Trust Board Meeting in Public: Wednesday 8th November 2017
TB2017.111

<table>
<thead>
<tr>
<th>Title</th>
<th>Oxford University Foundation Trust (OUHFT) Safeguarding (Children and Adults) Report 2016-2017</th>
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<tbody>
<tr>
<td>Status</td>
<td>For information</td>
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<tr>
<td>History</td>
<td>The previous Safeguarding Children and Adults Annual Report was presented at the OUH Trust Board on 9 November 2016</td>
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<tr>
<th>Board Lead(s)</th>
<th>Mrs Sam Foster: Chief Nurse</th>
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<tr>
<td>Key purpose</td>
<td>Strategy</td>
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<td>Performance</td>
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Executive Summary

1. This report is comprised of two sections which provide a summary of the key issues and activity in relation to Safeguarding of Children and Adults during 2016/17. This is an annual report.

2. The Chief Nurse represents the OUH on the Oxfordshire Children Safeguarding Board (OSCB) Oxfordshire Adults’ Safeguarding Board (OSAB) and is deputised by the Children Safeguarding and Patient Experience Lead and Safeguarding Adults and Patient Services Manager.

3. Safeguarding children activity increased by 58% (n=592). There were 1620 consultations averaging 135 per month. The main issue is neglect which reflects the county and national statistics. There has been an increase in complex cases requiring on-going support from the team.

   Activity to the Liaison Service has increased by 1,591 safeguarding cases to ensure information is shared to primary care and or children’s social care when attending the Emergency Departments (ED).

4. Safeguarding Adult Activity increased by 585 consultations (n=882) consultations. There were 24 Section 42 enquiries, 15 enquiries were substantiated and nine were unsubstantiated.

5. Training figures\(^1\) – Level 1: 88%, level 2: 87% and level 3: 77%. Changes to the safeguarding training strategy have been implemented and it is anticipated that this will improve compliance.

6. Partnership Working continues to be strong with membership at OSAB & OSCB sub groups, multi-agency meetings to share relevant information of risks to protect children and adults.

7. Policies reviewed this year include the Adult Restraint and Safeguarding Adults Policy. A new policy for Transition from Children’s to Adult’s Services Policy has been developed in line with NICE guidance and ratified this year. A steering group has been set up to oversee the implementation of the policy.

8. **Key achievement:** The OUH attaining the top level that can be achieved in the annual OSCB/OSAB self-assessment and peer review.

   **Key challenges:** The significant increase in consultations in both children and adult safeguarding, number of complex children’s cases requiring ongoing support, documentation surrounding Mental Capacity Assessment, DOLS applications, the length of time taken to open and close section 42 investigations and Patient Falls.

   **Key Learning:** The practical implementation of the Mental Capacity Act (MCA) and the responsibilities surrounding the application for a DOLS is poorly understood. The Trust will be
   - Learning from children’s serious case reviews. All Trust actions completed
   - Implementing a Trust wide thematic peer review of the MCA and DOLS; to ensure compliance with working knowledge and practice
   - Strengthening the size of the Safeguarding Team to support this work
   - Including lessons from the key investigation into training

9. **Recommendation**

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

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\(^1\) KPI 90%
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.
- Appendix 1 gives the definition of vulnerable adults according to the Care Act 2014.

2. Purpose

2.1 This paper presents the annual report for safeguarding children and adults for April 2016 to March 2017 in line with 'Working Together to Safeguard Children' 2015, the Children Act 2004 and the Care Act 2014.

2.2 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 on 9 November 2016.

3. Background

3.1 The safeguarding children team is led by the Lead Safeguarding Children and Patient Experience. Please refer to Appendix 2 Figure 1 for the structure of the Safeguarding Children team.

3.2 The safeguarding adult team is led by the Head of Adult Safeguarding. Please refer to Appendix 2 Figure 2, for the structure of the Safeguarding Adults Team.

4. Safeguarding Children Activity

4.1 Safeguarding activity is divided into 3 main areas:

- Consultations relating to safeguarding to support staff
- Safeguarding Liaison between emergency department and primary care
- Partnership working

4.2 There have been 1620 consultations (average 135 per month) with the safeguarding children team against the previous two years. This is an increase of 58% (n=592) from 2015-16 (see Figure 1).
4.2 There were 607 children with a child protection plan (CPP) in Oxfordshire at the end of March 2017. This was an increase of 6.7% from 2015/16. The main reason children were placed on a plan continues to be for neglect (67%). The number of children that were ‘Looked After’ rose a further 14% to 675.

4.3 There has been a significant increase in OUH safeguarding children activity reflected by child protection across Oxfordshire. There has also been an increase in complex cases requiring ongoing support to practitioners from the team, senior managers and legal services.

4.4 The main category for consultations relates to neglect which reflects the increase locally and nationally. The OUH are working with partner agencies as part of the neglect strategy to understand more about this category and how to improve the outcomes for children.

4.5 The number of complex cases has increased, mainly in the category of fabricating induced illness (see figure 2).

4.6 The safeguarding liaison service shares information with primary care in relation to all children who attended ED with a safeguarding concern, all under 1 year olds and when a parent attends ED and there is a safeguarding concern identified (Appendix 3). This allows primary care to have a greater awareness of potential safeguarding concerns and the impact on children.

4.7 There have been a total of 7,062 ED cases referred to the Liaison Service to ensure information is shared with primary care and or children's social care if involved. This is presented in Figure 3. This is an increase of 1,591 safeguarding cases to 3,342. The increase is partly due to greater awareness of safeguarding and two new paediatric consultants in ED to ensure opportunities to safeguarding children are not missed.

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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.
4.8 In maternity there were 8,665 bookings, of these 12% (n=1030) were identified as either category 3 or 4 public health risk\(^3\), these are presented in Table 2. As in previous years the dominant category of concern was maternal mental health issues. The Trust works closely with mental health services within the OUH to support maternal mental health needs.

<table>
<thead>
<tr>
<th>2016 – 17</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>8,665 Maternal Bookings</td>
<td>1030</td>
<td>138</td>
<td>135</td>
<td>682</td>
<td>92</td>
</tr>
<tr>
<td>12% (of all bookings)</td>
<td>1.6%</td>
<td>1.6%</td>
<td>7.9%</td>
<td>1.1%</td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Maternal Health and Social Score categories

4.9 A repeat maternity abduction drill took place to gain assurance that the updated policy was appropriate and functional, triggering an appropriate response to alert relevant staff and agencies and identified the abductor promptly. Further lessons to prevent such an event have been cascaded.

4.10 Maternity have incorporated the Child Sexual Exploitation screening tool in all teenage pregnancies too ensure early recognition of risks and escalate concerns to protect a young person and their baby.

4.11 The JR hospital children social care team received 294 safeguarding referrals from maternity and the children's hospital. There were 134 strategy meetings, 65 Initial Child Protection Case Conferences and 55 care orders to place children in care. Cases at the Horton hospital are managed by the North Assessment team.

| Table 3. Outcome of Referrals to JR Children's Social Care Team |
|----------------------|------------------|------------------|------------------|
| Strategy Meetings    | Children’s | 68 | 134 |
|                      | Maternity    | 67 |     |
| ICPCC                | Children’s | 21 | 65  |
|                      | Maternity    | 44 |     |
| Care Order           | Children’s | 29 | 55  |
|                      | Maternity    | 26 |     |

4.12 The applications to court for care orders, and the length of stay outside clinical need continues to be monitored on a case by case basis by managers.

\(^3\) Maternal Health & Social Score Level 3 = low obstetric/high public health risk Level 4 = high obstetric/high public health risk
4.13 The children safeguarding team attend strategy meetings working with practitioners and children’s social care ensures information is shared to help with the assessment of risk to protect a child. Support and debrief sessions for staff are provided as needed in these difficult situations either by the safeguarding team or psychological medicine.

5 Safeguarding Adult Activity

5.1 The Teams safeguarding activity and caseload divides into three work streams. These support:

- investigation of safeguarding concerns surrounding Trust services
- consultations relating to safeguarding, anti-radicalisation and domestic abuse
- supporting the safeguarding partnership working

5.2 Consultations: Figure 4 shows the number of consultations over the previous two financial years. The 882 consultations during this year, compares to 297 for 2015/16.

![Safeguarding Adults Consultations during 2015/16 and 2016/17](image)

5.3 The team’s consultations include advice on the completion of DASH forms\(^4\) when supporting someone at risk of domestic abuse, completion of Section 42 enquiries, eligibility for and completion of Deprivation of Liberty Safeguard application forms, advice on discharge if a patient is vulnerable and MAPPA assessments\(^5\).

5.4 Figure 5 shows that there were 51 concerns raised and 24 Section 42 enquiries into the Trust’s care\(^6\). Appendix 1 gives the definition and criteria for Section 42 enquiries according to the Care Act 2014.

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\(^4\) The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009, having been accredited by ACPO Council, now known as National Police Chief Council (NPCC) [http://www.dashriskchecklist.co.uk/](http://www.dashriskchecklist.co.uk/).

\(^5\) Multi-Agency Public Protection Arrangements.. It is the process through which the Police, Probation and Prison Services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public. [https://mappa.justice.gov.uk/connect.ti/MAPPA/groupHome](https://mappa.justice.gov.uk/connect.ti/MAPPA/groupHome)

\(^6\) An enquiry is any action that is taken (or instigated) by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect them because of those needs. [http://www.scie.org.uk/care-act-2014/safeguarding-adults/adult-safeguarding-practice-questions/](http://www.scie.org.uk/care-act-2014/safeguarding-adults/adult-safeguarding-practice-questions/)
5.5 Figure 6 shows the number of substantiated and unsubstantiated enquiries. The Team started collating this data in June 2016. During this period 15 enquiries were substantiated, 9 were unsubstantiated and at the time of reporting 1, subject to Divisional investigation, has yet to be closed.

5.6 In adults, the main themes for concerns and section 42 enquiries are hospital acquired category 3 pressure ulcers, complexities surrounding discharge and falls.

5.7 As can be seen in Appendix 4 there has been significant learning and change in practice. The learning from the Section 42 investigations is discussed at the Trust's Discharge Oversight Group, the Pressure Ulcer Group and the Falls Prevention Group.

- **Hospital acquired pressure ulcers.** In order to provide specialist advice and education about assessment of Hospital Acquired Pressure Ulcers (HAPU), the Tissue Viability Team review all patients with Category 2 pressure ulcers.
- **Discharge.** The Trust has invested in Discharge Liaison Nurses
- **Falls.** When there has been an incident, The Quality Improvement Team's Falls Specialist Nurse delivers ‘High Impact’ and ward based educational programme where there has been an incident which includes the lin k
between falls, mental capacity act and safeguarding adults, avoiding or minimising falls, clinical assessment, management and care and documentation.

6 Partnership working

6.1 The safeguarding children team continued to participate in the daily functioning of the Multi-Agency Safeguarding Hub (MASH). This function, in conjunction with the safeguarding children team in Oxford Health NHS FT, ensures that relevant information is shared in order to ensure there is an appropriate response to concerns raised.

6.2 There is also OUH participation in the 3 area Multi-Agency Risk Assessment Conferences (MARAC). This was set up to share relevant information in high risk domestic abuse cases. Information is recorded on the electronic record so that practitioners are aware of these risks when patients attend the Trust.

6.3 The OUH participated in the Multi-Agency Thematic Inspection for CSE and missing children and the ‘Front Door’ to children’s social care services. The CQC inspectors visited both JR and HGH EDs and the Oxford Sexual Health Service. The feedback was positive about the joint working between health and social care, knowledge and systems in place to share information and recognise abuse within health.

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

7.1 There were 152 applications for Deprivation of Liberty Safeguards (DOLS) which compares to 115 for 2015/16 (Figure 7). Declined/or inappropriate applications means that the patient had regained capacity prior to best interest and medical assessment as well as when there was an inappropriate application. Oxfordshire DOLS Supervisory Office is prioritising the assessment of inpatients using the ADASS (Association of Adult Social Services) prioritisation tool.

7.2 There is a risk surrounding DOLS patients who are not Oxfordshire residents as it is more complicated for DOLS Supervisory offices to organise Section 12 Doctors and Best Interest Assessors. This is being mitigated but weekly review telephone calls with the relevant offices and escalation to the respective Director of Adult Social care where appropriate.

7.3 Review of the training compliance and competency tests alone would indicate that there is a competent working knowledge in relation to the MCA and DOLS. However it is clear from the safeguarding team’s support and the recent CQC inspection, that the practical knowledge to implement the MCA and DOLS is poor.
To this end the training has been reviewed and changed, high impact training will be rolled out across the Trust and the Trust will implement a Trust wide thematic peer review of the MCA and DOLS; to ensure compliance with working knowledge and practice.

8 Case Reviews

8.1 Children Serious Case Reviews (SCR) are commissioned by the OSCB when a child or young person dies or experiences serious harm or injuries and there are multiagency lessons to be learnt.

8.1.1 The Trust participated in 3 reviews which shared joint agency learning which included how disability can mask abuse, increasing the involvement of fathers, recognising neglect and the value of professionals meetings to discuss cases and share information.

8.1.2 All actions from SCRs have been completed and learning has been disseminated in training and through the ‘At a Glance’ learning documents.

8.1.3 The Trust has participated in a new review that has been commissioned into a case of severe neglect of a teenager that was not known to services and home schooled.

8.2 Safeguarding Adults Reviews (SAR) are commissioned by the OSAB.

8.2.1 During 2016-17, 12 cases (nine deaths and three cases of serious harm) across the county were referred to the SAR. Of these, three adults did not have a care and support need as defined in the Care Act 2014, the referrals for seven adults’ centred on the practice of a single agency. The two SARs completed in 2016-17 involved agencies other than OUH.

9 Training

9.1 Table 2 presents the Key Performance Indicator (KPI) for safeguarding training is 90% and continues to be a challenge to achieve.

<table>
<thead>
<tr>
<th>Safeguarding Level</th>
<th>Compliance %</th>
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<tbody>
<tr>
<td>Adults</td>
<td>88%</td>
</tr>
<tr>
<td>Children Level 1</td>
<td>88%</td>
</tr>
<tr>
<td>Children Level 2</td>
<td>87%</td>
</tr>
<tr>
<td>Children Level 3</td>
<td>77%</td>
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Table 2. Safeguarding Training compliance.

9.2 The contributory factors to this are:

- The Electronic Learning Management System (ELMS) does not directly link to Electronic Staff Record (ESR) and thus when staff leave OUH they are not removed from the database
- There are too many training options on ELMS and they do not reflect the changes to streamline training.

Actions taken to increase compliance:

7 All level 1 and 2 Safeguarding Children and Safeguarding Adults were combined at the end of the year streamline training.
• In Quarter 4 there was an amalgamation of the children’s and adults safeguarding level 1 and 2 training.
• In order to align with national requirements, the training requirements were reviewed and included in the safeguarding training strategy.
• Where compliance was below the key performance indicator, this was brought to the attention of the Divisional Management Team to follow up with individuals and names of staff requiring training provided.
• The Safeguarding Adult Specialist Nurse delivered the Induction training on a weekly basis, this ensures that all staff receive a basic level of understanding of safeguarding and know who to contact for support.

9.3 Level 3 safeguarding children training is evaluated well, with 77% evaluating training as excellent, 21% good and 2% adequate.

9.4 Prevent is included in all Safeguarding training programmes. Figure 8, below shows the Prevent awareness and Wrap 3 training delivered in the Trust over the previous year.

9.5 In response to the CQC visit within the NOTSS division during October 2016, the Safeguarding Adult Team developed a pilot MCA and DOLS training.

9.6 The OUH contributed to the development and delivery of the Oxfordshire Multi-agency Safeguarding Adults & Children Training and participated in the OSCB/OSAB training sub group.

9.7 The Trust’s Safeguarding Leadership Programme was delivered in September and October 2016. The programme was extensive and included MCA, DOLS, and Domestic Abuse, working with the Police and Human Trafficking / Modern Slavery.

10 Services for People with Learning Disabilities

10.1 Southern Health NHS Foundation Trust handed over the provision of community and specialist inpatient services to Oxford Health NHS Foundation Trust on the 1st July 2017.

10.2 The Oxfordshire Clinical Commissioning Group (OCCG) has commissioned the Trust to deliver acute liaison services to people with learning disabilities and additional complex physical health needs.
10.3 It is planned jointly undertake a health needs project with Oxford Health and establish a cross county partnership and approach to service user and carer experience. Both projects will give a robust baseline on which to analyse the success of the services. Two liaison nurses, one specifically for Epilepsy, will be recruited during Quarter 2 2017/18.

11 Safeguarding Strategy

11.1 The joint Safeguarding Children's and Adults strategy was developed to reflect the increasing emphasis on transition of young people to adult services, sexual exploitation, FGM, Human trafficking, modern slavery and training. This is presented in Appendix 6.

12 Audit

12.1 The OSCB/OSAB joint annual safeguarding declared compliance against the 10 standards measured. The peer review concurred a rating of Blue\(^8\). This was the first year the OUH had submitted a joint adult and children declaration compliance with S11 of the Children Act 2004 and Care Act 2014.

12.2 The safeguarding children and adult knowledge and practice were audited as part of the OSAB/OSCB self-assessment. A survey monkey approach was used and 150 staff responded to the survey.

12.3 An audit was undertaken to review children aged 16-17 years of age attending ED as part of a serious case review an action plan. The main outcome of this audit led to this age group moving from being assessed on adult forms to children's assessment forms on EPR.

12.4 The 2017/18 Safeguarding knowledge and practice survey for the OSCB and OSAB Self-Assessment will follow this approach.

12.5 Audit of teenagers attending ED following drug or alcohol use and follow up provided.

12.6 The audit of MCA/DOLS practice included the review of 20 patients for whom DOLS applications were made between March and October 2016 and patients affected by delayed transfers of care. The results of the audit were presented to the Clinical Effectiveness Committee earlier this year.

13 Policies

13.1 The Adult Restraint and Safeguarding Adults Policy were reviewed and ratified by the Clinical Policy Group.

13.2 A new policy for Transition from Children's to Adult's Services Policy was developed in line with NICE guidance and ratified this year. A steering group has been set up to implement the policy.

14 Key challenges

14.1 The key challenges this year have been

- Significant increase in consultations in both children and adult safeguarding

\(^8\) compliant and able to provide evidence
• Number of complex children’s cases requiring ongoing support from the safeguarding team
• Documentation surrounding Mental Capacity Assessment
• The increase in DOLS applications and the length of time to assess
• The length of time taken to open and close section 42 investigations
• The number of Patient Falls classified as safeguarding concerns

15 Key achievements

15.1 At the joint OSCB/OSAB annual self-assessment and peer review the OUH attained the highest level in the self-assessment and peer review.

15.2 The significant amount of partnership working to safeguarding children and adults.

16 Key Learning:

16.1 The practical implementation of the Mental Capacity Act (MCA) and the responsibilities surrounding the application for a DOLS is poorly understood. The Trust will be

• Implementing a Trust wide thematic peer review of the MCA and DOLS; to ensure compliance with working knowledge and practice
• Strengthening the size of the Safeguarding Team to support this work
• Including lessons from the key investigations into training

17 Conclusion

17.1 The Safeguarding Children and Adults Teams continue to develop their profile within the OUH and worked 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 demonstrated the Trust commitment to work together to improve the identification and protect children and vulnerable adults within the Trust.

18 Recommendation

18.1 The Trust Board is asked to note and approve the content of this report

Executive Lead: Sam Foster Chief Nurse
Authors:
Tracy Toohey Safeguarding Children’s Lead and Patient Experience
Caroline Heason Head of Adult Safeguarding
08 November 2017
Appendix 1

The Care Act 2014 describes an adult with care and support as:

- an older person
- a person with a physical disability, a learning difficulty or a sensory
  impairment
- someone with mental health needs, including dementia or a personality
  disorder
- a person with a long-term health condition
- someone who misuses substances or alcohol to the extent that it affects
  their ability to manage day-to-day living.

Source: Care Act 2014

People with care and support needs are not inherently vulnerable, but they may come to
be at risk of abuse or neglect at any point due to:

- physical or mental ill-health
- becoming disabled
- getting older
- not having support networks
- inappropriate accommodation
- financial circumstances or
- being socially isolated.

Source: Care Act 2014

Section 42: Section 42 Enquiries

A. When a local authority has reasonable cause to suspect that an adult in its
area (whether or not ordinarily resident there)

   i. has needs for care and support: (whether or not the authority is meeting any
      of those needs),

   ii. is experiencing, or is at risk of, abuse or neglect, and

   iii. as a result of those needs is unable to protect himself or herself against the
        abuse or neglect or the risk of it.

B. The local authority must make (or cause to be made) whatever enquiries it
thinks necessary to enable it to decide whether any action should be taken in
the adult’s case (whether under this Part or otherwise) and, if so, what and by
whom.

Source: Care Act 2014

Section 44: Safeguarding Adults Reviews (SAR)
A Safeguarding Adults Board must arrange for a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if

- there is reasonable cause for concern about how the Safeguarding Adults Board, members of it or other persons with relevant functions worked together to safeguard the adult, and
- condition 1 or 2 is met.

Condition 1 is met if:

- the adult has died, and
- the Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if:

- the adult is still alive, and
- the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect.

A Safeguarding Adults Board may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Each member of the Safeguarding Adults Board must co-operate in and contribute to the carrying out of a review under this section with a view to:

- identifying the lessons to be learnt from the adult’s case, and
- applying those lessons to future cases.

**Source:** Care Act 2014.
Appendix 2

Safeguarding Children team

Catherine Stoddart
Chief Nurse
Executive Lead for
Safeguarding
Children and Adults

Nettie Dearmun
Children & Women’s
Divisional Nurse

Rebecca Allen &
Caroline Reeve
Administrators for
Liaison Service
(Total 36 hrs)

Denise Minter
Safeguarding
Admin Manager
(30 hours)

Tracy Toohey
Safeguarding
Children Lead &
Patient Experience

Anne Wilson
Named Nurse
(0.6 WTE)

Natalie Roberts
Named Professional
Horton (0.7 WTE)

Carrie Jackson
Named Professional
(1WTE)

Lucia Bell
Named Professional
(1WTE)

Janet Craze
Lead Named Dr
Safeguarding
JR Children’s

Julie Johnson
Named Dr
Safeguarding
Horton

Clare Robertson
Designated Dr
Safeguarding
OCCG

Kathy Bailey
Named Dr
Safeguarding
NOC

Brenda Kelly
Named Dr
Safeguarding
Women’s

Safeguarding Adult Team

Chief Nurse and Executive Lead for Safeguarding Children and Adults

Head of Adult Safeguarding

Safeguarding Adults Lead Nurse

Learning Disability
Liaison Nurse

Safeguarding Specialist Nurse

Safeguarding and
DOLS
Administrator
### ED Safeguarding Children Liaison 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>
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<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>
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<tr>
<td>H</td>
<td>Did not wait to see medical staff</td>
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<tr>
<td>I</td>
<td>Parenting / supervision concerns</td>
</tr>
<tr>
<td>J</td>
<td>Development / weight / hygiene concerns</td>
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<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>
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<tr>
<td>O</td>
<td>Death 0 - 18 yrs</td>
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<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>
</tbody>
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### Appendix 4
Learning from 2016/17 Section 42 Enquiries.
• Checking the patient transfer documentation travels with the patient for the care establishment.

• When patients are discharged with Pressure Ulcers, it is essential that assessment and care information is given to care establishment either prior to discharge or at time of discharge.

• All patients admitted on the ward must have a falls assessment within 4 hours of admission.

• Named nurses to assess a patient’s history in relation to falls risk and identify the possible need to re-allocate such patients to be in an area visible to nurse’s station.

• Use handover to highlight patients identified as high risk of falls during general hand-over and in addition and alert the bleep holder matron.

• The care plan/turning chart documents are an important aspect of care and enables deterioration to be found earlier and preventative measures taken to prevent further deterioration.

• Checking patient’s healthcare records documentation on admission/handover is vital.

• The process of agreeing and facilitating a discharge earlier in the day enables a patient to be transferred to a care home or intermediate care bed earlier in the day.

• Ward staff need to learn how to refer to an Intermediate Care Bed.

• It is important to share a relevant list of contact numbers including all ward numbers and the Bleep Holders to care homes.

• Clear, comprehensive and accurate documentation is key.

• Work closely with outside agencies and the patient’s family and friends when a patient is very challenging to support and considerable organisation and team work is needed to facilitate a calm and organised discharge and onward package of care for a Patient.

• The prompt liaison with the Trust’s Safeguarding team, OCC and DOLS Supervisory Office is necessary to support when situations are very complex.

• The prompt involvement of the Trust’s Chief Nurse and Director of Clinical Services is key when a ward is supporting an immensely complex patient and there is significant physical and emotional pressure on the ward team.

• Always share a patient’s care plan to a third party who are also supporting a patient on the ward.
## Appendix 5 Safeguarding Adults: Next Steps

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Timescale for completion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Documentation surrounding Mental Capacity Assessment</strong></td>
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</table>
| 1. Audit cross section of current DOLS to establish good practice and shortfalls in compliance  
2. Ensure that the MCA assessment is embedded within EPR | Head of Adult Safeguarding  
Head of Adult Safeguarding | Commence 04/09/2017  
Clarify status by 31/08/2017 |
| **DOLS applications** | | |
| 1. Full time Best Interest Assessor appointed  
2. Weekly update and review of all current Oxfordshire and Out of County DOLS applications | DOLS Office  
Safeguarding Administrator | Complete  
Enacted |
| **The length of time taken to open and close section 42 investigations** | | |
| 1. Escalation to Safeguarding Adults Area Manager  
2. Request to discuss at OSAB | Head of Adult Safeguarding | Complete  
Complete |
| **Patient Falls** | | |
| 1. Referral Criteria for a patient fall and safeguarding  
2. Training on the Quality Improvement High Impact Training | Safeguarding Adults Lead Nurse  
Safeguarding Adults Lead Nurse and Specialist Nurse | Complete  
Complete |
| **Rapidly increasing number of consultations** | | |
| 1. Head of Adult Safeguarding working clinically with the team  
2. Development of Safeguarding champions to increase sustainability | Head of Adult Safeguarding | Enacted 31/10/2017 |
| **ED Safeguarding Adult referrals on Electronic Patient Records** | | |
| 1. Write Standard Operating Procedure | Head of Adult Safeguarding | 08/09/2017 |
| **DOLS form and Safeguarding form incorporated in to EPR** | | |
| 1. Establish feasibility and timescale with the EPR team | Head of Adult Safeguarding | 08/09/2017 |
| **Quarterly data and information submission to the CCG as part of the NHS contract.** | | |
| 1. Quarterly data and information submission to the CCG | Head of Adult Safeguarding | Enacted |