Title | Oxford University Foundation Trust (OUHFT) Safeguarding (Children and Adults) Report 2015-2016

Status | For information

History | The previous Safeguarding Children and Adults Annual Report was presented at the OUH Trust Board on 9 March 2016
Presented to the Quality Committee on 12 October 2016

Board Lead(s) | Ms Catherine Stoddart, Chief Nurse

| Key purpose | Strategy | Assurance | Policy | Performance |
# Executive Summary

1. This annual report provides a summary of the key issues and activity in relation to Safeguarding of Children and Adults during 2015/16.

2. The Chief Nurse represents the OUH on the Oxfordshire Children Safeguarding Board (OSCB) as Deputy Chair.
   The Chief Nurse is represented on behalf of OUHT on the Oxfordshire Adults' Safeguarding Board (OSAB) by the Head of Patient Experience.

3. Safeguarding Children Activity has increased this year, consultations to the team by 346 and to the liaison service by 272. This is reflected in the Oxfordshire data.

4. Safeguarding Adult Activity has increased this year with 299 consultations. There have been 38 safeguarding alerts raised about OUH services, of these 32 have been Section 42 information requests (Care Act 2014).

5. Child Safeguarding Training meets the requirements set out by the national intercollegiate document. The training compliance for both children and adult safeguarding is below the Oxfordshire Clinical Commissioning Group’s Key Performance Indicator (KPI) of 90%.

6. Both teams provide considerable partnership support across the county. The Teams are active members of the OSCB and OSAB subgroups. Additionally the teams are core members of key multiagency for a including MARAC (Multiagency Risk Assessment Conferences) and Channel Panels.

7. The Children’s Safeguarding Team achieved exemplary (Blue) category in the OSAB Section 11 Self-Assessment.

8. Recommendation
   The Trust Board is asked to note the contents of the report.
1. Definitions

1.1 Safeguarding Children
- A child is an individual under the age of 18yrs.
- The Children Act (1989, 2004) states that the welfare of the child is paramount and that all practitioners are required to protect children prevent the impairment of health and development and ensure they are provided safe and effective care in order to fulfil their potential.

1.2 Safeguarding adults
- An adult is an individual aged 18yrs or over.
- The safeguarding duties apply to an adult who has needs for care and support (whether or not the local authority is meeting any of those needs), and:
  - is experiencing, or at risk of, abuse or neglect
  - as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

2. Purpose

2.1 This paper presents the annual report for safeguarding children and adults for April 2015 to March 2016 in line with ‘Working Together to Safeguard Children’ 2013 and the Care Act 2014. This sets out the requirement for Trust Boards to produce an annual report with an analysis of the effectiveness of local safeguarding arrangements. The last annual safeguarding report was received by the Trust Board in January 2016.

3. Background

3.1 The safeguarding children team is led by the Lead Safeguarding Children and Patient Experience. See appendix 1 fig. 1 for the structure of the Safeguarding Children team. In July 2015, following a service contract variation from Oxford Health, the Paediatric liaison Service was integrated into the team in July 2015.

3.2 The safeguarding adult team is led by the Head of Patient Experience. See appendix 1 figure 2, for the structure of the Safeguarding Adults Team. Strengthening the establishment has increased the support given to clinicians and expertise available to the organisation.

4. Safeguarding Children Activity

4.1 There were 1028 consultations with the safeguarding children team, which is an increase of 33% (n= 346) from the previous year (Figure 1). This averaged 86 per month. The predominant category of abuse was neglect and physical abuse (Figure 2). There was an increase in the number referrals in which Fabricating Induced Illness (FII) was suspected. These

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cases are always complicated and the investigation often takes considerable time to draw to a conclusion.

Figure 1: Safeguarding Children Team Consultations 2014-2016

4.2 The main categories of abuse are neglect and physical.

Figure 2: Categories of abuse

4.3 The safeguarding liaison service (formally the paediatric/health visiting service) was integrated into the safeguarding children team in July 2015. This service was previously managed by Oxford Health NHS FT. This service shared information to primary care for all under one year old babies and children who attended ED with a safeguarding concerns, as well as adults where a concern was raised related to a possible safeguarding concern for a child. The criteria for sending an alert for both adult and children can be seen in appendix 2. Cases were prospectively reviewed from EPR to ensure any gaps in referral to the safeguarding liaison service are identified and ensure information was shared.

4.4 The numbers of cases meeting the safeguarding alert criteria referred from ED has increased this year by 272 alerts (Figure 3).
4.5 There were 534 children with a Child Protection Plan (CPP) at the end of March 2016. This was a reduction of 11% from the 2015/16. Over half (58%) the children were on a CPP for neglect. However, there was also a rise of 18% (n=609) in the number of children that were ‘Looked After’.

4.6 There has been activity this year in all areas of child protection across Oxfordshire as shown in Table 1, below in the local authority statistics.

<table>
<thead>
<tr>
<th></th>
<th>13/14</th>
<th>14/15</th>
<th>% Change</th>
<th>15/16</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals</td>
<td>5905</td>
<td>5663</td>
<td>-4.1</td>
<td>6750</td>
<td>19.2</td>
</tr>
<tr>
<td>Single assessments</td>
<td>1195</td>
<td>3767</td>
<td>215.23</td>
<td>5516</td>
<td>46.4</td>
</tr>
<tr>
<td>Section 47</td>
<td>1582</td>
<td>1581</td>
<td>-0.06</td>
<td>1864</td>
<td>17.9</td>
</tr>
<tr>
<td>ICPC</td>
<td>604</td>
<td>677</td>
<td>12.09</td>
<td>767</td>
<td>13.3</td>
</tr>
<tr>
<td>Children coming onto a plan</td>
<td>579</td>
<td>634</td>
<td>9.5</td>
<td>708</td>
<td>11.7</td>
</tr>
<tr>
<td>Children coming off a plan</td>
<td>503</td>
<td>569</td>
<td>13.12</td>
<td>705</td>
<td>23.9</td>
</tr>
<tr>
<td>Children becoming Looked After</td>
<td>298</td>
<td>287</td>
<td>-3.69</td>
<td>355</td>
<td>23.7</td>
</tr>
</tbody>
</table>

Table 1: Oxfordshire Child protection data across Oxfordshire Source: Oxfordshire County Council

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2 A looked after child may either be accommodated (which means that the council is looking after them with the agreement, at the request or in the absence of their parents) or subject to a Care Order made by the Family Courts.
4.7 The Oxfordshire Children Safeguarding Board (OSCB) Section 11 (Children Act 2004) self-assessment report was submitted and graded as ‘Blue’\(^3\) which is the highest level that can be achieved. A peer review process was used again this year to validate the assessments. This will be the last children’s only review as from 2016 and 2017 this will be a joint children and adult review and the assessment tool was been agreed by the OSCB and OSAB.

4.8 There were 8,703 maternal bookings, of these 10.1\% (n = 879) were identified as either category 3 or 4 public health risk\(^4\). As in previous years the dominant category of concern was maternal mental health issues (Table 2).

<table>
<thead>
<tr>
<th>2015 – 16 Maternal Booking 8,703</th>
<th>H&amp;S 3&amp;4</th>
<th>Teenage Pregnancy</th>
<th>Safeguarding</th>
<th>Mental Health</th>
<th>Domestic Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>879</td>
<td>141</td>
<td>214</td>
<td>472</td>
<td>52</td>
</tr>
<tr>
<td>10.1% (of all bookings)</td>
<td>16%</td>
<td>24%</td>
<td></td>
<td>54%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Table 2: Health and Safety Public Health Risk Categories 3 and 4.

4.9 A simulation took place in maternity to abduct a baby from a ward, to follow the policy to test for any gaps. This was a successful exercise and identified areas of the policy that need to be reviewed. Changes were made to the hospital switchboard to ensure the correct cascade process. Plans are in place to repeat the exercise in different areas of maternity and children's services when the policy is updated.

4.10 Serious Case Reviews (SCR) are commissioned by the Local SCB when a child or young person dies, or experiences serious harm or injuries and where there are multiagency lessons to be learnt. Three reviews were completed during the year:
- The death of a baby where the father was convicted of manslaughter and serving a prison sentence.
- A baby who died from drowning in the bath. A CPP was already in place because of neglect.
- A joint SCR and domestic homicide review following the death of a 17 year old.

There were 4 on-going reviews:
- The death of a baby where the cause was attributed to co-sleeping
- The abuse of two children in guardianship care.

\(^3\)Is able to provide evidence of compliance for all 8 standards  
\(^4\)Maternal Health & Social Score Level 3 = low obstetric/high public health risk Level 4 = high obstetric/high public health risk
- The suicide of a 14 year old whilst in local authority care: This was delayed awaiting a corporate manslaughter judicial response from an organisation outside of Oxfordshire.
- The Domestic Homicide Review (DHR) following the murder of a six year old, along with her mother and stepfather, by the half-brother.

5. Safeguarding Adult Activity

5.1 The Adult Safeguarding Team has provided advice and support to clinical staff in relation to 299 vulnerable adult patients during the year. This advice is mainly offered to clinical staff and involves the Mental Capacity Act, DOLS, domestic abuse, safe discharge, packages of care at home and safeguarding.

5.2 The Care Act 2014 introduced a new legal duty to investigate if an adult with care and support needs is exposed to risk or is at risk of abuse or neglect, and is unable to protect themselves. This is contained in Section 42 of the Act and is now known as a ‘Section 42 investigation’.

5.3 The Care Act\(^5\) requires local authorities to make proportionate enquiries where there is a concern about the possible abuse or neglect of an adult at risk. Additionally, non-statutory enquiries may also be carried out or instigated by local authorities in response to concerns about carers, or about adults who, although do not have care and support needs, may still be at risk of abuse or neglect. This is defined as the local authority’s ‘wellbeing’ duty under Section 1 of the Act.

5.4 There have been 38 safeguarding alerts related to concerns expressed about OUH care. Of these, 32 were investigated under section 42 of the Care Act 2014. Figure 4, below, shows the number of Section 42 requests by month.

\[\text{Number of section 42 requests}\]

![Chart 1: Figure 4: The number of Section 42 requests across 2015/16.](http://www.scie.org.uk/care-act-2014/safeguarding-adults/adult-safeguarding-practice-questions/)

5.5 The themes relate to pressure ulcers, lack of information passed onto care homes and poor discharge processes.

5.6 Of the 32, 13 (40%) were substantiated. The themes related to Hospital Acquired Pressure Ulcers (HAPU), poor discharge processes and injuries sustained on the wards. The Safeguarding Adults team are members of the Pressure Ulcer Prevention Clinical Improvement Group (PUPCIG) and Discharge Oversight Group, and feedback the outcomes of investigations to aid Trust-wide learning.

5.7 There were 904 DATIX incidents which were been reviewed by the Safeguarding Adults Team. The vast majority of these related to pressure ulcers, and also those marked as being a safeguarding concern by the person completing the DATIX. These include concerns from within the OUH and from the community or other hospitals.

5.8 A representative from the Safeguarding Adults team attends the SIRI forum each week, to advise whether an incident should be raised as a Safeguarding Alert or a Safeguarding Adults review (SAR).

5.9 In order to avoid duplicating safeguarding investigations relating to HAPU, once the SIRI report was signed off and closed by the CCG it was forwarded to the Oxfordshire Safeguarding Group for information. The Annual Pressure Ulcer Audit will be presented at the Oxfordshire Safeguarding Adult Board (OSAB) Performance Information and Assurance Group (PIQA) on 14 December 2016.

6. **Partnership Working**

6.1 There has been participation at sub-groups of the OSCB, Training, Performance and Quality Assurance (PAQA), Child Death Overview Panel (CDOP) and Policies and Procedures. There was regular attendance at the Executive Group and at every Board meeting.

6.2 The Safeguarding Children Team continued to provide a practitioner for 2 days, and 1 day of administration a week to contribute to the Multi-Agency Safeguarding Hub (MASH). The Children’s Safeguarding Team attended both the MASH strategy and operational group to discuss effectiveness of the service.

6.3 The children's social care team, based at the JR, functioned alongside the MASH process to safeguard children who were admitted as inpatients and provided pre-natal assessment in maternity. As there was no social care team on site at the Horton Hospital referrals went directly to the MASH.

6.4 The Safeguarding Children team participated in the CQC Multi-Agency Thematic Inspection for CSE and missing children and included a review of the ‘Front Door’ children’s social care services. The feedback was positive, specifically joint working and sharing information to recognise abuse. The report, published May 2016, highlighted the need to review the ‘front door’ processes and the working and effectiveness of the MASH.

6.5 The Safeguarding Children team were involved in the Child Protection - Information Sharing (CP-IS) national data set. This was to enable a national check of children on CPP’s. There was collaborative working

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6 The MASH is based at Cowley Road Police Station and was set up in October 2014 to enable multi-agency sharing of information in order to assess risks to adults and children at an early stage and to identify vulnerable children and adults.
with NHS England with the aim for 80% of the counties in England and Wales to be able to access information and for an alert to be placed on the records of those children subject to plans.

6.6 There has been participation at sub-groups of the OSAB; Training, Performance, Information and Quality Assurance (PIQA), Policies in Practice, Safeguarding Adults Reviews (SAR) subgroups, DOLS Group and monitoring. There was regular attendance at every Board meeting.

6.7 Multi-Agency Risk Assessment Conferences MARAC: The Children and Adults Safeguarding Teams role within the MARACs is detailed in section 9, below.

6.8 CHANNEL Panel: The Children and Adults Safeguarding Teams role within the CHANNEL Panel is detailed in section 10, below.

7. Training

7.1 The Safeguarding Children training met the requirements set out in the Intercollegiate Document 2014\(^7\). Compliance was 6% below the 90% KPI set by Oxfordshire Clinical Commissioning Group (OCCG) (Table 3).

<table>
<thead>
<tr>
<th>Division</th>
<th>% Compliance</th>
<th>Staff trained</th>
<th>GAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>84.2%</td>
<td>3,039</td>
<td>551</td>
</tr>
<tr>
<td>Level 2</td>
<td>85.2%</td>
<td>5,155</td>
<td>908</td>
</tr>
<tr>
<td>Level 3</td>
<td>83.3%</td>
<td>1,320</td>
<td>322</td>
</tr>
</tbody>
</table>

Table 3: Trustwide Safeguarding Children Training Compliance figures

7.2 Compliance with Safeguarding Adults training was 84.7% (5.3% below the 90% key performance indicator (KPI) set with the OCCG (Table 4).

| Adult    | 84.7%        | 6,180         | 1,116 |

Table 4: Trustwide Safeguarding Adults Training Compliance figures

7.3 However, an analysis of the adult and children safeguarding training figures revealed that, at any one time, approximately 5% of all staff with Safeguarding training on their ELMS was either: no longer working for the Trust; working across two Trusts and completing the training with the other; on maternity leave; or held an honorary contract.

7.4 The introductory safeguarding training provided by the Trust was a joint children and adult presentation delivered during the Trust’s induction programme. It was reviewed and amended to include Mental Capacity Act (MCA), Prevent, Modern Slavery, Female Genital Mutilation (FGM) and Human Trafficking. It is currently delivered by the Learning and

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\(^7\) Safeguarding children and young people: Roles and responsibilities for health care staff. Intercollegiate Guidance Third Edition: March 2014
http://www.ehcp.co.uk/content/sites/ehcap/uploads/NewsDocuments/199/Safeguarding-Children-Roles-and-Competences-for-Healthcare-Staff--02-0----2.PDF
Development Team but from July 2016 this will be taken on by the Safeguarding Teams.

7.5 The Safeguarding Children’s and Adults Teams reviewed the Level 1 and Level 2 Children and Adults’ workbooks and the Level 2 e-learning, both of which are due to be uploaded later in 2016.

7.6 The second Safeguarding Leaders programme held during July and September 2015 was attended by 28 delegates, including Physiotherapists, Occupational therapist and Pharmacists’ from Neurosciences Orthopaedics, Trauma and Specialist Surgery (NOTSS), Clinical support Services (CSS), Medicine Rehabilitation and Cardiac (MRC) and Surgery and Oncology (SO). All delegates became key links for safeguarding adults within their departments; and provided additional local support and assistance on issues relating to safeguarding adults. The next three day training course will take place in September, October and November 2016. This training will be also open to partner agencies within the OSAB.

7.7 The Children and Adults safeguarding teams have delivered bespoke training to clinical teams to increase their knowledge and awareness of safeguarding.

7.7.1 There were 52 sessions of Safeguarding Children Level 3 or bespoke training sessions delivered to 912 staff. A further 501 staff attended Safeguarding Level 3 Forums where safeguarding children cases were discussed and peer reviewed.

7.7.2 Bespoke training, delivered by the Children’s Safeguarding Team, included the use of ‘Spotting the Signs for Child Sexual Exploitation’, assessing the ‘Consent to Sex Awareness’, FGM and bespoke level 3 to teams to meet their specific needs e.g. ED. Three safeguarding level 3 sessions were delivered at Oxford Brookes University. There was contribution by the team to three OSCB Designated Leads courses and one Sexual Health Awareness session.

7.7.3 Bespoke training was delivered by the Lead Adult Safeguarding including training staff working in Dermatology with a focus on Domestic Abuse, training in OCE and ICU with emphasis on DOLS, training on Sobell House prioritising the process of raising alerts, training on F Ward exploring complex safeguarding issues. This training was delivered because of a particular request by the ward staff, or because particular practice had been highlighted and support was required.

7.8 Prevent awareness training was received by 2379 members of staff. A further 76 received WRAP training and of these 28 staff were registered with the Home Office to deliver training.

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8 Prevent is part of the government counter-terrorism strategy, it’s designed to tackle the problem of terrorism at its roots, preventing people from supporting terrorism or becoming involved in terrorism themselves.

9 WRAP is a workshop to give an understanding of the Prevent strategy, the ability to use existing expertise and professional judgment to recognise the vulnerable individuals who may need support, and people to contact for further help and advice.
7.9 The Wrap 3 training was developed by the Home Office and has been in use since January 2015. It was felt timely to update this national training. This was escalated to Oxfordshire CCG. The Prevent training figures for the Trust were submitted to the NHS England and Oxfordshire CCG on a quarterly basis.

7.10 Delivering Compassionate Care (DCC) training programme was held on a weekly basis, facilitated by the Organisational Development Team (OD) within the Workforce Directorate. The training included an overview of safeguarding, particularly focussing on the ways in which safeguarding concerns could be revealed in the hospital setting and thus helps attendees to articulate their concerns in relation to a situation and how to escalate these appropriately.

8. Policies
8.1 Two policies pertaining to domestic abuse were produced to support both patients and staff.

8.2 There was collaborative work with Thames Valley Police (TVP), the Safeguarding Children Team, Lead Nurse (Patient Pathway Co-ordinator Team) and Head of Security Services to clarify the arrangements when a patient goes missing from Trust property. This culminated in the development of an algorithm and accompanying procedure, and will be presented to the Trust’s Clinical Policy and Procedures Group in October 2016.

9. Domestic Abuse
9.1 The Safeguarding Children’s and Adults teams’ and Community Safety Practitioner shared the responsibility for the Trust’s attendance at the county’s Multi-Agency Risk Assessment Conferences (MARACs)\textsuperscript{10}\textsuperscript{11}. It is envisaged that this will lead to more collaborative work with outside agencies to reduce families risk from Domestic Abuse.

9.2 Safeguarding Children attendance continues to provide a focus on child safeguarding, to support the co-ordinated safety plan and share relevant information in cases where there was high risk of domestic abuse. Information was documented on EPR where relevant information was shared.

9.3 The Safeguarding Children’s and Adults teams continue to strengthen the training, coordination, specialist support and partnership working in relation to Domestic Abuse.

10. Radicalisation and Prevent

\textsuperscript{10}MARAC http://www.caada.org.uk/practice-support/resources-identifying-risk-victims-face

\textsuperscript{11}MARAC: Regular local multiagency meetings where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared. The multiagency partnership with the voice of the victim is represented by an Independent Domestic Violence Advocate(IDVA), enables a risk focused, co-ordinated safety plan can be drawn up to support the victim. There are currently over 270 MARACs operating across England, Wales, and Scotland and Northern Ireland managing more than 64,000 cases a year.
10.1 Prevent forms part of the Counter Terrorism and Security Act, 2015. Prevent is concerned with preventing children and vulnerable adults becoming radicalised into terrorism.

10.2 NHS Trusts are required to

- Train their staff to have knowledge of Prevent and radicalisation and to spot the vulnerabilities that may lead to a person becoming radicalised, and how to raise a concern
- Train Wrap3 facilitators to cascade more detailed Prevent training to staff
- Report concerns of people becoming radicalised to the Prevent hotline
- Attend the local authority Channel panel. This multiagency panel discusses the risk posed by vulnerable people who are referred for multiagency support
- Report the training figures and number of people referred to Channel on a quarterly basis to NHS England.

10.3 There has been much debate within the media on the effectiveness of Prevent and its impact in terms of being divisive to certain communities, particularly Muslims. To this end, the Trust’s training is very mindful of this concern and potential to discriminate; and emphasizes the importance of remembering that Prevent is about all forms of radicalisation, not just one religious group and that vulnerable people are groomed in the same way as preparation for sexual exploitation and financial abuse.

10.4 That being said, it is important to remember that Prevent and Channel is valuable multiagency work to support vulnerable people and local communities.

11. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS)

11.1 The Mental Capacity Act (2005) is supported by the MCA Code of practice. It is imperative that clinicians adhere to the MCA code of practice when treating and looking after patients. This includes comprehensive assessment of capacity and adhering to the five principles at all times.  

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12 a. A person must be assumed to have capacity unless it is established that he lacks capacity.

b. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

c. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

d. An act done, or decision made, must be done, or made, in his best interests.

e. Before the act is done, or the decision is made, it must be achieved in the least restrictive manner
11.2 The challenge of accurately recording capacity assessments within patients' healthcare records is nationally recognised\(^{13}\). An informal audit of MCA and DOLS was undertaken in Quarter 2 2015. Although a very small number of healthcare records were reviewed, this showed varied understanding of the responsibilities to accurately and comprehensively document capacity assessments and best interest decision making.

11.3 The Team are undertaking a more comprehensive audit during 2016 to better understand the local issues relating to this national problem. They have already identified that the Neurosciences Directorate regularly undertake capacity assessments and DOLS applications. These assessments and applications can often be complex due to the severity of the patients’ health. To this end, the Safeguarding Adults Lead Practitioner and the new Matron for Neurosciences will undertake a collaborative project to determine the baseline knowledge within the teams, design and deliver comprehensive teaching and education sessions on both MCA and DOLS. It is envisaged that the clinicians knowledge and practical skills will be enhanced resulting in greater compliance in assessing, including patient and their families and documentation. This will be reviewed on a regular basis and reported to NOTSS Clinical Governance Group and the Safeguarding Adults Steering Group.

11.4 In March 2014 the Supreme Court passed judgement on Deprivation of Liberty Safeguards (DOLS) and Court of Protection, and defined the ‘Acid Test’ and clarified the parameters for DOLS. This ruling had a significant impact on the number of DOLS applications in Oxfordshire. Figure 5, below shows the number of DOLS applications made in Oxfordshire throughout the year.

![number of DOLS applications](image)

Figure 5: The number of DOLS applications from 2009 - 2016.

11.5 There were 1453 DOLS referrals made across Oxfordshire, and the Trust made 104 requests for DOLS. This amounted to 7.2% of the total DOLS referrals.

\(^{13}\) [https://www.cqc.org.uk/sites/default/files/documents/rp_poc1b2b_100563_20111223_v4_00_guidance_for_providers_mca_for_external_publication.pdf](https://www.cqc.org.uk/sites/default/files/documents/rp_poc1b2b_100563_20111223_v4_00_guidance_for_providers_mca_for_external_publication.pdf)
11.6 All DOLS applications were processed through the Safeguarding Adults Team; to ensure that the Trust was meeting its responsibilities as a DOLS Managing Authority. The Safeguarding Adult Lead Practitioner and Safeguarding Administrator facilitated an increase in compliance rates, quality of applications and knowledge of the clinical staff by assisting teams in the completion of the DOLS applications.

11.7 The Chief Coroner provided clarification that any patient in hospital who died with urgent or standard DOLS in place did so in “state custody”. This meant that all such deaths must be reported to the coroner. However, all patients who died who were still waiting to be assessed did not need to have their deaths investigated by the Coroner.

11.8 Due to the number of applications received by OCC since December 2015, the DOLS Supervisory Office had been unable to assess any of the patients with DOLS applications made by OUH. There were several implications of this; firstly, following the expiration of the urgent authorisation and the extension after 14 days, the patient was no longer under DOLS. Secondly, in most cases, the patient needed to remain in hospital for their own safety or because of risk of harm or medical deterioration and this created confusion with regard to the information that needed to be given to Coroner. Thirdly, when the extension to DOLS expired the patient was no longer under DOLS and the coroner did not need to be informed but the patient was still deprived of their liberty.

11.9 Following the Supreme Court judgement in March 2014 the Law Commission undertook a national consultation on DOLS. The consultation paper was published in May 2016 and concluded this process was ‘deeply flawed’ and thus the commission has provisionally proposed that DOLS should be replaced with a new system, called ‘Protective Care’. It is envisaged that there would be three aspects:

- The supportive care scheme
- The restrictive care and treatment scheme
- The hospitals and palliative care scheme

The publication of the consultation paper is outside the scope of this annual report but it will be reported in detail within the Safeguarding Adults Quarter 2 report 2016/17.

12. Female Genital Mutilation

12.1 The Trust FGM Strategy Group was chaired by the Chief Nurse. The purpose of this group was to ensure there was a specific focus on areas where women may present with health problems related to FGM.

12.2 In order to determine the prevalence of FGM in England, through the Health and Social Care Information Centre (HSCIC), there was a requirement to provide mandatory reporting of detailed data. However, there were concerns that this had the potential to deter women from accessing clinics for FGM health advice and education; which in turn could potentially impact on the protection of female children. Discussions

http://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty
have taken place with the Chairman of OUH and the President of the Royal College of Obstetricians and Gynaecologists in relation to patient data confidentiality concerns.

12.3 When cases of FGM were identified by Midwives, they were referred to the Oxford Rose Clinic and Public Health. All Community Midwives know the countries where FGM is a risk, the terms used for FGM locally and access to the National Risk Assessment Tool\(^\text{15}\). A robust system was implemented to document cases identified on EPR, in the Maternal Discharge Summaries to GPs, in the Child Health Records (red book) and communicated directly to Health Visitors. A FGM Special Interest Group with Oxford Health was held bi-monthly and was attended by a Midwife so that good practice could be shared with Health Visitors, School Nurses, Practice Nurses and GPs. Recruitment of a part time Band 7 Specialist Midwife for FGM was finalised in the autumn of 2015.

13. **Update on objectives from previous years**

13.1 The Modern Slavery Coordinator from Thames Valley Police delivered two training sessions on modern slavery. This enabled staff to better understand how to identify modern slavery in children and adults, the role of the clinician when slavery is suspected, and what to do in that situation, these were well received.

13.2 Collaboration between the adult and Children Safeguarding Teams and the Trust Designated Safeguarding Officers led to the development of a single safeguarding strategy for the Trust. Safeguarding is complex and spans all age groups and families in long term and short term crisis therefore this document provides information to staff to increase their understanding of the safeguarding agenda.

13.3 The single Association of Adult Directors of Social Services (ADASS) DOLS application form was implemented. This replaced forms 1 and 4.

13.4 Oxfordshire safeguarding leaders from partnership organisations were invited to attend the Safeguarding Leaders 2016 programme.

13.5 The proposal to undertake a MCA and DOLS audit was accepted by the Clinical Effectiveness Committee (CEC). This audit will focus on the patients affected by delayed transfers of care and those with a pending DOLS application.

13.6 The Trust and OSAB agreed to audit the section 42 investigation requests and outcomes as part of the commitment to making 'Making Safeguarding Personal (Care Act 2014).

14. **Key achievements**

- A comprehensive training opportunity was afforded by the fourth Safeguarding leader’s programme and was delivered to 19 clinical leaders.

\(^{15}\) DH FGM March 2015

- Prevent Awareness training was attended by 1802 Trust staff. This was delivered through Induction and integrated within safeguarding children and adults training.

- Seventy staff attended the Home Office’s WRAP 3 training.

- The appointment of a full time Safeguarding administrator to leads on DOLS administration for the Trust, the post holder is a registered Mental Health Nurse with experience of safeguarding issues.

- Completion of 3 safeguarding children audits:
  - Spotting The Signs of CSE audit for pregnant teenagers
  - Records Audit on the Use of the Child Protection Pro forma
  - Understanding Professional Knowledge and Attitude about Children and Consent to Sexual Relationships

- The requirements of the multiagency commitment to Safeguarding Children and Adults across the County were met by attendance at all three county MARAC and the MAPPA and missing Persons meetings.

- The Safeguarding Children’s, Adults and Human Resources Teams developed a joint policy for staff and patient regarding domestic abuse thus recognising the complexity of domestic abuse and its impact on patients and staff.

- The Community Safety Practitioner and the Safeguarding Adults Team collaborated with Reducing the Risk to develop the OUH based Domestic Abuse Champion Training.

- A multi-agency discharge liaison hub was formed with a key aim of establishing processes whereby those individuals affected a delay in transferring of care to the community could be moved to a nursing home whilst awaiting the finalisation of a permanent package of care. This encouraged Trust and Care home staff to work closely together to safeguard vulnerable people.

- The Safeguarding Adults policy was reviewed and amended to reflect Care Act 2014.

- An inclusive Privacy and Dignity Policy was developed to include the perspective of Patient Groups, Carers’, and Staff.

- The role of Adult Safeguarding Advisors within the Trust’s serious incident review meeting was identified. This provides an additional layer of support on serious incidents, safeguarding alerts and safeguarding adult reviews (SAR).

- There was confirmation of the process for making safeguarding alerts on behalf of patients with category 3 & 4 pressure ulcers.

- A Safeguarding training strategy was developed and this included an alignment between combining safeguarding children level 1 and adults that was delivered at induction.

15. Key challenges
15.1 The rapidly growing and international nature of the safeguarding agenda for vulnerable adults; particularly surrounding modern slavery, human trafficking, FGM and the vulnerability of people from black and minority ethnic backgrounds.

15.2 Information Sharing with Partners regarding complex cases. There are now a number of Oxfordshire multiagency fora whose purpose is to discuss children, vulnerable adults and families in high risk situations and to prevent avoidable tragedies by working as a multi-agency and multi-disciplinary team.

15.3 DOLS applications following the Cheshire West judgement\[^{16}\].

15.4 The impact of domestic abuse on patients and staff.

15.5 The safe and coordinated discharge of patients, particularly those who are vulnerable and/or require significant family or paid carer support.

16. **Next Steps**

16.1 In response to both national and local learning and statutory guidance the following objectives will be developed during 2016/17:

- To increase staff knowledge of MCA and DOLS. A ‘straw poll’ within Neuroscience directorate identified that clinical staff are concerned their knowledge of the Mental Capacity Act and about answering questions on the Act and its application. Training for the team will be delivered in the next year and will draw on action research methodology and working in collaboration with the Oxfordshire IMCA service and the Trust’s Psychological Medicine Service. This will commence in the Neuroscience Directorate and be led by the Safeguarding Adults Lead Practitioner and the Neurosciences Matron.

- To increase the availability of expert advice relating to domestic abuse by developing the role of Domestic Abuse Champions across the Trust. This will be led by the Head of Patient Experience, the Safeguarding Lead for Children, the Trust’s Community Safety Practitioner and the Human Resources Designated Safeguarding Officer.

- To develop a joint Safeguarding Children’s and Adults strategy to reflect the increasing emphasis on transition of young people to adult services, sexual exploitation, FGM, Human trafficking, modern slavery and training. This will be presented at the Trust’s Management Executive.

- To increase leadership potential by participation in the Oxfordshire Safeguarding Leader programme.

- To embed the safeguarding strategy across all services by incorporating safeguarding as an agenda item in quarterly Divisional Quality/Governance meetings.

- To improve the safe and coordinated discharge for vulnerable patient's. This is a Quality Priority for the Trust for 2016/2017.
- To co-produce the development of a Trust Carers Policy in conjunction with Oxfordshire Stakeholders.
- To implement the Child Protection - Information Sharing (CP-IS) national data set thereby providing SGT access information across England of children subject to a CPP or a Child in Need Plan 17.
- To embed a safeguarding audit programme to include
  o Audit to evidence safeguarding children knowledge and practice to provide assurance.
  o Audit of teenagers attending ED following drug or alcohol use and follow up provided.
  o Audit MCA/DOLS practice. Stage 1 to include the DOLS applications made between October and March 2016 and patients affected by delayed transfers of care. Stage 2 to include patients using consent form 4.
  o To audit the section 42 investigation requests made during the year. It is envisaged that this will provide considerable learning in terms of the reason for the request, standard of investigation, key findings and areas of concerns, the number of alerts substantiated and system wide learning and changes in practice. This audit is scheduled for July 2016.
- The production of standing operating procedures for sharing patient information at multiagency risk sharing fora; to be ratified at the Trust’s Information Governance Group.

17. Conclusion
17.1 The Safeguarding Children and Adults Teams continue to develop their profile within the OUH and work in partnership with agencies to meet the requirements set out in section 11 of the Children Act 2004 and the Care Act 2014.

17.2 The multiagency joint working demonstrates the Trust’s commitment to working in partnership, to improve the identification and protection of children and vulnerable adults.

18. Recommendation
18.1 The Trust Board is asked to note the contents of the report.

Catherine Stoddart
Chief Nurse

Report prepared by:
Tracy Toohey Safeguarding Children’s Lead and Patient Experience
Caroline Heason Head of Patient Experience

17 Children subject to a child protection plan are under s47 and Child in Need under s17 of the Children Act 1989
Appendix 1
Safeguarding Children and Adults team Structures

Figure 1: Safeguarding Children team

Figure 2: Safeguarding Adult Team
## Appendix 2

### Emergency Department Safeguarding Referral Criteria

<table>
<thead>
<tr>
<th>Referral Code</th>
<th>OUH Children's Safeguarding Liaison Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Children / young people subject to CPP &amp; LAC</td>
</tr>
<tr>
<td>B</td>
<td>Unaccompanied by adult with parental responsibility</td>
</tr>
<tr>
<td>C</td>
<td>Drugs &amp; Alcohol</td>
</tr>
<tr>
<td>D</td>
<td>Assault</td>
</tr>
<tr>
<td>E</td>
<td>Vulnerable Adult (incl.OD) with dependent children where there are safeguarding concerns</td>
</tr>
<tr>
<td>F</td>
<td>Frequent attendances - more than 3 in past year</td>
</tr>
<tr>
<td>G</td>
<td>Not registered with GP</td>
</tr>
<tr>
<td>H</td>
<td>Did not wait to see medical staff</td>
</tr>
<tr>
<td>I</td>
<td>Parenting / supervision concerns</td>
</tr>
<tr>
<td>J</td>
<td>Development / weight / hygiene concerns</td>
</tr>
<tr>
<td>K</td>
<td>Child not in school / school issues</td>
</tr>
<tr>
<td>L</td>
<td>0 - 18yrs - Concerns re nature of injury / presentation / NAI</td>
</tr>
<tr>
<td>M</td>
<td>Delayed presentation</td>
</tr>
<tr>
<td>N</td>
<td>Overdose / self-harm</td>
</tr>
<tr>
<td>O</td>
<td>Death 0 - 18 yrs</td>
</tr>
<tr>
<td>P</td>
<td>Dog bite</td>
</tr>
<tr>
<td>Q</td>
<td>Burns</td>
</tr>
<tr>
<td>R</td>
<td>Other - Any safeguarding concerns not listed above</td>
</tr>
<tr>
<td>Referral Code</td>
<td>OUH Adult Safeguarding Criteria</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>A</td>
<td>Alleged Domestic Abuse</td>
</tr>
<tr>
<td>B</td>
<td>Alcohol related problem</td>
</tr>
<tr>
<td>C</td>
<td>Drug related problem</td>
</tr>
<tr>
<td>D</td>
<td>Abuse of vulnerable person (EG those with learning disability)</td>
</tr>
<tr>
<td>E</td>
<td>Elder abuse</td>
</tr>
<tr>
<td>F</td>
<td>Vulnerable adult who absconds from ED</td>
</tr>
<tr>
<td>G</td>
<td>Vulnerable adult (Inc Overdose) with dependent children</td>
</tr>
</tbody>
</table>