**Report to the Meeting of the**

**Oxford Health NHS Foundation Trust**

**Board of Directors**

**Safeguarding Children and Adults Joint Annual Report 2020/2021**

**For: Assurance and Approval**

**Executive Summary**

2020/21 was overshadowed by Covid19. The information in this report should be read within this context. The Coronavirus Act 2020 allowed for easement of some statutory responsibilities. None of these easements were implemented within the local authority areas in which the Trust provides services. It was explicit that safeguarding services would continue as business as usual. A report on the safeguarding service response to COVID 19 was submitted to the Trust Quality Special Safe COVID subcommittee in June 2020 and is added as an appendix to this report.

A joint Safeguarding Children and Adult self-assurance/S11 audit for Oxfordshire was completed and following a peer review event, the Trust was rated green.

In Buckinghamshire, the self-assurance process is being completed separately for children and adults. This is being completed for adults during the first months of 2021/22 and was completed for children in March 2021. Partners are awaiting the final report and recommendations.

There was no inspection from CQC that involved the Safeguarding Service.

**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 contributes to the agendas of local safeguarding children boards/partnerships via sub-groups and must comply with laws and guidance related to safeguarding children. The Trust is a member of the Safeguarding Adult Boards in Buckinghamshire and Oxfordshire.

The safeguarding adult and children teams are 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, serious violence and Prevent.

This report provides the Trust Board with an overview of the progress against the safeguarding children and adult priorities for period 01/04/2020 to 31/03/2021.   It explains the structure of the Safeguarding Service and how it works in partnership with other Trust services and local agencies to influence positive change and support the most vulnerable in society.

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

**Publications, Awards and Team Development**

Members of the safeguarding service have published 2 articles. Three members of the team have completed master level courses.

**Multi-Agency working including public protection work**

The Safeguarding Service represents the Trust in the safeguarding partnerships covered by the Trust. This includes being active members of the Local Safeguarding Adult Boards (LSABs) Local Safeguarding Children Boards/Partnerships (LSCBs/LSCPs) and subgroups.  Additionally, the teams are core members of key multiagency fora including child exploitation, MARAC (Multiagency Risk Assessment Conferences) in relation to domestic abuse, Operational and Strategic Domestic Abuse, Modern Slavery and Female Genital Mutilation (FGM) groups.

Team activity in relation to the Multi Agency Safeguarding Hub (MASH) has increased in Oxfordshire in 2020/21. The MASH has processed 34% more cases in comparison to the previous year. In addition, child protection strategy meetings are now processed through the MASH, and these meetings require attendance by a named nurse.  A requirement for additional resource in the MASH has been escalated to the Chief Nurse and to commissioners.

There was a significant increase in the amount of safeguarding review activity in 2019-2020 which has an impact on workload as recommendations from reviews are taken forward.  Child safeguarding practice reviews have replaced serious case reviews previously carried out by Local Safeguarding Children Boards as detailed in Working Together 2018. In 2020/21 we have seen a decrease in child safeguarding practice reviews commissioned.

There has been improved joint working in relation to Safeguarding Adult work including reviews in Buckinghamshire.

|  |  |  |  |
| --- | --- | --- | --- |
| **Area of Work**  **(all counties)** | **Number completed 2018-2019** | **Number completed 2019-2020** | **Number completed 2020-2021** |
| **Serious Case Reviews/Child Safeguarding Practice Review** | **3** | **7** | **2** |
| **Partnership Reviews** | **0** | **5** | **1** |
| **Safeguarding Adult Reviews** | **2** | **0** | **3** |

The service also supports implementation of recommendations and sharing the learning, and this is detailed in the report.

**Child Death Overview Process**

The statutory requirements are set out in the revised Working Together to Safeguard Children 2018.

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.

**Training, Supervision and Consultation**

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

With Covid there was a temporary interruption as face-to-face training was cancelled. The safeguarding service is now providing training successfully through MS Teams. E-learning is available for some courses.

In 2020/21 safeguarding adults Level 3 training was piloted and is now available to staff. This training is in line with the Safeguarding Adults: Roles and Competencies intercollegiate document published in August 2018. This is a new development for the Trust. The initial evaluations are very positive. As we move out of the Covid restrictions and work pressures, we will be able to work in partnership with other NHS Trusts locally which helps ensure we are meeting the multi-agency element of the requirement of the training.

Safeguarding children training has been reviewed to meet level 3 requirements in line with the amended children intercollegiate document; Safeguarding Children and Young People:  Roles and Competencies for Healthcare Staff. (Fourth edition: January 2019).   This includes agreeing which staff require level 3 competencies and undertaking a minimum of 8 hours education, training and learning and an additional 16 hours of role specific knowledge skills and competencies.

Safeguarding children Level 3 training levels have slightly dropped this year but remain at 85-90% for the community directorate. The mental health directorates have 75-80% of their staff trained at Level 3. Training moved swiftly to a virtual package following the Covid lockdown, and these sessions have been well received by staff. Online options are also available for all levels.

For Level 2 safeguarding training all areas have maintained high levels of 85% and higher.

**Safeguarding service priorities for 2021/22**

1. **Communication**
   1. **The Safeguarding Service will have clear communication in place both within the organisation and with our partners**

**To achieve this:**

1. **Strengthen interface with multi agency partners and health providers**

* Consider the gap around links with team managers in Oxfordshire children’s social care.
* Planning and identifying support when there is a need to challenge partners.
* Identifying most appropriate representatives for key issues e.g. homelessness work following OSAB thematic review.

1. **Widen reach of the service within the Trust**

* Participate in peer reviews
* Widen circulation of safeguarding newsletter through inclusion in governance reports and email signatures.
* Regular attendance at social work forums for safeguarding update.
* Mapping existing groups within the directorates that provide the opportunity for safeguarding information to be discussed.
* Targeting specific information to relevant services, in addition to newsletter circulation.
* Accept and seek opportunities to increase visibility of safeguarding service (within capacity limitations) e.g. face to face presence at induction training, NAT sessions, speaking at conferences.
* Sharing resources on safeguarding issues to be displayed in service areas.

1. **Safeguarding service**
   1. **The safeguarding adult and children’s teams will be fully integrated in to one service.**

**To achieve this:**

* Shared budget management and resources being put in place.
* Annual away day to revisit shared values and priorities of the service.
* Review Terms of Reference of joint governance meetings: strategic and operational meetings/band 7/band 8 meetings.
* All members of the safeguarding service to receive invites to relevant internal meetings.
* Identify leads and working groups for safeguarding service work streams.
  1. **Safeguarding service arrangements post COVID.**
* Plan of use of office space within current Trust guidance to be in place by 31 May 2021.
* Plan of home working to be in place by 31 May 2021.
* To set standards and agree which meetings will be virtual and face to face by 31st May.
* Staff support and well-being to be considered at all stages.

1. **Audit**
   1. **The safeguarding service has an audit program in place.**

**To achieve this:**

* Audit leads and working group to ensure co-ordinated approach to safeguarding audit work across the service and directorates.
* Audit leads to strengthen links with the Trust wide audit program.
* Ensure audits consider all age safeguarding.
* Multi-agency audits to be included in the safeguarding service audit program and link with Trust wide and directorate audit program.

**4. Training**

* 1. **The safeguarding service has a robust training program in place.**

**To achieve this:**

* Training leads to roll out of learning passport and induction checklist across the Trust
* Plan of re-introduction of face-to-face training, taking in account a blended approach, following current Trust guidance to be in place by 31 May 2021.
* Integration of junior doctors into multi-disciplinary training by 1st January 2022.
* Correct levels of Prevent training to be on staff matrices.

1. **Public protection**
   1. **The safeguarding service participates in multi-agency public protection work and ensures information is disseminated across directorates**

**To achieve this:**

* Review of interface with MASH/MARAC/MAPPA processes across all areas to ensure consistent, proportionate approach within existing resources by July 1st, 2021.
* Agree long term funding for Oxfordshire MASH health team. Revised offer of input may be needed if funding not secured.
* Implement changes required because of the updated national prevent guidance.
* To engage in serious violence work as this develops.

**6. Whole family approach**

**a. The safeguarding service will work with services towards a Trust wide whole family approach**

**To achieve this:**

* Staff across adults and children’s services in Oxfordshire to be supported in engaging with early help processes via supervision and consultations
* Sharing learning and quality improvement projects to promote joint ownership of processes across the organisation.
* Working with clinical services to roll out and embed the Joint Activity Pathway by September 2021.

**Safeguarding service priorities for 2020/21 and actions taken**

|  |  |  |
| --- | --- | --- |
|  | **Priorities 2020/21** | **Action Taken** |
| **1** | Maintaining a consistent safeguarding service during the Covid 19 pandemic and participating in the recovery work to improve practice. | Core work of the safeguarding service has continued throughout the pandemic. Feedback from the Section 11 audit - staff survey monkey questionnaires has evidenced that staff felt safeguarding leads were accessible during this period. |
| **2** | 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. | This was delayed due to changes in the learning and development electronic system. The system is planned to go live in June 2021. |
| **3** | Implementation of the revised training strategy. | All core safeguarding children training packages have been reviewed and updated. Learning passport developed to enable recording of additional training. For launch in June 2021. |
| **4** | Maintaining active engagement with Violence Reduction and exploitation work. | The safeguarding service are members of exploitation sub-groups, modern slavery network, Bucks serious violence task force and feedback via internal governance meetings and safeguarding newsletter. |
| **5** | Support the establishment of the Working with Family's Group to promote all age safeguarding | The safeguarding service attend the Working with Families group and have led and contributed to projects to promote all age safeguarding. |
| **6** | Develop a framework to support adult teams to take account of the needs of children | This is in development. The Named Doctor for Safeguarding Adults is involved with this work alongside the children team and OSCP. |
| **7** | 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. | The Quality Assurance requirement is still being developed in Buckinghamshire across the partnership for adults.  Safeguarding Adults self-assurance is being completed in May 2021. |
| **8** | Supporting the organisation to implement/embed the relevant recommendations from CSPRs and SARs. | Links with the Patient Safety Team are established and actions are being shared with this team to ensure corporate oversight and monitoring. This also provides the opportunity to link with other existing action plans. |
| **9** | Review administrative functions to source additional administrative resources across the safeguarding service to support the breadth of work undertaken. | New administrator funded and employed. |
| **10** | 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. | Paper written and escalated to Chief Nurse. Interim funding agreed for 0.5 WTE Band 6 nurse for 12 months while long term funding is agreed with commissioners. |

**Governance Route/Approval Process**

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/>

**Recommendation**

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

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

**Moira Gilroy, Safeguarding Adult Manager**

**Safeguarding Children and Adults**

**Annual Report 2020/21**



***Authors: Lisa Lord/Jayne Harrison (Trust Lead Nurses Safeguarding Children)*** ***Moira Gilroy (Safeguarding Adults Manager)***

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1. **Introduction**

2020/21 was overshadowed by Covid19. The information in this report should be read within this context. The Coronavirus Act 2020 allowed for easement of some statutory responsibilities. None of these easements were implemented within the local authority areas in which the Trust provides services. It was explicit that safeguarding services would continue as business as usual. A report on the safeguarding service response to COVID 19 was submitted to the Trust Quality Special Safe COVID subcommittee in June 2020 and is added as an appendix to this report.

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 unlawful deprivation of liberty.

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.

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.

Safeguarding is a complex and challenging area of work and COVID-19 has added another dimension to this complexity. Staff have had to make adaptions to their practice for COVID-19. Typically, this was related to changes from face-face and home contacts to virtual working. The Child Safeguarding Practice Review Panel (Dec 2020) identified increasing family stressors such as domestic abuse, mental health and reduced support from extended family; harm to children under 1 years old; young people’s mental health, (especially self-harm, exposure to sexual abuse and on-line bullying) and school closures as factors in reviews. These themes have also been present in local reviews and safeguarding consultations with staff. In addition, a theme locally and nationally has been an increase in eating disorders. The document also recommends practitioners would benefit from the development of practice guidance and best practice standards for virtual visits. The safeguarding service have been involved in the Trust project in this area of work and included this subject in safeguarding supervision and training to support staff.

This annual report identifies the progress and accomplishments made within the Trust, led by the safeguarding service during 2020/21 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 2021/22 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 national guidance**

New national guidance is available for the areas below. The guidance has been highlighted in governance meetings. Training, policies, and procedures have been reviewed in relation to any changes.

**2.1 Modern slavery statutory guidance (March 2021)**

<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974794/March_2021_-_Modern_Slavery_Statutory_Guidance__EW__Non-Statutory_Guidance__SNI__v2.1_.pdf>

Guidance has been replaced by statutory guidance. Healthcare responsibilities are set out on page 41 of the guidance and are to identify potential victims in primary and secondary health care settings and raise awareness of this crime amongst patients, visitors and staff. Healthcare has a responsibility to provide emergency and ongoing medical treatment to potential and confirmed victims. The guidance gives details of indicators of modern slavery and the National Referral Mechanism.

* 1. **Key updates to Working Together to Safeguarding Children (2018) introduced in Dec 2020**

Key additional guidance included early help, homeless duty, information sharing, domestic abuse, child mental health and allegations.

* 1. **Channel Duty Guidance (Nov 2020)** <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/928326/6.6271_HO_HMG_Channel_Duty_Guidance_v13_WEB_Engish.pdf>

In summary the main changes are.

* Emphasis on the statutory nature of Channel Panels and provide a more prescriptive framework.
* Updated to reflect policy and legislative changes and emerging trends, such as unclear, unstable and mixed ideologies.
* Additional clarity on meeting arrangements
* New section on disclosure and confidentiality
* Requirement to review every closed case at 6 and 12 months after closure, and hold exit reviews with individuals
* New monitoring compliance framework
* A self-assessment tool will be available
  1. **Domestic Abuse Act (April 2021)**

<https://services.parliament.uk/bills/2019-21/domesticabuse.html>

Domestic Abuse Act 2021: overarching factsheet - GOV.UK (www.gov.uk)

The Domestic Abuse Act 2021 raises awareness and understanding about the devastating impact of domestic abuse on victims and their families. It improves the effectiveness of the justice system in providing protection for victims of domestic abuse and bringing perpetrators to justice and strengthens the support for victims of abuse by statutory agencies.

**2.5 Multi-agency statutory guidance on Female Genital Mutilation (July 2020)**

[HM Government - Multi-agency statutory guidance on Female Genital Mutilation (publishing.service.gov.uk)](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/912996/6-1914-HO-Multi_Agency_Statutory_Guidance_on_FGM__-_MASTER_V7_-_FINAL__July_2020.pdf)

This guidance has three key functions: to provide information, strategic guidance and advice and support to front-line professionals on FGM.

1. **Safeguarding Service**

The safeguarding adult and children teams are 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.

**3.1 Safeguarding Service Structure**

The Safeguarding Service is led by lead nurses and the lead doctor, reporting to the Associate Director of Social Care. 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.

**3.2 Structure Chart**

**Chief Nurse**

**Executive Lead for Safeguarding**

**Associate Director of Social Care**

**2 Sessions Per Week**

**Named Safeguarding Children & Adult Doctors**

**Safeguarding Lead Nurses**

**(2:2 WTE)**

**1 Session Per Week**

**Lead Safeguarding Adult Doctor**

**Named Nurses Safeguarding Children**

**(5.8 WTE)**

**Safeguarding Adults Practitioner**

**(2.53 WTE)**

**3.3 Team development, publications, and awards**

The safeguarding service establishment has remained unchanged during 2020/21. The team have mainly been working from home due to Covid. However, our MASH administrator, who started her post in April 2020 has been office based for induction and for ease of access to the multi -agency MASH systems. In April 2021 we have recruited a 0.5 band 6 secondment for a 12month period in order to manage the increased workload through the MASH.

In February 2021 we were able to appoint a new part time administrator for the safeguarding service, who works across the adult and children teams.

Development of members of the safeguarding service is considered important and individuals have been involved in research; completed master level courses; had an article and chapter published and received an innovation award. Further details of these achievements can be seen below.

* Dr Nick Hindley and Lisa Lord’s article on “*developing Trust guidance for non-recent disclosure*” was published in the journal *Child Abuse Review* in January 2021.
* Jayne Harrison co-authored the Safeguarding chapter for the book *Community Public Health in Policy and Practice* which was published in August 2020.
* Lucia Bell is involved in ERICA a Pan European training development study that the Trust has been involved in with Oxford Brookes University and seven different countries across Europe. The focus of the study is to look at developing training for professionals across Europe on Child Maltreatment.
* The Community Hospitals have received an award for innovation from the Community Hospitals Association for the Creating with Care project. One of the Safeguarding Practitioners was very much involved in the development of this project before joining the Safeguarding Service. The project demonstrates the value of interventions that help prevent harm to service users.
* Elizabeth Navrady-Wilson completed a *Master of Science in Child Welfare and Wellbeing* at Oxford Brookes University. Elizabeth will present her dissertation *How do interventions to support children who have a parent with a mental illness impact on the child’s health and wellbeing?* at the Trust’s Working with Families group.
* Lisa Lord and Carmel Cooney have completed master’s modules in Applied Leadership and Leadership in Quality Improvement.

1. **Safeguarding activity**

**4.1 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** | **2017/18** | **2018/19** | **2019/20** | **2020/21** |
| **Telephone Consultations** | 220 | 341 | 283 | 402 | 380 | 336 |
| **Referrals to local authorities** |  |  |  | 132 | 173 | 163 |
| **s.42 enquiries undertaken** | 7 | 32 | 22 | 19 | 16 | 19 |

The figures do not include any s.42 enquiries delegated to Oxford Health by the local authorities.

The number of telephone consultations with the clinical teams may have decreased because there are a number of consultations undertaken via e-mail. There is no process in place to collect the number of e-mail consultations.

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.

**4.2 Children activity**

The safeguarding children 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.  In addition, the safeguarding children team support staff who are providing reports or attending the family courts. This year, 19 staff have been supported to write court reports compared to 26 last year. There has been a delay in court systems due to Covid which may explain this.

The information below gives an overview of the core areas of work undertaken by the safeguarding children team.

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

There have been 3 allegations against staff in Oxfordshire in the past year, none of which proceeded to a formal investigation. There was 1 allegation in Swindon which did not proceed to a formal investigation. There have been no allegations in Bucks.

**4.2.1 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 2020/21 there were 1250 calls to the consultation line, a slight decrease on the previous year. The decrease relates to fewer face-to-face contacts with children and families during the period of Covid-19 lockdown.

Calls from Talking Space/Healthy Minds decreased from 569 in 2018/2019 to 401 in 2019/20 and 296 in 2020/21. This suggests that supervision in place for IAPT supervisors has increased their confidence in managing lower-level cases without seeking safeguarding team support.

Out of 318 children safeguarding consultations in April-June 2020, 52 were marked as related to COVID.

Calls into the Childrens’ consultation line reduced by approximately one third in Q1 across all directorates compared to the same period in 2019. This coincided with the period of full lockdown, when fewer people were being seen face to face and most children were not attending school. However, consultations returned to pre-COVID-19 levels by Q3 in nearly all geographical areas, apart from Buckinghamshire. A possible reason for this in Buckinghamshire could be increased attendance at safeguarding supervision groups and closer working relationships between children’s social care and CAMHS.

Themes of the consultations during this period include:

* Lack of confidential space due to home circumstances, social distancing guidance leading to more people at home, less face-to -face contact away from family home.
* Families on child protection/in need plans using self-isolation as reason to avoid face to face visits.
* Difference in guidance around social distancing and PPE between agencies e.g. schools and health
* Increasing tension within households and family relationships due to anxiety around COVID and impact of reduced opportunity for coping mechanisms e.g. leaving house, time with friends. One family described life to practitioner as “COVID pressure cooker”
* Burn out of parents having impact on their ability to parent.
* Children with additional needs having limited school attendance putting extra pressure on family relationships.
* Impact of COVID on support for families from grandparents.
* Impact on mental health of COVID restrictions.

**Safeguarding children consultation data**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Quarters** | **Oxon & South West Mental Health** | **Bucks Mental Health** | **Community Health** | **Specialised Services** |
| **Q1-2019/20** | **189** | **86** | **123** | **3** |
| **Q1-2020/21** | **127** | **55** | **76** | **4** |
| **Q2-2019/20** | **154** | **90** | **113** | **7** |
| **Q2-2020/21** | **107** | **48** | **37** | **4** |
| **Q3-2019/20** | **134** | **89** | **91** | **4** |
| **Q3-2020/21** | **150** | **44** | **93** | **8** |
| **Q4-2019/20** | **135** | **61** | **87** | **4** |
| **Q4-2020/21** | **158** | **69** | **91** | **5** |

**4.2.2 Referrals to children’s social care**

Data on referrals is reported from Carenotes and is dependent on clinicians filling in the correct Carenotes form. Urgent care follows a different process and complete an incident form for each referral made.

For mental health services, the number of referrals in Oxfordshire reduced this year from the previous year. In Bucks, the numbers dropped for Q1 & Q2 and then returned to normal levels. In BSW the referrals remained consistent.

In community services, where there was significant redeployment of children’s staff, particularly health visitors, the referrals were significantly lower in Q2. They were higher than average for Q1 and Q4, so the overall referral rate for the year was 50% higher than for 2019/20.

The increase in referrals gives assurance that despite changes in working practices, safeguarding concerns were still being identified and local procedures followed.

The referrals from Urgent care have also increase this year compared to the previous year. It has been noted that there has been an increase in dog bite incidents during lockdown, which may explain the increase in referrals. There is a multi-agency protocol in place to support management of these incidents.

**Referrals made to children’s social care by mental health**

|  |  |  |  |
| --- | --- | --- | --- |
| **Quarters** | **Oxon** | **Bucks** | **BSW** |
| **Q1-2019/20** | **20** | **12** | **12** |
| **Q1-2020/21** | **11** | **5** | **11** |
| **Q2-2019/20** | **9** | **10** | **7** |
| **Q2-2020/21** | **13** | **3** | **8** |
| **Q3-2019/20** | **21** | **11** | **7** |
| **Q3-2020/21** | **14** | **14** | **14** |
| **Q4-2019/20** | **15** | **6** | **17** |
| **Q4-2020/21** | **10** | **6** | **22** |

**Referral made to children’s social care by Community Health (Children’s Services)**

|  |  |  |
| --- | --- | --- |
| **Oxon** | **2019/20** | **2020/21** |
| **Quarter 1** | **23** | **42** |
| **Quarter 2** | **19** | **3** |
| **Quarter 3** | **10** | **19** |
| **Quarter 4** | **18** | **47** |
| **Total** | **70** | **111** |

**Referrals made to children’s social care by urgent care**

|  |  |  |
| --- | --- | --- |
| **Oxon** | **2019/20** | **2020/21** |
| **Quarter 1** | **2** | **8** |
| **Quarter 2** | **4** | **10** |
| **Quarter 3** | **10** | **4** |
| **Quarter 4** | **8** | **9** |
| **Total** | **24** | **31** |

**4.2.3 Safeguarding children incidents**

Incidents that are identified as safeguarding are shared with senior members of the safeguarding service for review and followed up by the lead nurses as required. Themes are collated and reported to the safeguarding committee as shown in the report below. Use of the Health Based Place of Safety 136 suite on adult inpatient wards by children (admissions have increased from 6 in 2019/20 to 10 in 2020/21), concerns regarding domestic abuse and referrals for dog bites have featured in 2020/21. Reporting of these concerns as incidents is positive as it demonstrates issues are identified and action taken.

|  |  |  |  |
| --- | --- | --- | --- |
| **CHILDREN** | **Area** | **Total number** | **Themes** |
| **Q1** | **Oxon** | **15** | **Self-harm, witnessing DV in the home** |
| **Bucks** | **4** |  |
| **BSW** | **2** |  |
| **Q2**  **(July & Aug** | **Bucks** | **3** | **Young person on 136 suite** |
| **Community** | **14** | **Baby presented with bruising, found on examination to have multiple fractures. Sexual abuse.** |
| **Oxon & West** | **5** | **Young person arrested for attempted manslaughter**  **Young person on 136 suite** |
| **Specialised** | **1** |  |
| **Q3** | **Bucks** | **2** | **Concerns about parenting, physical violence at home** |
| **Community** | **9** | **Dog bites, delay in presentation** |
| **Oxon & West** | **11** | **Non-accidental injury to baby, concern parental health, self-harm, child on 136 suite, head injury** |
| **Q4** | **Bucks** | **5** | **136 suite use** |
| **Community** | **17** | **Dog bites, comms with partners, domestic abuse** |
| **Oxon & West** | **7** | **Self-harm** |

 5**. Multi-agency Working**

**5.1 Safeguarding Adult Reviews**

Safeguarding Adult Review (SAR) is a process through which the safeguarding board partners 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 2020/21 two SARs related to individual service users and one thematic review encompassing the deaths of 9 individuals who were on the homeless pathway were completed.

The homeless thematic review has system wide implications and partners are working together to implement the recommendations. In Oxford Health, the lead is the Associate Director for Social Care.

In Buckinghamshire one SAR has been completed. The recommendations are primarily focussed on the commissioning and monitoring of a placement out of area. Oxford Health completed its own investigation related to the death of this person and the subsequent actions are being monitored by the Patient Safety Team.

SARs from previous years in Buckinghamshire continue to be relevant. The overriding theme is one of how services respond to someone who is seen to be self-neglecting. The sub-groups of the BSAB are working to further develop the framework around self-neglect.

**5.2 Children - Serious Case Reviews/ Child Safeguarding Practice Reviews**

Child safeguarding practice reviews (CSPR) have replaced serious case reviews (SCR) 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.

**5.2.1 Child Safeguarding review activity which has involved Trust Services**

In 2020/21 we have seen a decrease in child safeguarding practice reviews commissioned.

However, there has been development of the rapid review process where safeguarding partners promptly undertake a rapid review of the case which involves gathering facts, discussing immediate actions, identifying improvements, and deciding next steps. When the rapid review is completed this is then sent to the Child Safeguarding Practice Review subgroup who then make a decision on whether a child safeguarding practice review is recommended. The Oxfordshire CSPR subgroup has reviewed 9 cases in the past year, leading to 2 CSPRs and 1 partnership review. There have also been 2 completed CSPRs that have been published this year. In Buckinghamshire & BSW there have been no new CSPRs. There are 2 CSPRs awaiting publication in Buckinghamshire.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Area** | **Published CSPRs** | **Completed & awaiting publication** | **Ongoing CSPRs** | **Partnership review** | **Outstanding actions** |
| Oxfordshire | 2 | 1 | 2 | 0 | 2 |
| Buckinghamshire | 0 | 2 | 0 | 0 | 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.

**5.2.2 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

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

**5.3.1 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 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.

**5.3.2 Data Breakdown 2020-2021**

In 2020-2021 the Trust supported CDOP processes for 61 children.

|  |  |
| --- | --- |
| Area | CDOP cases reviewed |
| Berkshire | 1 |
| BSW | 8 |
| Bucks | 31 |
| Oxon | 21 |

Due to cross border services being accessed by families in south Oxfordshire, Trust support CDOP requests from Berkshire so support to families can be maximised.

* **Oxfordshire**

|  |  |
| --- | --- |
| Oxfordshire CDOP Cases reviewed by Trust | 21 |
| Neonatal | 5 |
| Known to Community Services | 11 |
| Known to Mental Health services | 1 |
| Unknown to Trust services at time of death | 5 |

Some families were known to more than one service.

Neonatal deaths follow a specific CDOP pathway and do not have Joint agency review meetings at the time of the child’s death. The Midwifery teams lead on supporting the family’s bereavement support needs. They are included in this report as the Health Visiting team in Oxfordshire are notified of the neonatal deaths so the family can be offered support if there are other siblings under 5 in the family and to prevent antenatal appointments letters being sent to the family.

There were no Trust Oxfordshire cases known to CAMHs at the time of their death. One child, who died expectedly, Mother was being supported by the Adult Mental Health Team (AMHT). The referral to the AMHT was made as a result of the mother’s mental health support needs being identified as part of the palliative care plan for the family. The AMHT were responsive and worked very collaboratively with the other services to support a consistent care package for the family at such a difficult time.

The Community Children’s Nursing team supported 2 cases where the child sadly died of their long-term health conditions.

Of the 5 cases who were unknown to Trust services at the time of their death all were school aged children. The School Health Nurses and CAMHS teams supported the CDOP process by attending the Joint Agency Review (JAR) meetings to support the school and community support planning stage or were actively involved in supporting the child’s siblings directly.

The CAMHS services were actively involved in working with schools to identify children open to CAMHs whose support needs may change due to the death of a friend or person within their community and to identify others, not open to CAMHS, within the school community who may require support.

* **Buckinghamshire**

|  |  |
| --- | --- |
| Bucks CDOP cases reviewed | 31 |
| Neonatal | 15 |
| Not known to Trust | 13 |
| Known to CAMHS | 3 |

Of the 3 children known to CAMHS, 1 child died expectedly, and the other 2 children had discharged from CAMHS services at the time of their death but had been known in the previous 12 months.

Neonatal deaths are checked within Bucks to identify if the parents are known to Adult mental health services who could support the bereavement plan for the family and to potentially identify any additional mental health support needs the parent may have as a result of their sad loss.

* **BSW**

|  |  |
| --- | --- |
| BSW CDOP cases reviewed | 8 |
| Not known to Trust | 5 |
| known to CAMHS | 3 |

**5.3.3 Joint Agency Review (JAR) meetings**

Joint agency review meetings are only called when a child died unexpectedly. Neonatal and expected deaths do not have JAR’s within the CDOP pathway.

In Buckinghamshire the JARS are coordinated by the Bucks Healthcare Trust Paediatric service. Trust staff are not always invited to attend the meetings. No JARS were attended in Bucks during this reporting period.

In BSW CAMHS staff attend the JAR meetings.

The decision who should attend the JAR is made in collaboration with service leads and the safeguarding children team. Factors taken into account in deciding who attend the JAR are the needs of the member of staff who know the family; the time and availability people to attend the JAR as they need to occur within days of the child passing to offer the best support to the family; any additional internal processes being followed as a result to the child death.

|  |  |  |  |
| --- | --- | --- | --- |
| **Joint Agency Reviews Oxon** | |  | |
| Number of JARs attended by Safeguarding service  (One JAR discussed 3 children in the same family) | | 5 | |
| HV attended |  | | 1 | |
| FNP and Safeguarding service | | 1 | |
| SHN attended | | 1 | |

1 Health visitor was identified as CDOP keyworker for one family.

**5.3.4 Child Death Review Meetings (CDRM)**

Due to COVID-19 working practice changes, CDRMs held approximately 12 weeks after the child died did not take place.

**5.3.5 CDOP panel meetings**

Panel meetings occur quarterly and are the final stage of the local CDOP processes.

Trust representatives only attend CDOP panel meetings in Bucks when cases are reviewed who are known to CAMHS. No Panel meetings have been attended in 2020-21.

Oxon CDOP Panel are attended by lead nurses for safeguarding children. 11 cases known to the Trust were discussed during 2020-21.

No actions were identified for the Trust as part of the panel discussions. It was noted that the support to families by the FNP nurses was very good. The response by School health Nursing and CAMHS to the wider school community was noted as very supportive in a number of panel reports.

**5.3.6** **Thematic reviews**

Thematic reviews were introduced when CDOP processes were updated in 2018. The reviews are supported at a regional level. A service manager within the community directorate has been supporting a working group to establish a thematic review focussing on Safe Sleeping - Improving the Response. The safeguarding children team will join this working group in 2021-22 at the request of the service manager to widen the scope of learning across the Trust.

A review of mortality and CDOP processes has taken place between safeguarding service and the quality team. Updated flowcharts have been agreed to enhance application of the processes and learning outcomes being shared.

**5.4 Multi-agency safeguarding hub (MASH)**

|  |  |  |
| --- | --- | --- |
| **Area of work** | **Number completed 2019-20** | **Number completed 2020-21** |
| MASH enquiries processed | Oxon; 3336 (average 13/day) | Oxon: 4834 (average 19/day) |
|  | Bucks: 364 processed (110 open cases) | Bucks: 367 (139 open cases) |

**5.4.1 Oxfordshire**

There is currently insufficient resource within the Oxfordshire MASH health team to meet demand, leading to a backlog in cases. This presents a risk to children who need safeguarding, as well as reputational damage within the partnership. An options paper has been presented to Commissioning manger and senior OH and OUH managers. There is agreement that additional resource is necessary, but funding agreement not yet in place. The OHFT Chief Nurse has agreed funding for 0.5WTE band 6 12-month secondment as an interim measure and this post has now been recruited to. There is a plan for a meeting to be set up with the new commissioning manager to discuss a longer-term solution.

**5.4.2 Buckinghamshire**

A review of Bucks children’s MASH is underway by partners to review workload and capacity. OHFT is a virtual partner in the MASH. Bucks Health Care Trust (BHT) has seen their workload treble. This may be due to BHT undertaking initial information checks and business has increased going through the MASH. OHFT has remained consistent until the beginning of this year. We are closely monitoring increase in workload as OHFT teams are now attending more strategy discussions, this is partly due of changes to the self-harm pathway adopted by children social care and due to virtual working practices increasing the opportunity for OHFT staff to attend strategy meetings. A paper has been written by Elizabeth Navrady-Wilson Senior Nurse safeguarding children, outlining OHFT involvement, data and current challenges. This has been shared with the review group.

**5.4.3 BSW**

Wiltshire MASH have established named CAMHS practitioners who act as partners within Wiltshire. Swindon MASH are currently recruiting to two shared CAMHS/ MASH posts and will be fully embedded. BANES to not operate a MASH to the same effect, there is a system in place for duty to link with the children’s teams. The Safeguarding service do not collect data on this activity.

**5.5 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.

**5.5.1 Oxfordshire**

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.

**5.5.2 Buckinghamshire**

A choice of two neglect assessment tool is to be agreed by partners.  The Trust has submitted its preference and is awaiting feedback from the Bucks Safeguarding Children Partnership.

**5.5.3 BSW**

Both Swindon and Wiltshire local authorities are bought into the NSPCC’S Graded care Profile 2 (GCP2) and partners including CAMHS currently feed into the implementation groups. Multi agency training is offered to all agencies and CAMHS staff have been encouraged to attend this. Carol Oram, the Named Nurse for Safeguarding in BSW is trained as a trainer and it is hoped local training events can be held to help increase numbers of staff trained. This is a priority area for the coming year.

BANES do not currently use a specific tool but staff are aware of the trust use of the Neglect tool and are encouraged to use this as appropriate.

**5.6 Policy and procedure updates**

**Management of bruising in Pre-mobile babies and children**

* There has been a multi-agency piece of work in Oxfordshire to develop a protocol for managing bruising in pre mobile babies and children. This has now been agreed by the OSCB policies and procedures committee. The policy and a leaflet for families have been shared with Trust staff and are available on the intranet and the OSCB website.
* [Protocol for management of bruising in pre-mobile babies/children](https://www.oscb.org.uk/wp-content/uploads/2021/04/Bruising-Protocol-final.pdf)
* [What’s going on? Information for parents and carers about bruising to pre-mobile babies and children](https://www.oscb.org.uk/documents/whats-going-on-information-for-parents-and-carers-about-bruising-to-pre-mobile-babies-and-children/)

**Professionals only meeting guidance**

Findings from local and national case reviews indicate that the commitment to working in partnership with families has inadvertently led to an assumption that professionals cannot meet together without the family being present, e.g. when they have concerns regarding the progress of a child’s plan.

Although working in partnership with and involving families in decisions and meetings about them should be normal practice, there will be times when it is beneficial for professionals to come together not only to share information, but also to explore and understand differing views to help determine the direction of the plan for a child.

The link below takes you to the OSCB guidance for practitioners to organise or be part of a professionals only meeting .

<https://www.oscb.org.uk/practitioners-volunteers/multi-agency-guidance-tools>

**6.  Audits**

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

Due to Covid-19, we have not prioritised audit this year, recognising that staff have been focused on delivering safe and effective care in the context of the pandemic. Teams have been involved in a number of multi-agency audits via the safeguarding board/partnerships and the safeguarding service have been part of the Trust peer review programme.

**6.1**

**Trust wide**

* **Services Response to applying Domestic Abuse Policy CP101**

This audit was completed to test current domestic abuse practice in Trust clinical services against the Trust policy and to identify strengths and gaps in practice.

35 responses were received. Responses were received from adult and children’s services with the community directorate, Bucks mental health directorate and Oxon and South West directorate. No responses were received from specialist directorate and one ward responded.

Responses to each question demonstrated an approximate 50/50 split in regard to the policy being applied. Practice in some services (who are noted to support a higher frequency of people who are or have experienced domestic abuse) was to a high standard and staff had training to meet the needs of the people they support. Proactive activities to promote understanding of “what a healthy relationship is” were reported to be occurring in 16 services, predominantly children’s services, which supports a prevention agenda to potentially reduce frequency of domestic abuse in the longer term. This prevention agenda is in line with Domestic Abuse Strategic Plans, within local safeguarding partnerships, the Trust are affiliated to.

Only one service, the Phoenix Team offered interventions to perpetrators of domestic abuse. All local Domestic Abuse strategies identify the lack of support for perpetrators of Domestic Abuse, so Trust practice is in line with local reported provision across agencies.

Some services reported it was not within their service specifications to deliver the aspect of work identified in the policy, hence the reason they did not offer it to their service users.

Staff training regarding domestic abuse was predominantly through internal mandatory safeguarding training.

**Recommendations**

1. Trust domestic abuse training strategy to be agreed and implemented
2. Implementation of TRUST domestic abuse policy to be reviewed Quarter 4 2021/2022 financial year to determine training strategy has been effective in changing practice.
3. Adult community services, specialist directorate services and inpatient wards to be met with to identify their specific support needs around domestic abuse practice.
4. Perpetrator support pathways to be developed in line with local geographic areasstrategic plans.

**6.2 Multi agency audits**

**6.2.1 Oxfordshire**

* **Closure summaries audit**

This piece of work was one of the actions from the Child M serious case review. Assurance was required around the way information is shared and utilised when patients transfer or are discharged to the care of their GP.

Small audits carried out within different organisations. Hence sample sizes were small. The findings found that information is not always robust and effectively utilised. Due to the huge volume of information received by GP surgeries, anything significant or requiring urgent action, needs to be verbally shared as well as sharing a written record.

All organisations asked to identify their role in ensuring information transfer that is fit for purpose.

* **Audit of Oxfordshire Domestic Abuse Pathway for Young People**

A professional’s questionnaire was developed in response to challenges identifying cases to be included an audit of the Oxfordshire Domestic Abuse Pathway for Young People. There was good response from school and college nurses.

1. **What worked well?**

* DAY programme tools
* Decision making tool
* DASH
* Effective communication – open, honest, listening, non-judgemental
* Careful language use – ‘domestic abuse’ not always helpful
* Time to build a Trusting relationship
* Multi-agency working – collective effort and consistent messages
* Healthy relationships work, opening up conversation and helping them to identify abuse
* Specialist services, inc. SAFE!, Children Seen & Heard
* “Treating the young person with respect, listening, building therapeutic relationships, asking questions about the abuse in a sensitive way, being honest about my concerns and the risks to the parent and child.”
* “Listening to the young person, explaining their options to them and letting them make their own informed choices.”

1. **What didn't work so well?**

* Using the wrong language, or having difficult conversations
* Can be tricky to engage young people, and to get them to recognise the abuse they’re experiencing
* Being too prescriptive, telling young people what to do
* Thresholds / waiting time for support / intervention from other services
* Lack of support available, especially for young ‘perpetrators’
* Lack of understanding and appropriate response from school
* Lack of parental support / positive role models
* **Performance and Quality Assurance (PAQA) Neglect Audit**

The multi-agency neglect audit was undertaken jointly by Children’s Social Care, Health, Police and Education representatives on 28th September and 23rd November 2020. One child was reviewed in depth at each desktop audit, bringing together and analysing information from each agency participating in the audit.

The focus of the audit, on children who have been subject to child protection planning for 12 months or more, and/or subject to multiple episodes of child protection planning due to neglect, was selected to examine the extent to which agencies’ responses to children suffering the cumulative impact of neglect are timely and proportionate, and to examine whether or not families experience “start-again” interventions that fail to take sufficient account of previous interventions and their impact, or children’s lived experience over time.

Key points of learning

* Tools were not used effectively to provide evidence of the child's lived experience
* Consideration should be given to historic involvement with the child and family
* Practitioners require a knowledge of the parent's level of understanding with regard to neglect
* The improved use of Early Help assessments to provide a multi-agency coordinated response to concerns

The audit findings and learning points was taken to Operational meetings to discuss with team managers for dissemination to staff.

* **Joint Safeguarding Adults and Children Self-assessment/section 11 and Peer Review**

The Oxfordshire safeguarding partnerships undertook this annual self-assessment/s.11 and peer review of the safeguarding arrangements in place for each agency again this year. There was a particular focus on inclusivity and diversity which reflected the national concern reflected by the Black Lives Matter protests in the summer. The Trust was identified as having robust systems in place (green).

The work of the Trust Inclusion Team did a large piece of work providing an event each day during Black History Month in October 2020 which raised awareness and helped develop further understanding around the issues.

**6.2.2 BSW**

The safeguarding children team participate in monthly MASH audits in Swindon and learning is shared directly with the relevant CAMHs teams.

A piece of work is ongoing with Wiltshire MASH to quality assure referrals made by Wiltshire CAMHs. 15 referrals made during August & September 2020 were audited. As a result, staff have been provided with individual feedback regarding their written referrals. A guidance sheet for making referrals is being updated as a good practice example for all staff. Future audit dates have been planned to ensure that this piece of quality improvement work continues.

**6.2.3 Buckinghamshire**

There was an audit of the quality of the delegated s.42 enquiries completed in Buckinghamshire. This was completed by Buckinghamshire Council. It demonstrated the process used by Oxford Health staff was not robust.

Buckinghamshire Council have now introduced a new electronic recording system which has simplified the recording and monitoring processes. In Oxford Health steps have been taken to strengthen the overview of the enquiries undertaken. Changes have been made within the teams to clarify the roles and responsibilities in relation to completing this work.

The section 11 audit questions and survey monkey questionnaire has been completed and feedback shared with the safeguarding team by the Bucks Safeguarding Children Partnership (BSCP). There was an excellent response from Trust staff. At time of writing the draft report is awaiting agreement of recommendations and sign off by partners and will be shared when available.

**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. New Channel Duty Guidance has been available since Nov 2020. Channel panels continue to take place virtually. Information is being shared by the Trust Prevent lead as required. The Trust Prevent lead sits within the safeguarding service and the safeguarding service has deputy Prevent leads in Oxfordshire, Buckinghamshire and BSW. The Prevent Boards in Oxfordshire and Buckinghamshire will be attended by the Associate Director of Social Care from 2021.

A project with learning and development to update appropriate staff training matrix and ensure the correct prevent training is in place was delayed but is due to go live in June 2021. This is 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.

**7.2 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.

The focus of the work in 2020/21 has been to provide internal support to Domestic Abuse Champions bi-annually. An increase in domestic abuse has been evident during the COVID-19 pandemic and domestic abuse resources and information to support staff and their clients has been shared via the working group. An audit was completed to test current domestic abuse practice in Trust clinical services against the Trust policy and to identify strengths and gaps in practice. This has been completed and actions identified.

A business case was submitted and accepted to make domestic abuse stalking and honour-based violence (DASH) checklist available on the Carenotes, patient electronic record. The checklist is in the final stages of testing and will be available by July 2021.

**7.2.1 Joint Tasking Meeting (JTM) - Oxfordshire**

The JTM meeting is managed by the community safety team from the district council. There is a JTM representative from adult mental health and the safeguarding service review the agenda for any relevant information sharing required by Trust children services.

**7.2.2 Domestic Abuse Strategic Board and Operational Group**

There is representation from the safeguarding service at the Oxfordshire domestic abuse operational group. A new Domestic Abuse Act (“the Act”[[1]](#footnote-2)), was enacted in parliament in April 2021 and confers additional responsibilities on County Councils within England. This includes appointing a Domestic Abuse Partnership Board with prescribed membership. Representation from the Trust is from the Associate Director of Social Care in Buckinghamshire and Oxfordshire.

**BSW**

Domestic abuse stakeholder events have taken place in 2021 involving partner agencies, these have been represented by the Named Safeguarding professionals in BSW. Workshops have looked at the evaluation of both Vicitim and Perpetrators programmes and young people’s pathway. A multi-agency group is moving forward with a revised Domestic abuse strategy for Wiltshire.

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

The safeguarding service is involved in supporting MARAC meetings in all geographical areas. There is a representative from the safeguarding team on the Buckinghamshire and Oxfordshire MARAC steering group. BSW deliver children’s mental health services only and the input into MARAC processes relates to children in the family who may be open to CAMHs services. The reduction of MARAC referrals in Oxfordshire may relate to the reduction in domestic abuse incidents reported by the police during lockdown and changes to working practices during the early days of the pandemic.

**MARAC referrals made by the Trust**

|  |  |  |
| --- | --- | --- |
|  | **2019/20** | **2020/21** |
| Oxfordshire | 12 | 4 |
| Buckinghamshire | 0 | 3 |

* 1. **Multi-agency public protection arrangements (MAPPA)**

|  |  |  |
| --- | --- | --- |
|  | **2019/20** | **2020/21** |
| **Multi-Agency Public**  **Protection Arrangements**  **(MAPPA) information shares** | **43** | **51** |

There is representation at MAPPA by adult mental health and safeguarding adult team as required. The safeguarding children team review the agenda in Oxfordshire for any children of those people under MAPPA and provide information as appropriate. Input into MAPPA by the safeguarding children team is being reviewed to ensure consistency across geographical areas.

**7.4 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.

19 cases were discussed at the monthly No Name FGM meeting from April 2020 - March 2021. The numbers of referrals are reduced this year possibly due to due to national and international travel restrictions.

Of the 19 women discussed, 10 names of children or mothers were shared with School Health Nurses or Health Visitors.  Carenotes alerts were added to two families. The rest required no further action as plans were in place or male babies were delivered.

2 Cases were reported to DoH NHS Digital in 2020-21 compared to 5 in 2019-20. Safeguarding service review identified all appropriate safeguarding support was provided to the family who agreed to reporting occurring.

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.

**7.5 Modern slavery**

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 network meetings were paused during 2020 and have recommenced at the beginning of 2021. The safeguarding service has shared information with the Elmore modern slavery research project that has been commissioned by Oxford City Council.  The report was expected in 2020/21.

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.

**7.6 Child Sexual Exploitation**

In 2020/21 there were 42 calls from staff; 23- criminal exploitation; 17- CSE; 1- modern slavery. This compares to 35 calls in 2019/2020.

Themes from these calls include:

* Risk of online exploitation
* Risky sexual behaviour
* Young person reporting using drugs
* At risk of exploitation- due to issues at home such as parent and child mental health, domestic abuse, parents/relative criminal behaviour, substance misuse
* Children at risk of exploitation with additional needs such as ADHD/ASD
* 2 cases included reports by young people of either being threatened by knives or knives being brought in to school

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

**Buckinghamshire** 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.

Numbers of cases open to CAMHs and discussed at the MACE meeting are shared with CCG and Bucks Safeguarding Children’s Partnership.   
   
The exploitation sub-group is attended by the safeguarding service. The CAMHS Service manager has agreed changes to Exploitation Protocol and Missing Guidance for the Trust in April 2021.

**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. In October 2020, the Kingfisher Team formally joined with the Youth Justice Service to form the Youth Justice and Exploitation Service (YJES). The remit of the YJES expanded to include children at risk of all forms of exploitation and the family safeguarding model was also adopted. Referrals into the YJES have increased since the inception of the new service and there are now approximately 90-100 children on the caseload, approximately double the number compared to October 2020.

**BSW:**

A Pan Wiltshire Exploitation group exists to cover Swindon and Wiltshire under one police service with a named safeguarding professional representing. In Banes, operational exploitation meetings take place, again with representation from the Safeguarding Professionals. Learning is implemented through training, supervision and consultations with BSW staff.

Wiltshire is one of 5 pilot sites across the UK with the university of Bedfordshire to implement a Contextual Safeguarding service that serves children and young people at risk of extra familiar harm. There is both a health group and steering group for the implementation. Lisa Williams, Senior Named Professional for Safeguarding Children represents on these groups. Multi agency training is offered locally and CAMHS staff are encouraged to attend this. The Senior Named professional is working with the implementation lead on ensuring active service user participants through the Oxford Health CAMHS participation group.

1. **Training**

|  |  |  |
| --- | --- | --- |
| **Area of Work** | **Number completed 2019-2020** | **Number completed 2020-2021** |
| **Level 2 & 3 safeguarding children training sessions delivered** | **34** | **12** |
| **Level 2 and 3 safeguarding adult training sessions delivered** | **12** | **14** |
|  |  |  |

Training in 2020/21 was temporarily interrupted as the organisation responded to Covid 19. Face to face sessions have been continued in a Covid safe environment for small numbers of people. The majority of training has been completed via MS Teams or as e-learning. As a consequence, there has been a small drop in the number of people being trained.

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.  The development of a staff held “learning passport” document to record training and learning opportunities outside of the Corporate training programme is continuing. It is aimed to launch this document in June 2021.

Training for safeguarding adults is also provided on an ad hoc basis and in less formal environments including through team forums. This is an opportunity to discuss current scenarios and develop insight into the formal information provided in the corporate training.

**8.1 Effectiveness and Evaluation of training**

Throughout 2020/2021, training has been evaluated electronically. This is being further developed into 2021/2022. There is a new system being introduced in Learning and Development which will automatically require completion of an evaluation by all attendees.

The Safeguarding Level 2 training has been reviewed and refreshed to reflect the priorities.

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**

**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. This was tested in 2020/21 when an apprentice nurse had an adverse experience on one of the wards. The ward team sought advice and worked with the processes constructively.

1. **Supervision**

|  |  |  |
| --- | --- | --- |
| **Area of Work** | **Number completed 2019-2020** | **Number completed 2020-2021** |
| **Safeguarding Children Supervision sessions** | **147** | **153** |

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 has delivered 153 Safeguarding Children Supervision sessions in 2020/1 compared to 147 session in 2019/20. This demonstrates the success of transferring supervision to online as there was not a decrease in the number of sessions being available to staff.

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 and Oxfordshire
* 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
* Perinatal Teams in Oxfordshire and Buckinghamshire

**9.1 Safeguarding supervision feedback**

There was not an evaluation completed in 2020/21 however feedback below was received in 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. Safeguarding service priorities for 2021/22**

**1.Communication**

**The Safeguarding Service will have clear communication in place both within the organisation and with our partners**

**To achieve this:**

**Strengthen interface with multi agency partners and health providers**

* Consider the gap around links with team managers in Oxfordshire children’s social care.
* Planning and identifying support when there is a need to challenge partners.
* Identifying most appropriate representatives for key issues e.g. homelessness work following OSAB thematic review.

**Widen reach of the service within the Trust**

* Participate in peer reviews
* Widen circulation of safeguarding newsletter through inclusion in governance reports and email signatures.
* Regular attendance at social work forums for safeguarding update.
* Mapping existing groups within the directorates that provide the opportunity for safeguarding information to be discussed.
* Targeting specific information to relevant services, in addition to newsletter circulation.
* Accept and seek opportunities to increase visibility of safeguarding service (within capacity limitations) e.g. face to face presence at induction training, NAT sessions, speaking at conferences.
* Sharing resources on safeguarding issues to be displayed in service areas.

**2.Safeguarding service**

**The safeguarding adult and children’s teams will be fully integrated in to one service.**

**To achieve this:**

* Shared budget management and resources being put in place.
* Annual away day to revisit shared values and priorities of the service.
* Review Terms of Reference of joint governance meetings: strategic and operational meetings/band 7/band 8 meetings.
* All members of the safeguarding service to receive invites to relevant internal meetings.
* Identify leads and working groups for safeguarding service work streams.

**Safeguarding service arrangements post COVID.**

* Plan of use of office space within current Trust guidance to be in place by 31 May 2021.
* Plan of home working to be in place by 31 May 2021.
* To set standards and agree which meetings will be virtual and face to face by 31st May.
* Staff support and well-being to be considered at all stages.

**3.Audit**

**The safeguarding service has an audit program in place.**

**To achieve this:**

* Audit leads and working group to ensure co-ordinated approach to safeguarding audit work across the service and directorates.
* Audit leads to strengthen links with the Trust wide audit program.
* Ensure audits consider all age safeguarding.
* Multi-agency audits to be included in the safeguarding service audit program and link with Trust wide and directorate audit program.

**4.Training**

**The safeguarding service has a robust training program in place.**

**To achieve this:**

* Training leads to roll out of learning passport and induction checklist across the Trust
* Plan of re-introduction of face-to-face training, taking in account a blended approach, following current Trust guidance to be in place by 31 May 2021.
* Integration of junior doctors into multi-disciplinary training by 1st January 2022.
* Correct levels of Prevent training to be on staff matrices.

**5.Public protection**

**The safeguarding service participates in multi-agency public protection work and ensures information is disseminated across directorates**

**To achieve this:**

* Review of interface with MASH/MARAC/MAPPA processes across all areas to ensure consistent, proportionate approach within existing resources by July 1st, 2021.
* Agree long term funding for Oxfordshire MASH health team. Revised offer of input may be needed if funding not secured.
* Implement changes required because of the updated national prevent guidance.
* To engage in serious violence work as this develops.

**6.Whole family approach**

**The safeguarding service will work with services towards a Trust wide whole family approach**

**To achieve this:**

* Staff across adults and children’s services in Oxfordshire to be supported in engaging with early help processes via supervision and consultations
* Sharing learning and quality improvement projects to promote joint ownership of processes across the organisation.
* Working with clinical services to roll out and embed the Joint Activity Pathway by September 2021.

**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/P** | **Local Safeguarding Children Board/Partnership** |
| **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.** |

# 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.

1. **Safeguarding- system wide**
   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.



**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 TRUST 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 6 month 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.

It has been identified that BSW would benefit from an additional process document for CDOP locally and therefore the Senior Named Professional is working with the Service managers and Team managers to review existing processes and policies and update to include a customised specific process for CAMHS due to the information flow of Child Death’s being different than Oxfordshire and Bucks.

**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.

1. **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 2020/21**

The annual safeguarding report produced for BaNES, Swindon and Wiltshire CCGs is available upon request.

1. https://www.legislation.gov.uk/ukpga/2021/17/contents/enacted [↑](#footnote-ref-2)