

# Report to the Meeting of the

**BOD 111/2018**

(Agenda item: 10)

# Oxford Health NHS Foundation Trust

# Board of Directors

**27 September 2018**

**Safeguarding Children and Adults Joint Annual Report 2017/2018**

**For: Information and Approval**

**Executive Summary**

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

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. Under the Care Act 2014 the Trust has a responsibility to work co-operatively with partners to ensure the welfare of adults at risk.

The Trust is a statutory member of the Local Safeguarding Children Boards (LSCBS) under section 13 of the Children Act 2004 and must comply with laws and guidance related to safeguarding children. We are also members of the Safeguarding Adult Boards in Buckinghamshire and Oxfordshire.

This report provides the Trust Board with an overview of the progress against the safeguarding children and adult priorities for period 01/04/17 to 31/03/18.

An annual safeguarding children report for the Swindon, Wiltshire, Bath and North-East Somerset area has also been produced for CCG commissioners provides more details of work in that geographical area.

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| Consultations to the safeguarding children team have reduced slightly. This year there were 1,743 consultations to the team, compared to 1,963 the previous year. It is recorded that there have been 82 safeguarding adult concerns reported by the Trust services.Activity in relation to the Child Death Overview process has increased significantly. This is due to the safeguarding children team now managing the process for neo natal deaths in Oxfordshire.Child Safeguarding Training meets the requirements set out by the national intercollegiate document. Safeguarding training in the Children and Young People Directorate is above the 90% target set by the Clinical Commissioning groups. However, the Adult and Older People Directorates fall below the target. |
| Both the Safeguarding Adult team and the Safeguarding Children team provide considerable partnership support across the areas covered by the Trust. The teams are active members of the OSCB and OSAB subgroups. Additionally, the teams are core members of key multiagency fora including MARAC (Multiagency Risk Assessment Conferences) and Operational and Strategic Domestic Abuse, Modern Slavery and FGM groups.In the joint Safeguarding Children and Adults self-assurance/S11 audit for Oxfordshire, the Trust was rated blue (exemplary) or green (good) in all areas. In the latest S11 audits (safeguarding children only) for Buckinghamshire and Swindon Wiltshire, Bath and North East Somerset (SWB) all areas were rated green. |

**Governance Route/Approval Process**

This is an annual report for the Trust board. It has been previously presented at the Quality Sub-committee: Safety on 8th August 2018 and the Trust Safeguarding Committee on 5th September 2018 for comments and approval.

**Recommendation**

The Board is asked to note and approve the report.

**Author and Title: Lisa Lord & Jayne Harrison, Trust Lead Nurses Safeguarding Children,**

**Moira Gilroy, Safeguarding Adults Manager.**

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

1. *A risk assessment has been undertaken around the legal issues that this report presents and there are no issues that need to be referred to the Trust Solicitors*
2. ***Strategic Objectives*** *– this report relates to or provides assurance and evidence against the following Strategic Objective(s) of the Trust*

*1) Driving Quality Improvement*

*(Goals: patients will be safe from harm; patients will achieve the clinical outcomes they want; and patients and carers will have an excellent experience)*

*2) Delivering Operational Excellence*

*(Goals: our services will be effective and efficient; information will be translated into knowledge; and our planned surplus will be delivered)*

*3) Delivering Innovation, Learning and Teaching*

*(Goals: the impact of the AHSN, AHSC and CLAHRC will be maximised; we will collaborate in research and innovation; and we will deliver high quality teaching)*

*4) Developing Our Business through Collaboration and Partnerships*

*(Goals: we will work in collaborative partnerships; we will maintain and grow our services where we add value; and we will have strong relationship with our stakeholders)*

*5) Developing Leadership, People and Culture*

*(Goals: staff satisfaction will be in the top 20% of Trusts nationally; our staff and teams will be high-performing; and we will recruit and retain an excellent workforce)*

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| ***MAIN BODY OF THE REPORT*** |
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1. **Introduction**

In all geographical areas covered by Trust services, safeguarding activity has increased over the past year. This is within a context in which all agencies are facing reduced public sector budgets, staff shortages and significant organisational change.

1. **Purpose**

This report provides the Trust Board with an overview of the progress against the safeguarding children and safeguarding adult priorities for the period 01/04/2017 to 31/03/2018.

Full detail of safeguarding activity is reported Quarterly both to the Trust and the CCGs via the contract monitoring process. A full annual activity report has also gone to the Safeguarding Committee and the Quality Sub-committee: Safe domain in August 2018.

This joint safeguarding report outlines current areas of joint working between the safeguarding teams in the Trust. The priorities and areas for development for 2018/19 are set out within the report.

1. **Context**

Safeguarding is a complex and challenging area of work. The aim of the safeguarding teams is to provide high quality advice, training and support to practitioners across Oxford Health NHS Foundation Trust (The Trust) to keep children safe and safeguard adults with care and support needs. Safeguarding should be integrated into people’s day to day practice.

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 People 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 Team is led by the Trust Lead Nurses and by the Trust Lead Doctor. See appendix 2 for the structure of the Safeguarding Children Team.

The Safeguarding Adults Team is led by the Safeguarding Adults Manager. The Social Care Professional Leads (Social Worker Leads employed by the Trust) provide safeguarding adults advice and support as part of their social care function. In September 2017 a named doctor for safeguarding adults was appointed to provide medical leadership. See appendix 3 for the structure of the Safeguarding Adult Team.

For the safeguarding of individuals, the accountability remains with the clinical teams. The safeguarding teams do not carry caseloads.

1. **Safeguarding children and adults joint working**

**5.1 Key achievements**

 **Joint achievements**

* Joint working between the safeguarding teams to provide in-house training that meets the standards set by the local safeguarding boards.
* Development of joint safeguarding children and adult training strategy.
* Both children and adult safeguarding teams provide (telephone/email/face to face) consultation accessible to all Trust staff. This provides the opportunity to signpost/liaise where there are safeguarding issues for children and adults.
* The safeguarding teams cover 5 LSCBs and 2 LSABs. The Trust is represented at all boards and relevant sub-groups.
* Joint safeguarding self-assurance exercise was completed in Oxfordshire.
* The safeguarding children lead nurses and the Safeguarding Adults Manager were interviewed as part of the CQC inspection of core service Community Services including Urgent Care in March 2018 and for the Well Led inspection in April 2018.
* Adult Learning Disability services transferred to the Trust in July 2017. This introduces a new aspect for safeguarding. Understanding and clarifying the issues will continue into 2018/19 as work around learning disability issues develop. The Safeguarding Adults Practitioner who started in April 2018 is working closely with the Learning Disability teams to identify areas of practice, audit and planning of change.
* The Safeguarding Children policy and Safeguarding Adult policy have both been reviewed and updated.
* The Trust has been involved in the local strategic reviews around Domestic abuse in Oxfordshire and Buckinghamshire and the resulting action plans.
* 100% attendance at multi-agency risk assessment conferences (MARAC) around domestic abuse.

**Safeguarding Children**

* All children placed on an adult ward in a place of safety have received a safeguarding children assessment.
* Supervision groups for CAMHs have been embedded in 2017/18 and safeguarding input into the Family Assessment and Safeguarding Service (FASS) team and Improving Access to Psychological Therapies (IAPT) introduced.
* Embedding learning from recent homicide reviews and serious incidents to ensure there is closer collaboration between children and adult services. This has included taking learning to team meetings and Operational and Governance meetings and changes to the mental health general risk assessment form on CareNotes.
* Gaining evidence of learning from serious case reviews as part of trust safeguarding children audit.
* Safeguarding children team has been actively involved in multi agency audits and implementing learning in all LSCB areas.
* In response to learning from audit, serious case reviews and LSCB priorities workshops were developed for staff around domestic abuse and making referrals to children’s social care. In addition, the safeguarding training has incorporated domestic abuse themes into all training levels.
* The safeguarding children team has worked with the clinical commissioning group (CCG) to develop a system of notifying GPs when one of their patients is discussed at MARAC.
* Continued development of MASH involvement in all areas. Meeting targets set for information share returns.
* Contributing to strategic neglect work across all the LSCB areas.
* The Safeguarding Children Team submitted an abstract for non-recent disclosures of child sexual abuse workshop and poster promoting the safeguarding children consultation line as evidence of good practice to the BASPCAN (British Association for the Study and Prevention of Child Abuse and Neglect) international conference, which was accepted.
* Safeguarding training is provided jointly by the safeguarding teams to the relevant staff. The commissioner’s target is that 90% of staff across all geographical areas will receive this training. This target has been met in the Children and Young Peoples directorate.
* The award-winning Let’s Talk FGM app developed within the Trust has now been launched nationally. It is actively promoted during the safeguarding training sessions.

**Safeguarding Adults**

* The team has expanded to include a named doctor and a safeguarding adults practitioner (Registered Learning Disability Nurse).
* The Trust has been invited to join the Buckinghamshire and Oxfordshire Safeguarding Adults Boards and is an active member of the Boards and of the relevant sub-groups.
* During 2017/18, two SARs have been completed in Buckinghamshire. The issues were about self-neglect and there has been awareness raising activity in response to these reports. A missing person’s process has been established in Buckinghamshire which the safeguarding adults team has actively supported by contributing information for each individual risk assessment. It is planned this process will be extended across the Thames Valley.

**5.2 Key Challenges**

In 2017/18 in Oxfordshire a joint adult and children impact assessment was undertaken on current pressures and activity of each organisation (member) of the safeguarding boards (Oxfordshire safeguarding children and adult boards. Both these processes have informed the Trust about future developments as the safeguarding agenda moves forward. In 2018/19 the self-assessment and impact assessments will be a combined exercise.

* All LSCBs are considering their arrangements in light of the Wood review 2016 and Oxford Health representatives are engaged in these discussions. This includes discussion around future health representation in the context of changes to CCGs and Integrated Care Systems (ICSs).
* The impact of domestic abuse on patients and staff. A strategic Trust response around domestic abuse needs to be developed. This is also a priority for all safeguarding boards. In 2018/19 the following audits are planned:
	+ there is a planned audit of the Trust’s approach to identifying domestic abuse and how adult services respond to issues of domestic abuse.
	+ There is a re-audit of consistency of documentation around MARAC meetings. To ensure documentation standard are being met.
* Information sharing with partners around complex cases. There is now a number of multi-agency fora whose purpose is to discuss children, adults and families in high risk situations and how those risks can be managed with an aim to prevent avoidable tragedies. The detailed work to check patient records and attending meetings is undertaken by the safeguarding teams.
* The rapidly growing and complex nature of the wider safeguarding agenda. Specific areas are modern slavery, criminal and drug exploitation, human trafficking, FGM and the vulnerability of black and minority ethnic groups and those who identify as lesbian, gay, bi-sexual and transgender (LGBT). These issues involve on-going evaluation of risk.
* The Allegations against staff policy has been reviewed in 2017/18. This was done jointly by the safeguarding teams and Human Resources and will be approved during 2018/19. The changes to the policy provide clear guidance to managers when taking actions following an allegation against a member of staff. The policy has a template appended which will provide a consistent approach to the risk assessment of any allegation.
* Deprivation of Liberty Safeguards (DOLS): The Trust has experienced problems in obtaining DOLS authorisations in line with the requirements of the law. See paragraph 11.4.1 for further information about this topic.
* The safeguarding children team have seen an increase in consultations relating to the lack of appropriate placements for children and young people displaying extremely challenging behaviour. This has been an issue recognised and escalated by the Trust and LSCBs.
* The safeguarding children team has taken on the processing of child death notifications using the eCDOP process in Oxfordshire and Buckinghamshire. This is made more complex by lack of consistent systems across all geographical areas.
* It has been agreed that the safeguarding children team will attend the mortality review meeting as required to share learning and themes identified from CDOP processes.
* Members of staff are completing Vulnerable Adult Mortality reviews using the Learning Disability Mortality Review (LeDeR) process. The requirement for these reports is anticipated to increase in 2018/19.
* Commissioner targets of 90% for safeguarding children training are consistently not met across adult and older adult directorates. The Safeguarding Committee is monitoring an action plan to achieve this training target. There is no positive impact to report at this time.

**5.3 Next steps**

 **New Priorities for 2018/2019**

* To include recording of DOLS training separately on the learning and development portal.
* To support work on increasing equality and diversity with a focus on Lesbian, Gay, Bi-sexual and Transsexual (LGBT). In the first instance this will be done by developing a system of recording people’s sexual identity.
* To support work on gender identity pathways for children.
* Modern Slavery
	+ To comment on modern slavery strategy as appropriate and to share strategy when completed.
	+ Trust staff to support the planning of activities for Modern Slavery Week in October 2018.
	+ To support raising awareness across the Trust during Modern Slavery Week in October 2018.
* To consider the Children and Social Care Act 2017 and new version of Working Together 2018 (when published) and any implications for patient/clients and the Trust.
* Operational and Strategic leads for domestic abuse within the Trust to be identified.
* To share and embed learning from serious case reviews and audits to effect changes in practice.
* To support implementation of the action plan from the domestic homicide thematic review which focused on joint working between adult and children services.
* Develop the safeguarding children form on community CareNotes and support the case for read only access to records by relevant staff.
* Development of the Safeguarding Adults Practitioner and the named doctor roles within the Trust.
* Formal recording of information:
	+ Supervision
	+ Learning disability issues and actions
	+ Develop a process to capture equality data for consultations
* Training
	+ To develop a joint safeguarding training Level 1 (basic awareness) training package
	+ Further training with CYP services to understand decision making and deprivation of liberty
	+ Promote the e-learning that is available on the LSAB websites
	+ Ensure the Making Safeguarding Personal concepts underpin all training and the Trust’s approach to safeguarding adults
	+ Support the development of multi-agency Mental Capacity Act/decision making training
* Audit
	+ Domestic abuse audit
	+ Mental Capacity Act audit

**Ongoing priorities**

* Strengthen joint safeguarding work between children and adult services. A Safeguarding Adults Practitioner was appointed during 2017/18. This will provide the capacity to further develop links with adult services where there are safeguarding issues and where a Think Family approach is required.
* With the recruitment of staff to both the safeguarding teams, there is the opportunity for the teams to work together to support the induction of the new staff to their roles e.g. development of training skills, reflective practice, day to day support.
* Continue to work in partnership with the local authorities and partner agencies and ensure the Trust is able to demonstrate effective and safe practice through the inspection framework.
* To work with all LSCBs and LSABs to operationalise the identified Board priorities. The priorities include:
	+ Domestic abuse
	+ Modern slavery/exploitation/trafficking
* Underpinning these priorities is the individual’s ability to make relevant decisions. Staff need to be able to assess a child’s competence to make decisions (Gillick Competence) and to assess for evidence that a person aged 16 or over is unable to make decisions (Mental Capacity Act). For children the scope of parental responsibility needs to be taken into account.
* Continue to support services and staff to ensure multi-agency partnership working in the context of increasing demand and the need to manage risk collectively. For example, the missing adult and children process within Buckinghamshire is jointly managed by both safeguarding teams.
* With the integration of Learning Disability services into the Trust in 2017/18 time is being invested in understanding the issues for this client group. This will move forward in 2018/19 as relationships develop with the learning disability teams and other services provided by the Trust.
* Support clinical services through supervision and consultation to enable a smooth transition of young people into adult services especially where there are known safeguarding concerns.
* As part of the mortality review work, continue to ensure the Trust robustly reviews and learns from deaths of children and adults, ensuring consistent engagement with the five LSCBs and the Child Death Processes. Child death processes have been reviewed in all areas and links made with the Trust mortality review process.
* To continue to support the development of understanding issues related to Female Genital Mutilation (FGM), the implications and response across adult and children services.
* Supporting the further development of the governance arrangements around DoLS.
* To continue to embed the arrangements for safeguarding children supervision groups for CAMHs services in Oxon and Bucks and universal services in Oxon. To work with service managers to ensure that supervision is meeting requirements and well attended.
* To continue to provide assurance of safeguarding children practice within the Trust to inform assurance for CQC regulatory requirements and Section 11 compliance. To contribute to related action planning.
* To continue to work in partnership with MASH arrangements for all LSCBs.
* To continue to review safeguarding children service model considering 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 continue to raise the profile of safeguarding children within the Older Adult directorate, specifically Urgent Care.
1. **Safeguarding Activity**
	1. **Safeguarding adult concerns**

The information available is reported to the OSAB and the BSAB. There are different reporting arrangements to each LSAB and the information is not consistent across both counties. The Trust is not involved with the safeguarding adults’ boards that cover the SWB area as the service provision for adults is very small.

The table below shows the number of safeguarding adults concerns in Oxfordshire and Buckinghamshire during 2016/17 which is the most recent information available. Oxfordshire receives some of the highest number of concerns reported across the South-East Region, while Buckinghamshire receives some of the lowest number of concerns reported.

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| --- | --- |
| **County** | **Number of concerns reported per 100,000 of population** |
| Oxfordshire | 1335 |
| Buckinghamshire | 308 |

The table below shows the number of people who are subject to safeguarding adults concerns. In Oxfordshire approximately 25% of concerns become formal s.42 enquiries. In Buckinghamshire approximately 40% of concerns become formal s.42 enquiries.

The table below gives some information as to the (primary) category of abuse that is most frequently reported. The reporting trend in Oxfordshire is very similar to the South East region and nationally across England.

|  |  |  |  |
| --- | --- | --- | --- |
| **Abuse type** | **Oxfordshire** | **South East** | **England** |
| Physical | 520 | 5,450 | 33,185 |
| Sexual | 150 | 1,090 | 6,510 |
| Psychological | 475 | 3,235 | 19,050 |
| Financial | 450 | 3,350 | 21,675 |
| Discriminatory  | 5 | 100 | 930 |
| Organisational | 45 | 470 | 6,290 |
| Neglect | 855 | 8,535 | 48,035 |
| **TOTAL** | **2,500** | **22,230** | **135,675** |

The role of the Trust in these concerns and enquiries is at different levels. Under the s.75 agreements with the local authorities the social workers employed by the Trust have the delegated duty to complete the enquiries. This activity is recorded directly on to the Local Authority system.

All Trust staff have a duty to identify safeguarding concerns. The recorded consultations with staff provide a sense of the range of issues and the number that are subsequently reported as concerns.

**6.2 Safeguarding adult consultations**

The table below shows the number of consultations with the Safeguarding Adults Team. The column on the right shows the number that were recorded as being reported as safeguarding adults concerns to the local authority.

|  |  |  |
| --- | --- | --- |
| **Abuse type** | **Number of issues raised** | **Number reported as safeguarding adults concern** |
| Children | 20 | 0 |
| Other | 63 | 9 |
| Domestic Abuse | 65 | 12 |
| Exploitation | 13 | 6 |
| Financial | 19 | 5 |
| Delayed reporting of abuse | 23 | 3 |
| Neglect | 36 | 17 |
| Physical | 22 | 10 |
| Psychological | 23 | 11 |
| Radicalisation | 1 | n/a |
| Self-neglect | 19 | 5 |
| Sexual | 17 | 4 |
| Organisational | 1 | 0 |
| **TOTAL** | **322** | **82** |

Where there are clear indicators of abuse or neglect, the clinical team is likely to recognise this and are highly unlikely to contact the safeguarding adults team. The clinical team will report their concern directly to the local authority. The number of these referrals was not collected in 2017/18 but this information is being collected in 2018/19 from the Trust incident reports. This is why the number of safeguarding adults concerns reported is about 25% of the total number of discussions. Where no report is made, the teams will still be taking steps to manage any identified risk e.g. onward referral to adult social care, patient education.

In Oxfordshire, there is information available from the County Council that shows the ethnic origin of adults where concerns are reported in 2016/17. The overwhelming majority were white (approximately 75%). This is reflective of the situation both in the South East and across England.

**6.3 Ethnic Origin**

|  |  |  |  |
| --- | --- | --- | --- |
| **Ethnic Origin** | **Oxfordshire** | **South East** | **England** |
| White | 1140 | 16425 | 91835 |
| Mixed/multiple | 15 | 115 | 990 |
| Asian/Asian British | 25 | 300 | 3185 |
| Black/African/Caribbean/Black British | 20 | 200 | 3315 |
| Other Ethnic Group | 5 | 95 | 1020 |
| Refused | 25 | 110 | 370 |
| Undeclared/Not known | 245 | 2040 | 8430 |

The Trust collects information about ethnic origin for individual patients, but this is not information that has been collected by the safeguarding adults or children teams, when there are consultations or concerns are raised. This is something to consider for 2018/19 and may help to provide information about how the Trust is working with equality issues.

**6.4 Safeguarding children consultations**

The safeguarding children consultation line is an established service which is well used by staff and has been well evaluated through a staff survey.

In 2017/18 there has been a small reduction in calls to the safeguarding children team. There are several reasons which may explain this drop. The decrease in calls may be a consequence of the safeguarding children team starting to attend supervisors’ meetings for staff working for Improving Access to Psychological Therapy (IAPT) services in Oxfordshire and Buckinghamshire. This may have resulted in an increase in confidence in supervisors dealing with safeguarding issues. IAPT services are the largest group from adult services who access the consultation line.

In Oxfordshire, the local authority has implemented the Locality & Community Support Service (LCSS) which provides advice and guidance to partner agencies. This may have resulted in staff not needing to seek advice internally. Also, staff involvement in LCSS multi-agency case panels has been reported anecdotally to have increased confidence.

Finally, access to safeguarding supervision might also be increasing confidence in dealing with safeguarding concerns. Safeguarding supervision introduced to CAMHs staff in Oxfordshire and Buckinghamshire in 2016 has now embedded and the review of the supervision model in 2017 to address issues of access has improved staff attendance.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Directorate** | **No. of consultations 2015/16** | **No. of consultations 2016/17** | **No. of consultations 2017/18** | **% increase/decrease from 2016/17** |
| **Children and Young People** | **872** | **958** | **1008** | **5% increase** |
| **Adult** | **663** | **872** | **724** | **20% decrease** |
| **Older Adult** | **1** | **4** | **11** | **100% increase** |
| **Total No/ of consultation** | **1572** | **1963** | **1743** | **13% decrease** |

1. **Impact assessment and s.11/self-assurance.**

**7.1 Oxfordshire**

For the second year, both the impact assessment and the self-assurance (S11) pieces of work were conducted jointly via the safeguarding children and safeguarding adults boards.

The Trust was graded blue or green for all areas of the Self-assurance assessment and these grades were agreed at the multi-agency peer review event in February 2018. The Trust’s work on Equality and Diversity was particularly noted as good practice.

The 3 key pressure points identified by the Trust in the impact assessment were:

1. Rise in overall safeguarding work both children and adults and level of regulatory activity. This is placing an increasing demand on the resilience of staff with increasing workloads in the light of increasing safeguarding and public protection work.
2. Growing aging population in the county. With age, the population is becoming increasingly frail and placing greater demands on services. Primary and Community nursing and therapy workloads are becoming more task orientated as demand grows. In turn this introduces a risk that individual clinicians may be less alert to safeguarding issues that are not immediately part of the task. There are growing pressures in urgent care and in primary, community and mental health.
3. Mental health waiting times are a concern in all age groups and all specialties, and these are closely monitored and reported to commissioners. There is an increase in need in relation to emotional health, mental health and eating disorders. This is likely to increase as early intervention services are re-configured and needs are potentially identified at later stages of the health problem.

 **Actions for 2018/2019**

 The Self-assurance and Impact assessment will be conducted as a combined exercise rather than separate pieces of work

**8. LSCB Multi – agency audit work**

**8.1** **Oxfordshire**

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| --- | --- |
| **Date** | **Title of Audit** |
| **May 17** | Multi agency audit on neglect |
| **May 17** | Education, Health and Care Plans: Multi-agency case sampling |
| **November 17** | Multi agency audit on children with a disability |
| **January 18** | Domestic abuse pathway evidence including voice of the child |

**8.2 Buckinghamshire**

Audits undertaken by Buckinghamshire LSCB include the following:

|  |  |
| --- | --- |
| **Date** | **Title of Audit** |
| **June 2017**  | **Neglect: A Summary of Local Activity** |
| **August 2017** |  **Private fostering survey** |
| **October 2017** | **Domestic abuse audit** |

**Outcomes**

Overall the findings from audits were positive and considerable good practice was evidenced in relation to decision making, ensuring a wide perspective of underlying causes, the quality of information sharing, the voice of the child, good use of tools, a strong focus on other siblings and a whole family approach.

There was good evidence of strong multi-agency working across key partners in very complex and challenging circumstances for the children and families involved. Child protection planning was seen to be effective and achieving results although could have been instigated earlier in some cases.

Learning summaries have been shared with services through governance meeting and the monthly safeguarding update. The safeguarding children team are exploring how learning can be taken forward effectively within teams.

**9. Serious case reviews**

The OSCB has worked on four serious case reviews (SCRs) over the past year and the Trust has participated in all of them. There have been no published SCRs this year in Buckinghamshire or SWB with Oxford Health involvement.

See Appendix 1 for further detail. Published reports are available via the LSCB websites.

**9.1 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 via supervision, consultations and resources
* Facilitating better information sharing between adult and children services via Think Family meetings
* Highlighting escalation policy in training and safeguarding reviews
* Disseminate multi-agency domestic abuse pathway for under 18s
* Continue to promote strategic work regarding domestic abuse ie develop public protection area for staff on the intranet
* 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 to include dissemination and refection on learning from SCRs
* Development of recording of safeguarding children information within risk assessment for adult and child mental health services
* Review of learning from SCRs at directorate quality and governance meetings.
* Ongoing audits to provide evidence of learning from SCRs

**10. Safeguarding Adults Reviews**

A Safeguarding Adults Review (SAR) is undertaken by the local safeguarding adults board (LSAB) when someone with care and support needs dies because of abuse or neglect and there is a concern that the local authority or its partners could have done more to protect them.

**10.1 Safeguarding Adults Reviews in Oxfordshire**

There was one SAR in Oxfordshire during 2017/18 (Adult C). It has been published on the Oxfordshire Safeguarding Adults Board website: <http://www.osab.co.uk/wp-content/uploads/SAR-Adult-C-Full-Report-published-version.pdf>. The overall conclusion of the author was:

The overall conclusion of the author and SAR sub-group is that there was good inter-agency working in relation to the two psychiatric assessments in 2016 and 2017, and that even if the fire was deliberate, this incident was not predictable or preventable by mental health services or TVP.

Learning

A gap was identified in the system in place for ensuring that NHS Step-Up picked up referrals in a timely way and that information is accurate. The work to bridge the gap has been completed.

The gap and actions were identified originally through the Serious Incidents Requiring Investigation (SIRI) process.

**10.2 Safeguarding Adults Reviews in Buckinghamshire**

There were two SARs commissioned in Buckinghamshire during 2017 (SAR Q and SAR T). These have been published on the BSAB website. <http://www.buckinghamshirepartnership.co.uk/safeguarding-adults-board/about-the-bsab/safeguarding-adults-reviews/>

Both these situations were about self-neglect and the learning was shared by the Buckinghamshire Safeguarding Adults Board through a Practice Learning Guide. The learning was:

* First recognise when people are self-neglecting either themselves or their environment – the Board has produced a Self-Neglect Tool kit.
* Not make judgements based on a practitioner’s own values around what is neglect, instead use the self-neglect tool kit such as the hoarding charts etc.
* That when practitioners come across people who are self-neglecting that they consider reporting their concern to Adult Safeguarding in the Local Authority and that they use the Threshold Tool to assist in determining when to make a referral.
* That practitioners look at the network around a person and understand that when there is a change in this network this may affect other aspects of their life. It might be useful to do a draw an eco-map to look at people who support them
* That when clients go missing, consideration is given to using the “missing person protocol” which can be found on the BSAB website. Record in detail what has been done to contact the person, including phone calls.
* Mental Capacity may be an issue at some point when someone is self-neglecting and practitioners should record whether they have considered mental capacity as an issue and record any evidence of mental capacity assessments and Best Interest Decisions.
* One of the main learning points is the need to share information with other people working with the client. Support can be provided through a multi-agency meeting or by making a referral to Risk Assessment Multi Agency Panel.

**11. Partnership working**

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

Across all the LSCBs the Trust supports the work of the local MASH, either through virtual information sharing (SWB areas and Bucks) or through participation in a MASH health team (Oxfordshire)

**11.2 Adult Enquiries undertaken by the Local Authorities**

The Care Act 2014 requires the local authority to undertake further enquiries where it thinks it is necessary. These are known as s.42 (of the Care Act 2014) enquiries and are a formal process. The Trust is obliged under the Care Act to cooperate with these enquiries.

There is an agreement in place (s.75 agreement) with both Oxfordshire and Buckinghamshire County Councils that delegate the s.42 enquiry process to Social Workers employed by the Trust. They will pick up the s.42 enquiry where the person is on a Care Plan Approach (CPA). This work is recorded on the relevant local authority electronic system and it is not monitored within the Trust.

**11.2.1 s.42 Enquiries in Oxfordshire**

There were 23 s.42 enquiries requested by Oxfordshire County Council outside of the s.75 agreement.

|  |  |  |
| --- | --- | --- |
| **Number substantiated** | 1 | Allegation against a member of staff. DBS notification completed |
| **Number inconclusive** | 1 |  |
| **Number not substantiated** | 5 |  |
| **No further action** | 7 |  |
| **No outcome to date** | 9 | Reasons are 1. awaiting conclusion from OCC
2. Trust HR investigation being completed
 |

**11.2.2 s.42 Enquiries in Buckinghamshire**

There were 3 s.42 enquiries involving the ward teams during 2017/18. Two were allegations against staff and one involved the ward team identifying the issue and putting safeguards in place in partnership with the police.

|  |  |
| --- | --- |
| **Number substantiated** | 2 |
| **No further Action** | 1 |

**11.3 Mental Capacity Act (MCA)**

During 2017/18 there were 40 MCA training sessions provided for Trust staff. 6 of these sessions were tailored for specific teams. The discussions in the training sessions demonstrate that Trust staff know the framework. The challenge for 2018/19 is to help all the staff to integrate this into their practice and to dispel the notion of mental capacity assessment being a specialist skill.

In Oxfordshire there is a multi-agency approach to the Mental Capacity Act through the Mental Capacity Act forum. This forum allows for the sharing of information and learning from the different agencies who attend. This includes the deprivation of liberty work. The forum is chaired by the Safeguarding Adults Manager from the Trust.

**11.4 Deprivation of Liberty (DoL)**

Deprivation of liberty comes from the European Convention of Human Rights which is in British Law through the Human Rights Act 1998. Any deprivation of liberty that is imputable to the State must be authorised. The purpose of any authorisation is to ensure the person subject to a deprivation of liberty has a formal process to appeal against the arrangements in place.

1. People who are deprived of their liberty in hospitals are managed through the Deprivation of Liberty Safeguards (DoLS) process.
2. People who are deprived of their liberty in their own home must have an authorisation issued by the relevant Court (Judicial DoL).

In 2014 the Supreme Court stated that a person is deprived of their liberty if they are subject to continuous supervision and control and if they are not permitted to leave.

 **11.4.1 DoLS**

A DoLS authorisation is an authorisation issued by the local authority for people who:

1. Are aged 18 or over
2. Are in a hospital or care home
3. Lack mental capacity to consent to the arrangements in place to enable care or treatment interventions.
4. Are not otherwise detained under the Mental Health Act.

The DoLS process is part of the MCA.

The 2014 judgement means that there has been an increase in the number of DoLS applications from the Trust hospital wards which has resulted in significant delays in obtaining an authorisation.

2017/18 was the first complete year where there has been robust information gathering regarding the delays in obtaining an authorisation. There were:

* 158 new applications for a DoLS authorisation.
* 193 people who the wards believed were deprived of their liberty but who did not have an authorisation in place.
* 134 people had an application made but were discharged or died before an authorisation was received.
* There was a total of 597 weeks where people were deprived of their liberty but did not have an authorisation in place.
* There was one DoLS authorisation received by the Trust.

The majority of the DoLS delays for the Trust are in the community hospitals in Oxfordshire. To help manage the delays there is a quarterly meeting with the Supervisory Body (Oxfordshire County Council) to review the applications and understand the prioritisation process.

CQC are clear about their expectations in how to manage the delays. The Matrons in the Community Hospitals are implementing processes to ensure:

* All staff know when a DoLS application has been made
* The arrangements in place have been care planned and are reviewed at a minimum of weekly
* Relevant staff know the progress of the DoLS application (including whether it is still relevant to the person
* All staff know when an authorisation has been issued and what arrangements have been authorised
* Relevant staff know how to contact the Supervisory Body to request a review should the arrangements in place change from those authorised/the authorisation is no longer required.

 This work will continue into 2018/19.

**11.4.2 Judicial DoL Authorisation**

A judicial DoL authorisation will be issued by the relevant Court depending on the person’s age and if they are being deprived of their liberty outside of a hospital or care home (ie in their own home). A child may be deprived of their liberty and require an authorisation if the arrangements in place sit outside of the scope of parental responsibility.

Applications are normally made as part of the safeguarding processes and will be made from the Local Authority (the arrangements are part of the person’s social care).

Children and Young People services are picking up this issue and are planning for training in 2018/19. The training will take account of the scope of parental responsibility and Gillick competence as well as mental capacity (for those aged 16 and 17).

**11.4.3 Law Commission Recommendations**

In June 2017 the Law Commission made recommendations to change the approach to managing mental capacity and deprivation of liberty. In March 2018, the Government accepted at least in principle most of the recommendations made; the recommendation relating to a statutory codification of capacity law in relation to children was not accepted. <http://www.mentalcapacitylawandpolicy.org.uk/law-commission-deprivation-of-liberty-report-the-government-responds/> It is unlikely that there will be a legislative change in 2018/19. However, the Trust is mindful of the upcoming changes.

**11.4.4 Best Interest Assessor**

The Trust employs people who also work as Best Interest Assessors with Oxfordshire County Council. This means that there are people employed in the Trust who have an indepth knowledge and understanding of deprivation of liberty. This places the Trust in a positive position when the changes to the MCA and Deprivation of Liberty come into being. In 2018/19 there will be benefit in having a central list of the Best Interest Assessors to ensure this expertise can be accessed to support the changes.

**12. Oxford Health NHS Foundation Trust safeguarding activity**

The table below gives an overview of the core areas of work undertaken by the Safeguarding Children Team. Last year there was a significant increase of support for staff to write a report for court from 13 in 2015 to 31 in 2016. This year there is still an increase from 2015 but less than 2016. Staff that have been called to give evidence at court has increased from 4 to 6 staff; this could be explained by one case involving 3 practitioners this year.

This year there has been an increase in the number of workshops delivered to staff. This was around topics such as domestic abuse and making a referral to children’s social care. These were delivered in response to recommendations from serious case reviews and audits.

Reducing the number of audits this year has allowed capacity to focus on other areas of work.

|  |  |
| --- | --- |
| **Area of Work** | **Number completed 2017-2018** |
| Serious Case Reviews | 2 |
| Level 2 & 3 training sessions delivered | 49 |
| Additional workshops | 52 |
| Safeguarding Children Supervision sessions  | 166 |
| Trust audits | 1 |
| LSCB audits | 16 |
| Support for staff to write court reports | 23 |
| Support for staff to attend court | 6 |
| LSCB sub-groups attended | 132 |
| MAPPA information shares | 34 |
| MASH enquiries processed | Oxon :1,456 (average 9 a day) |
| Bucks: 428 processed. 101 open cases. |
| MARAC meetings attended | Oxon: 20 |
| Bucks: 17 |
| MARAC information shares processed | Oxon: 197 |
| Bucks: 230 |
| FGM cases reported to NHS digital | 2 |
| Child Death Overview Panel cases processed | Oxon: 43 |
| Bucks: 1 |
| SWB: 6 |
| Rapid response meetings attended | Oxon: 6 |
| Bucks: 0 |
| SWB: 6 |
| Allegations against staff (none of these proceeded to a formal investigation) | Oxon: 1 |
| Bucks: 0 |
| SWB: 4 |

**12.1 Internal Audits**

During 2017/18 the safeguarding children service undertook one significant piece of audit work to support frontline staff and to provide assurance of safeguarding practice.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Service** | **Type of audit** | **Date completed** | **Actions completed** | **Actions outstanding** |
| 1. Safeguarding Children team
 | Safeguarding children case audit of 60 children (20 from each geographical area) who have safeguarding concerns | March 2018 | 5 | 2 (dates set for completion later in the year) |

**Summary of audit findings:**

**Good practice demonstrated**

* Effective safeguarding practice is keeping children safe
* Positive outcomes for children
* Child being seen alone/ child’s views being considered
* Observations of children’s behaviour appearance recorded
* Information sharing and risk management being shared
* Mental health risk assessment includes needs of children
* Multi-agency working
* Families involved in developing care plans
* Early indicators of abuse identified and acted upon

**Areas of development**

* Implementation of the Think Family approach
* Use of assessment tools/ uploading of assessment tools.
* Writing conference reports / sharing with parents
* Recording of children’s details on adult records
* CPA meeting attendance/ Health Visitors attending CPA meetings
* Improving the quality of referrals to children’s social care

Examples of documented improved outcomes for children include:

Case 7 - 28/04/2017 She says she feels more happy and settled and feels happier at school. Acknowledges that being in a routine really helps with her mental health. Improved school attendance. No longer self-harming.

Case 5Mother appreciates funding for nursery so she can then attend Turning Point appointments.

Case 18 Domestic abuse identified and Mother and child supported to live in a refuge, support provided to re-house, feelings and behaviour assessed at every visit.

Case 4525.07.17 Care Notes describe child’s reducing anxiety supported by an improvement in family functioning. The family have an improved ability to connect listen and understand each other.

Case 13 12.01.2017 observation by SALT reported increase in communication use; increase in PECs use; increased time in group. Mental health records 04.08.2017 records able to occupy self more; more sociable.

Case 29 - The family were supported well enough at the child in need stage, preventing the situation deteriorating to child protection. There was a holistic approach involving the multi-professional team (Think family) to consider and support all the individual families (and extended family) needs - referring and supporting as required. Child's mental health / resilience improved.

**12.1.2 Implementation of audit outcomes**

Because of the audits completed in the previous year the following actions are being implemented:

* The safeguarding form has been reviewed on Care Notes. Mental health services now complete the general risk assessment form to record safeguarding children information.
* Workshops have been delivered to staff to share good practice around referrals to children’s social care.
* Completion of thematic review of domestic homicide reviews looking at joint working between adult and children services. Findings of safeguarding children audit shared with risk team to inform thematic review action plan.
* Quality and development team contacted to include alerts within CareNotes project.
* Named nurses/professionals including in consultation and supervision discussions consideration of other family members and documentation of use of assessment tools.

**12.1.3 Planned audits for 2018/19**

The audit programme will continue in 2018/19, and will include the following:

* Survey of staff who have called the consultation line in March 2018 (Quarter 1)
* Supervision survey monkey/evaluation (Quarter 2)
* A review of designated MARAC officer’s guidelines (Quarter 3)
* Dip sample of children’s social care referrals (Quarter 4)

**Appendix 1 : Serious Case Reviews.**

**Completed and ongoing SCR/Reviews**

**Oxfordshire**

**Completed SCRs/DHR**

**Child A and Child B** published on 1st March 2017. This involved 2 young children who were abused whilst in the care of a special guardian.

**Outstanding action** - Service managers have been asked to consider how we ensure health needs are co-ordinated for children who have complex needs and a number of health professionals involved. Need to convene a meeting with senior managers and DCO. This will also link in with the SEND action plan.

**Child K-** home schooled child who was admitted to OUH severely underweight. Publication date will be agreed once criminal investigations are concluded.

**Outstanding Action-** Need update from commissioners that joint constipation pathway with OUH/OH/GPs has been agreed.

**DHR** has been commissioned in relation to a death by stabbing. This is being managed as a joint DHR/mental health Homicide review. Report with home office awaiting publication date. No outstanding action for OH.

 **Ongoing SCRs in Oxfordshire**

There are two ongoing SCRs.

1. The first is the death of a 5-year-old child. His mother was known to adult mental health and health visiting services. Trust SI and local safeguarding board SCR processes are running alongside each other and the case is also a mental health homicide review.

 SCR overview report completion planned for summer 2018.

1. The second involves 2 teenage boys who have alleged physical and emotional abuse by the carers in a private fostering placement. We had school nurses and PCAMHs involved in this case. There was a recent criminal case and following this, agency’s will consider whether they need to include the birth child of the perpetrators in the review. The victims will be spoken to including the adult children of the perpetrator and next steps agreed after this.

 Jayne Harrison is the panel member for this case.

**Buckinghamshire**

No new or current SCRs underway.

**DHR-** A domestic homicide review has been commissioned by the Aylesbury Vale Community Safety Partnership (CSP) in response to the death of a male caused by his brother following an incident on 16th January 2017. The perpetrator had been referred to CAMHs liaison and diversion two years before the homicide whilst in custody for another offence. He wasn’t seen and declined follow-up. Submission of a statement of fact has been submitted to the CSP from the trust.

**SWB**

BaNES commissioned a SCR involving 4 CSE cases, 3 of which were known to CAMHs. Process has been delayed as there is a court case ongoing and there has been a change of overview author. Publication date awaited.

Chronology and summary have been compiled and submitted to BaNES LSCB for a 17 year old boy, known to CAMHs who died after apparently throwing himself in front of a train. This will be a learning review not a SCR.

**Thematic review**

Following the findings of recent DHRs the Trust is conducting a thematic review which is being led by Fran Liles in the Risk team with Safeguarding and AMH input. Final report has been sent out and action plan is with service managers for sign off.

**Appendix 2**

The safeguarding children team consists of the following staff:

* Trust Lead Nurses 8b 1.2 WTE (2 x O.6WTE)
* 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 0.8 WTE for Buckinghamshire
* Senior Named Nurse 8a 1.0 WTE Swindon, Wilts and B&NES
* Band 7 0.7 WTE Swindon, Wilts and B&NES (from August 2017 funded by CAMHs)
* Named Doctor 1 session per week Swindon, Wilts and B&NES
* An additional Named Doctor session was passed to safeguarding adults to recruit a new Named Doctor for adults’ post.
* Admin support Band 4 0.6 WTE



**Appendix 3 Safeguarding Adults Staffing**

Adults Practitioner 1 WTE 8b Safeguarding Adults Manager

Named Doctor for Safeguarding Adults 1 session per week (from September 2017)

Since 1st April 2018 there have been further additions to the team:

1WTE band 7 Safeguarding Adults Practitioner

0.6 WTE band 7 Safeguarding

1WTE band 8a

