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**BOD 65/2022**

(Agenda item: 13)

# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

# Board of Directors

**28 September 2022**

**Safeguarding Children and Adults Joint Annual Report 2021/2022**

**For: Assurance and Approval**

**Executive Summary**

1. **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.

This report provides the Trust Board with an overview of the activity of the Oxford Health NHS Foundation Trust Safeguarding Service.

1. **Assurance processes**

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

In Buckinghamshire, the Trust was engaged with the children’s section 11 audit and was completed in March 2021. No actions for the Trust have been identified.

In BSW, the section 11 audit programme is carried out via a joint Swindon and Wiltshire Audit and a separate BANES audit. This year the trust engaged with the section 11 audit for Swindon and Wiltshire which was completed in October 2021. The trust was RAG rated green.

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

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

Team activity in relation to the Multi Agency Safeguarding Hub (MASH) has increased by 63%in Oxfordshire between 2018/19 and 2021/22.This data reflects the increase in referrals for children at risk of harm. In addition, involvement of the safeguarding service in Buckinghamshire MASH has increased by 50% due to the introduction of strategy meetings and changes in children’s social care processes.

Additional resource for MASH staffing has been agreed by the Trust Exec to meet the increased workload so the health team is able to meet its responsibilities in MASH.

1. **Safeguarding Training**

Training levels were not at the target levels for achievement. There was a change in learning and development system which resulted in the training levels being less than recorded previously. In 2022/23 there is a regular meeting in place with the Learning and Development team to address data quality issues and promote the achievement level for all courses.

1. **Governance Route/Escalation Process**

This annual report was presented at the Safeguarding Committee on the 24th August 2022.

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 confirm that it is assured that there are systems in place to protect service users from abuse and improper treatment.

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Moira Gilroy, Interim Deputy Head of Safeguarding

**Lead Executive Director:** Marie Crofts, Chief Nurse

**Safeguarding Children and Adults**

**Annual Report 2021/22**

****

***#Think Family***

***SUPPORTING AND ENABLING STAFF TO KEEP ADULTS, CHILDREN AND FAMILIES SAFE***

***Authors: Lisa Lord- Interim Head of Safeguarding, Moira Gilroy- Interim Deputy Head of Safeguarding***

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1. **Introduction**

The Safeguarding Service support staff in dealing with complex safeguarding concerns. 2021/22 has continued to see increased referrals to both adults and children’s social care. This is alongside an increase in demand for services, staff turnover and absence some of which is ascribed to COVID 19 across the system. This is reflected in the concerns discussed with staff on the safeguarding consultation lines and through discussion at safeguarding supervision.

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.

This annual report identifies the progress and accomplishments made within the Trust, led by the safeguarding service during 2021/22 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.

This report provides the Trust Board with an overview of the activity of the Oxford Health NHS Foundation Trust Safeguarding Service. In previous years a specific report for area has been produced for BaNes, Swindon and Wiltshire (BSW) CCG commissioners. In line with the safeguarding service working towards a consistent and integrated approach across all geographical areas, BSW information is included in this report.

1. **Safeguarding service priorities for 2021/22- We Said-We Did**
   1. **Communication**

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

* We have participated in work as a result of safeguarding reviews.
* We have responded to the changes within partner agencies and worked collaboratively with those across the health economy.
* We have taken part in Trust peer reviews.
* We have raised awareness of the newsletter through inclusion in governance reports and email signatures
* We will be attending social work forums to make our interface more effective.
* We have more robust representation at directorate governance meeting and formalising our input into these meetings.
* We have presented at conferences and delivered multi-agency training with partners
* A resource library on the safeguarding intranet pages is being further developed
  1. **Safeguarding service**

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

This is a continued priority for 2022/23 as the service has undergone significant structure changes.

We are in the process of developing a safeguarding strategy which will pull together the vision and culture and further embed the safeguarding service into the organisation.

**Safeguarding service arrangements post COVID**

We have made changes in line with Trust guidance and are adopting a blended approach, recognising the benefits of both face to face and virtual communication.

We maintain visibility of the well-being agenda and completion of the relevant training.

* 1. **Audit**

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

An annual report of audit activity has been produced. We are engaging with the new Trust audit system.

* 1. **Training**

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

A blended approach is being taken towards training.

We have worked closely with learning and development (L&D) to address some development issues with the new electronic system.

We have made positive progress with adoption of the learning passport. Staff can use this to record additional required safeguarding training and experiential learning.

* 1. **Public protection**

1. **Public Protection**

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

We represent the Trust at public protection fora and report into Trust governance structures. Our interface is likely to be influenced by the integrated care boards.

MASH resource is agreed for 2022/23.

We take note of national guidance and integrate it into our practice.

1. **Whole family approach**

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

The integration of the safeguarding service will model this approach and continue to work towards this aim.

We have supported quality improvement projects and initiatives associated with this topic.

1. **Safeguarding priorities 2022/23**

**Given recent staff changes the safeguarding service is focusing on delivery of core work.**

The additional priorities of the service are:

**Additional priorities**

Following review of the safeguarding service we have identified having a safeguarding strategy in place will facilitate development of clear priorities and support the further integration between safeguarding adults and children.

It has been identified that safeguarding adult reviews (SAR) and child safeguarding practice reviews (CSPR) require greater integration into Trust quality processes. The safeguarding service is working with governance teams to achieve this.

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.

**4.1 Prevent Training and Competencies Framework**

A revised version of the Prevent training and competencies framework was published. Prevent training was reviewed in 2021/22 and Health education England and home office prevent training is now on staff training matrices.

* 1. **Domestic Abuse Act (April 2021)**

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

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.

Domestic abuse boards were set up as a result of the Domestic Abuse Act and has representation from the Trust.

* 1. **Safeguarding children under 1 year old from non-accidental injury - National review into babies seriously harmed or killed by their father or male carer**

The Child Safeguarding Practice Review Panel (CSPRP) has published a review of the circumstances involved in cases where babies under-one-year-old have been harmed or killed by their fathers or other males in a caring role. Findings include: a range of risk factors were common in many of the cases, a lack of information sharing was a key factor that prevented practitioners from responding to risk to babies, and many services aimed at new parents are predominantly focused on the mother. Recommendations include: the government should fund pilots to develop holistic work with fathers and the engagement of fathers must be embedded in prospective and current family-focused programmes. NSPCC Learning has published a CASPAR briefing summarising learning from the review.

**Read the report:** [Safeguarding children under 1 year old from non-accidental injury](https://protect-eu.mimecast.com/s/p2SZCZ8jBsPkKRxizREa1m?domain=email.nspcc.org.uk)

**4.4 Serious Violence Duty: draft guidance for responsible authorities**

A draft of the statutory guidance was published on the 13 May 2021. This was to inform the discussions during the passage of the Bill. There is a further commitment to develop the guidance in relation to safeguarding and add new content on housing and homelessness. The revised draft guidance also takes into consideration the following amendments made during the Parliamentary passage of the PCSC Act: ∙ making clear that the definition of violence for the purpose of the Duty includes domestic abuse and sexual violence.

[https://www.gov.uk/government/consultations/serious-violence-duty](https://protect-eu.mimecast.com/s/f5uKCNO4mHjK1zBCz0Pym?domain=gov.uk)

1. **Safeguarding Service**

The safeguarding adult and children’s 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.

The safeguarding service establishment remained unchanged during 2021/22. The team have adopted a blended model working mainly from home and some hours within the office. In March 2022 the Chief Nurse asked the safeguarding service to review the safeguarding service structure and this is a priority for 2022/23.

**5.1 Safeguarding Service Structure**

In 2021/22 the Safeguarding Service was by 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.

**5.2 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 /Professionals Safeguarding Children**

**(5.8 WTE)**

**Safeguarding Adults Practitioner**

**(2.53 WTE)**

1. **Safeguarding activity/core work**

**6.1 Adult activity**

Safeguarding adult activity is core work for all clinicians. The Safeguarding Adults Policy provides an up-to-date framework. This policy was updated in 2021/22. 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 requests for information from the local authority as part of their further enquiry 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.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **2018/19** | **2019/20** | **2020/21** | **2021/22** |
| **Telephone Consultations** | 402 | 380 | 336 | 429 |
| **Referrals to local authorities** | 132 | 173 | 163 | 266 |
| **s.42 enquiries undertaken** | 19 | 16 | 19 | 31 |

The figures do not include any s.42 enquiries delegated to Oxford Health by the local authorities as part of the s.75 of the National Health Services Act 2006 agreements in place, whereby responsibilities of the Local Authority are delegated.

This information reflects the increase in activity across all services. It illustrates that the staff are sensitive to concerns about service users. The outcomes of the Care Act s.42 enquiries are not always shared with Oxford Health, and this is an action we need to take forward in the forthcoming year.

**6.2 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, 13 staff have been supported to write court reports compared to 19 last year.

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 Buckinghamshire.

**6.3 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 BSW and Oxfordshire increased this year from the previous year. In Bucks, the numbers remained consistent.

In community services, the overall referral rate has returned to previous levels as referrals had increase in 2020/21 by 50% to 2019/20 figures.

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

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Oxon** | **Bucks** | **BSW** |
| **2020/21**  **Total** | **48** | **28** | **55** |
| **2021/22**  **Total** | **63** | **27** | **85** |

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

|  |  |  |
| --- | --- | --- |
| **Oxfordshire** | **2020/21** | **2021/22** |
| **Total** | **111** | **86** |

**6.4 Safeguarding Childrens incidents**

Incidents that are identified as safeguarding are shared with senior members of the safeguarding service for review and followed up by the named nurses as required. Themes are collated and reported to the safeguarding committee as shown in the report below. Concerns regarding domestic abuse, non-accidental injury and referrals for dog bites have featured in 2021/22. Reporting of these concerns as incidents is positive as it demonstrates issues are identified and action taken.

|  |  |  |  |
| --- | --- | --- | --- |
| **CHILDREN**  **2021/22** | **Area** | **Total number** | **Themes** |
|  | **Bucks** | **19** | **Child on 136, self-harm, suicide, communication, Elderly relative with dementia showing aggression towards children, eating disorder, overdose** |
| **Community** | **67** | **Sunburn, non-accidental injury, information sharing, domestic abuse, dog bite, unexplained injury** |
| **Oxon & west** | **58** | **Exploitation, self-harm, suicide, parental mental health, non-recent disclosure child sexual abuse, eating disorder** |
|  | **Specialised** | **5** | **Patient met with children when not allowed contact.** |

**6.5 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 2021/22 there were 1427 calls to the consultation line, an increase of 177 calls on the previous year. The increase correlates with a return to more normal working practices with a reduction in COVID 19 restrictions and an increase in face-to-face contacts with children and families.

Consultations regarding Emotional abuse continue to be the category with the highest number of calls, with Neglect and Domestic Abuse following. The numbers of calls regarding Domestic Abuse and neglect have risen steadily over the last year following lockdown.

Many of the consultations for emotional abuse note that time in lockdown for families at home was extremely challenging. Schools were closed and in turn community and peer support was reduced. This was manifested in challenging behaviours and concern for parents managing them.

In 2021-2022 there were 28 calls, 21 relating to criminal exploitation: 7 to CSE. This compares to 17 calls in 2020/2021. The increase in contacts from staff is in line with increasing concerns relating to criminal exploitation.

Themes from these calls include:

* Risk of online exploitation
* Behaviours indicating that the child may be at risk of exploitation
* 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

**Safeguarding children consultation data**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Oxon & South West Mental Health** | **Bucks Mental Health** | **Community Health** | **Specialised Services** |
| **2020/21**  **Total** | **542** | **216** | **297** | **21** |
| **2021/22**  **Total** | **748** | **281** | **382** | **16** |

* 1. **Training**

|  |  |  |
| --- | --- | --- |
| **Area of Work** | **Number completed 2020-2021** | **Number completed**  **2021-22** |
| **Level 2 & 3 safeguarding children training sessions delivered** | **12** | **30** |
| **Level 2 and 3 safeguarding adult training sessions delivered** | **14** | **26** |
|  |  |  |

The Safeguarding Service is providing training successfully through MS Teams, these sessions have been well received by staff. E-learning is available for some courses. We are beginning to offer face to face training sessions now restrictions surrounding COVID have been reduced.

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).  Safeguarding training is regularly reviewed to reflect national guidance, learning from reviews and the roles and competencies intercollegiate documents for adults and children.

Training levels were not at the target levels for achievement. There was a change in learning and development system. In 2022/23 there is regular meeting in pace with learning and development to address data quality issues and promote the achievement level for all courses.

We are active members of the Safeguarding Boards/Partnerships training groups. There is nothing significant to report for 2021/22.

**6.6.1 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. For those people who have attended the Safeguarding level 2 training (children and adults), the evaluation was that it was is effective and helps people build confidence. Professional curiosity was identified as a point of learning from the training. These evaluations may explain the increase in safeguarding activity.

* 1. **Supervision**

|  |  |  |  |
| --- | --- | --- | --- |
| **Area of Work** | **Number completed 2019-2020** | **Number completed 2020-2021** | **Number completed 2021-2022** |
| **Safeguarding Children Supervision sessions** | **147** | **153** | **146** |

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 146 Safeguarding Children Supervision sessions in 2021/2 compared to 153 sessions in 2020/21. A decrease in numbers of sessions is due to the changes in supervision model for the Family Nurse Partnership.

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
* Psychological Therapies Buckinghamshire

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. The team have supported the supervision provided to the Perinatal Service in Buckinghamshire. Forums for the community mental health teams have been set up in Buckinghamshire which have used a supervision approach to allow for reflection on safeguarding issues.

* **Community Hospitals**

Supervision sessions have been initiated monthly as a result of a root cause analysis. All community hospital staff are invited and attend as they are able. A session may cover current safeguarding themes, and issues around the Mental Capacity Act, including Deprivation of Liberty.

* **SCAS Street Triage Team Buckinghamshire**

Safeguarding Supervision was held with the Street Triage team 20th September following a service review it was an identified need. Waiting for feedback if this is to become a regular occurrence.

* **Care Home Support Service**

There is a four-week team supervision schedule that is working well. Sessions are well attended, and the team demonstrate good engagement.

* **Community Development Leads (DN team managers) (CDL)**

A group of CDLs (including specialist nurses) meet every 6-8 weeks for supervision. This is a longstanding arrangement and is positively evaluated by members of the group. Other CDLs have successfully joined the supervision sessions set up for the community hospitals.

* **Individual Supervision**

There are times following significant events when people request ad hoc individual supervision to reflect on the event (safeguarding implications). There are two separate individuals currently who are accessing this option.

The clinical teams and individuals are able to request ad hoc reflective sessions with the safeguarding adult's team as required.

**6.7.1 Safeguarding supervision feedback**

Supervision groups continued to be delivered via MS teams during 2021/22. An audit was completed by the safeguarding service to identify benefits, drawbacks, and any quality issues of using virtual mode of delivering supervision. There were 115 responders. Feedback from practitioners has been positive they said.

*Easier to attend, more efficient use of time, more comfortable, feel safe, more orderly interaction, works well, been a lifeline, know my supervisor well – so supportive and knowledgeable.*

‘The virtual medium supports larger groups of attendants than would face to face. A large group with professionals from as many disciplines as possible just serves to provide a wider variety of input. I feel the virtual medium provides for a more orderly interaction and promotes my ability to contribute. I also feel able to reflect and think critically when I attend virtually - even while attending.’

* 1. **Audits**

The Trust safeguarding service audit framework moved to reflect the think family approach being championed across OHFT in its audit programme for 2021-22. Audit activity being supported centrally by the Trust quality team were reviewed for safeguarding children activity being monitored in the audit tool, a safeguarding service team member joined the reviewing group for those audits to support action planning in relation to safeguarding activity requiring improvement.

The safeguarding service participated in multiagency audit work as part of its role as members of the Safeguarding Partnerships/Boards or in partnership with other health providers. The safeguarding service have been part of the Trust peer review programme.

Learning from safeguarding service audits is shared with staff through the safeguarding service newsletter; governance reports; training and supervision sessions.

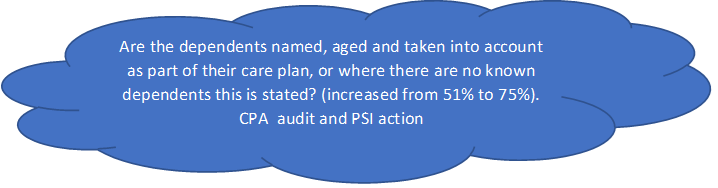
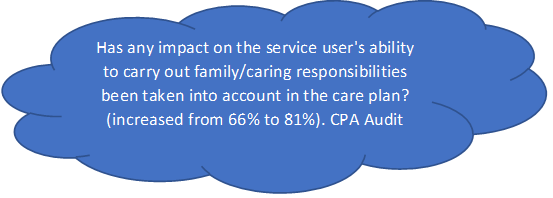
**6.8.1 Trust wide**

**Trust audits reviewed included:**

* SEND Audit
* Safety Plan audit – Mental health services only.
* Care Planning Approach Audit – Community Mental Health Services
* School Nurses Documentation
* Health Visitors Documentation
* Family Nurse Partnership Documentation audit

The service level audits reviewed did not identify any specific areas of safeguarding practice which required actions. Process issues identified by the clinical teams have been addressed by safeguarding service team members.

Key Successes include:



**6.8.2 Safeguarding Service audits**

|  |  |
| --- | --- |
| **Completed Audits 2021/22** | **Safeguarding Service Action Taken** |
| Community Hospitals Deprivation of Liberty Safeguards (DOLS)- | Safeguarding service Named Nurse supported Ward managers and modern matrons to develop DOLS standard operating procedure and Flowchart and make practice changes on the wards. |
| Safeguarding welfare check of child on adult ward processes (Health Based Place of Safety/136 Welfare checks) Audit | Working group established with HBPOS ward staff, Modern Matrons, HBPOS Patient Bed Flow and Case Managers, and policy leads for child on adult ward guidance. The working group has identified changes in practice. These changes to be implemented from 01.08.2022 |
| Supervision audit | Groups offered in the Trust have been reviewed.  Liaison with clinical leaders to support effective group size and timing of sessions.  Safeguarding service have facilitated internal discussions regarding supervision style and delivering supervision virtually. |
| Dip Sample of Domestic Abuse inclusion in risk assessments | Liaison with CRAM trainer has been completed.  Work with wards and clinical staff will commence in Q3 2022-23. |

* + 1. **multi-agency audits**

Findings from Multiagency audits did not identify any specific actions for the Trust to implement. Learning reflected existing knowledge regarding vulnerabilities of certain groups of children; need for professional curiosity and the need to implement think family approaches with specific reference to including fathers more. Safeguarding training resources have been reviewed to ensure learning from audits is reflected in training content. Safeguarding supervision sessions have focused on aspects of learning identified in the multiagency findings.

**Oxfordshire**

The Safeguarding Service have supported the following multi-agency audits

* Neglect Deep dive
* Neglect Child in Need
* Exploitation Audit
* Oxfordshire Section 11 Audit
* Frequent attenders to OUH Emergency Department and/or OHFT out of hours services

**Buckinghamshire**

No multi-agency audits requested by the Buckinghamshire Safeguarding Adults Board or Buckinghamshire Safeguarding Children Partnership in 2021-22.

**BSW**

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

There is local agreement for MASH managers to flag up individual referrals made that are of poor quality to the Senior named professional for safeguarding children so these can be reviewed, feedback provided to staff and learning implemented. A guidance sheet for making referrals in BSW has been updated as a good practice example for all staff.

BSW have engaged in an audit program carried out by the BANES LSCB to review young people who are victim too / involved in exploitation. This piece of work is to contribute towards the review of contextual safeguarding, the outcomes are not yet known.

1. **Policy and procedures**

The following policy updates were completed in 2021/22

* Allegations Policy (HP33)
* Safeguarding Adults Policy (CP25)

1. **Multi-agency Working**

**8.1 multi-agency safeguarding hub (MASH)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Area of work** | **Number completed 2019-20** | **Number completed 2020-21** | **Number completed 2021-22** |
| **MASH enquiries processed** | **Oxon; 3336 (average 13/day)** | **Oxon: 4834 (average 19/day)** | **Oxon : 4726 (average 18/day)** |
|  | **Bucks: 364 processed (110 open cases)** | **Bucks: 367 (139 open cases)** | **Bucks: 638 (253 open cases)** |

**8.1.1 Oxfordshire**

Additional resources have been agreed for the MASH as there was insufficient resource within the Oxfordshire MASH health team to meet demand, leading to a backlog in cases being processed. This presented a risk to children who need safeguarding, as well as reputational damage within the partnership. The Trust Chief Nurse has agreed to funding for 0.5WTE band 6 12-month secondment as an interim measure and this post has now been recruited too.

**8.1.2 Buckinghamshire**

The number of cases processed in Buckinghamshire MASH by the Safeguarding Service has been closely monitored. There has been a significant increase in work in 2021/22 due to the introduction of strategy meetings within the MASH and changes in children’s social care processes.  Additional administrative hours have been agreed by the Trust to help meet this demand.

**8.1.3 BSW**

Wiltshire MASH have an established named CAMHS practitioner who acts as a partner within Wiltshire MASH. The role includes information sharing, joint decision making where a mental health concern is present, attending complex strategy discussions and planning and delivering bespoke training sessions to the MASH team. Swindon MASH are currently recruiting to mental health specialist MASH posts and will be fully embedded in the MASH. BANES to not operate a MASH as the front door, there is a system in place for duty CAMHs clinician to link with the children’s teams. The Safeguarding service do not collect data on this activity as it occurs through the CAMHS duty system.

**8.2 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 and Buckinghamshire during 2021/22 there were SARs completed that explored the issues for people with whom services had difficulty engaging. There is a tension between individual autonomy and duty of care. Services need to be clear about the legal framework in which they work as well employing expert communication skills within the boundaries of the service provision. SAR Ian in Oxfordshire built further on the information from the thematic review of the death of people who were homeless which was completed in 2020/21.

The SARs can be accessed on the website of the local safeguarding adult's board.

**8.3 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 policymakers.

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.

**8.3.1 Child Safeguarding practice review activity which has involved Trust Services**

In 2021/22 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 local Child Safeguarding Practice Review subgroup who make a decision on whether a child safeguarding practice review is recommended. The subgroup will then submit to the national CSPR panel for a decision. The table below shows the rapid response and CSPR activity over the past year.

**8.3.2 CSPRs and rapid reviews undertaken in 2021/22**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Area** | **Rapid review completed** | **Published CSPRs** | **Completed &/or awaiting publication** | **Ongoing CSPRs** | **Partnership review** | **Outstanding actions** |
| **Oxfordshire** | 6 | 1 | 2 | 1 | 1 | 0 |
| **Buckinghamshire** | 1 | 1 | 1 | 1  (Joint SAR/CSPR) | 1 | 0 |
| **B&NES** | 1 | 0 | 0 | 1 | 0 | 0 |
| **Swindon** | 2 | 0 | 0 | 0 | 1 | 0 |
| **Wiltshire** | 1 | 0 | 0 | 0 | 0 | 0 |

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

* + 1. **Learning identified from CSPRS**
* Child sexual abuse. We need to know how to recognise it, how to talk about it

and how to address it with care. Children need to feel heard and feel safe.

* Behaviours demonstrating a child’s trauma and their need for help when they

are not telling us using words, in particular if they are non-verbal.

* Thinking about how we talk ‘to’ and ‘about’ children. Thinking through what

words we use when we respond to children seeking help. Moving from “what is

wrong with you” to “what has happened to you”. This includes how we write

about children.

* The long-lasting impact of adverse childhood experiences which play out as

a child becomes an adolescent and then a young person.

* We need to recognise emotional abuse and emotional neglect and the role that child blame plays within

this.

* Safe sleeping. Getting the message out there to all parents and carers, not just

Mums

* Working with fathers and male carers. In the majority of reviews, where a

child was harmed by an adult; the adult was a male and not enough was known

or understood about that adult. Attention needs to be given to the whole family

and all those who care for the children.

**8.3.4 Implementing learning from CSPRs**

The safeguarding children team has been actively involved in sharing learning from 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. The professionals involved in developing this work received a commendation from the Chair of the OSCB.
* Development of a consistent approach around frequent attenders who present to acute, out of hours and ambulance services
* 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
* Embedding Early Help processes via supervision, consultations and resources and working with multi-agency partners
* The learning from reviews is included in a monthly safeguarding children newsletter/update and shared at governance and locality meetings
* A school health nurse has played a proactive role with a newly developed multi-professional Child Exploitation education workstream group
* A school health nurse who previously worked in the CSE team, has been part of the subgroup tasked to develop a Threshold of Needs resource to support, those in education, to “Recognise and Respond to Exploitation.” This resource will follow a contextualised safeguarding approach and will help with identifying early indicators and risks associated with exploitation. This resource will be available to all on the OSCB website once completed and aims to go live from September 2022.
* Family nurse partnership (FNP) service are developing stronger connections with GPs by attending GP safeguarding meetings in their area.
* FNP have increased their understanding around the impact of sexual abuse on parenting. Stronger links have been made with the Horizon team, and the team’s psychotherapist supports discussions in team supervision.
* FNP explore rigorously in supervision, children who have high scores for emotional and social development, and plans put in place for follow up with paediatricians if needed.
* There is representation at the Care Leavers and Parenthood Work Group by FNP and the Safeguarding service. The group are involved in addressing a recommendation from a recent CSPR which is looking at more focused support and interventions for teenage parents, in particular “Children We Care For” and Care Leavers who are likely to have experienced trauma and potentially greater safeguarding risk. A project plan is being developed within this group.
* The safeguarding service has been part of a scoping group for delivering child sexual abuse training and which included FNP feedback.
* A service manager within the Community directorate and representative from the safeguarding service has been supporting a working group established from a thematic review focussing on Safe Sleeping - Improving the Response in 2021-22.

**Health visiting use of the joint activity pathway:**

*A health visitor was working with a pregnant mother who had complex mental health needs and was diagnosed with learning disability; severe depression and a binge eating disorder. She was put on a child protection plan due to concerns around neglect. The health visiting team and the adult mental health team liaised to ensure core groups were updated and plans were combined to ensure a consistent approach.*

*The adult mental health team, health visitor and social workers worked together to enable the mother to move into a supported mother and baby placement where she received intensive support and care.*

*The collaborative working enabled the mother to have the best possible chance to be able to demonstrate that despite her complex circumstances she could provide a loving, safe, and emotionally stable start to her baby's life.*

**9. Child Death Overview Process (CDOP)**

**9.1 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 across all Trust geographical areas. 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.

**9.2 Data Breakdown 2021-2022**

In 2021-2022 the Trust supported CDOP processes for 92 children. (2020/21- 61 children)

In Oxfordshire the Health Visiting team acted as CDOP keyworker for 2 families.

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

The School Health Nurses (Oxfordshire) and CAMHS teams supported the CDOP process by attending the Joint Agency Review (JAR) meetings to support the school/college and local 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/ colleges 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. In cases where the child had been in placements in more than one area, CAMHS staff linked across all three geographic areas and were proactive in identifying children who may know the child due to their placements, education setting or social contacts and ensure they were effectively supported if there were changes to their mental health as result of hearing of a child’s sad death.

* Some families were known to more than one service.

|  |  |  |  |
| --- | --- | --- | --- |
| **Area** | **CDOP cases reviewed 2020-21** | **CDOP cases reviewed 2021-22** | **Known to Oxford Health services 2021/22** |
| **Berkshire** | 1 | 25 | 0 |
| **BSW** | 8 | 4 | 3 |
| **Bucks** | 31 | 31 | 3 |
| **Oxon** | 21 | 33 | 34 |

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

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

In Buckinghamshire, the JARS are coordinated by the Buckinghamshire Healthcare Trust Paediatric service. Trust staff are not always invited to attend the meetings. 3 JARS were attended in Bucks during this reporting period.

In BSW the Safeguarding Named Professional attends the JAR. A CAMHS service manager may also attend. JAR meetings are also attended in BSW when the child is not known to services to support safeguarding actions for children attending the same school/ leisure activities who may be affected by the death of the child and implement wider learning.

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

CDRMs are held approximately 12 weeks after the child. During 2020-21these meeting did not take place. Some CDRM’s began to be held in Oxfordshire towards the end of 2021-2022.

**9.5 CDOP panel meetings**

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

No OHFT specific learning has been identified at CDOP panel meetings in Oxfordshire. Learning regarding professional curiosity when mother reports to services they are fine but clinical assessment is they are not, was shared to OUH midwifery services and OHFT health visiting teams.

OHFT only attend CDOP panel meetings in Bucks when cases are reviewed who are known to CAMHS. No Panel meetings have been attended in 2021-22.

Panel Meetings are not attended in BSW.

**9.6** **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 and Safeguarding Named Nurse has been supporting a working group established form a thematic review focussing on Safe Sleeping - Improving the Response in 2021-22. The group has now ended.

* + 1. **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.

**10.1.1 Oxfordshire**

Neglect work continues to be a priority across all agencies in Oxfordshire. Oxford Health has produced an action plan, that is updated every quarter and presented at the OSCB Neglect Strategic Meetings by a member of the children facing part of the safeguarding service.

A new Neglect Task and finish group is being developed across both adult and children services to ensure that new developments, tools, and initiatives can be discussed and shared with teams operationally. The Neglect Tool or Childcare Development checklist has been on Carenotes since March 2021 allowing staff to have more improved access to completion of the assessment tool. Reports from the performance team have highlighted that this is not being accessed as well as it could be and that the numbers completed are low.

One of the functions of the task group will be to identify how this can be improved. The safeguarding service have been working closely with community teams to deliver bespoke sessions for teams and at conferences on managing challenging conversations with families where neglect may be identified. Neglect continues to be one of the key points of discussion at supervision groups giving the opportunity to promote the use of tools with families.

Neglect forums continue across the county with a wide range of practitioners from agencies attending and varied sessions delivered with a focus on neglect.

**10.1.2 Buckinghamshire**

The Graded Care Profile -2 has been agreed as the tool of choice for Buckinghamshire, however, having met with the NSPCC it is clear that this tool can only be used by trained staff in particular roles and would not be suitable for all practitioners in all organisations. (Social Workers, Health Visitors, School Nurses and Early Help Practitioners were identified as suitable practitioners by the NSPCC)

 Consideration will need to be given of how individual organisations will approach assessment of children and families at risk of or suffering neglect and how this will feed into those practitioners who will be using the GCP-2 tool.  This work will remain the responsibility of ALL practitioners and we need a process that ensures working together with those trained in the GCP-2 tool to not only assess but continue to work with and monitor outcomes for these children and families.

 A senior level steering group is being set up to achieve this and will include Trust representation.

**10.1.3 BSW**

Both Swindon and Wiltshire local authorities are partners in the implementation of 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.

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.

**11. Public protection work**

**11.1 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. 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 a deputy Prevent lead to ensure cover for Channel meetings. The Prevent Boards in Oxfordshire and Buckinghamshire were attended by the Associate Director of Social Care in 2021/22.

The Prevent Training and Competencies Framework was published in April 2021. Work with the learning and development team has ensured that the correct prevent training is included on staff training matrices.

**11.2 Domestic Abuse**

The safeguarding service recognises that domestic abuse continues to be one of the top reasons from staff to the consultation to the safeguarding service. However, the numbers of referrals from the Trust into Multi-agency risk assessment conference (MARAC) remain at a low level.

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 2021`/22 has been to provide internal support to Domestic Abuse Champions quarterly. 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 with specific reference to working virtually. 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 and implemented.

**11.2.1** **Domestic Abuse Adults DASH Checklist for Adults, and Domestic Abuse Children and Young People (CYP) DASH Checklist**

The Domestic Abuse DASH Checklist for Adults, and Domestic Abuse DASH Checklist for CYP was available in Mental Health and Community Health Carenotes from October 2021.

The DASH checklist assesses risk associated with domestic abuse and is also part of the process of referral to the multi-agency risk assessment conference (MARAC). MARAC is a multi-agency meeting to ensure there is a safety plan around victims considered at high risk from domestic abuse.

**11.2.2 Domestic Abuse Strategic Board and Operational Groups**

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 in 2021/22 was the Associate Director of Social Care in Buckinghamshire and Oxfordshire. There is representation from the Safeguarding Service on the operational groups.

* + 1. **Multi-agency domestic abuse scrutiny panels**

Multi-agency domestic abuse scrutiny panels have been introduced across the Thames Valley. The safeguarding service provided representation at these panels.

The panel will provide independent oversight and scrutiny to review and improve the response to, and the investigation of domestic abuse and the support and safeguarding of domestic abuse victims. See embedded terms of reference. Representative will feedback good practice and learning.

**11.2.4 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 Victim and Perpetrators programmes and young people’s pathway. A multi-agency group is moving forward with a revised Domestic abuse strategy for Wiltshire.

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

The safeguarding service is involved in supporting MARAC meetings in all geographical areas. Health staff attend MARAC to contribute to safety plans around those experiencing domestic abuse, with an aim for people to make changes and reduce their personal risk.

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.

**MARAC referrals made by the Trust**

|  |  |  |
| --- | --- | --- |
|  | **2020/21** | **2021/22** |
| Oxfordshire | 4 | 2 |
| Buckinghamshire | 3 | 1 |
| BSW | 0 | 0 |

**11.3.2 Multi-Agency Task and Coordination (MATAC)**

There is Safeguarding Service representation at Buckinghamshire and South Oxfordshire MATAC. This is a meeting where cases are discussed which do not meet the risk level for MARAC but have frequent contact with the police. Information sharing agreements are in place for both counties. Buckinghamshire meetings are held on an ad hoc basis when cases are identified by TVP (Thames Valley Police). MATAC happens monthly in South of Oxfordshire and is part of the Joint Tasking Meeting. In the future MATACs may take place in North Oxfordshire and the City.

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | **2019/20** | **2020/21** | **2021/22** |
| Multi-Agency Public  Protection Arrangements  (MAPPA) information shares | 43 | 51 | 21 |
|  |  |  |  |

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 to support risk planning as appropriate. Input into MAPPA by the safeguarding children team is being reviewed to ensure consistency across geographical areas.

**11.5 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.

30 cases were discussed at the monthly No Name FGM meeting from April 2021 - March 2022. An increase from 19 cases in 2021-22.

Of the 30 women discussed, 10 names of children or mothers were shared with School Health Nurses or Health Visitors.  Carenotes alerts were added to 5 families. The rest required no further action as plans were in place or male babies were delivered.

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

BSW have been involved in reviewing the FGM Policy with BANES Safeguarding board, this concluded in 2022.

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

The monthly No Names FGM meetings have continued via Teams. This has proved an effective way to enhance the multiagency attendance at this meeting and has aided communications by widening attendance for participating organisations. We now have more Social Work students observing on a regular basis.

Case study

A victim of FGM, arrived in the UK. She had children from an arranged marriage but sadly her husband died, she was ordered to marry his brother. She declined and became subject to Honour Based Violence. To escape she had to leave her children behind in her country of origin and was allowed no contact with them. She presented to the Rose Clinic pregnant to a local man.

The client had been sent a routine antenatal letter advising of the HV service and inviting contact. The client never responded. Unknown to the Midwives and Health Visitors, the client lived in fear of being found and was grieving for her children.

Once the history was shared with the HV service, a follow up appointment was arranged, and targeted support commenced.

**11.6 Modern slavery**

Modern slavery continues to be highlighted to staff within the Trust to recognise and respond if they identify modern slavery which meets our statutory commitment. 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.  Buckinghamshire anti-slavery network has joined with the exploitation sub-group in 2021/22. Members of the safeguarding service represent the Trust at the Oxfordshire network and Buckinghamshire Exploitation sub-group.  The network meetings were paused during 2020 and recommenced in 2021.

**11.7 Serious violence**

The Government’s Serious Violence Strategy sets out the government’s response to serious violence and recent increases in knife crime, gun crime and homicide. The Strategy advocates a Public Health approach with a focus on early intervention, safeguarding and disruption activities with young persons under the age of 25 years.

**11.7.1 Oxfordshire**

Designated safeguarding lead CCG attends the Violence Reduction Unit strategic board meeting for the Integrated Care System. Providers were asked to offer any suggestions additions and issues would want to see as part of the strategic planning for the next year in relation to reducing serious violence including violence against women and girls. The plan focuses on supporting partners to build local capacity, to work with the community and voluntary sector, to support a shift in activity to earlier interventions and prevention, and to support the increased use of data-informed approaches.

**11.7.2 Buckinghamshire**

A serious violence task force convened in April 2021. The meeting monitors the Safer Buckinghamshire serious violence plan and asks for updates from partners regarding any work/projects relating to serious violence. There is representation on this group from the safeguarding Service.

**11.7.3 BSW**

Wiltshire formed an Early Intervention & Violence Reduction Subgroup in Jan 2022 which went on to form a further working group across Wiltshire and Swindon to discuss the potential implementation of ‘The Blunt Truth’ within schools/colleges and consider the wider prevention offer around knife/weapons awareness across the Wiltshire and Swindon Partnership.

**11.8 Child Exploitation**

The Trust are engaged at a strategic and operational level to respond to child exploitation.

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

**11.8.1 Oxfordshire**

A Child Safeguarding Practice Review relating to Jacob a young person who was exploited has resulted in the introduction of three work stream groups- Working Together, Education Delivery, Child Exploitation. Each group has identified priorities to implement the learning from Jacob and support the aim to have a revised system for tackling exploitation in Oxfordshire. Each group has representation from appropriate Trust staff.

Progress of these groups have been monitored by Child exploitation work steam meeting, the exploitation sub-group, OSCB and Multi-Agency Safeguarding Arrangements group.

Missing and Exploited Panel meetings, 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.

**11.8.2 Buckinghamshire**

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. 

In December 2021 it was agreed by Buckinghamshire Safeguarding Adults Board, Safer Bucks Board and Buckinghamshire Safeguarding Children Partnership exploitation subgroup that a joint adult and child exploitation subgroup should be formed which would also include the modern slavery network meeting. The Serious Violence Task Group will remain at a separate group until the new duty was embedded.

The exploitation sub-group is attended by the safeguarding service.

**11.8.3 BSW**

The child exploitation and missing sub-groups in Wiltshire and Swindon have merged into one ‘Pan Wiltshire criminal exploitation’ sub-group, held virtually with all partners. These meetings are attended by members of the safeguarding service. The exploitation sub-group in BANES is attended by the BANES CAMHS team manager.

Wiltshire is a pilot for the University of Bedfordshire’s contextual safeguarding project. A member of safeguarding service is a member of the implementation / steering group and for the Wiltshire health group led by the CCG Safeguarding Designated Nurse. This project has seen the redesign of the Wiltshire CSE team within the MASH to an ‘Exploitation team’ which offers children at risk of extra familiar harm a service. A new ‘Risk outside the Home’ (ROTH) pathway has been introduced in 2022 under the Department of Education, meaning children in Wiltshire may be referred to a ROTH conference instead of an Initial child protection conference.

BANES are also linked to Bristol city as another contextual safeguarding pilot site. The implementation of this is discussed in the ‘Regional complex safeguarding’ meeting which is attended by the Safeguarding service in BSW. Both BANES and Swindon are considering the learning from the Wiltshire pilot and how these changes can be implemented within their own services.

**Appendix 1**

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| **Glossary** | |
| **CAMHS** | **Child and Adolescent Mental Health Services** |
| **CCG** | **Clinical Commissioning Group** |
| **CDOP** | **Child Death Overview Process** |
| **CSE** | **Child Sexual Exploitation** |
| **FGM** | **Female Genital Mutilation** |
| **Intercollegiate Documents** | **This refers to two documents developed by the Royal Colleges. There is one document for roles and responsibilities in safeguarding adults and one for roles and responsibilities in safeguarding children.  They have been accepted by the NHS as the competency framework for safeguarding.** |
| **Kingfisher Team** | **This was set up within Oxfordshire County Council in response to the child sexual exploitation identified.  It is a multi-agency team.** |
| **LSAB** | **Local Safeguarding Adults Board; Under the Care Act 2014 every local authority area has a safeguarding adults board in place.  Its functions as set out in the Care Act are:**   * **assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance** * **assuring itself that safeguarding practice is person-centred and outcome-focused** * **working collaboratively to prevent abuse and neglect where possible** * **ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred** * **assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.** |
| **LSCB/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.** |

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