspectors spent time in the Multi-Agency Safeguarding Hubs (MASH) and met with strategic leads. The inspectors visited the Kingfisher team, and health leads from OHFT and OUH. Inspectors also visited the Horizon team, CAMHs, Child and Adolescent Harmful Behaviours service (CAHBS) , School health Nursing service and Looked after Children teams.

Feedback from the inspection was positive about health services provided to children at risk of CSE. It was noted that there was good collaboration and sharing of information between health agencies, and strong safeguarding leadership. The final report stated:

*The quality of joint working in health is highly developed, underpinned by a shared vision and purpose between local health providers and joint commissioners.*

*Good attention is paid to developing the skills of frontline health staff through a range of learning and development activities, underpinned by regular case consultation, peer review and supervision to support continuous professional development. Additional resourcing for safeguarding leadership across primary care, community health and the hospital sector effectively supports the development of frontline professional confidence and expertise, and ensures that there is effective health service provision to vulnerable young people.*

The report particularly noted the positive work of the CAHBs and Horizon service.

The inspection raised concerns about the functioning of the MASH, particularly around timeliness and about strategy meetings. Oxford Health Safeguarding Children Lead nurse is involved in the multi-agency work to re-design the MASH model following the inspection findings.

**6. Partnership Working**

The Mandate from the Government to NHS England for April 2016 to March 2017 (published in December 2015) states:

*“NHS England should ensure the NHS helps to identify violence and abuse early and supports victims to get their lives back sooner, including through improved data sharing with community partners”[[8]](#footnote-8)*

**6.1 Oxfordshire**

The trust has representation on the following Oxfordshire Safeguarding Children Board (OSCB) subgroups: Training, Child Sexual Exploitation, Serious Case Review, Health Advisory Group, Disabilities, Policies and Procedures, Performance and Quality Assurance (PAQA), Child Death Overview Panel, local area panels. The Trust Lead Nurse sits on the OSCB Executive committee. The Director of Nursing or Service Director for Children and Young people sit on the Board.

There is productive multi-agency working at a local level. This includes the following:

**6.2 Child Sexual Exploitation**

This continued to be a main area of work in 2015-2016. It included:

* Contribution to the Joint Targeted Area Inspection into CSE and Missing Children as outlined in Para 5.2 above.
* Implementing the recommendations from the SCR regarding Children A – F (Operation Bullfinch)
* A pathway to clarify the role of the SHN service re CSE.
* Contribution to the Oxfordshire CSE stocktake. This report, commissioned by the government in response to publication of the A-F SCR, considered the progress that has been made since 2011.
* Contribution to Operation Reportage review, following convictions in April 2015: this review focused on the experiences of victims of child sexual exploitation and the agency response.
* Engagement with CSE virtual multi agency service pilot in B&NES, which commenced in January 2015.
* Developing therapeutic services for children who disclose abuse and exploitation. The Horizon service was launched on 24th February 2016.
* The development of a sexual abuse pathway to ensure that children receive appropriate and effective assessment and treatment.
* The development of a smooth transition between children’s services and adult mental health services.
* Developing and implementing a training strategy for child sexual exploitation.

**6.3 Oxfordshire MASH update**

The Oxfordshire MASH supports a co-located team and partnership working approach between the Children’s Social Care, Thames Valley Police, Early Intervention services, Oxford Health and Oxford University Hospitals. This includes the Trust provision of Named Nurses to support interagency working.

The Safeguarding children element of the Oxfordshire MASH went live for Oxford City cases on 23rd Sept 2014 and for the whole County on 27th October 2014. The MASH has continued to be an important priority for the Trust in 2015/16.

The MASH health team consists of 1 WTE Named Nurse (band 7 or 8a) and 1.2 WTE admin (band 4).

The Named Nurse element is provided by a rotation of nurses from the Trust, Oxford University Hospitals Trust (OUH) and CCG Safeguarding teams, with the Trust providing 3 days per week, OUH 2 days per week, and the CCG 1 day per month.

In the first year of the Oxfordshire MASH, the health team received 2799 requests for information. This averages at 12 cases per day.

Oxfordshire County Council are currently reviewing their input into the MASH following the findings from an internal LEAN review, the Joint Targeted Area Inspection report (March 2016) and financial pressures. Oxford Health is engaged in multiagency discussions to consider the role of the health team within the revised model.

**6.4 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 and their children. In Oxfordshire the Named Nurses attend as Trust representatives alongside adult mental health representatives.

As a result of Child J SCR/DHR in Oxon OHFT Designated MARAC Officer guidance was updated and enhanced recording processes implemented using CareNotes.

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

The Trust has adult mental health representatives engaged in Oxfordshire Multi-Agency Public Protection Arrangements. The model of engagement of the Named Nurses with MAPPA has been reviewed and revised. The Named Nurses provide information virtually. This is to inform the risk management and multi-agency working, as part of the Trusts public protection role regarding high risk violent or sex offenders. The Named Nurse attends the MAPPA meeting if it becomes evident from information obtained from the patient’s records and MAPPA organisers that representation is required,

**6.6 Refocus on Neglect: North Pilot**

During January – May 2015 a pilot was undertaken in the north of Oxfordshire which sought to establish better outcomes for children subject to Child Protection Plans for neglect.

A summary of the key findings are listed below:

• Multi-professional working is critical to effectively support and challenge families with Child Protection Plans for neglect to make and sustain change

• The importance of multi-agency working and multi-agency training

• Family engagement is the critical factor in enabling change

• Ensuring there is capacity for practitioners to deliver intensive support

• Understanding and planning for the needs of the whole family is vital to achieving better outcomes.

Summary of recommendations included;

1. Multi-agency coordination and strengthening the core group function

2. Assessing and evidencing neglect

3. Think Family: supporting the network around the child

A multi-agency task and finish group has been convened by the OSCB in December 2015 to oversee /implement the identified actions and recommendations and to implement the learning from Child Q where neglect was a concern. This group is chaired by Oxford Health Senior Safeguarding Nurse Jill Berry. Action plans are currently being developed in relation to the above.

**Actions for 2016/17**

To ensure that assessment tools to identify neglect are used consistently by trust practitioners, in order to identify neglect and develop a plan of care.

An OSCB neglect pathway is currently being developed in order to give clear guidance for staff about what steps to take when neglect is a concern.

This pathway will also reflect the transformation work being undertaken by Oxfordshire County Council regarding early intervention and MASH services

**6.7 North Oxfordshire self- harm network.**

This multiagency forum was established in 2014 because of unexpected growth in the number of children self-harming and attempting suicide who attended secondary schools in Banbury. The trust is represented at this forum by the Safeguarding Children team, CAMHS and School Health Nursing.

Key outcomes from this work stream have been the development of self harm [guidance](http://www.oscb.org.uk/wp-content/uploads/Self-Harm-Guidance.pdf) for schools and residential settings in Oxfordshire, and a multi agency learning summary on mental health and self-harm: <http://ohftintranet.oxfordhealth.nhs.uk/PatientSafety/Safeguarding%20children%20documents/Self%20Harm/Mental%20Health%20and%20Self%20Harm%20Learning%20Summary.docx>

**6.8 Oxfordshire domestic abuse advisory group (ODAAG).**

The team has representation on the Oxfordshire domestic abuse advisory group (ODAAG). This is an amalgamation of Oxfordshire Domestic Abuse Strategy Group (ODASG) and the Oxfordshire Domestic Abuse Children’s Strategy Group (OCDASG).

The group comprises senior managers and operational staff from all key agencies and from the OSCB and adult services. The group provides an overview of development, delivery and monitoring of the domestic abuse strategy and to take responsibility for actions agreed by ODDAG.

**Actions for 2016/17**

The development of the young person’s domestic abuse pathway has been supported by the team. OSCB approval is pending; then it will be rolled out across the services.

Strategic overview of domestic abuse services is being undertaken across partner agencies by Oxfordshire County Counsel domestic abuse co-ordinator.

A Dynamic Pathway is in development to support staff on how to respond to a disclosure of domestic abuse.

**6.9 Building relationships between partners**

The team has facilitated building relationships with children’s social care and adult mental health services. Examples include, a senior locality social worker attends Oxfordshire ‘Think Family to safeguard children meetings’ and this meeting also has visitors from services such as young carers The senior locality social worker has also agreed to attend every other complex needs service safeguarding supervision if required.

The team also meet with senior locality social workers on a quarterly basis to try and resolve any operational issues that may arise at a local level.

**7. Buckinghamshire**

There is representation by the Safeguarding Children team on four BSCB sub-groups. These are Learning and Development, CSE, Policies and Procedures and Performance and Quality assurance. In addition, the Early Help Panels and Missing and Sexual Exploitation Risk Assessment Conference (MSERAC) in Buckinghamshire have a representative from CAMHs. CAMHs also represent adult mental health at the Early Help Panels.

**7.1 Child Sexual Exploitation**

There have been a number of arrests made across Buckinghamshire for CSE with successful prosecution. Most recently on 24 July 2015, six men were found guilty in regard to Operation Articulate, for offences that occurred between January 2006 and December 2012.

The Trust is fully engaged with multi-agency working to include support for the identified victims and some of the actions above are applicable for Buckinghamshire.

Other Trust actions include:

* Joint working in relation to CSE training and awareness raising including staff attendance at CSE events.
* Shared learning from the experience of CSE in Oxfordshire.
* Active engagement by CAMHs services at SERAC (sexual exploitation risk assessment conference) a multi-agency meeting working to safeguard children at risk of sexual exploitation.
* Joint working with Thames Valley police to incorporate data from OHFT to improve the victimology analysis for their work on the Problem Profile for CSE in Buckinghamshire.
* Representation on the CSE working group. This group provides a multi-agency forum for the strategic development and overview of the Buckinghamshire response to CSE through identified local and regional requirements, national trends and local service needs.
* Contribution to SCR thematic review of CSE in Buckinghamshire between 1998 and 2013 focusing on six Thames Valley Police investigations.

**7.2 Buckinghamshire MASH update**

Buckinghamshire MASH went live on 22nd September 2014 and includes adult safeguarding. In Buckinghamshire the Trust is 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.

MASH enquiries are actioned by the named nurse who is covering the safeguarding children consultation line. Enquiries are sent by MASH to the team via a secure email account.

194 enquiries have been actioned from July 2015- March 2016.

**Action for 2016/17**

The MASH operational group has been reconvened and the group is in the process of a final review of the MASH operating principles and agreeing the dataset and information which will be made available to partners.

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

In Buckinghamshire there is currently representation by adult mental health at MARAC.

**Actions for 2016/17**

The Named Nurse from the Safeguarding Children Team to be the designated MARAC officer (DMO) for Children and Young People directorate to ensure robust information sharing processes are in place.

To establish what governance processes there are in regard to development of a domestic abuse strategy in Buckinghamshire and ensure the Trust has representation.

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

The Trust has adult mental health representatives engaged in Buckinghamshire Multi-Agency Public Protection Arrangements. Named nurses from the safeguarding children team are currently not involved.

**Action for 2016/17**

To ensure an equitable service across the Trust in regard to children that may connected to adults in the MAPPA process.

**7.5 Buckinghamshire County Council Ofsted Inspection September 2014 and improvement plan**

The Ofsted Inspection of Buckinghamshire County Council took place in September 2014 and the judgement was inadequate. An Improvement Board meets monthly to oversee the delivery of the Improvement Plan with representation from partners and other local authorities. The work streams are:

1. Improving Leadership, Governance and Partnerships

2. Improving Quality of Social Work Practice

3. Improving the Strength and Capacity of the Workforce

4. Improving Early Help and the Front Door

5. Improving Services for Children on the Edge of Care, in Care & Permanence Planning

6. Improving Tools

The Trust Children and Young Peoples Service Director has been a member of the improvement board

**Key actions**

* **Local Government Committee Peer Review –October 2015**

This was completed in October 2015 and formally reported back at the beginning of November 2015. The review found that there had been improvements in areas such as development and commitment to and from partners; but there were still areas of improvement.

Workshops took place with partner agencies at 3, 6 and 9 months to monitor and take forward the improvement plan.

* **Department for Education audit January 2016**

The Department for Education (DfE) commissioned further auditing to be undertaken before making a recommendation to the Minister of State for Children and Families on progress. This audit was completed in January 2016.

* **Refreshed improvement plan January 2016**

In light of the recent reviews from both the Local Government Association and DfE

there is a refreshed the Improvement Plan for Children’s Safeguarding, in partnership with key stakeholders. The partnership agreed the following priorities for the refreshed plan:

 The leadership, culture, values & behaviour of the partnership ensure good

outcomes for children and young people

 Best Practice is consistent in all areas of frontline services

 Resources support good practice and improved outcomes for children and young

people

 Self Knowledge, informed by listening to and acting on the voice of children and

young people drives improvements

**Action for 2016/17**

Ofsted are due to return for a repeat inspection before September 2016. Oxford Health NHS Foundation Trust continues to work with partners to implement the improvement plan.

**7.6 Connecting for Children**

There is representation at the Connecting for Children meeting, chaired by the Trust Children and Young Peoples Service Director. This has been set up to establish a common operational framework which enables key partners from children’s social care, education, health, third sector and the police to ensure that there is a shared understanding and responsibility around safeguarding children.

This meeting includes mapping of a child’s journey which forms part of the audit plan for the BSCB.

**Action for 2016/17**

Dip sample of six cases open to Learning Disability CAMHs and partner agencies looking at multi-agency working for these children.

**7.7 First Response and Bucks/Safeguarding Children Team**

A quarterly meeting takes place with the service manager of First Response and MASH and the Buckinghamshire Healthcare Trust safeguarding children team. This allows an opportunity for operational issues to be discussed and resolved.

**8. Swindon, Wiltshire and Bath North East Somerset**

The Trust is a statutory member of Swindon and Wiltshire & B&NEs LSCB’s, and is represented on the board by the Head of Service. Senior staff, including the Senior Named Nurse attend relevant sub-groups. Work includes supporting delivery of business plans and priorities in line with national and local safeguarding priorities.

**8.1 Safeguarding arrangements in SWB during 2015/2016.**

The previous Senior Named Nurse left the trust on 2nd July 2015.

There was a five month period where interim arrangements were in place until the new Senior Named Nurse commenced her role on 8th December 2015.

The priority has been given to re-establishing safeguarding children supervision groups and regular communication with the service managers and Trust lead nurse.

**Action for 2016/2017**

* Review of safeguarding practice by individual teams
* Audit of referrals to social care
* Workshops to share learning from SCR’s
* Audit of case conference attendance and reports.

**8.2 MASH Update**

Interface with other Named Nurses in W&B ensures engagement with the Multi Agency Safeguarding Hub (MASH). There are no formal arrangements in place to provide mental health input into Swindon and BANES MASHs at this time.

**Action for 2016/17**

The Wiltshire CAMHS Transformation Plan has established a role for a Senior Mental Health Practitioner who will work alongside professionals working in the MASH. This will mean that those working within the MASH will have access to specialist mental health advice which will support the assessment and management of risk and the planning of care where there are concerns raised about mental and emotional health.

**8.3 MARAC and MAPPA**

Work is in place to re-establish the interface between the Senior Named Nurse and other named nurses which ensures the Trusts public protection role is maintained in cases that involve high risk violent or sex offenders.

**Action for 2016/17**

To formalise arrangements to ensure that adequate information sharing arrangements are in place for these meetings.

**9. Updated policies and guidelines 2015/16**

The Court report guidelines were updated in July 2015 and incorporated as Appendix 9 of the new Legal Proceedings policy, Corp 17

<http://ohftintranet.oxfordhealth.nhs.uk/pp/Policies/2%20Corporate%20Policies/Legal%20Proceedings%20Policy.pdf>

The case conference guidelines were updated in December 2015 and are available to staff on the Intranet:

<http://ohftintranet.oxfordhealth.nhs.uk/pp/Policies/1%20Clinical%20Policies/Safeguarding%20Children/Case%20conference%20guidelines%20.pdf>

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Local Authority Area** | **2012** | **2013** | **2014** | **From**  **01.04.15- 01.05.16** | **Other** |
| Oxfordshire | 1 | 3 | 3 | 1 (partnership) | 2 SCRs /critical reviews pending |
| Buckinghamshire | 1 | 1 | 1 | 1 |  |
| SWB |  |  | 1 | 1 SCR (led by another LSCB)  2 LCRs | 2 DHRs |

**Oxfordshire**

Five new cases were brought to the attention of the OSCB for consideration of a serious case review in 2015/16. Of these referrals one serious case review was commissioned.

The OSCB has worked on five serious case reviews over the last year, one of which is also a homicide review. Of those reviews: two have been completed in 2015/16

**Buckinghamshire**

There were no SCRs involving Trust services completed in 2015/16. One SCR was commissioned that involved Trust services and is in progress at time of reporting.

**SWB**

1 SCR was published with Oxford Health involvement in 2015/16. This was led by a neighbouring LSCB.

IMR’s were submitted for 2 Domestic Homicide reviews. The final reports are due to be published.

The Trust contributed information to 2 local case reviews in Swindon.

**A list of SCRs by county and updates are available at Appendix 1.**

**10.1 Learning from Serious Case Reviews:**

Serious Case reviews signed off by Local Safeguarding Children Boards in 2015/16 have highlighted a number of areas for improvement as well as good practice. None of the reviews indicated significant gaps in practice by Oxford Health. Key learning points are as follows:

**Learning points for practitioners**

* When assessing: always make an assessment of what a father/male partner and his family can offer to a child (positives), as well as of the risks he/they may pose.
* Remember: the quality of assessment can impact on all your future plans. Be sure to review and reappraise those assessments over time.
* When responding to incidents: ensure that you speak to a child alone in relation to any allegation of harm or physical signs of harm.
* When you are working with complex adolescents seek out proper management support
* Remember: the risk to a young person is not reduced if they do not live with the perpetrator
* Consider the unborn child and be aware of pre-birth assessment procedures

**Learning points for managers**

* **Assessment**: Comprehensive thoughtful assessment which is reviewed over time is fundamental to the success of future safeguarding. Ensure that systems for support, supervision and challenge are effective.
* **Supervision**: Ensure that reflective supervision is carried out in neglect cases, with a focus on the lived experiences of the child/ren.
* **Management**: Ensure that neglect cases have clear plans – with desired outcomes, timescales, etc. – which are reviewed robustly on a regular basis
* **Risk Management**: Make use of the multi-agency risk assessment and management plan (MARAMP) and support inter-agency colleagues to reduce risk and impose boundaries on dangerous behaviour.
* **Working with adolescents**: Damaged and dangerous young people are often well known to services. Ensure that your service collates risk information so that it is easily accessible in records. Working with adolescents: Consider what contribution you should be making to improving your organisation’s approach and services for working with adolescents.

**10.2 Implementing the learning from SCRs**

The safeguarding children team has been actively involved in sharing learning from SCR both internally and in conjunction with the LSCBs. This has included:

* Working with LSCB on multi-agency learning events regarding learning from SCR
* Incorporating local and national themes in level 3 safeguarding children training
* Continuing to embed the use of threshold document via training, resources, supervision and intranet
* Encouraging use of Early Help processes eg Family Resilience and TAC via supervision, consultations and resources
* Facilitating better information sharing between adult and children services via Think Family meetings
* Sharing and embedding the learning from the SCR re: children A-F. To date 11 workshops have been delivered across the Trust.
* Highlighting escalation policy in training and safeguarding reviews
* Developing a multi-agency domestic abuse pathway to include under 18s
* Formation of a strategic working group in regard to domestic abuse
* The learning from SCRs is included in a monthly safeguarding children newsletter/update and shared at governance and locality meetings
* Maintain high quality individual and group supervision and expand existing supervision arrangements to include identified high risk teams eg Bucks OSCA
* Ongoing audits to provide evidence of learning from SCRs

**11. Think Family**

Since 2014 Think Family practice within the Trust is the responsibility of identified Band 7 practitioners within the AMHTs and individual Modern Matrons on the wards.

The senior nurses in the safeguarding children team are the Think Family leads. Current responsibilities and ongoing work include;

* A quarterly “Think Family to Safeguard Network” meeting is chaired by the senior nurse. The venue alternates between Oxfordshire and Buckinghamshire. The meeting provides an opportunity to cascade new information via think family/safeguarding leads, for useful discussion and to establish professional links, including with outside agencies. Family resilience, Young carers and locality social workers have attended meetings. Membership of the group has widened, with think family champions being identified from Early Intervention Service (EIS). There is also an opportunity at each meeting for case discussion.
* The safeguarding children team maintain and update the Think Family folder on the intranet.
* Work is continuing across the Directorates to ensure that Think Family is embedded in practice. This has involved members of the safeguarding children team building links with the AMHTs by attending team meetings. The Safeguarding Children team will continue to support adult mental health services and ward managers to ensure that progress continues to be made.
* The safeguarding children SOP for adult clients has been updated with the implementation of Care Notes and has been sent to team managers and shared at governance and Think family meetings. This includes how to record children details as dependants. The new safeguarding form has is highlighted in level 2/3 training and safeguarding reviews undertaken with AMHTs and Early Intervention Service.
* The safeguarding children consultation line has been highlighted to staff in adult services and data indicates a continued increase in contacts by adult staff (See para 9.2).
* A Serious Incident Requiring Investigation (SIRI) in 2015 of a homicide where the perpetrator was known to children and adult services; identified that joint working does not appear to be usual clinical practice. Feedback from the think family meeting and health visitor conference to identify barriers and good practice and establish what actions are required to move this area forward have been shared with the Heads of Nursing for the children and young people and adult directorate.
* All levels of safeguarding training reinforce the importance of joint working practice.

**Actions for 2016/7**

A review of the Think Family roles and responsibilities and the Think Family meeting is underway. This is to understand the different leads identified within teams and how they relate to each other. Also to review the Think Family meeting to make it more efficient and consider if one meeting is appropriate for all leads.

The head of social care is in discussion with the Director of Nursing and Clinical Standards and Clinical Director in regard to developing the Think Family role. A paper will be prepared by the head of social care for consideration at the Safeguarding Committee.

**12. Implementation of Safeguarding Children Training strategy 2015/6**

In line with the intercollegiate guidance, there are three levels of training for staff within the Trust. All Trust staff are required to undertake training commensurate with their role. The core level of training required will be shown on the training matrix by staff group and on the individuals training record.

**12.1**

**Training Data**

Trust wide Safeguarding Children Training data as of end March 2016



At the end of March 2016, Safeguarding children training is at 87%. The biggest training gap is those staff who require Level 2 refresher training. Courses are often fully booked but it is rare that all the delegates attend; one reason for this is staff having to prioritise their clinical work.

Actions taken

* Additional and bespoke training sessions have been delivered.
* Managers continue to be sent details about staff that require safeguarding training
* Training data continues to be monitored at Operational and Governance meetings.

CPD training

The safeguarding team have also delivered 4 workshops on managing historical disclosures of sexual abuse and 11 workshops on child sexual exploitation to ensure the learning from the Serious Case Review regarding Children A-F continues to be embedded.

**12.2 Evaluations of training**

Participants are requested to complete a self-assessment of knowledge and skills relating to the course objectives before and after training on a scale of 1 – 5.

Participants are also required to evaluate the role of the facilitators and how the training presentations could be improved.

A copy of evaluation form and evaluation data is embedded below.





The evaluation forms are reviewed in order to ensure that the training meets the requirements of the workforce. Actions taken in response to the themes from the evaluations include;

* + The development of pre-course reading materials
  + Clarity of the referral pathways for adults and children
  + Developing a glossary of safeguarding terms

A senior safeguarding nurse is currently working with L&D to develop safeguarding training resources and learning opportunities via the Moodle (a new web based learning environment) in order to improve accessibility for staff.

**13. Child Protection Consultation and Supervision arrangements.**

**13.1 Advice and consultation**

There is a safeguarding consultation line in place for all Trust staff to call if they have a concern about a child. This number is manned by the named nurses on a rota system Monday – Friday 0900-1700hrs.

A summary of the consultation is then sent to the practitioner; this can be uploaded on to the patient/clients` clinical record.

Staff have access to Local Authority Emergency Duty social care teams for out of hours advice and Trust on call managers.These numbers are highlighted on the safeguarding children intranet page.

The safeguarding team data base which is used to capture the consultation data has been amended to reflect the number of consultations received about historical sexual abuse, child sexual exploitation, domestic abuse, FGM, modern slavery, perplexing presentations and forced marriage. This is in addition to the standard categories of physical, sexual, emotional abuse and neglect.

**13.2 Activity Data**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Total number of consultations** | **2014/15** | | | **2015/16** | |
| **Quarter** | **Children and Young People**  **2014/15** | **Adult & Older Adult**  **2014/15** | **Children and &Young People**  **2015/16** | | **Adult & Older**  **Adult**  **2015/6** |
| Q1 Apr-Jun | 246 | 61 | 248 | | 151 |
| Q2 Jul-Sept | 218 | 98 | 245 | | 159 |
| Q3 Oct-Dec | 267 | 145 | 237 | | 175 |
| Q4 Jan-Mar | 244 | 111 | 240 | | 189 |
| **Total Consultations** | 975 | 415 | 970 | | 674 |

The data from 2014/15 indicated a significant overall increase in consultation activity. The data from 2015/16 indicates that the consultation levels from the C&YP directorate remain at similar levels. Consultations from the Adult Directorate continue to increase from 415 to 674.

Overall consultations have increased by 18% (1390 to 1644)

Calls from adult services have increased by 62% (415 to 674)

Calls from children’s services have decreased by 1% (975 to 970)

The overall increase in activity may be due to a combination of factors, continued awareness raising of the service, focussed work with adult services and embedding of the consultation line.

**Survey monkey review of safeguarding children consultation line- April 2016**

This was undertaken to evaluate the safeguarding consultation line from a staff perspective.

The report showed that the overall experience of staff was very good, useful and they were responded to in a timely manner. 92% said the response to their call was timely, 87% said the experience of using the service was either good or very good and 89% reported feeling empowered and more confident to manage safeguarding issues after contacting the consultation line, and 89% felt that the advice they were given had a positive impact on the safety of a child.

**13.3 Group child protection supervision**

The Named Nurses currently deliver child protection supervision groups to Children’s Universal Services, Family Nurse Partnership, Oxfordshire PCAMHS, Complex needs service Oxford/ Buckinghamshire, Clinical Nurse Specialist central area and Paediatric Continence services.

Child protection supervision is now being delivered for the Outreach Service for Children and Adolescents (OSCA) in Buckinghamshire since October 2015. The OSCA group was evaluated in April 2016 and the group will continue as the supervision was valued by staff.

A review of current safeguarding supervision arrangements is underway in consultation with service managers / heads of service to agree which services should be prioritised and how the needs of other services could be met regarding safeguarding support. The proposals will be taken to the Safeguarding Committee for approval in June 2016.

An evaluation of safeguarding supervision was undertaken in April – July 2015 and included all groups. Practitioners identified a number of ways as to how their practice has altered due to attendance at safeguarding supervision and reported that they found the supervision beneficial.

The Named Nurses and Named Doctors receive their own Safeguarding Supervision and this is facilitated by the Trust Lead Doctor.

**Actions for 2016/17**

Ongoing supervision arrangements will be confirmed to service managers following approval of paper in June 2016.

To continue to request staff record supervision on the Learning and Development portal, and to obtain reports to formally evidence supervision uptake by service.

**14. Safeguarding Children audit work**

During 2015/16 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 via the relevant sub-groups.

**Internal Audits completed:**

|  |  |  |
| --- | --- | --- |
| **Service** | **Type of audit** | **Date completed** |
| Universal Childrens Services | Safeguarding review | April 2015 |
| Adult directorate & Children and Young People directorate (CY&P) | Family Friendly wards Re-audit | April 2015 |
| CAMHs (Bucks) | Safeguarding reviews | July 2015 |
| Childrens Community nursing | Safeguarding review | July 2015 |
| C&YP Directorate | Childrens Social Care referrals audit | September 2015 |
| C&YP Directorate | Evaluation of Safeguarding Children Supervision | September 2015 |
| C&YP Directorate | Consent audit | October 2015 |

**Summary of audit findings:**

1. **Safeguarding Reviews**

The safeguarding reviews were undertaken with Universal Children Services, CAMHs (Buckinghamshire) and Community Children Nursing. The reviews provide assurance that staff are aware of safeguarding policies and procedures and know who to contact if they have a safeguarding concern. Staff also know how to escalate a concern; feel confident to raise a safeguarding issue with a family and are aware of vulnerability and risk at times of transition. Staff report that they are aware of tools to support them in assessing risk.

1. **Family Friendly Ward- re-audit**

The Safeguarding Children Team across Oxford and Bucks and SWB have completed the audit to review if inpatient units across the Trust are welcoming and appropriate for all family members.

This audit is a re-audit following two previous audits in 2013/14 and 2011/12 on how family friendly our mental health inpatient wards are. All the standards (4) that were rated as unacceptable or require improvement during the 2013/14 audit were re-audited.

The finding was that areas were still in need of improvement and recommendations were made. An action plan is in place with modern matrons across relevant areas.

1. **Audit of the quality of referrals to Oxfordshire and Buckinghamshire MASH**

Fifteen cases were audited in July- August 2015. The audit found that whilst in most cases the concerns about the child were clearly stated, there was inconsistent use of assessment tools and threshold matrices. An action from the audit was that workshops would be delivered in Jan- March 2016. This has had to be put on hold due to the planned changes to the social work model in Oxfordshire. It is anticipated that they will now be delivered in the Autumn 2016.

1. **Safeguarding supervision audit**

The aim of this evaluation was to assess the quality of Safeguarding Children Group Supervision and its impact on safeguarding practice.

The evaluation has provided evidence that supervision allows practitioners to update their learning and reminds them about the use of safeguarding tools and record keeping. As a result they feel more confident and skilled in their work; they will readily seek advice via supervision or the safeguarding consultation line. Practitioners reported how their practice has altered due to attendance at safeguarding supervision.

1. **Consent audit**

This was an Oxfordshire audit, to seek assurance from NHS bodies that staff include consideration that consent has been eroded through exploitation when assessing a child’s ability to consent and that referrals to statutory agencies will be made appropriately.

Semi-structured interviews were undertaken with 14 staff from children’s services; these were then collated with those completed by other health providers.

Oxford Health demonstrated an awareness and understanding of CSE and consent. The degree of knowledge / expertise about CSE and consent was dependent on the role of the individual. Several staff highlighted the difficulties of exploring consent when a child has a learning disability.

**14.1 Implementation of audit outcomes**

As a result of the audits completed in the previous year the following actions are being implemented:

* A safeguarding form for the new Care Notes has been developed following consultation with universal children’s services and the EHR team.
* The Safeguarding audit tool has been shared with managers in children’s services to use as part of preceptorship process with new staff.
* A review of Safeguarding resources on the Intranet has been completed and documents are now more accessible to staff.
* Process in place to inform staff as soon as the Trust become aware a case conference is taking place; to improve time available to prepare a case conference report and attend.
* A system is now in place to ensure accurate recording of LAC status on Care Notes for children open to CAMHs services in Bucks.
* Training highlights escalation process and clarifies differences between Child in Need and Child protection processes.
* Actions from the Family Friendly re-audit have been shared with ward managers, and highlighted at governance and Think family meetings. The actions will be taken forward by relevant services and monitored through the audit team.
* Workshops will be delivered to staff to share good practice around referrals to children’s social care.
* Issue of timeliness of receipt of outcomes of referrals to social care in Oxfordshire and Buckinghamshire has been raised with social care managers.

**Audits for 2016/17**

The audit programme will continue in 2016/17, and will include the following:

* A survey monkey review of the Consultation line (Quarter 1)
* Safeguarding review Early Intervention Service ( Oxon and Bucks) (Quarter 1)
* Safeguarding review of Adult Mental Health Teams (Bucks) (Quarter 1)
* Safeguarding review of Adult Mental Health Teams (Bucks) (Quarter 1)
* Safeguarding review with dental service (Quarter 2)
* Audit of referrals to Children’s Social Care in SWB. (Quarter 3)
* Audit of Child protection conference reports and attendance in SWB. (Quarter 4)
* Audit of Child protection recording on Carenotes in SWB. (Quarter 4)

**14.2 LSCB Multi – agency audit work**

The Trust participates in multi- agency case file audits as part of Oxfordshire and Buckinghamshire Safeguarding Children Boards Performance and Quality Assurance (PAQA) subgroups

1. **Oxfordshire**

Audits undertaken by Oxfordshire LSCB include:

* Multi agency case file audit
* Neglect audit:
* Domestic abuse
* CSE stocktake (reported in year 2015/16)

The learning documents from the audits are below:

  

1. **Buckinghamshire**

Audits undertaken/being undertaken by Buckinghamshire LSCB include the following:

* Supervision audit (shared in January 2016)
* Transitions protocol audit (shared in June 2015)
* Child in need (shared Autumn 2015)
* CSE (shared February 2016)

**Plan for 2016/17**

Recommendations from audits which are relevant to Oxford Health staff will be shared with service managers and via governance meetings and actions monitored via the local safeguarding board’s quality assurance sub-groups.

**15. Care Notes- Safeguarding Form**

The team has developed a safeguarding form for Care Notes. The form allows data to be captured, audited and reported which has previously been unavailable.

* Generic form for the use of adult and children services.
* Levels of safeguarding concerns from early help to children on child   
  protection plans.
* Childrens social care referrals.
* Cases escalated using escalation policy.
* Record of attendance at case conferences and details of meetings.
* How to record children as dependants has been developed.

Guidance on how to use the safeguarding form and has been sent out to staff via the safeguarding update, champions newsletter, highlighted at training and governance and locality meetings, and is available on the safeguarding intranet and EHR intranet pages.

**Actions for 2016/17**

To review use of the safeguarding form and any additional CareNotes functionality to improve recording and reporting on safeguarding practice and activity

1. **Communication Plan**

The team has a communication plan in place. This covers communication to the

Trust board, to staff, partner agencies and internal team communication.

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 Internet pages to ensure they are clear for children and young people to access support.

In addition a monthly safeguarding update email now goes out to all teams across the Trust.

Workshops are delivered on specific areas in regard to safeguarding children as required.

**17. Safer Recruitment**

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. In August 2015 the Trust Executive Team, have made the decision to re-check all employees where an enhanced or basic DBS check is required and is more than 3 years old.

* Enhanced 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 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 managers who recruit staff.
* 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.

**Actions for 2016/17**

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.

The Trust 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.

**18. Allegations Management**

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

During 2015/16 there was 1 allegation in relation to staff working with children. This resulted in a strategy discussion with the relevant Designated Officer for Allegations, but did not meet the threshold for a formal investigation.

**18.1 Complaints**

There were 43 complaints in 2015/6 involving the CYP Directorate. Of these, 4 had elements relating to safeguarding. The safeguarding children team have been involved in supporting complaints with a safeguarding element when required.

**19. 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 Regulation 13 assurance and learning from SCRs/SIRIs and Safeguarding Audit

This will draw together all the key actions required for 2016/17and progress will be monitored through Directorate Operational and Governance Groups and the Safeguarding Committee.

**19.1 Summary of Key Priorities for 2016 / 2017**

* 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 continue to work in partnership with MASH arrangements for all LSCBs
* Ensure support and advice to frontline staff and managers is in place across each LSCB area
* To embed the new arrangements for supervision which includes establishing safeguarding children supervision groups for CAMHs services in Oxon and Bucks
* To continue to provide assurance of safeguarding children practice within the Trust to inform assurance for CQC and Section 11 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 at service level.
* To provide safeguarding input to the trust wide mortality review group
* To ensure robust service evaluation for 2016/17.The Board is asked to note progress of work and approve this report.

**Lisa Lord and Jayne Harrison- Trust Lead Nurses Safeguarding Children (Interim) 19th July 2016**

**Appendix 1**

**Completed Serious Case Reviews (SCR) & partnership reviews 2015/2016**

**Oxfordshire**

1. **Child J – 17 years old**

OSCB published the Domestic Homicide and Serious Case Review Child J on 24.2.16.

Full details of the DH and SCR can be found at <http://www.oscb.org.uk/case-reviews/>

1. **Death of Baby L- 11 weeks old**

Publication not yet completed. There was Health Visitor (HV) involvement.

The Safeguarding children team have linked with HV managers to agree how to take forward the action plan. The action for HVs is to review the records of siblings in high risk cases, and for use of assessment tools to be audited.

1. **Child Q 14 months old**

The SCIE methodology was used for this SCR. The final report went to the OSCB in October and still waiting publication delay due to criminal investigation. Learning for services is around avoiding drift in ongoing neglect cases, strengthening information sharing when families transfer out, and engaging with parents who have parental responsibility but are not resident in the family home.

The recommendations from this report have been incorporated into the work on neglect being undertaken by the OSCB. Senior Named Nurse Jill Berry is one of the leads for this work

1. **Death of 13 year old girl in an out of county placement 2013**

Trust IMR completed and submitted to OSCB. This SCR is being managed in two parts due to ongoing criminal investigation in another area. There is ongoing delay due to the police investigation. Interim findings have been discussed with relevant managers in CAMHs and CCHC and learning implemented. No further update as of 14.06.16.

1. **SIRI 4 & Homicide Review**

Adult stabbing by a female patient who was a mother. Safeguarding children team support was provided for this investigation. This showed that there was a lack of awareness between health visiting and adult mental health of each other’s roles. Action plan completed.

Learning from the SIRI was highlighted at the Health Visitor Conference in May 2016.

Homicide Review is in progress

**Buckinghamshire**

1. **Baby M**

Parents were known briefly to CAMHS and Forensic Services. Information was submitted to the BSCB. SCR completed and waiting sign off in April. Publication delayed due to ongoing criminal proceedings.

**SWB**

1. **Child C**

Local case review of a young person who was exploited and had been open to CAMHs. This is now completed.

1. **Child N**- local case review involving a girl with learning difficulties who was sexually abused. Her parents also had learning difficulties and weren’t able to keep her safe.
2. **DHR 1**- Swindon: Domestic Homicide review- Essex case. This related to an adult male who had been known to Swindon CAMHs for a short period of time 4 years prior to the incident. An IMR was submitted by CAMHs service manager with support from the Senior Safeguarding Children nurse.
3. **DHR 2**- Wiltshire: Domestic Homicide. This case concerned the death of a young woman who had been open to the Wiltshire OSCA team for 6 months prior to her 18th Birthday. The OSCA worker was praised in the report for working intensively with the young person during this time period.

**Appendix 2: Safeguarding Children and Young People**

This is the annual report specific to the Swindon, Wiltshire and BaNES area:

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1. Kate Lampard & Ed Marsden , *Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile- Independent report for the Secretary of State for Health*, February 2015 [↑](#footnote-ref-1)
2. Monitor is part of NHS improvement and has responsibility to oversee foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. [↑](#footnote-ref-2)
3. Verita is a consultancy service who aids improvement through learning and investigation. www.verita.net [↑](#footnote-ref-3)
4. Safeguarding Vulnerable People in the Reformed NHS - Accountability and Assurance Framework. NHS England, July 2015 [↑](#footnote-ref-4)
5. The children’s safeguarding performance information framework. HM Government, January 2015 Ref DfE 00016-2015 [↑](#footnote-ref-5)
6. Verita is a consultancy service who aids improvement through learning and investigation. www.verita.net [↑](#footnote-ref-6)
7. IICSA investigation in to the extent to which institutions have failed to protect children from sexual abuse, led by Hon Dame Lowell Goddard DNZM [↑](#footnote-ref-7)
8. Department of Health , December 2015, The Government’s mandate to NHS England 2016-17, A mandate from the Government to NHS England: April 2016 to March 2017 [↑](#footnote-ref-8)