**Report to the Meeting of the**

 **BOD 93/2019**
(Agenda item: 14)

**Oxford Health NHS Foundation Trust**

**Board of Directors**

**25 September 2019**

**Safeguarding Children and Adults Joint Annual Report 2018/2019**

**For: Information and Approval**

**Executive Summary**

This report provides the Trust Board with an overview of the progress against the safeguarding children and adult priorities for period 01/04/2018 to 31/03/2019 in addition to key legislative changes and response to Trust CQC Well Led Inspection 2018 safeguarding adult actions.

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

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| --- |
| Consultations to the safeguarding children team have remained stable. For adults there has been a significant increase, which reflects the expansion of the safeguarding adult team and associated work that can then be completed.Activity in relation to the Child Death Overview process has increased in Buckinghamshire due to efficiency of the process.Safeguarding Training is under review with the amended children intercollegiate document and the adult intercollegiate document being published. Safeguarding children 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. For Level 2 safeguarding training all areas have achieved the target of 90%. |
| 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 LSCB and LSAB 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 Adult self-assurance/S11 audit for Oxfordshire, the Trust was rated green (good) in all areas. The Safeguarding Children Team presented their work at the BASPCAN (British Association for the Study and Prevention of Child Abuse and Neglect) international conference in April 2018. This was related to developing the non-recent disclosure guidance for the Trust. The team also displayed a poster promoting the safeguarding children consultation line as evidence of good practice. An article on developing the guidance has been submitted to the journal Child Abuse Review in June 2019.Priorities for 2019/20 are outlined within this report. |

**Governance Route/Approval Process**

This report has been previously presented at the Quality Sub-committee: Safety on 24th July 2019 for comments and approval.

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.

This report relates to or provides assurance and evidence against the Strategic Objective(s) of the Trust, see link below:

<http://intranet.oxfordhealth.nhs.uk/strategy/>

**Statutory or Regulatory responsibilities**

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.

**Recommendation**

The Board is asked to note the work undertaken approve the report.

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**Moira Gilroy, Safeguarding Adult Manager.**

**Safeguarding Children and Adults**

**Annual Report 2018/19**



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1. **Introduction**

The Trust is regulated by the CQC and must demonstrate compliance with Regulation 13. The intention of this regulation is to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, such as inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005.

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 statutory duty to work co-operatively with partners to ensure the welfare of adults at risk.

Safeguarding is a complex and challenging area of work. The aim of the safeguarding service is to provide high quality advice, training and support to practitioners across 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.

This report identifies the progress and accomplishments made within the Trust lead by the safeguarding service, during 2018/19 and provides details regarding the key safeguarding priorities for the year ahead. It explains the structure of the safeguarding children and adult teams, and how they work in partnership with other Oxford Health NHS Foundation Trust (the Trust) services and local agencies to influence positive change and support the most vulnerable in society.

As the safeguarding agenda is continuously developing in both its complexity and scope, our priorities must also evolve. With this in mind, our key safeguarding priorities for 2019/20 are shared at the end of this document.

This document aims to be informative in how the Trust works to protect vulnerable children, young people and adults.

1. **National context**

**Key legislative changes**

**2.1. The Children and Social Work Act 2017**

Changes to Safeguarding Children Boards

This new law removes the legal authority of Local Safeguarding Children Boards (LSCBs). Statutory safeguarding responsibilities now reside with a new partnership made up of Clinical Commissioning Groups (CCG), Local Authorities and local police.

This new partnership is required to decide on a set of arrangements that will include decisions about the geographical footprint of their working area, a funding plan, and criteria for intervention. They must, importantly, also make arrangements for the scrutiny of the effectiveness of their arrangements by an independent person. Descriptions of the working arrangements were due to be published by 29th June 2019.

As a health provider, the Trust has been part of the consultation process for the changes and through representation at sub-groups continues to be involved in the delivery of work associated with local priorities identified by the safeguarding children boards.

In Oxfordshire the Trust continues to be part of the Oxfordshire Safeguarding Children Board Business group meeting (previously known as the Executive group) and represented on the sub-groups.

In Buckinghamshire we have representation on the sub-groups and outcome focused working groups. The Deputy Director of Nursing is in discussion with the CCG on ensuring clear communications with the Safeguarding partnership Executive Group to ensure the Trust can maintain robust multiagency safeguarding working.

In Bath and North-East Somerset (B&NES), Swindon and Wiltshire the new arrangements will all involve partnerships that include services for children and adults. The Trust will be represented in all of these forums.

Changes to Case Reviews

The legislation introduces new local and national review processes. The Trust continues to be part (if there has been involvement with Trust services) of Serious case/partnership reviews commissioned by the Boards.

**2.1.2 Working Together to Safeguard Children 2018**

An updated Working Together to Safeguard Children was published in July 2018 and provides a framework for the changes made in the Children and Social Work Act 2017. It covers the legislative requirements placed on individual services, the framework for the three local safeguarding partners and the two child death review partners. The guidance replaces Working Together 2015.

The Safeguarding Children policy has been updated to reflect these changes.

**2.1.3 HM Government - Child Death Review Statutory and Operational Guidance**

This guidance was published in October 2018. There are changes which will affect service providers. This includes a new key worker role, and meetings for every child death. Implications of these changes will be discussed further in section 6.3.

**2.2 National Guidance – Intercollegiate documents Roles and Competences for Healthcare Staff**

The fourth edition of “Safeguarding Children and Young People: Roles and Competences for Healthcare Staff” was updated in 2018 and published in January 2019. This was led by the Royal College of Nursing (RCN).

In August 2018 the RCN published on behalf of all the Royal Colleges “Adult Safeguarding: Roles and Competencies for Health Care Staff”. This document has been accepted by the NHS and forms the core guidance (and measure) for staff, registered, unregistered and at board level in their day to day safeguarding functions and responsibilities.

This means there are additional training requirements for some of our staff groups. We are undertaking work in 2019/20 to ensure the Trust is supporting staff to meet the required competencies.

**2.3 Mental Capacity (Amendment) Act**

In July 2018 the Mental Capacity (Amendment) Bill was published. This is following the scrutiny report from the House of Lords in 2014 and the subsequent recommendations from the Law Commission in 2017. Royal Assent was given in April 2019 and the new processes for the Liberty Protection Safeguards (which replace the Deprivation of Liberty Safeguards) will need to be completed by October 2020.

The details of the changes are not yet known as this information will be in a new Code of Practice that will come before Parliament in the autumn of 2019. There will be a requirement for the Trust to develop processes for senior clinicians and managers to oversee any arrangements in place that are preventing a patient who is not detained under the Mental Health Act from leaving one of the Trust’s hospitals. This will primarily affect the community hospitals. Mary Buckman Associate Director for Social Care is leading on this work and initial scoping is taking place.

* 1. **Independent Inquiry into Childhood Sexual Abuse (IICSA)**

The IICSA’s Truth Project is coming to Oxford in Autumn 2019. This is an opportunity for any victim and survivor of child sexual abuse to tell the Inquiry what that they wish to about the events, impacts and consequences of sexual abuse experienced in childhood.

The IICSA will be holding a multi-agency awareness raising event in June 2019 in preparation for the visit. Although they provide additional support around the time of the event, it will be important that survivors have information about how they can access ongoing support.

The Trust non-recent disclosure leaflets have been updated to include reference to the Truth project. Information has been circulated via governance meetings and Trust communications.

1. **Regulatory Activity**

As part of the Care Quality Commission (CQC) regulatory activity, the Trust was subject to a well-led inspection in March and April 2018. The final report was published in August 2018. The Trust was rated overall as Good.

The Trust lead nurses and safeguarding adult manager submitted information for the inspection and were interviewed by the inspection team. No issues of concern about safeguarding children were noted. Safeguarding adult areas identified for improvement were:

* **Must action: Urgent Care**

**All staff are aware and adhere to the referral process for safeguarding adult concerns.**

Action taken:

The service has reviewed their processes

Action taken to produce a flow chart to communicate the process and a review of supervision arrangements has been completed.

Additional training provided in addition to mandatory safeguarding training.

The Trust’s Safeguarding Committee in January 2019 reviewed the number of safeguarding referrals which demonstrated the urgent care service is making referrals and considering safeguarding concerns appropriately.

The Safeguarding Adult Team is monitoring the number of safeguarding adult referrals made to the local authority

Ongoing monitoring is reported to the Safeguarding Committee.

Further work by safeguarding adult team is in progress to provide review of the appropriateness and quality of the referrals being made during 2019/20.

* **Must action: Community Hospitals**

**Deprivation of Liberty Safeguards applications should be completed appropriately and tracked effectively.**

Action taken:

Robust tracking in place in Community hospitals in addition to Trust monitoring process via MHA office

DOLS/MCA audits completed and ongoing improvement work in place to ensure robust documentation is consistently in place.

MCA/DOLS assessments are monitored bi-monthly via matron walkarounds which report to service management meetings and the directorate quality senior management meeting.

* **Should Action: Community Hospitals**

**All staff who are band 7 or above have completed multi-agency safeguarding adults training.**

This is complete.

1. **Safeguarding Service**

The Trust has restructured the directorates this year, and the safeguarding teams have been brought together as one service within the Corporate Directorate. This reflects the trust wide nature of its work and supports improved integrated working across children and adults and the cross cutting public protection work such as domestic abuse, modern slavery and Prevent.

The safeguarding service has maintained connection with the directorates through regular attendance at directorate governance meetings and safeguarding being a standard slot on agendas.

The Trust Executive Safeguarding Lead during 2018/19 was the Director of Nursing and Clinical Standards. The new Chief Nurse role maintains this accountability.

The Deputy Director of Nursing is responsible for the safeguarding service

The Safeguarding Children Team is led by the Lead Nurses and by the Lead Doctor.

The Safeguarding Adult Team is led by the Safeguarding Adult Manager and the named doctor for safeguarding adults provides medical leadership.

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

The safeguarding service covers the five Local Safeguarding Children Boards (LSCB) (Oxfordshire, Buckinghamshire, Bath and North-East Somerset, Swindon, Wiltshire) and 2 Local Safeguarding Adults Boards (LSAB) (Oxfordshire and Buckinghamshire). As discussed in section 2.1.1 the Trust is represented within the new arrangements and relevant sub-groups and has high attendance rates.

The Social Care Professional Leads (Social Worker Leads employed by Oxford Health) provide safeguarding adult advice and support as part of their social care function but sit outside of the safeguarding service.

See the structure chart below.

**4.1 Structure Chart**

**Chief Nurse**

**Executive Lead for Safeguarding**

**Deputy Director of Nursing**

**2 Sessions Per Week**

**Named Safeguarding Children Doctors**

**Safeguarding Lead Nurses**

**(2:2 WTE)**

**1 Session Per Week**

**Named Safeguarding Adult Doctor**

**Safeguarding Adults Practitioner**

**(2.53 WTE)**

**Named Nurses Safeguarding Children**

**(5.8 WTE)**

**4.3 Team Developments**

**4.3.1 Safeguarding Adults**

In 2018/19 the safeguarding adult team expanded from 1WTE to 3.53WTE and a new safeguarding adult named doctor has been recruited.

The expanded team has been able to focus on new areas of work and provide more dedicated support to services than previously.

* **Buckinghamshire**

The Senior Safeguarding Adult Practitioner role was introduced in July 2018. The post holder works closely with the County Council Safeguarding Adult Practitioners within the MASH (multi-agency safeguarding hub) in Buckinghamshire. The role involves informing risk assessments when there are concerns, oversight of s.42 enquiries delegated to the Trust from Buckinghamshire County Council and providing support and information to the community mental health teams. Feedback from the MASH Manager has been very positive.

The role enables effective working between agencies in Buckinghamshire and promotes consistency especially in relation to work around missing persons (the system is known as ELPIS) and the MARAC (Multi-agency Risk Assessment Conference). This increases the potential for a positive impact for service users and victims.

Safeguarding leads meetings, case presentation and support network mean there are strong links between the safeguarding adult team and clinical teams. This provides for an opportunity for managers and staff to be actively supported in raising safeguarding alerts and safety planning for service users.

* **Learning Disability**

Throughout 2018/19 a safeguarding adult practitioner was in post with a specific remit to work alongside the learning disability teams. At the time of the learning disability teams moving into Oxford Health in July 2017, there were changes to the safeguarding arrangements with the social workers moving back to Oxfordshire County Council. The safeguarding adult practitioner role helped support the adjustment to the changes and provided insight into the risks experienced by service users with a learning disability. The consultation element of the work was a significant factor in this.

* **Community Services**

The third safeguarding adult practitioner role is promoting links with the community hospitals. The post holder is an RMN and has an expertise in dementia care.

* **Named Doctor**

The named doctor for safeguarding adults is a consultant working in forensic services. This role provides a medical and forensic perspective on the work of the safeguarding service.

The expertise of each member of the team enables the team to provide a broad perspective on issues to the benefit of the wider organisation and across all professions.

* + 1. **Children**

Following retirement of two Band 7 named nurses, the team have restructured and introduced a Band 6 safeguarding nurse post, to be based in the multi-agency safeguarding hub (MASH) in Oxfordshire. This will support career progression into the team.

The team has taken over responsibility from the performance team for adding alerts to Care Notes for looked after children for Buckinghamshire and children on child protection plans in Oxfordshire. This has resulted in a need for increased administrative resource.

1. **Safeguarding activity**

**Positive feedback consultation line from a School Nurse**

 ***“I personally feel that I could not work in a busy city secondary school with a high level of vulnerable students if I did not have access to the Named Nurses for Safeguarding in Oxford Health. They are always extremely helpful and provide very thorough sound advice. It is always so helpful to talk through distressing cases and feel reassured that I have done my job properly, so many thanks to the whole team”***

***“Thank you \*\*\*\* for your time, I felt so much better after speaking to you, and it helped me switch off to work when I went home”.***

* 1. **Adult activity**

Safeguarding adult activity is very much day to day work for clinicians. The Safeguarding Adults Policy provides an up to date framework. The safeguarding adult team provides additional and timely support.

Key indicators of effective safeguarding are consultations, the number of referrals made to the local authorities and enquiries completed under s.42 of the Care Act 2014 (known as section 42 enquiries). Together this activity information demonstrates that the Trust has processes in place to prevent harm and identify concerns, take actions to protect people and that services are accountable for actions taken (or not taken) and that it is working in partnership with other agencies.

|  |
| --- |
|  **Telephone Consultations** |
| **Directorate** | **No/ of consultations 2015/16** | **No/ of consultations 2016/17** | **No/ of consultations 2017/18** | **No/ of consultations 2018/19** |
| Children and Young People |  4 |  14 |  9 |  14 |
| Adult  |  94 |  165  |  168 |  257 |
| Forensic | 10 | 8 | 10 | 13 |
| Older People  |  112 |  109 |  87 |  94 |
| Learning Disability |  |  | 9 | 24 |
| **Total No/ of consultations** |  **220** |  **296** |  **283** |  **402** |
| **Referrals to the Local Authority** |
| **Directorate** | **Number of referrals to LA 2018/19** |
| Children and Young People | 0 |
| Adult | 33 |
| Forensic | 15 |
| Older People | 68 |
| Learning Disability | 16 |
| **Total number of referrals recorded** | **132** |

The referral information was not collected in 2017/18 so there is no comparable information.

|  |
| --- |
| **Section 42 Enquiries** |
| **Directorate** | **2015/16** | **2016/17** | **2017/18** | **2018/19** |
| Children and Young People | 0 | 0 |  1 | 0 |
| Adult | 3 | 6 | 2 | 22 |
| Forensic | 0 | 3 | 6 | 3 |
| Older People | 4 | 23 | 12 | 12 |
| Learning Disability |  |  | 1 | 1 |
| **Total number of s.42 enquiries** | **7** | **32** | **22** | **38** |

The changing numbers reflect the changes in processes in the Trust. In 2018/19 s.42 enquiries completed by the Buckinghamshire community mental health teams has been recorded for the first time following the Senior Safeguarding Adults Practitioner being in post.

There has been a significant piece of work in the Older Adult Directorate around the management of pressure ulcers. The significant decrease in the number of s.42 enquiries for the Directorate (2016/17 – 2017/18) coincides with this project.

**Joe has a chronic mental illness resulting in self-neglect. He was living in “complete squalor”. The Trust staff worked with him, enabling him to explore options. He is now accepting support and has maintained both his mental and physical health. He states his life has improved.**

s.42 of the Care Act 2014 requires the local authority to make further enquiries when they receive a concern about an adult with care and support needs. The Trust is a partner to the local authority and under the Act is required to co-operate with those enquiries.

The aim of all s.42 enquiries is to make a difference to the service user. The Making Safeguarding Personal agenda aims to raise awareness of keeping the service user at the centre and actively involved in all decisions related to their engagement with services and safeguarding issues. The vignette above demonstrates that the voice of the service user is heard.

There are agreements in place with the local authorities (known as s.75 agreements) that enables the Trust to employ social workers in some of the mental health teams. This means that service users access their social work support from the relevant mental health teams and that the s.42 enquiries are delegated to the mental health teams to manage. The vignette above describes how effective these integrated teams can be in safeguarding someone who was subject to self-neglect.

During the year, 5 s.42 enquiries about one clinical area. The Trust responded by commissioning its own in-depth review to identify themes. Practical recommendations were made about changing the environment, about changing how staff communicate relevant information to service users and their relatives and about the embedding of clinical and management supervision into practice.

There have been no further safeguarding adult concerns raised about this area since August 2018.

There was a significant concern raised about how the Trust works in partnership with its mental health partners. This was reviewed both as a s.42 enquiry and by the Trust processes. This resulted in a clear review of the relevant policies and understanding of the service criteria to promote common understanding.

* 1. **Children activity**

**5.2.1 Consultations**

Individual advice and consultation is available from the Safeguarding Children team to all Trust staff by telephone via a dedicated consultation line number and/or by face to face contact. This is available 9-5, Monday – Friday.

In 2018/19 there were 1747 calls to the consultation line, which was similar to the previous year (1743) and averages 7 calls per working day.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Directorate** | **No/ of consultations 2015/16** | **No/ of consultations 2016/17** | **No/ of consultations 2017/18** | **No/ of consultations 2018/19** |
| Children and Young People | 872 | 958 | 1008 | 1027 |
| Adult  | 663 | 872  | 724 | 720 |
| Older People  | 1 | 4 | 11 | 0 |
| **Total No/ of consultations** | **1572** | **1963** | **1743** | **1747** |

In April 2018 the team did a dip sample evaluation of the consultation line to gain feedback from clinicians. The survey found that practitioners value the Consultation Line. Talking through safeguarding issues and formulating a plan helps them feel they have ownership of the decisions. The Consultation Line is considered an excellent service offering good advice. Named Nurses were described as knowledgeable, providing helpful practical advice with a sound knowledge of support services.

**The Safeguarding Children Team presented their work at the BASPCAN (British Association for the Study and Prevention of Child Abuse and Neglect) international conference in April 2018. This was related to developing the non-recent disclosure guidance for the Trust. The team also displayed a poster promoting the safeguarding children consultation line as evidence of good practice.**

**An article on developing the guidance has been submitted to the journal Child Abuse Review in June 2019.**

* + 1. **Core work**

The safeguarding team’s core work is supporting staff in managing highly complex cases through training, supervision and consultation. Another significant area is representing the

Trust in multi-agency working.

The table below gives an overview of the core areas of work undertaken by the Safeguarding Children Team.

|  |  |  |
| --- | --- | --- |
| **Area of Work** | **Number completed 2017-2018** | **Number completed in 2018-2019** |
| **Serious Case Reviews** | **2** | **3** |
| **Partnership Reviews** | **0** | **0** |
| **Safeguarding 136 visits** | **6** | **5** |
| **Level 2 & 3 training sessions delivered** | **49** | **39** |
| **Additional workshops** | **52** | **11** |
| **Team visits** | **12** | **31** |
| **Safeguarding Children Supervision sessions**  | **166** | **129** |
| **Trust audits** | **1** | **1 (feedback from staff related to 2017 audit)** |
| **LSCB audits** | **16** | **6** |
| **Support for staff to write court reports** | **23** | **26** |
| **Support for staff to attend court** | **6** | **0** |
| **LSCB sub-groups attended** | **132** | **113** |
| **Multi-Agency Public Protection Arrangements** **(MAPPA) information shares** | **34** | **59** |
| **MASH enquiries processed** | **Oxon: 1,456 (average 9 a day)** | **Oxon: 2,964 (average 11 a day)** |
| **Bucks: 428 processed** **101 open cases** | **Bucks: 383 processed****78 open cases** |
| **Multi-Agency Risk Assessment Conferences (Domestic Abuse) meetings attended** | **Oxon: 20** | **Oxon: 25** |
| **Bucks: 17** | **Bucks: 30**  |
| **MARAC information shares processed** | **Oxon: 197** | **Oxon: 214** |
| **Bucks: 230** | **Bucks: 163**  |
| **FGM cases reported to NHS digital** | **2** | **6** |
| **Child Death Overview Panel cases processed** | **Oxon: 43** | **Oxon: 25** |
| **Bucks: 1** | **Bucks: 32 (2 children were open to the Trust at the time of death. 2 child deaths where parents were open to mental health services.** |
| **SWB: 6** | **SWB: 9** |
| **Rapid response meetings attended** | **Oxon: 6** | **Oxon: 9** |
| **Bucks: 0** | **Bucks: 2** |
| **SWB: 6** | **BSW: 2** |
| **Allegations against staff****(Unless indicated allegations did not proceed to a formal investigation)** | **Oxon:1** | **Oxon:1** |
| **Bucks: 0** | **Bucks: 0** |
| **SWB: 4** | **SWB: 3 (2 went to formal investigation)** |

* 1. **Audits**

To ensure we can evidence effective practice there is a safeguarding audit programme in place as part of the Trust audit programme.

**5.3.1 Safeguarding children audit**

In 2017 the team undertook a large internal safeguarding children audit - looking at think family, neglect, use of tools and general good safeguarding practice to provide assurance and identify any learning. 60 cases were reviewed, 20 from each geographical area looking at children and parents’ records (if open to mental health services).

Review of the records provided assurance that effective safeguarding practice was present in 88% (53/60) of cases resulting in keeping children safe and ensuring positive outcomes.

Good practice included:

* 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 included:

* 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

Following the audit, a piece of work was undertaken in 2018/19 by the safeguarding team to ask clinical staff via targeted team visits for feedback around the areas that required improvement. Information from these meetings has been captured and reviewed to see if there are areas of practice that the safeguarding team can support to improve.

No themes were identified that required bespoke workshops, hence there has been a reduction in the numbers delivered in 2018/19. Staff have been able to access training on emerging themes provided by other agencies e.g. criminal exploitation and modern slavery.

**Next steps:**

The report on the findings from discussions with staff has been completed in June 2019 and an action plan developed to address areas of improvement.

**5.3.2 Review of implementation of Designated MARAC Officer guidance**

All Oxfordshire and Buckinghamshire Multi-agency Risk Assessment Conference (MARAC) minutes were reviewed using MODUS (electronic tool used to support MARAC meetings in Oxfordshire and Buckinghamshire) from 01/04/2017 to 31/03/2018.  14 Care Notes records were selected at random to review documentation processes implemented by the Designated MARAC Officers (DMO).

The review of records established that MARAC meetings are attended by Trust staff.  Where staff are unable to attend, information is shared with the Chair of the meeting or a representative sent to support risk analysis and safety planning.

The review of records found that DMO’s are confident in understanding the proportionality of what information should be shared at MARAC.

In Oxfordshire, letters sent to GPs by the safeguarding team to let them know their patient has been discussed at the MARAC meeting, are now routinely copied to Out of Hours services. This decision was made to support information sharing where there has been a high risk of domestic abuse identified. This information is essential to enable staff to support the person if they present to out of hours services with injuries.

**5.4** **Safeguarding Children Under 18 in Adult Mental Health or Places of Safety.**

The Trust in principle would not seek to admit someone under 18 to an adult ward and has adolescent units for the care of children under the age of 18. However, the Trust recognises that there are circumstances such as emergency situations or atypical cases, albeit infrequent, when admission of a young person to an adolescent unit is either not possible or is inappropriate. In such circumstances, admission to adult services may be the only safe alternative.

A child may be subject to Section 136 of the Mental Health Act. This allows the police power to remove a person from a public place when they appear to be suffering from a mental disorder, to a place of safety. If this does occur a member of the safeguarding team undertakes a safeguarding visit to the place of safety on the adult ward. This is to ensure the needs of the child are being met. This will take place within one working day for a child under the age of 16.

The number of safeguarding visits where children have been admitted to the 136 Suite was five during this period reduced from six in 2017/18

**Next steps:**

Additional guidance is being developed by the mental health directorate with input from the safeguarding team. This guidance will support staff with when the outcome of the mental health assessment does not identify a mental health condition but a placement is still required.

**6. Multi-agency Working**

**6.1 Safeguarding Adult Reviews**

Safeguarding Adult Reviews (SAR) are a process through which the safeguarding boards can identify lessons about the way local professionals and agencies work together to benefit adults with care and support needs.

In 2018/19 there was one SAR in Oxfordshire that reported. For the Trust the learning was about adjusting internal communication systems to ensure service users are seen by the relevant team at the relevant time. This action was completed prior to the publication of the report.

Communication is a frequent theme in the findings of SARs. This is a broad theme considering the communication processes with service users, family and friends, with outside agencies and within the Trust. With the changing demographic of the population and increasing demand on services, it seems likely that this will continue to be an issue. Effective Management, Clinical and safeguarding supervision all have a part to play in managing this.

**6.2 Children - Serious Case Reviews**

[[1]](#footnote-1)The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policy-makers.

Serious child safeguarding cases are those in which:

* abuse or neglect of a child is known or suspected **and**
* the child has died or been seriously harmed

Serious harm includes (but is not limited to) serious **and/or** long-term impairment of a child’s mental health or intellectual, emotional, social or behavioural development.

**6.2.1 Serious case review activity which have involved Trust Services**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Area** | **Published SCRs** | **Completed & awaiting publication** | **Ongoing SCRs** | **Partnership review** | **Outstanding actions** |
| Oxfordshire | 0 | 3 | 1 | 1 | 8 |
| Buckinghamshire | 0 | 0 | 2 | 1 | 0 |
| B&NES | 0 | 0 | 1 | 1 | 3 |
| Swindon | 0 | 0 | 0 | 1 | 0 |
| Wiltshire | 0 | 0 | 0 | 0 | 0 |

Outstanding actions are in the process of completion or have been escalated if there have been barriers to completion.

**6.2.2 Implementing the learning from SCRs**

Due to legal processes, and other parallel review processes, it is sometimes the case that a serious case review is completed, and an action plan agreed whilst publication is delayed. In these cases, the learning is shared with staff at the earliest opportunity.

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 and think family approach via training, targeted team visits and supervision
* Working with service managers to develop a lead professional role for children with complex health needs
* Embedding Early Help processes via supervision, consultations and resources
* Facilitating better information sharing between adult and children services through consultation/level 3 training sessions/supervision and changes to risk assessments within Care Notes
* The learning from SCRs is included in a monthly safeguarding children newsletter/update and shared at governance and locality meetings
* Delivering workshops on making a referral to children’s social care and child exploitation

**6.3 Child Death Overview Process (CDOP)**

**6.3.1 Changes to current arrangements**

Statutory requirements set out in the revised Working Together to Safeguard Children 2018 clarify how individual professionals and organisations across all sectors involved in the child death review should contribute. Management of CDOP has moved from local safeguarding children boards to clinical commissioning groups (CCGs) and local authorities (the child death review partners). They are required to make arrangements for child death reviews to meet the statutory requirements under the Children Act 2004. Organisations have a duty to support and engage with this process. The process is designed to capture the expertise and thoughts of all individuals who have interacted with the case to identify changes that could reduce child mortality.

The new National Child Mortality Database (NCMD) is a repository of data relating to all children’s deaths and will enable detailed analysis and interpretation of all data to ensure that lessons are learned, widely shared, and that actions are taken, locally and nationally.

A significant change is that partners should be reviewing a population ‘footprint’ of 60 child deaths. This has resulted in Oxfordshire and Buckinghamshire coming together to achieve this. Themed panels will meet three times a year, to learn lessons for the prevention of future child deaths and there will be consistent use of the electronic system across both areas.

The CCGs and health providers across Oxfordshire and Buckinghamshire have had discussions to understand changes and impact on services. The main implications for providers, as highlighted in section 2.1.1., is the introduction of the Key Worker[[2]](#footnote-2) and having a meeting for every child death. In Oxfordshire, Trust staff will take on the role of Key Worker, whereas Buckinghamshire have chosen a different model. A staff member in midwifery and paediatrics will have this task as part of their governance role.

**6.3.2 Trust involvement in CDOP process**

The safeguarding service co-ordinates the child death process for the Trust when a child dies or if family members are known to our services. The service ensures staff are alerted to the death who are directly involved with the family or have management responsibilities for that service, so appropriate contact is made with the family and support for staff is put in place. The safeguarding service also support staff with related processes/meetings, makes sure documentation is completed/submitted and represent the Trust on the Child Death Overview Panel. This meeting reviews deaths of all children normally resident in the area. There is also representation from the safeguarding service at the Trust Mortality review meeting to give feedback on themes of child deaths and any modifiable factors. In turn any learning from the Mortality review meeting is fed back to the CDOP meeting.

There has been a decrease in neonatal deaths where the baby was resident in Oxfordshire in 2018/19 compared to 2017/18. This explains the decrease in child deaths processed by the safeguarding team. There has been an increase in Buckinghamshire CDOP cases processed due to improvements in use of the ECDOP system and communication by the Clinical Commissioning Group (CCG).

**Next steps:**

The safeguarding service has produced a draft of roles and responsibilities of the Key Worker role. This will be agreed with local partners in Oxfordshire in July 2019. The draft has been shared with managers and through governance meetings.

**6.4 Multi agency audits**

There has been a reduction in audits carried out by local safeguarding boards. This may be due to restructuring of the boards and capacity across agencies.

**6.4.1 Oxfordshire**

We have participated in 3 Oxfordshire Safeguarding Children Board (OSCB) audits over the past year relating to the young person’s domestic abuse pathway, harmful behaviours and use of translation services.

 **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.

**6.4.2 Buckinghamshire**

**The re-referrals audit identified a good example of a referral made by CAMHs which gave a clear picture of the child’s living experience, including historical content, as well as a clear record as to what the referrer was seeking to achieve.**

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**including historical content, as well as a clear record as to what the referrer was seeking to achieve.**

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**including historical content, as well as a clear record as to what the referrer was seeking to achieve.**

We have participated in 2 Buckinghamshire Safeguarding Children Board (BSCB) audits over the past year relating to re-referrals to children’s social care and children with disabilities.

<http://www.bucks-lscb.org.uk/wp-content/uploads/About%20the%20BSCB/Audits%20and%20findings/Re-Referrals-Audit-July-2018.pdf>

<http://www.bucks-lscb.org.uk/wp-content/uploads/About%20the%20BSCB/Audits%20and%20findings/CWD-Audit-Summary-July-2018.pdf>

**Outcomes**

Most of the repeat referrals met the threshold, with agencies recognising risk and sharing appropriate and relevant information. There was not always an indication of whether the parents and carers were aware of the referral. Referral forms from other agencies are not particularly ‘child-focused’.The CAMHs referral was highlighted as a good example of practice.

The children with disability audit found in one case there was “a lot of collaboration” noted for one case at Care Programme Approach (CPA) discharge, as well as Head of Service discussion between the Children Social Care (CSC) and Special Educational Needs (SEN) Teams. Mental health was also reported as responding well in the event of a crisis.

CAMHS records also showed evidence of good multi-agency working; positive communication and the combined working of services to meet the needs of the family resulting in the mother’s increased trust in agencies.

Recommendations from the audit include a multi-agency perspectiveon children “not brought” to appointments. Assessments to include lived experience of the childnot just the impact of the disability. All adults who are significant in a child’s life should be visible in assessments. Children should receive appropriate services as early as possible when need is emerging. Consideration should be given to services for children who may not meet the age criteria for diagnosis. For example: Pre – CAMHS.

Outcomes from the audits are shared in internal governance meetings, supervision and highlighted in the internal safeguarding newsletter.

**6.5 Multi-Agency Safeguarding Hubs (MASH)**

**In Oxfordshire we have created the role of a 0.6WTE band 6 Safeguarding nurse. This will create greater continuity within the MASH team.**

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).

There is a MASH for safeguarding adults in Buckinghamshire but not Oxfordshire. From August 2018, the Senior Safeguarding Adult Practitioner has been integral to the MASH in Buckinghamshire. This has facilitated better communication with our partners in Buckinghamshire. It has also enabled the Trust to be an active participant in the monitoring of people who are identified as going missing. In Oxfordshire the number of MASH cases processed has increased marginally. The overall figure has increased significantly as we are collating the data for all MASH cases processed by the Trust and Oxford University Hospitals.

**Next steps:**

The information about people of all ages who go missing is being analysed for an overview of how this information can inform the work of the Trust.

**6.6 Multi agency neglect work**

Neglect is a priority for all of the LSCBs covering the Trust’s services.

Neglect is the most common reason for children to be subject to child protection plans in Oxfordshire (458, 67%). This is higher than the national average where the proportion of children subject to child protection plans for reason of neglect is 45% and 11 % higher than last year. The Trust is engaged in multi-agency work addressing this form of abuse.

The neglect strategy group for Oxfordshire is co-chaired by the Trust’s service director for community services. There is also a practitioners’ forum with good representation from both children and adult services.

The Neglect tool (childcare and development checklist) has been revised and is currently being piloted. The use of Multi-agency chronologies is being developed in order to promote broader understanding of risk. Workshops have been delivered and will also be included in all OSCB training.

A quarterly neglect newsletter goes out to all staff to ensure they are kept updated of developments.

**Next steps:**

Work is underway with the Electronic Health Record to add a chronology template currently used in Oxfordshire and explore adding neglect screen tools. This would allow staff easy access to tools. Use of tools has been identified as an area of improvement in internal and multi-agency audit.

**6.7 CP-IS (Child Protection - Information Sharing)**

This is a nationwide project to improve communication between emergency care settings and children’s social care, around attendances for children subject to child protection planning. This is specific to Oxfordshire due to the Trust providing out of hours and minor injury units within this area. There is a project implementation program in place. There have been delays to the system going live due to governance issues relating to access to Adastra and the local authority implementing a new electronic system.

**6.8 Mental Capacity Act (MCA)**

**Training evaluation: This is just to say thank you for your presentation about the MCA and DoLS. It was very clear and helpful and 24 out of 25 evaluations stated excellent or good.**

The Mental Capacity Act 2005 is about making relevant decisions. The CQC report in 2018 identified variable practice in the implementation of the Act. There are however some excellent examples of staff working very closely with individuals and their families to make complex decisions in the person’s best interests.

The Mental Capacity Act applies to people from the age of 16. It applies therefore to children and young people services and is part of the framework supporting young people as they transition to adulthood and adult services.

In 2018 both the School Health Nurses and CAMHS recognised a need to receive training to consider decision making across the age range. This was evaluated positively by the teams.

**Next steps:**

A form has been developed to be included on Care Notes to help staff have a structured approach to complex decision making for mental capacity assessment and best interest decision making.

 **6.9 Deprivation of Liberty Safeguards (DoLS)**

**(see also 3. Regulatory Activity)**

**Mr G was deprived of his liberty in hospital. He did not agree with the arrangements in place and he stated he felt he was “incarcerated”. He was invited to all meetings so his voice could be heard. His ability to make the decision about consenting to the arrangements in place was continually reassessed to ensure any restrictions in place were immediately lifted if they were not required.**

The Trust has continued to monitor the applications made for a deprivation of liberty authorisation and has been working in partnership with the Local Authorities to promote the quality of care given.

**Next steps:**

In future under the MCA (Amendment) Act 2019 the Trust will be fully accountable for authorising any deprivation of liberty that occurs in its services. New processes will need to be put in place.

An MCA/DoLS lead (Associate Director of Social Care) has been identified in the Trust. Systems will be developed in response to the revised MCA Code of Practice which is being developed and is anticipated to be available in spring 2020.

**7. Public protection work**

**7.1 Prevent**

The Counter-Terrorism and Security Act 2015 contains a duty on specified authorities to have due regard to prevent people from being drawn into terrorism. The Governments’ strategy, CONTEST, is the framework that enables the government to organise this work to counter all forms of terrorism.

The Prevent programme depends on leadership and delivery through a wide network of partners – with communities, civil society organisations, public sector institutions including local authorities, schools and universities, health organisations, police, prisons and probation, and the private sector.

The Head of Nursing for Forensic Services has been the Prevent lead for the Trust. The Prevent lead is responsible for ensuring policies and procedures are in place to address Prevent concerns and ensuring that staff training is available to build staff understanding of issues. The role also includes having networks in place for advice and support to make referrals to the Channel programme, attending Channel meetings and being the link between Channel and the Trust for Oxfordshire and Buckinghamshire. It also includes submitting data to NHS Digital relating to the number of referrals made by the Trust to the Prevent lead with in Thames Valley Police and providing training data to the Clinical Commissioning Group.

**Next steps:**

In May 2019 the Prevent lead role is being handed over from the Head of Nursing for Forensic Services to the Lead Nurse for Safeguarding Children who has responsibility for public protection. The current Trust Prevent protocol will be reviewed as part of developing a joint adult and children safeguarding policy.

* 1. **Domestic Abuse**



A domestic abuse working group which has membership from services across the Trust has been established in 2018/19. The group met in February 2019 and is meeting quarterly. The aim of the group is to be aware of work being undertaken around domestic abuse as a trust and ensure a co-ordinated consistent response that links with national guidance and local areas strategic plans and safeguarding board priorities.

The first actions from the group were as follows:

* Develop internal domestic abuse pathway to support staff to respond to clients linked to the review of the domestic abuse policy.
* Review roles and responsibilities of trust Domestic Abuse Champions
* To display DA posters in patient areas

**Next steps:**

The Trust domestic abuse policy is due for revision in 2019/20. The working group will be part of the consultation process.

Request new project for Care Notes, to make domestic abuse stalking and honour-based violence (DASH) checklist available on electronic record.

**7.2.1 MATAC (Multi-Agency Tasking and Co-ordination)- Oxfordshire**

The safeguarding team attend the MATAC. This is a new, perpetrator focused approach to tackling domestic violence reoffending within standard and medium risk cases. This new approach commenced in August 2018 and is a monthly 2-hour meeting. Meetings are established in north and south of the county. Due to staff changes within the police, Oxford city meetings have been on hold.

The aim is that perpetrators will be involved in the MATAC process for a few months, and a strong perpetrator multi-agency focus will reduce their RFG (recency, frequency, gravity matrix) score, and in turn reduce offending and the risk to the victims.

**7.2.2 Domestic Abuse Operational Group Oxfordshire**

There is representation from the safeguarding team at the Oxfordshire domestic abuse operational group. Members were involved in advertising the re-launch of the young person domestic abuse pathway.

Following a multi- agency review, the Pathway has been redeveloped to take account of the findings from the review, changes in local policy and practice and changes to the law in respect of GDPR, the most recent data protection legislation.

Training sessions were advertised to staff.

**Next steps:**

The Domestic abuse strategy is being developed by the operational group in consultation with partners and will be published in 2019.

The Multi-agency Risk Assessment Conference (MARAC) protocol for Oxfordshire is being updated and awaiting sign off. A MARAC working group is being convened by the police in July 2019 to ensure this is completed and MARAC meetings/processes are running efficiently. There is Representation from the safeguarding team at this meeting.

**7.2.3 Dynamic Multi-agency risk assessment conference (MARAC) Buckinghamshire**

In 2018/19 there was a change to MARAC meetings in Buckinghamshire.The previous system was not seen as being effective in supporting a timely response to victims and their children. There was a move to daily meetings named dynamic MARAC which was piloted from May 2018. There has been a review of the pilot and there is now weekly rather than daily meetings.

The Senior Safeguarding Adult Practitioner is responsible for this area of work with cover from other members of the safeguarding team. It is perceived by the safeguarding team that the new arrangements are promoting consistency of approach and increasing the potential for a positive impact for victims.

**7.2.4 Domestic Abuse Strategic meeting Buckinghamshire**

There is representation from the safeguarding team at the Buckinghamshire domestic abuse strategic meetings. The domestic abuse strategy and action plan has been developed and signed off by representatives at this meeting. All actions for the Trust have been completed.

* 1. **Female Genital Mutilation (FGM)**

In Oxfordshire the Trust is represented at a monthly “no names” multi-agency meeting held at the John Radcliffe Hospital. This meeting discusses cases where a risk assessment has been completed and establishes if multiagency involvement is required to support the victim or family. There have been31 cases discussed in the last 12 months on ‘no names’ basis with 6 being referred to Children’s Social Care.

Multi-agency training is available in Oxfordshire for Trust staff to attend.

A scoping exercise was held in Buckinghamshire by the Community Safety Partnership and Health and Wellbeing Board to review any changes regarding FGM in the local area. It was reported at the meeting that FGM numbers are still low. There are processes in place to refer cases of FGM but due to low numbers it is difficult to establish if this is working well. There are plans in the future to hold a Challenge Event.

**7.4 Modern Slavery**

**On 18th October 2018 it was Anti-Slavery Day. The Trust participated with awareness raising by displaying posters, circulating information and promoting Oxford Health at an anti-slavery event held at Brookes University.**

The Modern Slavery Act came into force in 2015; this is the first piece of UK legislationfocusing on the prevention of modern slavery, the prosecution of perpetrators and the protection of victims. Modern Slavery encompasses: sexual exploitation, forced labour, criminal exploitation, domestic servitude and organ harvesting.

The Thames Valley Anti-Slavery Network has three regional sub-groups responding to modern slavery in the Thames Valley region. These three sub groups are Oxfordshire, Buckinghamshire and Berkshire. The safeguarding teams represent the Trust at the Oxfordshire and Buckinghamshire networks.

The purpose of the networks are:

* To make the counties hostile to modern slavery through:
	+ inter-agency collaboration,
	+ increased awareness and information sharing to Prevent, Pursue, Protect and Prepare in line with the UK Modern Slavery Strategy and the strategy of the Inter Agency Standing Committee for the coordination of humanitarian assistance (IASC).
* To develop and maintain a collective understanding of the extent and nature of modern slavery in each county.
* To sustain communication with all agencies concerned with modern slavery, to avoid duplication and promote comprehensive and joined-up responses
* To develop strategic partnerships and collaborate with other regional, national and international organisations to tackle modern day slavery.
* To identify gaps in the modern slavery response in the county and work with best placed network partners to address these.
* To raise awareness of modern slavery within member organisations in order to increase reporting, and referrals of potential modern slavery cases and potential victims of trafficking.

 **Next steps:**

There is now a strategic vision in Oxfordshire re Modern Slavery. This will form the basis for the development of a mission statement for the Trust.

The Trust will support Anti-Slavery Day on 18th October 2019.

There is a research project about Modern Slavery that has been commissioned by Oxford City Council. The Trust has agreed to be actively involved with this.

* 1. **Child Sexual Exploitation**

In all LSCB areas the Trust has strong links with multi agency CSE teams. In Oxfordshire there is a specialist nurse employed by the Trust linked to the Kingfisher team. In Bucks, a CAMHS worker is linked with the Swan unit. A similar arrangement is set up in the Wiltshire for a named practitioner. In Swindon and BaNES there are processes in place for CAMHS involvement. This ensures that there is good health input for young people known to these teams.

There are Trust representatives on all the LSCB exploitation sub-groups, which enables engagement at a strategic level and a forum for raising issues that require escalation. The Trust is engaged in strategic plans to address exploitation in a wider sense across all areas ie to also address criminal and drug exploitation. Trust representatives have been involved in developing local exploitation screening tools. When sexual exploitation concerns are identified, the safeguarding team support practitioners in completing one of the tools, which may lead to a subsequent referral to children’s social care/MASH as per local safeguarding children procedures. All tools are available to staff via the safeguarding children page of the trust intranet, along with links to the LSCB exploitation tool kits.

CSE is recorded within the risk assessment form on Care Notes. This enables all practitioners working with a young person to understand risk and plan of care. The safeguarding children consultation service received 49 consultations relating to CSE in 2018/19. There were 401 screening tools completed and uploaded on to Care Notes.

For adult service users, sexual exploitation is a concern that is readily identified by staff through consultations and discussion in training. It requires individual long-term responses in most cases. This is a developing area of work and can link with the work around Modern Slavery.

**Next steps**:

To engage with multi agency partners across all areas to develop strategic response to wider child exploitation.

To commence a Trust exploitation working group.

1. **Training**

**“The trainer brought a wealth of experience to the training, which really brought the session to life “ – feedback from safeguarding training evaluation.**

The requirements for safeguarding training in relation to both children and adults are outlined in the intercollegiate documents, as outlined in paragraph 2.2. These are a collaboration between all of the relevant Royal colleges and professional bodies. The children intercollegiate document has been revised and updated this year and the adult document was published in August 2018. They outline additional requirements for core training for particular staff groups along with additional requirements for continuous professional development (CPD).

Joint work continues with clinical practice teachers (CPT`s) to develop the safeguarding competences of specialist community public health nurse (SCPHN) trainees by using a safeguarding framework to ensure that the Trust fulfils its aims, objectives and statutory duties effectively and safely.

We are working with our partners to provide consistency in our approach to safeguarding training, particularly with reference to the Intercollegiate changes.

Key training achievements:

* 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 children’s community services and adult services.
* 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 that reflects the requirements of the Intercollegiate documents.
* Discussion with Learning and Development regarding improving staff’s ability to record their CPD on the trust system.
* Actions are taken to further improve training compliance this includes informing staff and managers in a timely way to book on to training.

**Volunteers**

The Trust has 130 volunteers. Their work falls into the following generic areas:

* Patient Engagement
* Peer Support
* Environmental Support
* Staff Support
* Community Engagement

All volunteers have a training matrix and this includes safeguarding training via e-learning. All volunteers are DBS checked (enhanced level if involved in patient engagement or peer support) and are required to sign a Safeguarding statement which outlines expectations around conduct and boundaries.

**8.1 Effectiveness and Evaluation of training**

**Evaluation of safeguarding training to volunteers: Several of the trainees said that yesterday was their favourite day of the training so far as it was very tangible content. They said this meant that they could understand how they would apply the learning in practice as volunteers.**

* Training programmes are reviewed annually and updated to ensure materials reflect latest research and/or legislation. For example, with the recognition of organised crime in the form of county lines drug/criminal exploitation, information on county lines has been added to the training. There has been an increase in consultations to the safeguarding team relating to modern slavery which includes drug and criminal exploitation. This would suggest there is an increased awareness by staff regarding this area. Participants are encouraged to reflect on their learning and discuss practice implications with managers/supervisors during management and clinical supervision.
* A review of training evaluations (for combined Level 3 children and alerter level adults) evidenced that clinicians found a combined adult and children approach confusing; they required a specific focus on child protection processes and procedures. From April 2017, Level 3 has been delivered separately; the training focusses on early help, referral, escalation, resources to support practitioners and the learning from serious case reviews whilst maintaining a Think Family approach.
* A review of the evaluations evidence that learning needs have been met.
* Following the training, participants are advised to complete a safeguarding self-evaluation form to inform their on-going professional development.

**Nursing associates and Apprentices**

The learning and development department are providing training for Nursing associates and apprentices. The safeguarding service has worked alongside the Learning and Development team to develop clear safeguarding processes with special consideration given to those students who are under 18.

1. **Supervision**

**‘Supervisor able to tread the line between containment of anxieties and challenges to practice’**

**‘Very experienced and knowledgeable supervisor’**

**‘Supervisor shows good experience and good knowledge of managing safeguarding concerns and ongoing/new issues ‘.**

Child protection supervision provision is in addition to the safeguarding consultation line service, clinical supervision and line management supervision that clinicians receive.

The safeguarding children team provides supervision to:

* Health Visitors
* School Health Nurses
* Family Nurse Partnership
* CAMHS teams in Oxfordshire, Buckinghamshire and BSW.
* Inpatient units, Oxford and Swindon.
* Family Assessment and Safeguarding Service (FASS) team
* Improving Access to Psychological Therapies (IAPT)
* Community Childrens Nurses.
* Specialist school nurses.
* Bowel and bladder team

**New safeguarding supervision groups for Family Assessment and Safeguarding Service (FASS) team and Improving Access to Psychological Therapies (IAPT) in 2018**

**9.1 Safeguarding supervision evaluation**

This audit was completed in June-July 2018 and was designed to provide evidence of the quality of safeguarding supervision. 21 health visitors/family nurses and 13 SHNs responded.

95% of respondents felt that the skills of the supervisor met their safeguarding supervision needs. 70% of staff believed their practice had changed following supervision and outcomes for children and families had improved. Staff reported an increased use of safeguarding tools in assessments and in their referrals to other agencies. Staff also described increased confidence in their own safeguarding practices.

**Next steps:**

The plan in 2019/2020 is to integrate children therapy services with children community nurses safeguarding supervision.

The next evaluation will capture the feedback from a larger sample of staff.

It is now possible to record safeguarding adult supervision on the Learning and Development portal. From this year, safeguarding adults will be able to provide information about this activity.

**10.** **Safeguarding service priorities 2018/19 - actions taken**

|  |  |
| --- | --- |
| **Priority**  | **Action Taken** |
| * To include recording of DoLS training separately on the learning and development portal.
 | **This was not achieved in 2018/19. This is an action that will need to be taken in partnership with the MCA Working Group that was set up in June 2019.** |
| * 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.
 | **Trust LGBTQ strategy group set up in Feb 19. Awareness training sessions delivered across Oxfordshire, Bucks and BSW.** |
| * To support work on gender identity pathways for children
 | **An action from the strategy group is to explore the options for commissioning a Transgender Clinical Pathway for children and young people**. |
| * To comment on modern slavery strategy as appropriate and to share strategy when completed
 | **Oxford delivery plan completed and ready for comments. To be shared at Safeguarding Committee July 2019** |
| * Trust staff to support the planning of activities for Modern Slavery Week in October 2018
 | **Supported modern slavery event at Brookes University and displayed Trust materials at market place.**  |
| * To support raising awareness across the Trust during Modern Slavery Week in October 2018
 | **Linked with the Trust comms team and highlighted in safeguarding update to advertise event and shared modern slavery posters at governance meeting to be displayed in service areas.** |
| * 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.
 | **Working with partners to implement changes to local safeguarding board arrangements, child death over view processes and serious case reviews.**  |
| * Operational and Strategic leads for domestic abuse within the trust to be identified.
 | **Reorganisation of the safeguarding service created a lead for public protection this includes domestic abuse. A domestic abuse working group is in place and chaired by the public protection lead.** |
| * To share and embed learning from serious case reviews and audits to effect changes in practice.
 | **In response to findings of the 2017 safeguarding audit a further piece of work took place to capture feedback from staff regarding areas of development. This has led to work with EHR team to explore including assessment tools within Care Notes.** |
| * To support implementation of the action plan from the domestic homicide thematic review which focused on joint working between adult and children services.
 | **Safeguarding service worked with EHR team to make changes to promote joint working via the mental health risk assessment form, which is now completed.** |
| * Develop the safeguarding children form on community Care Notes and support the case for read only access to records by relevant staff.
 | **Safeguarding form on community Care Notes completed and waiting date for go live.** |
| * Development of the Safeguarding Adults Practitioner and the named doctor roles within the Trust
 | **Management and clinical supervision processes in place. Joint meetings with safeguarding children team in place. Workplans being developed.** |
| * Formal recording of information:

SupervisionDevelop a process to capture equality data for consultations | **System is now able to record safeguarding adult supervision for 2019/20****Actions to be taken to capture equality data.** |
| Training * To develop a joint safeguarding training Level 1 (basic awareness) training package
 | **Training leads in the safeguarding teams identified and to plan to do this within their workplans** |
| * Further training with CYP services to understand decision making and deprivation of liberty
 | **Training being provided with the teams and is being reported to L&D. Further training needs to be identified.** |
| * Promote the e-learning that is available on the LSAB websites
 | **Both e-learning and face to face training is promoted. Awareness raising days are good times to promote this information further.** |
| * Support the development of multi-agency Mental Capacity Act training
 | **This is an issue to be developed within the MCA Working Group** |
| Audit* Domestic abuse audit
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| * Mental Capacity Act audit
 | **Qualitative audit in the community hospitals completed in May 2019** |

* 1. **Safeguarding service priorities 2019/20**

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| **1** | Complete actions identified from domestic abuse working group. |
| **2** | Develop combined safeguarding adult and children policy to include review of Prevent protocol. |
| **3** | Complete action plan to address areas of improvement identified from feedback from staff relating to 2017 safeguarding audit. |
| **4** | Completion of additional guidance for staff regarding s.136 Place of Safety.  |
| **5** | Draft of roles and responsibilities of the Key Worker to be agreed with partners in Oxfordshire and communicated to Trust staff through governance meetings and safeguarding newsletter. |
| **6** | Information about people of all ages who go missing is being analysed for an overview of how this information can inform the work of the Trust. |
| **7** | Chronology and neglect screen tools to be available within Care Notes.  |
| **8** | Safeguarding service to engage as necessary for CPIS go live. |
| **9** | A form has been developed to be included on Care Notes to help staff have a structured approach to complex decision making for mental capacity assessment and best interest decision making. The safeguarding adults team need to monitor to ensure this is implemented – it is currently in the Sandpit of Care Notes.  |
| **10** | In future the Trust will be fully accountable for authorising any deprivation of liberty that occurs in its services. New processes will need to be put in place.An MCA/DoLS lead (Associate Director of Social Care) has been identified in the Trust and a working group has been set up. Systems will be developed in response to the revised MCA Code of Practice which is being developed and is anticipated to be available in spring 2020.  |
| **11** | Safeguarding service to engage in development of Oxfordshire Domestic abuse strategy. |
| **12** | To support review of Multi-agency Risk Assessment Conference (MARAC) protocol for Oxfordshire and result in sign off. |
| **13** | Strategic vision in Oxfordshire re Modern Slavery to form the basis for the development of a mission statement for the Trust.  |
| **14** | To support research project about Modern Slavery that has been commissioned by Oxford City Council.  |
| **15** | Support Anti-Slavery Day on 18th October 2019. |
| **16** | To engage with multi agency partners across all areas to develop strategic response to wider child exploitation. To commence a Trust exploitation working group. |
| **17** | Update training strategy to reflect changes relating to safeguarding children and adults’ intercollegiate documents.  |
| **18** | Integrate children therapy services with children community nurses safeguarding supervision. |
| **19** | It is now possible to record safeguarding adult supervision on the Learning and Development portal. Safeguarding adults supervision will be recorded in 2019/20. |

**Appendix 1**

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| **Glossary** |
| **CAMHS** | **Child and Adolescent Mental Health Services** |
| **CCG** | **Clinical Commissioning Group** |
| **CDOP** | **Child Death Overview Process** |
| **CSE** | **Child Sexual Exploitation** |
| **FGM** | **Female Genital Mutilation** |
| **Intercollegiate Documents** | **This refers to two documents developed by the Royal Colleges. There is one document for roles and responsibilities in safeguarding adults and one for roles and responsibilities in safeguarding children. They have been accepted by the NHS as the competency framework for safeguarding.** |
| **Kingfisher Team** | **This was set up within Oxfordshire County Council in response to the child sexual exploitation identified. It is a multi-agency team.** |
| **LSAB** | **Local Safeguarding Adults Board; Under the Care Act 2014 every local authority area has a safeguarding adults board in place. Its functions as set out in the Care Act are:*** **assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance**
* **assuring itself that safeguarding practice is person-centred and outcome-focused**
* **working collaboratively to prevent abuse and neglect where possible**
* **ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred**
* **assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.**
 |
| **LSCB** | **Local Safeguarding Children Board** |
| **MAPPA** | **Multi-Agency Public Protection Arrangements** |
| **MARAC** | **Multi-Agency Risk Assessment Conference** |
| **MASH** | **Multi-Agency Safeguarding Hub** |
| **MATAC** | **Multi-Agency Tasking and Co-ordination** |
| **Prevent** | **This is the term used to describe working with and responding to people who appear to be radicalised.** |
| **Swan Unit** | **The Swan Unit was set up in July 2015 in response to CSE concerns within Buckinghamshire County Council. It is a multi-agency team.** |

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1. Working Together to Safeguard Children- A guide to inter-agency working to safeguard and promote the welfare of children, HM Gov (2018) [↑](#footnote-ref-1)
2. A person who acts as a single point of contact for the bereaved family, who they can turn to for information on the child death review process, and who can signpost them to sources of support. (HM Gov,2018) [↑](#footnote-ref-2)