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Safeguarding Children and Adults

Annual Report 2019/20

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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, including 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 2019/20 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 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 2020/21 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.

2. National context

Key legislative changes

2.1 Mental Capacity (Amendment) Act 2019

The Mental Capacity (Amendment) Act 2019 will be introducing a new process to authorise people who are deprived of their liberty – the Liberty Protection Safeguards. The date to have these processes in place in April 2022. The details of any changes will be in the new Code of Practice which has yet to be published. This will primarily affect the community hospitals. The Associate Director for Social Care is leading on this work.

3. Regulatory Activity

As part of the Care Quality Commission (CQC) regulatory activity, the Trust was subject to a well-led inspection 30th July – 1st August 2019. The final report was published in December 2019. There were no concerns specifically related to the Safeguarding Service. The report states:

> "*Staff followed good practice with respect to safeguarding. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.*"

The Trust is rated overall as good.

The Safeguarding Service worked with the Learning and Development Team as part of their OFSTED inspection in October 2019. Overall it was assessed that the Learning and Development Team were making good progress.

4. Safeguarding Service

The safeguarding adult and children teams are now one service within the Corporate Nursing & Clinical Standards 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 is in regular attendance at directorate governance meetings with safeguarding being a standard slot on agendas.

Structure

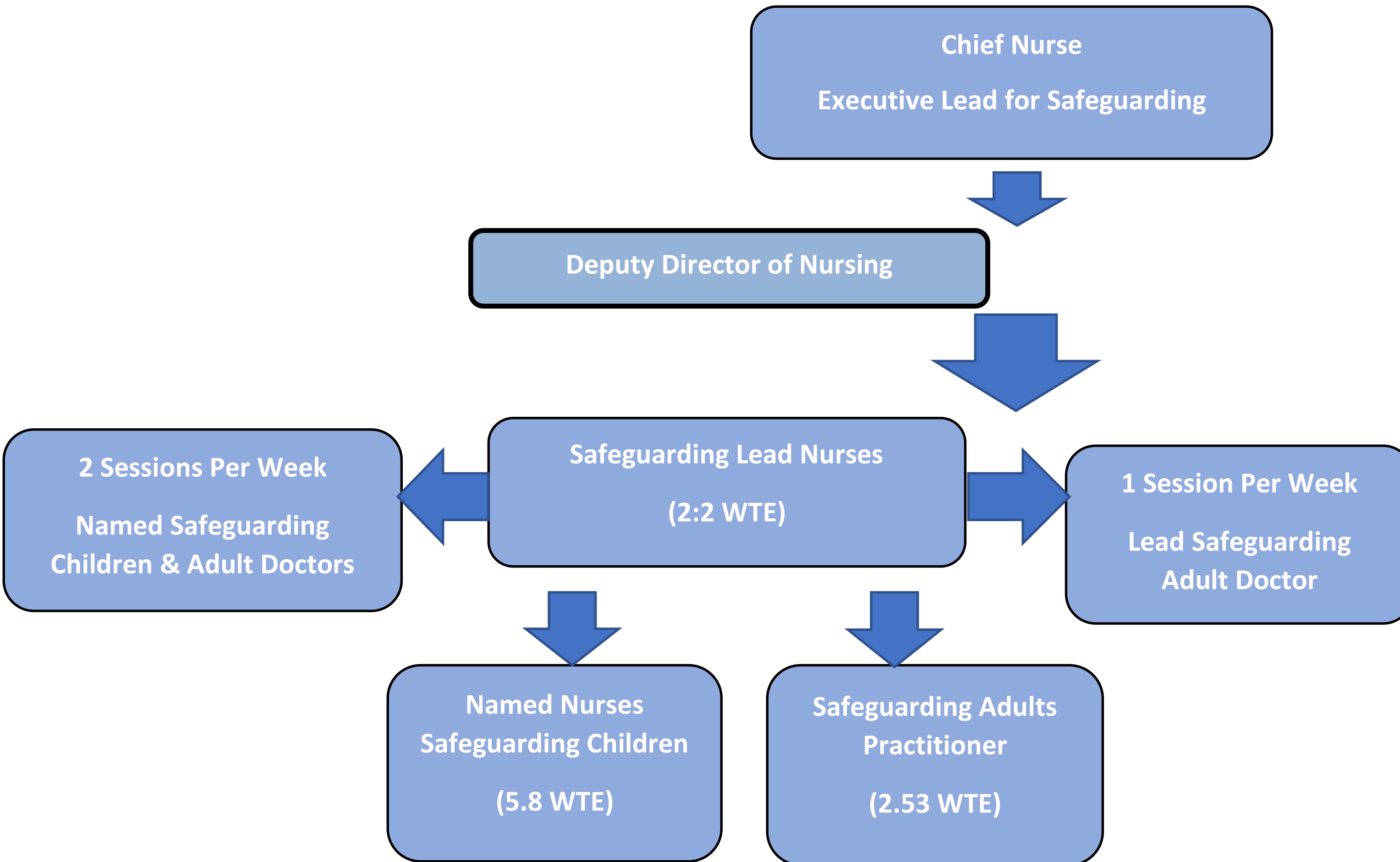
- The Trust Executive Safeguarding Lead is the Chief Nurse.
- The Deputy Director of Nursing is responsible for the safeguarding service
- The Safeguarding Children Team is led by the Lead Nurses and by the Lead Doctor.
- The Safeguarding Adult Team is led by the Safeguarding Adult Manager and the named 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/Partnerships (LSCB/LSCP) (Oxfordshire, Buckinghamshire, Bath and North-East Somerset, Swindon, Wiltshire) and two Local Safeguarding Adults Boards (LSAB) (Oxfordshire and Buckinghamshire).

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



4.2 Team Developments

4.2.1 Safeguarding Adults

The safeguarding adult team has recruited a new member of staff in 2019. The team is comprised of 3.5WTE - three nurses (one RN, two RMN) and one social worker.

With the establishment of the current team, we have been able to increase our involvement in specific developments with clinical teams as required. Particular priorities are:

- In partnership with the social care leads, supporting the mental health teams in Buckinghamshire to manage safeguarding issues for people in their caseload
- Supporting community hospitals to develop their safeguarding work and in particular working with people who are deprived of their liberty.

The team is now involved with the Safeguarding Adult Reviews which are commissioned by the LSABs. As we go forward, this will enable an overview of themes and influence how these issues are taken into account by the Trust services.

4.2.2 Children

The safeguarding children team establishment has not changed this year. Due to vacancies, the team has recruited to a 0.6 Band 6 Safeguarding nurse and a full-time admin within the Oxfordshire multi-agency safeguarding hub (MASH). The Senior Named Professional in BSW returned

from maternity leave in November 2019. The team is now at full staffing complement.   We have had one staff member on long term sick for much of the year.

Next steps: the admin support to the service has remained unchanged for approximately 12 years despite significant expansion of the service and an increase in multi-agency work which involves reviewing records, which is essentially an administrative function. Additional resource across the safeguarding service is in the process of being agreed at a senior level.

5. Safeguarding activity

5.1 Adult activity

Safeguarding adult activity is core work for clinicians. The Safeguarding Adults Policy provides an up to date framework. The safeguarding adult team provides additional and timely support through telephone consultation and review of incidents notified to the team.

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.

	2015/16	2016/17	1017/18	2018/19	2019/20
Consultations	220	341	283	402	380
Referrals to local authorities				132	173
s.42 inquiries undertaken	7	32	22	38	42

The changing numbers reflect the development of the safeguarding adults team over the past 5 years. Collection of information has improved. The expansion of the team has allowed for different areas of work to be taken forward. 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.

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 voice of the service user is paramount in all work to safeguard individuals and is a priority for teams.

There are agreements in place with the local authorities (known as s.75 agreements) that enable 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 change in activity data is reflection on changes in how the Councils and Trust work together.

Next Steps

To develop an audit programme that reflects the Quality Assurance Framework that is being put in place in Buckinghamshire.

5.2 Children activity

5.2.1 Consultations

Individual advice and consultation are 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. The calls have reduced by approximately 300 to 1369 in 2019/20. This could be due to the embedding of children's social care no names consultation service in Oxfordshire and safeguarding supervision being commenced with Talking Space plus and Healthy Minds to support their supervisors.

Calls from Talking Space/Healthy Minds decreased from 569 in 2018/2019 to 401 in 2019/20.

Directorate	No of consultations 2019/20
Oxon & South West Mental Health	611
Bucks Mental Health	326
Community Health	414
Specialised Services	18
Total No of consultations	**1,369**

Previous dip sample evaluations regarding the consultation line have been very positive. A dip sample evaluation has not been completed in 2019/20. This will be undertaken in 2020/21.

5.2.2 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.

There has been a significant increase in the amount of safeguarding review activity. This also generates additional work across services to implement recommendations.

The number of team visits has reduced. There had been a high number the previous year due to visits associated with the trustwide safeguarding audit.

Safeguarding supervision sessions have increased as we now offer supervision to more services.

MASH enquiries processed have increased in both Oxfordshire. The County Council are undertaking some data analysis to provide more detail around this.

MARAC information shares in Oxfordshire have increased.

Area of Work	Number completed 2018-2019	Number completed 2019-2020
Serious Case Reviews/Children Safeguarding Practice Review	**3**	**7**
Partnership Reviews	**0**	**5**
Safeguarding 136 visits	**5**	**6**

Level 2 & 3 training sessions delivered	**39**	**34**
Additional workshops	**11**	**9**
Team visits	**31**	**16**
Safeguarding Children Supervision sessions	**129**	**147**
Trust audits	**1** **(feedback from staff related to 2017 audit)**	**2**
LSCB audits	**6**	**6**
Support for staff to write court reports	**26**	**26**
Support for staff to attend court	**0**	**1**
LSCB sub-groups attended	**113**	**54**
Multi-Agency Public Protection Arrangements (MAPPA) information shares	**59**	**43**
MASH enquiries processed	**Oxon: 2,964** **(average 11 a day)**	**Oxon: 3,336** **(average 13 a day)**
	Bucks: 383 processed **78 open cases**	**Bucks: 364 processed** **110 open cases**

Multi-Agency Risk Assessment Conferences (Domestic Abuse) meetings attended	**Oxon: 25**	**Oxon: 29**
	Bucks: 30	**Bucks: 13**
MARAC information shares processed	**Oxon: 214**	**Oxon: 280**
	Bucks: 163	**Bucks: 98**
FGM cases reported to NHS digital	**6**	**5**
Child Death Overview Panel cases processed	**Oxon: 25**	**Oxon: 29**
	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.)	**Bucks: 12**
	BSW: 9	**BSW: 2**
Rapid response meetings attended	**Oxon: 9**	**Oxon: 10**
	Bucks: 2	**Bucks:0**

	BSW: 2	**BSW: 2**
Allegations against staff **(Unless indicated allegations did not proceed to a formal investigation)**	**Oxon:1**	**Oxon:1**
	Bucks: 0	**Bucks:1**
	BSW: 3 **(2 went to formal investigation)**	**BSW: 2**

5.3 Audits

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

Over the past 2 years there has been an extensive piece of work which involved a wide ranging safeguarding audit across all areas of the trust in 2017/18 followed by smaller follow up audits in 2018/19 to provide assurance about areas that had been identified as requiring improvement.

It was agreed that for 2019/20 we would focus on a small number of key areas of practice as the previous year's audits had not identified any areas of concern that indicated that a further large trustwide audit was required. In addition, the teams have been involved in a number of multi-agency audits via the safeguarding partnerships.

Supervision audit

The main trust audit was around safeguarding children group supervision. The overall rating of the audit was good. 91 staff responded to the audit request. 90% of the respondents reported they attend safeguarding supervision; find it valuable in developing plans to meet the safeguarding needs of children and families and supports their own confidence to implement safeguarding practice. For the 8 staff who reported they do not attend safeguarding supervision sessions they demonstrated they knew where to access safeguarding materials and had opportunities to discuss safeguarding concerns within their clinical supervision processes.

An identified area for improvement related to the documentation processes for the safeguarding supervision sessions. Frequency and accessibility of sessions were identified as factors restricting clinical staff attendance.

Being able to think in this way as a team in the safeguarding supervision has helped us to recognise the importance of a multidisciplinary approach which has been containing for the child and family at a very worrying and complicated time.
CAMHs psychotherapist

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Immediately after the supervision the core group of professionals met to discuss the way forward with the case and set collective actions that we wanted to see to progress the situation further. This family were then subjected to further assessment and review by all the professionals involved, and after an initial reluctance, they have responded well. It is likely the LAC will become a CIN in the coming months

Health visitor Oxon

Actions following the audit were:

- Standard Operating Procedure to be developed for Safeguarding children team supervision facilitators regarding recording sessions and storage of records.
- Discussion with Service managers and team leaders to review current teams receiving safeguarding supervision, frequency of sessions and duration of sessions.
- Staff awareness of when safeguarding supervision sessions are happening to be reviewed.

In Buckinghamshire the service undertakes a quarterly audit of attendance at case conferences and whether a report has been submitted. Non-attendance is highlighted to team managers. It is also reported to commissioners and the performance and quality improvement sub-group of the BSCP. A report is not produced, but figures and context are part of the information dashboards submitted.

In addition, the team has been involved in several multi-agency audits which are detailed in section 6.4 below.

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. All SARs are by their very nature complex.

In Oxfordshire during 2019/20 there were two SARs related to service users and one thematic review encompassing the deaths of 9 individuals who were on the homeless pathway. These three reviews are reporting in 2020/21.

In Buckinghamshire there has been one new SAR commissioned in 2019/20 which is reporting in 2020/21. SARs from previous years continue to be relevant and action plans are being developed. A key theme is about how agencies engage with people who are perceived to be self-neglecting and making assessment tools effective in influencing interventions.

It seems likely there will be common themes for those people self-neglecting and the thematic review for people who were on the homeless pathway.

6.2 Children - Serious Case Reviews/ Child Safeguarding Practice Reviews

Child safeguarding practice reviews have replaced serious case reviews previously carried out by Local Safeguarding Children Boards as detailed in Working Together 2018.

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.

Activity around child safeguarding practice reviews and outstanding actions are included in quarterly reporting and in the Trustwide annual multi-agency incidents report to the Quality Sub Committee on Safety.

6.2.1 Child Safeguarding review activity which has involved Trust Services

Area	Published SCRs	Completed & awaiting publication	Ongoing SCRs	Partnership review	Outstanding actions
Oxfordshire	0	2	1	3	3
Buckinghamshire	0	2	1	1	0
B&NES	0	1	0	0	0
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.

It is anticipated that there will be an increase in activity around CSPR actions for 2020/21 due to the high number of reviews currently in progress.

6.2.2 Implementing the learning from CSPRs

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/CSPR both internally and in conjunction with the LSCB/LSCPs. This has included:

- Working with LSCB/LSCP on multi-agency learning events regarding learning from SCR/CSPRs
- Development of joint activity pathway with children's social care and adult mental health
- Development of guidance for children who are transferring out of the area and reach level 2 or 3 on the Threshold of Needs matrix. This pathway is included in CP47 the policy for the transfer and transition of patients and their care between services and providers
- Development of a consistent approach around frequent attenders who present to acute, out of hours and ambulance services
- Encouraging staff to request dual access to community and mental health electronic patient record, and work with the information governance team to facilitate this process.
- Supporting the Trust's working with families group
- Continuing to push forward work relating to domestic abuse through the domestic abuse working group

- 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
- The learning from reviews is included in a monthly safeguarding children newsletter/update and shared at governance and locality meetings

6.3 Child Death Overview Process (CDOP)

6.3.1 Trust involvement in CDOP process

The statutory requirements are set out in the revised Working Together to Safeguard Children 2018 which have been implemented in 2019/20.

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 and represent the Trust on the Child Death Overview Panel. 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.

Information was reviewed for 34 child deaths in Oxfordshire. There was an increase in the number of children who had life limiting conditions dying unexpectedly in 2019/2020.

26 child deaths were reviewed in Buckinghamshire. Safeguarding team and CAMHS managers have attended CDOP panel meetings in Buckinghamshire for cases open to the Trust to support learning to be shared.

Safeguarding team and clinical staff have supported attendance at the child death review meetings in Oxfordshire. No Child death review meetings were scheduled for children known to the Trust in Buckinghamshire.

Identification of children who are Berkshire residents but access Trust services in Buckinghamshire and Oxfordshire has supported the safeguarding team having stronger links with the Berkshire CDOP team. 12 cases were reviewed, and no involvement was identified.

Requests were made for 4 cases to be reviewed by CDOP teams in BSW. Only one child was known to the Trust.

Safeguarding team have attended one thematic review of cases across Oxfordshire and Buckinghamshire.

Next steps:

In 2019/20 new child death processes have been implemented, to update pathways.

6.4 Multi agency audits

6.4.1 Oxfordshire

Neglect peer review and follow up

Action as part of the Neglect Strategy to ascertain the quality of practice and to highlight positive and restorative casework, noting learning and reflecting quality of practice and outcomes. To review timeliness of response in relation to children subject to long term statutory intervention due to neglect. Findings made will aid learning in order to strengthen multi-agency practice in response to neglect. This audit is part of an ongoing multiagency review, which has been on hold during COVID 19 however reconvening in July 2020.

Housing audit.

Following findings from previous reviews, this aim of this audit was to analyse whether housing issues were properly considered within assessments of families' needs and whether housing providers were included in multi-agency communication.

Children's mental health

This audit topic was selected by PAQA to evaluate the experience of children identified as a 'child in need' or subject child protection planning, and children in care who have mental ill health. It focused on children aged 10–15 years, in line with the current theme of Joint Targeted Area inspections (JTAI).

Themes from the audits

- Importance of recognising the experience of individual children within sibling groups.
- Evidence of good information sharing between agencies.
- The caring responsibilities of children were not always understood.

6.4.2 BSW

There were audits in both B&NES and Swindon around the Joint Thematic Area Inspection (JTAI) theme of children's mental health. Findings highlighted evidence of good multi agency working. It was also noted that for those children who had to change areas due to suitable placements being out of area, this was very disruptive to their multi-agency care due to the change of professionals.

6.4.3 Buckinghamshire

There were 2 multi-agency audits. One on children at risk of exploitation which was focused on children's social care and the other on child protection and domestic abuse

https://www.bucksscp.org.uk/about-the-bscb/audits-other-learning/

Key themes include:

- Social care assessments, plans and actions taken were not clear in relation to exploitation.
- Missing episodes were not closely linked to risk of exploitation.
- Voice of the child was not consistently being heard over the parents' voices.
- Professionals at conference needed to voice what they can do, rather than relying on external services and understand each other's roles in plans.
- The need for greater awareness of coercive control.
- Agencies needed a victim focussed approach and a holistic assessment needs to take place (history, all agencies involved, professionals that are working with the family).

Since the audits, there has been extensive work in Buckinghamshire with the development of the exploitation hubs and closer links with children who are missing and exploitation. CAMHs are involved in the hubs to support delivery of children's plans. The safeguarding service are involved

in developing the multi-agency domestic abuse delivery plan and the Trust's domestic abuse working group continues to support staff to identify and respond to families experiencing domestic abuse.

Outcomes

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)

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

There is a MASH for safeguarding adults in Buckinghamshire but not Oxfordshire. The Senior Safeguarding Adult Practitioner sits within MASH in Buckinghamshire. This has facilitated better communication with our partners and monitoring of people who are identified as going missing. In Oxfordshire the number of MASH cases processed has increased significantly. This is in part because we now collect data for all MASH cases processed by the health team which includes the Trust and Oxford University Hospitals.

Since September 2019 strategy meetings have been processed through the MASH. This has created significant additional work to gather the health information and then for the Named Nurse to share this at the strategy meeting. It has been a positive development as it means that health information is included at an early stage of the assessment process, which was a requirement of Working Together 2018.

Next steps:

A review of the resource for the health team in the Oxfordshire MASH is required due to the increase in cases processed in the MASH along with the additional work relating to strategy meetings.

In Buckinghamshire, 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 LSCB/LSCPs 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 rolled out across the county. The use of Multi-agency chronologies is being developed in order to promote broader understanding of risk and to have a greater understanding of 'the lived experience of a child' from a multi-agency perspective. Workshops have been delivered and will also be included in all OSCB training. A programme of work is ongoing for these tools to be held on the electronic records.

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

Next steps:

To take forward the OSCB neglect priority, partners are required to develop an internal action plan. A working group has been convened to co-ordinate development and implementation of the plan.

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.

CPIS went live on the 30th July 2019. Digital Transformation NHS South, Central and West requested assurance that CPIS was operating correctly. A request was made by NHS Digital that a dip sample of 5 cases were reviewed to establish if information was being shared between the local authority, Urgent Care via CPIS and that children known to be on child protection plans were present on CPIS on Adastra. This was completed and identified that the system was operating well.

6.8 Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards

The Mental Capacity Act 2005/Mental Capacity (Amendment) Act 2019 is about service users being autonomous (where possible) and making relevant decisions with the support of staff and other relevant agencies.

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

This is an area of work that continues to develop within the Trust. There is now a formally identified lead for the MCA who is the Associate Director for Social Care.

The Trust has continued to monitor the applications made for a deprivation of liberty authorisation and ensure people are protected in line with the Human Rights Act 1998. This has been a particular focus for the community hospitals as people are not detained under the Mental Health Act within the community hospital environment. It is part of the quality improvement work within that service.

Next steps:

From April 2022, 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. Systems will be developed in response to the revised MCA Code of Practice which is being developed nationally and has not yet been received.

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 Government's 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 which includes health organisations. The Prevent programme is under review and the outcome of this review is expected in 2021.

A Prevent policy is now in place and has replaced the Prevent protocol.

Next steps:

To meet requirements of the Prevent Duty 2015; NHS England Prevent training and competencies framework and Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: January 2019 and ensure the correct prevent training is on the appropriate staff training matrix.

7.2 Domestic Abuse

100% attendance/information share at multi-agency risk assessment conferences (MARAC) around domestic abuse

A domestic abuse working group which has membership from services across the Trust has been established since February 2019. 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.

Actions completed by the group in 2019/20 are as follows:

- Internal domestic abuse pathway to support staff included in the revised domestic abuse policy
- Roles and responsibilities of trust Domestic Abuse Champions agreed and support meeting convened
- Domestic Abuse resources acquired to display in patient areas
- Business case submitted and accepted to make domestic abuse stalking and honour-based violence (DASH) checklist available on the electronic record
- Template developed for services to record any domestic abuse work/interventions to understand provision across the Trust.

Next steps:

To ensure staff are trained to level 1 or 2 to respond to domestic abuse in line with the requirements of NICE guidance.

To provide internal support to Domestic Abuse Champions bi-annually.

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

The MATAC is a perpetrator focused approach to tackling domestic violence reoffending within standard and medium risk cases. MATAC meetings will now take place within the joint tasking meeting (JTM) held every month. The JTM meeting is managed by the community safety team from the district council. Discussions are taking place with the current JTM representative from adult mental health and the safeguarding service to agree management of the JTM/MATAC and how information can be shared appropriately.

7.2.2 Domestic Abuse Operational Group - Oxfordshire

There is representation from the safeguarding team at the Oxfordshire domestic abuse operational group. Members have been involved in the development of the county's domestic abuse strategy. Consultation events have been delayed due to the COVID-19 pandemic.

A task and finish group is meeting aimed at addressing gaps in support for victim survivors and children needing recovery programs and counselling or trauma-based therapy. The purpose of the meeting is to address an issue identified in our year 1 delivery plan under the strategic aim, PROVISION.

The Multi-agency Risk Assessment Conference (MARAC) protocol and Thames Valley information sharing agreement has been signed off by the Trust.

Next steps:

Publication of the Domestic abuse strategy.

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

The Dynamic MARAC is supported by the Senior Safeguarding Adult Practitioner with cover from other members of the safeguarding service. A review completed in December 2019 of MARAC partners in Buckinghamshire identified that the new arrangements are promoting consistency of approach and increasing the potential for a positive impact for victims.

There is a representative from the safeguarding team on the Buckinghamshire MARAC steering group.

7.2.4 Domestic Abuse Strategic meeting Buckinghamshire

The Domestic abuse strategic meeting has been disbanded and domestic abuse will come under the umbrella of the Safer Stronger Bucks Partnership Board. The Trust is providing evidence to support agreed priorities and key actions for the Safer Buckinghamshire Plan and contributing to the domestic abuse delivery plan.

7.3 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 been 31 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.

No cases of FGM were reported to Trust staff in Buckinghamshire or BSW. Safeguarding children process would be followed if cases were reported.

In response to the Modern Slavery Act 2015 the Thames Valley continues to have an Anti-Slavery Network which has three regional sub-groups. These three subgroups are Oxfordshire, Buckinghamshire and Berkshire. The safeguarding teams represent the Trust at the Oxfordshire and Buckinghamshire networks. The safeguarding service has shared information with the Elmore modern slavery research project that has been commissioned by Oxford City council. The report is expected in 2020/21.

Next steps:

The Trust will take account of the recommendations of the report.

7.4 Child Sexual Exploitation

The forensic CAMHS, CAHBS, Youth Justice Liaison and Diversion and Horizon Teams all continue to link with social care, police and education colleagues in a number of cases where young people are involved in either sexual or criminal/drug exploitation. Such young people frequently have highly complex needs including high levels of traumatic experience. These trust services have particular expertise in supporting other professionals and providing direct clinical input with young people who are frequently difficult to engage.

Dr Nick Hindley, Consultant Forensic Psychiatrist and lead doctor for Safeguarding children.

There have been changes in the organisation of exploitation services/meetings within Oxfordshire and Buckinghamshire.

Buckinghamshire now has an Exploitation hub which is responsible for the risk management of exploitation concerns, taking a multi-agency approach to reduce risk, protect and disrupt. CAMHs attend Multi-agency Child Exploitation (MACE) meetings fortnightly. The MACE meeting identifies patterns, i.e. areas of crime, patterns of missing and pass this information into the STEMM (Strategic Exploitation and Missing Meeting). The STEMM is the senior strategic meeting with partners agencies. The purpose is to determine the local picture, develop strategies to reduce risk and crime, review and deploy services in a targeted approach. There is senior representation from CAMHs on the STEMM. Numbers of cases open to CAMHs and discussed at the MACE meeting are shared with CCG and Bucks Children's Partnership.

The exploitation sub-group has been temporarily suspended by the Chair of the Bucks Safeguarding Children Partnership while the terms of reference are reviewed.

Oxfordshire have introduced Missing and Exploited Panel meetings, which take place monthly in North, City and South. The panel meetings are being attended by CAMHS team mangers, team manager Phoenix team and the Specialist Nurse for Exploitation. Network Meetings taking place North, city, South monthly are being attended by School Health Nurse Locality Leads and CAMHS deputy Team Leaders. Initial feedback from staff is that there are barriers to information sharing due to clarification of an information sharing agreement. This has been fed back to the Exploitation sub-group.

The Child Exploitation Hubs are still in the planning process and have been delayed until September due to the COVID-19 pandemic.

In both areas the safeguarding board/partnership exploitation screening/indicator tools have been reviewed and updated and are available on their websites.

Bucks: http://bscb.procedures.org.uk/assets/clients/5/Exploitation%20Indicator%20Pathway%20-%20June%202019.pdf

Oxfordshire: https://www.oscb.org.uk/wp-content/uploads/2019/11/Child-Exploitation-ScreeningTool.pdf

BSW: 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.

In 2019/20 there were 35 calls relating to CSE and 8 to modern slavery (which includes criminal exploitation). This compares to 49 calls in 2018/2019 and 54 in 2017/18. Decrease in calls to the consultation line could suggest that clinicians are more confident in their response to child exploitation.

Themes from these calls include:

- Risk of online exploitation e.g. being asked to share sexual images
- Risky sexual behaviour
- At risk of exploitation - due to issues in at home such as parental substance misuse
- Children at risk of exploitation with additional needs such as ADHD/ASD

2 referrals to children's social care were made by mental health services with the category of exploitation and recorded on the patient electronic health record. Currently Oxford Health community services are unable to record a category for referral. This will change in July 2020.

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 continue to develop services which respond effectively to child exploitation.

8.Training

The requirements for safeguarding training in relation to both children and adults are outlined in the intercollegiate documents (Adult Safeguarding: Roles and Competencies for Health Care Staff. First edition: August 2018 and Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. Fourth edition: January 2019).

Joint work continues with clinical practice teachers (CPTs) 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. We anticipate in 2020/21 that staff will be able to record safeguarding training including CPD hours on a staff held document.

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. The overall target has been met across the organisation.

8.1 Effectiveness and Evaluation of training

Training programmes are reviewed annually and updated to ensure materials reflect latest research and/or legislation. The primary themes of the current safeguarding have been contextual abuse, domestic abuse and neglect. This is in response to outcomes from adult and children reviews and safeguarding board/partnership priorities. In 2020/21 the changes in gangs and how they operate is likely to be included.

A review of the evaluations evidence that learning needs have been met.

Really liked the presentation and how you pitched it. The information was great and liked how you touched on our place as workers, our need for others to support, and offer supervision and other perspectives. I was recommended this training by an experienced colleague...who said it was the best safeguarding training she had come across.
BSW CAMHS worker

Thanks for the training today. I really liked hearing about the more modern risks that face young people such as county lines and sexting and those are the things that are really relevant to our everyday work.

CAMHS OT

Next steps

In 2020/21, capturing evaluation data will be enhanced by use of the Slido application which allows delegates to give instant feedback on training.

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.

9. Supervision

Members of the safeguarding adults team undertake clinical supervision with teams and individuals on a 4 – 8 weekly basis. Supervision is provided for specific safeguarding issues on an ad hoc basis in addition to this. This may be by appointment or through the consultation line and at a time when individuals are working through complex 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, Swindon.
- Adult Eating Disorders Buckinghamshire
- Family Assessment and Safeguarding Service (FASS) team

- Improving Access to Psychological Therapies (IAPT) Supervisors Oxfordshire and Buckinghamshire
- Complex Needs Service Oxfordshire and Buckinghamshire
- Phoenix team
- Community Children's Nurses.
- Specialist School Nurses.
- Integrated Children's Therapies Services
- Bowel and Bladder Team

9.1 Safeguarding supervision evaluation

The evaluation completed in 2019/20 is outlined in section 5.3. Feedback below received June 2020.

Safeguarding supervisions have been such a great help when working with vulnerable families. It is a peer support and a safe place to discuss our most vulnerable families.

During safeguarding supervision we are able to talk about our complex cases and discuss our plans or ask for further support from colleagues and supervisor.

During the meetings you gain information and strategies that stays with you and you tend to feel more confident when dealing with complex cases.

What I like most about the meetings is that there are always well supported and feel that we leave with a robust plan.

Safeguarding supervision has a robust role within our service as we tend to support more and more complex families and their support is priceless.

I always feel well supported and reassured with our safeguarding nurses and they have always helped me to make the right decisions.

10. Priorities and action taken 2019/20

	Priorities 2019/20	**Action Taken**
1	Complete actions identified from domestic abuse working group.	Domestic abuse policy in place which includes an internal domestic abuse pathway for staff. Domestic abuse briefing developed for staff to take to team meetings. Template completed for recording service areas interventions relating to domestic abuse. Internal domestic abuse champion group convened. Domestic abuse training promoted to staff. Domestic abuse resources shared across the trust.
2	Develop combined safeguarding adult and children policy to include review of Prevent protocol.	The safeguarding service came together last year, and this is a work in progress. Prevent is a separate policy which was signed off by Quality Committee in May 2020.
3	Complete action plan to address areas of improvement identified from feedback	All actions relating to this audit are completed.

	from staff relating to 2017 safeguarding audit.	
4	Completion of additional guidance for staff regarding s.136 Place of Safety.	Guidance has been developed to support staff
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.	Roles and responsibilities of the Key Worker has been developed with partner agencies and shared with services.
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.	This is on-going work. Ways of accessing reports from the system owned by the police are being explored.
7	Chronology and neglect screen tools to be available within Care Notes.	This project was delayed due to other trust priorities by the electronic health record team. This will be revisited in 2020 as part of the trust neglect action plan.
8	Safeguarding service to engage as necessary for Child protection information system (CPIS) go live.	CPIS is live and has been audited. The audit confirmed the process is working.

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.	Documentation is in place. Work to further develop the Mental Capacity Act and introduce the Liberty Protection Safeguards is being lead outside of the Safeguarding Service.
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.	The Mental Capacity (Amendment) Act 2019 was passed in April 2019. We are still awaiting the new MCA Code of Practice before this work can be progressed. Work to further develop the Mental Capacity Act and introduce the Liberty Protection Safeguards is being led outside of the Safeguarding Service.

11	Safeguarding service to engage in development of Oxfordshire Domestic abuse strategy.	Development of the strategy was delayed due to COVID. Consultation will commence later in 2020.
12	To support review of Multi-agency Risk Assessment Conference (MARAC) protocol for Oxfordshire and result in sign off.	MARAC protocol has been reviewed and signed off.
13	Strategic vision in Oxfordshire re Modern Slavery to form the basis for the development of a mission statement for the Trust.	Mission statement is in place for the Trust. Completion of the Elmore Modern slavery research project and development of the violence reduction work by the police will inform the strategic vision. This will be considered in 2020/21.
14	To support research project about Modern Slavery that has been commissioned by Oxford City Council.	The data collection has been completed for this and the report is awaited. The Researchers provided positive feedback about the support and participation of the Oxford Health staff.
15	Support Anti-Slavery Day on 18th October 2019.	Information was shared across all directorates to raise awareness of modern slavery.
16	To engage with multi agency partners across all areas to develop strategic response to wider child exploitation.	The Trust has been engaged in developing the new exploitation specialist services within geographical areas.

	To commence a Trust exploitation working group.	A virtual exploitation group has been created to share information and good practice.
17	Update training strategy to reflect changes relating to safeguarding children and adults' intercollegiate documents.	Complete
18	Integrate children therapy services with children community nurses safeguarding supervision.	Complete
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.	Complete

10.1 Safeguarding service priorities 2019/20

	Priorities for 2020/21
1	Prevent training to be included in the training matrix for staff.
2	Implementation of the Training Passport and recording of level 3 training for both safeguarding children and adults.
3	Maintaining a consistent safeguarding service during the Covid Emergency and participating in the recovery work to improve practice.
4	Developing on-line and virtual training options for safeguarding adults and children.
5	Maintaining active engagement with Violence Reduction and exploitation work.
6	Support the establishment of the Working with family's group to promote all age safeguarding
7	Develop a framework to support adult teams to take account of the needs of children
8	Further development of working across the safeguarding partnership in Buckinghamshire. A Quality Assurance Framework has been agreed which will require audit of service user and staff perceptions of the safeguarding process.
9	Supporting the organisation to implement/embed the relevant recommendations from CSPRs and SARs.
10	Develop an audit programme for safeguarding adults in partnership with other agencies that reflect the quality assurance framework in place in Buckinghamshire.

Appendix 1

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.**

Appendix 2 - Covid report presented at Quality Sub-Committee Safety Meeting 30th June 2020

Safeguarding Committee

SAFEGUARDING SERVICE HIGHLIGHT AND ESCALATION REPORT

- **The safeguarding committee did not take place in Q4 in line with Trust governance meetings being paused due to priority work to manage COVID 19 response. This report is a summary of the core safeguarding service provision that continued, including themes and trends, during the COVID-19 pandemic.**

Summary and recommendations:

1. **COVID 19 Safeguarding Service**

- The Safeguarding service business continuity plan has been followed and has worked well.

- In line with prioritisation planning guidance provided by NHSE and supported by the designated nurses, essential multiagency meetings including some safeguarding partnership sub-groups, safeguarding review work, case conferences, strategy meetings continue. These are taking place virtually and are working well.

- In line with trust policy, the safeguarding service are working from home. A risk assessment has been undertaken and measures are in place for those who are working from Trust premises. For example, we had a new member of staff who joined in April and needed inducting on to multi agency systems which needed to be done at a trust site.

- One member of staff has been absent and self-isolating and two members of staff have been shielding. No members of staff have been absent and unable to work throughout the period since lock down.

- Communication is maintained within the service by a virtual daily meeting. This has facilitated good communication and allowed quick identification of any themes across the adult and children's teams.

- Communication relating to staff safeguarding support and training has been regularly updated via governance meetings, weekly (now fortnightly) newsletter and made available on the Trust intranet throughout this period.

- Adult and children safeguarding consultation lines have been a priority and continue to operate as normal. The safeguarding service has been recording those safeguarding consultations that are related to the impact of COVID-19.

- Group safeguarding children supervision is in place virtually and extra sessions offered as required. Feedback has been positive from staff and it has worked well in small groups and with individuals. In some services such as mental health, there has been an increase in numbers accessing supervision. In children's community services, where there has been redeployment to support the COVID work, there has been a reduction in attendance at safeguarding children supervision.

- Face to face safeguarding training is suspended both in Oxford Health and by the safeguarding boards. Training is available via e-learning and course materials are accessible on the L&D portal. With the introduction of paid placements for 2nd and 3rd year students during this period, the service has supported face to face safeguarding training in their trust induction. Current training compliance is good. The overall adult and children safeguarding training compliance figure is only slightly lower than for Q1 2019/20 (87% compared to Q1 2020/21 90%). Level 3 safeguarding children compliance in community services has increased slightly from 85% in Q1 2019/20 to 88% in Q1 2020/21.

- Mental capacity act training compliance has increased from Q1 2019/20 68% to 76% Q1 2020/21 but remains below 85% target.

- In all relevant geographical areas, the safeguarding service involvement in MASH has continued with staff working virtually. Referrals into MASH had been reported as reduced in April however, in May referrals in Oxford increased to normal levels from 200 to 300. This is back to the same levels as May 2019.

1.1 Safeguarding Consultations

Access to safeguarding consultation was maintained throughout the COVID period. Consultations initially reduced after lockdown for the safeguarding children team and then have returned to normal pre-pandemic levels. Out of 82 safeguarding children consultations recorded in April 2020, 11 were marked as specifically related to COVID.

Themes of the consultations include:

Staff redeployment - staff accessed support via the consultation line to access the informal supervision that working in a team would normally provide. Also seeking support around assessing risk in new caseloads due to re-deployment.

Access to children/families- One School Health Nurse dealt with a teenager via email as the YP didn't want to use the phone. (worry about being overheard by family members.) Clients running out of credit on their phones due to financial difficulties. COVID presenting practitioners with an added layer of complexity in addition to already complex cases. One case, already difficult to manage with query fabricated induced illness practitioner was needing support with how to manage the case when face to face meeting were cancelled at client's request.

Reduced face to face contact – i.e. staff using video links/ telephone to talk to clients instead of face to face. Staff concerns that this makes risk assessing challenging. For example, some clients manipulating the use of technology. A parent shared a photo of a fridge filled with food which was taken from the internet. Families ensuring cameras on their phones are pointed at the ceiling so unable to assess home environment. These circumstances have strengthened multi-agency working and communication to promote a shared understanding of risk.

Escalating Domestic Abuse – Triggers have included financial concerns as well as isolation with perpetrator. Some reporting by the children living in those families. Work has been undertaken to safely share information to clients on how to access support around domestic abuse. Domestic abuse has been highlighted across the trust to support staff to respond to domestic abuse.

For adults, in April 2020, 6 out of 22 consultations were as a direct result of COVID. Two about domestic abuse, one about self-neglect, one about concerns about a care home and one about a poor hospital discharge. For the period between 1st April and 6th June 2020 there have been 17 out of 62 consultations related to COVID.

2. Safeguarding- system wide

2.1 Safeguarding service risk assessment

The safeguarding service has produced a risk assessment relating to COVID-19. This includes activity which gives service level assurance that those children and adults who are identified as most vulnerable are safeguarded. This includes services completing risk management plans around their caseloads and these being reviewed by the safeguarding service. An example of good practice comes from the Family Nurse Partnership, who used a Walking and Talking approach to facilitate confidential discussions with their most vulnerable clients. This model was then shared with other trust services and with partner agencies.

In Oxfordshire children's social care have shared a RAG rated list of vulnerable children on their caseload to assist risk assessment and care planning by clinical teams.

In Buckinghamshire information around vulnerable children and adults on mental health caseloads have been shared with Bucks County Council for cross referencing with the national shielding list to enable a coordinated response to those identified as most vulnerable. See full risk assessment embedded below.

risk assessmemt
safeguarding servic

2.2 Additional COVID 19 meetings

Additional COVID meetings are taking place across all geographical areas. These are attended by the safeguarding service/senior leaders. These include system wide meetings across partners and health provider meetings. These have been effective in improving communication, facilitating stronger relationships and identifying emerging themes quickly.

In Oxfordshire a Safeguarding COVID19 pandemic prioritisation plan has been developed by the designated safeguarding lead at the CCG for health providers. This is updated as required. This meeting was initially weekly and has now moved to fortnightly. Work is beginning on the recovery phase and the model used is reflective of the one being used in Oxford Health at this point.

In Buckinghamshire there is a systemwide meeting which has been meeting weekly and has now started meeting fortnightly. This meeting has been using the national and local public health and social care data available to promote partnership working across Buckinghamshire during this period.

There were initially weekly meetings with each of the Designated Nurses for B&NES, Swindon and Wiltshire which is now a combined meeting. In addition, there was a weekly CAMHs COVID command meeting for BSW.

Reports from other countries have shown that incidents of domestic abuse increased significantly following the outbreak, and this is already visible in our national services. Local information has suggested that this increase of referrals into services has not been experienced. As a response contact details of local domestic abuse services have been highlighted to professionals and the public. The safeguarding service has not had to date an increase in consultations relating to domestic abuse.

In Oxfordshire there has been a multi-agency meeting specifically related to domestic abuse. These meetings have ensured that there has been consistent information cascaded to partners and has identified local themes as they emerge. Information from all geographical areas has been shared with staff through governance meetings, TEAMs groups and safeguarding newsletters.

As the most vulnerable people become more visible and accessible, discussions at system wide meetings suggest that there will be a surge of safeguarding activity with the move out of lockdown. Activity will be closely monitored across the system and discussions are taking place around managing this increase.

2.3 Changes to child death review process during COVID-19

The national child death reporting system was updated to include COVID-19 related reasons for a child death. There were 5 child deaths across the geographic areas that OHFT provides services for from January – April, none of which were COVID related.

As per normal processes, for the deaths which have occurred during the COVID-19 period, staff have continued to support families. Managers and the Safeguarding Service have supported staff who have been working with these families.

For Oxfordshire due to managing staffing recourses across partner agencies all child death review meetings (CDRM) are suspended, in line with national guidance. Joint agency review meetings and the Child Death Overview Panel are taking place virtually and working well.

2.4 Safeguarding Adults and Children Reviews

Government guidance acknowledges that a rapid review report might not always be achievable within 15 days during this period and hence there is some local flexibility around this. However, it is still anticipated that child safeguarding practice reviews should be completed within a 6month period.

There have been no new child safeguarding practice reviews initiated in this period. Panel meetings and practitioner events for reviews already underway are taking place virtually to move on recommendations and actions. Details of existing reviews are included in the attached report.

During this period there has been scoping for 8 Safeguarding Adult Reviews in Buckinghamshire and Oxfordshire together. None of these have been explicitly COVID related.

Internal action planning for case reviews continues. Whilst there was a delay due to cancellations of meetings in the initial period of the pandemic, this work is now being resumed. For example, the working with families meeting.

2.5 Moving to recovery phase

- The priority of the safeguarding service this year is to look at the training provision and developing virtual options.
- Virtual supervision with some smaller groups will be considered as an option going forward.
- The daily team meeting will continue.
- Progressing serious case review actions
- Safeguarding service to continue to access external supervision
- Maintain multi-agency communication that has been strengthened during the Covid period.
- Acknowledging that some areas of safeguarding have changed, and models of exploitation developed in the current climate. For example, perpetrators are focusing on online exploitation. We will need to consider how our services respond e.g. to support young people with online safety.

3. Conclusion

During this period the safeguarding service has not seen a change in the expected activity levels, and the service have adapted well to the new ways of working and continued to work closely with our partner agencies.

Author and title:

Jayne Harrison/Lisa Lord, Lead Nurse Safeguarding Children.

Moira Gilroy, Safeguarding Adults manager.

Appendix 3 BSW annual report 2019/20

The annual safeguarding report produced for BaNES, Swindon and Wiltshire CCGs is embedded below.

BSW annual report
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