Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 8 September 2021

TB2021.76

Title:	**Safeguarding (Children and Adults) Report 2020-2021**

Status:	**For Information**
History:	The previous Safeguarding Children and Adults Annual Report was presented at the OUH Trust Board on 8th July 2020

Board Lead:	**Chief Nursing Officer**
Author:	**Tracy Toohey, Head of Safeguarding**
Confidential:	**No**
Key Purpose:	Assurance

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 2020/21. This is an annual report.
2. The Chief Nursing Officer represents the OUH on the Oxfordshire Children Safeguarding Board (OSCB) Oxfordshire Adults' Safeguarding Board (OSAB) and is deputised by the Head of Safeguarding.
3. Safeguarding children consultations increased by 21%, there were 3423 consultations, an average of 285 per month. Neglect remains the main consultation category which is reflected in the Local Authority as 62% of children are on Child Protection Plans for neglect. Domestic abuse continued to be high and adolescent mental health presentations and eating disorders increased. There was an increase of 5.5% (n=457) maternity bookings (n=8,710) this year of which 21.5% (n=1875) of all bookings had either category 3 or 4 public health risk or safeguarding concern identified. Maternal mental health remains the main category of concern. Domestic abuse and drug and alcohol issues are an ongoing issue. Emergency department cases referred to the Liaison Service totalled 7056, a reduction of 19% (n=1645) due to reduced attendances curing the Covid-19 pandemic. Requests for information were provided to support decision making at 372 Initial Child Protection Case Conferences involving 657 children and 67 unborn babies which was comparable with last year.
4. Safeguarding Adult consultations increased 24% (n=2438); there were 5135 Emergency Department (ED) Electronic Patient Record reviews, following referrals from ED, an increase of 9%. There was a 29% reduction of clinical incident reviews where clinical teams were concerned there may have been a safeguarding concern following a clinical incident (n=1198). There were 23 Section 42 enquiries, 11 partially or completely substantiated, 10 unsubstantiated and one inconclusive. There remains one open due to complexities and needing a repeat review by the LA. There were 283 DoLS applications made during the year, an increase of 83..
5. Training compliance[1]

Adult Level 1 = 84%	Children Level 1 = 84%	Prevent Level 1&2 = 91%
Adult Level 2 = 79%	Children Level 2 = 78%	Prevent Level 3,4&5 = 88%
	Children Level 3 = 73%	

6. Partnership Working continues to be strong with membership at OSAB & OSCB subgroups, multi-agency meetings, participation in the MASH for the children's

[1] Local Safeguarding KPI is 90%: National Prevent Level 3,4 and 5 KPI is 85%

team, participation in multiagency audits and processes in place to share relevant information of risks to protect children and adults.

7. **Key achievements** significant partnership working to safeguard children and adults. The OUH achieved the full level of compliance in annual OSCB/OSAB self-assessment and peer. Significant increases of activity and complexity of cases continued to be managed to support staff with safeguarding functions and positive interagency partnership working. Continuity of effective safeguarding advice and support despite staffing challenges and changes to working over the Covid -19 pandemic. **Key challenges** include the timely mental capacity assessments and documentations, increased presentations of domestic abuse, mental health, eating disorders and complex cases. Increase maternity safeguarding concerns. Number of adolescent children presenting with complex safeguarding mental health needs and prolonged stays in hospital due to delays identifying appropriate placements by children social care or CAMHS.

   The challenges in achieving the KPI of 90% for safeguarding children and adults training; including the introduction of training passports. Increased activity across the MASH and partner agency requests for information to inform risk assessments.

Recommendations

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

Contents

[Table can be updated by clicking 'Update Table' and should not be edited. This can be removed for most short papers of less than 10 pages. It is expected that the majority of papers will be shorter than this and not require this table.]

Safeguarding (Children and Adults) Report 2020-2021

Annual Report

1. **Definitions**

1.1 Safeguarding Children

- A child is an individual under the age of 18 years.
- 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 with 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 1st April 2020 to 31st March 2021 in line with 'Working Together to Safeguard Children' 2018, 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 8th July 2020.

3. **Background**

3.1 In January 2021 the adult and children safeguarding team merged and is managed by the Head of Safeguarding (see updated structure in Appendix 2). Prior to this the safeguarding children team was led by the Head of Children Safeguarding and Patient Experience and the safeguarding adult team was led by the Head of Adult Safeguarding.

3.2 The safeguarding teams merge forms a single, all age, and family based safeguarding service in line with national excellent practice.

4. **Safeguarding Children Activity**

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

4.1 There were 3423 consultations (average 285 per month) with the safeguarding children team. This is an increase of 21% (n=596) from 2020-21 (see Figure 1).

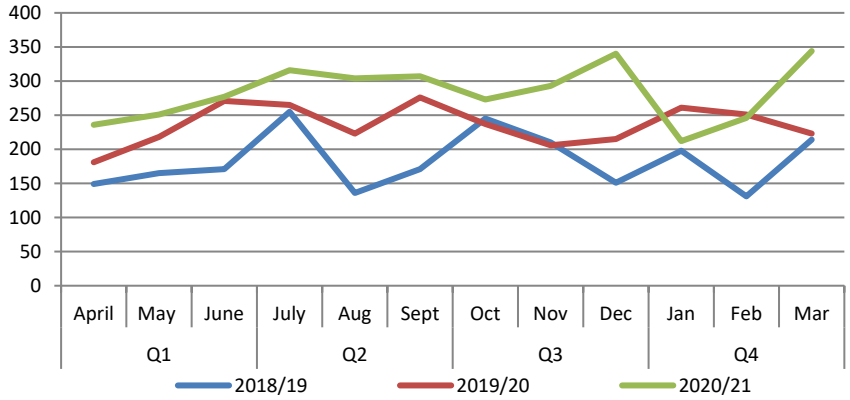


Fig. 1: Safeguarding Children Team Consultations 2018-2021

4.2 There were 452 children at the end of March 2021 with a Child Protection Plan (CPP) in Oxfordshire, a decrease of 16% (n=87) from 2020/21. Neglect remains the main category (62%) of CPP. The number of children that were 'Children We Care For'[2] reduced by 6 to 776 with 25% out of these children placed out of county. All these children on a CPP or cared for by the LA are flagged manually on the Trust Electronic Patient Record (EPR) to inform clinical staff assessments.

4.3 Neglect remains the main consultation category to the safeguarding children team which reflects the Local Authority (LA) figures as 62% of children are placed on CPPs for neglect in Oxfordshire. Participation continues at the multiagency Neglect Strategy Group to advise and champion work to tackle neglect and increase early help for families.

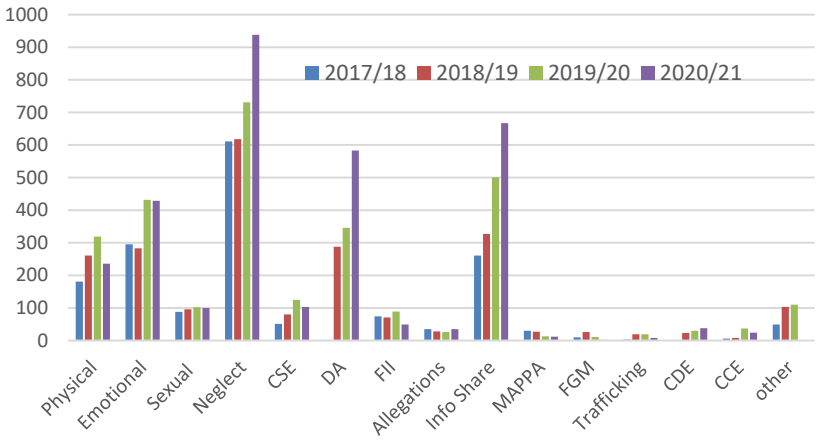


Fig. 2: Main consultation categories over last four years

[2] Children We Care For (previously called Looked After Children) may either be accommodated (which means that the LA 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

4.4 The increase in domestic abuse consultations related to children and parents that reflects a national increase during the Covid-19 pandemic. There has been an increase in awareness and information publicised that could reflect the reason for more disclosures or could be related to increased pressures on families during this unprecedented year.

4.5 The Liaison Service shares information with primary care in relation to specific criteria (see Appendix 3) for children that present to the Emergency Department (ED with a safeguarding concern, all under 1-year olds due to their vulnerability for health visitor support and finally when a parent or carer attends ED and their presentations raises a safeguarding concern. Children's Social Care is also notified when a child is known to their services. This service ensures information of potential vulnerability is available to professionals working with families to inform any risk assessments.

4.6 Referrals from the ED totalled 7,056 as presented in Figure 3. This was a drop of 19% (n=1654) over the year related to reduced numbers of children attending ED during the Covid-19 pandemic and not having the usual presentation of babies with seasonal winter illnesses.

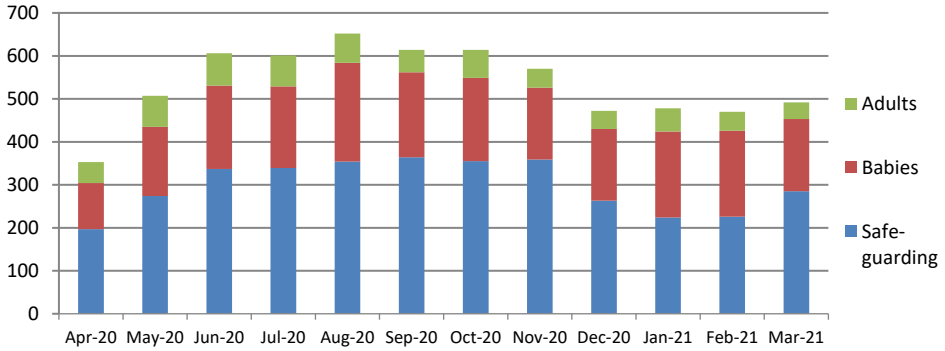


Fig. 3 Safeguarding Children Liaison Service ED Attendances April 2020 – March 2021

4.7 Attendance to ED for self-harm is recorded in 2 age groups in line with the public health national data set. Self-harm attendances for 10-14 (n=261) showed an increase of 48 on the previous year and an increase of 102 for the 15-19 age group (n=1482) see figure 4.

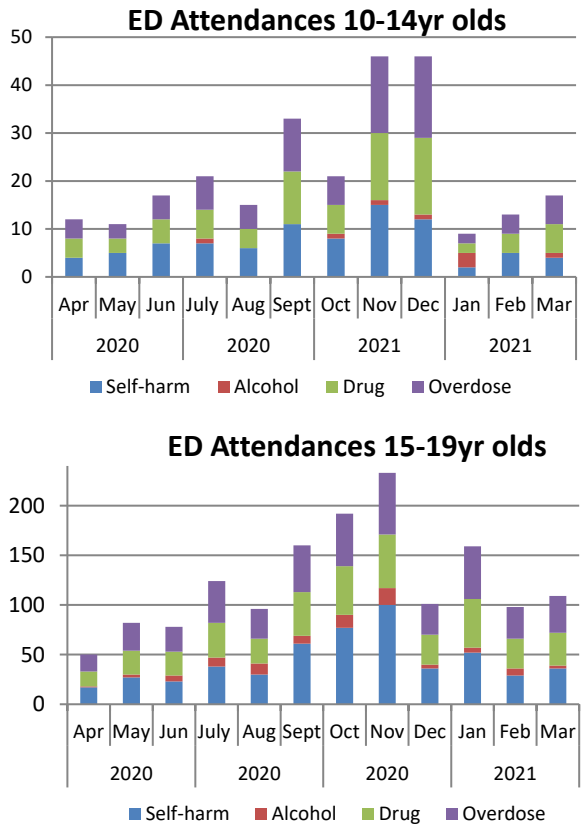


Fig. 4 ED Attendances for Self-Harm

4.8 Participation continues at the 3 Oxfordshire multi-agency locality self-harm fora to review the self-harm to ensure support and treatment is targeted to reduce presentations.

4.9 Complex cases related to adolescent mental health, eating disorders have been a feature this year. Escalation procedures have continued to be used due to delays in discharging children that require mental health settings or social care placements.

4.10 Psychological Medicine continue to support staff and debrief sessions have been provided following significant safeguarding events or complex safeguarding cases.

4.11 Maternity have seen an increase of 5.5% (n=457) maternity bookings (n=8,710) this year. There were 21.5% (n=1875) of all bookings that were identified as either category 3 or 4 public health risk[3], an increase of 183. Maternal mental health remains the main category of concern. Domestic abuse and drug and alcohol issues are an ongoing issue.

4.12 Delays in discharge due to awaiting social care placements for mothers and/or babies is monitored. There were 15 days where there was a delay beyond clinical need involving 9 maternity cases, this is a reduction of 8 cases. A process has been implemented to directly inform the LA of the cases known

[3] Maternal Health & Social Score Level 3 = low obstetric/high public health risk Level 4 = high obstetric/high public health risk. A mother with a public health score of 3 or 4 is reviewed by safeguarding to assess level of support needed.

to maternity with a plan for removal has improved forward planning to reduce delays for court attendance.

4.13 The children safeguarding team attended 187 strategy meetings working with practitioners and children's social care to ensure information is shared to help with the assessment of risk to protect a child or unborn baby. This is an increase of 32.

4.14 The LA moved to a Family Safeguarding model across Oxfordshire, this has resulted in a reduced hospital social care team. The remaining team are now co-located with the children safeguarding team and provide joint working across both the hospital and the Multi-Agency Safeguarding Hub (MASH).

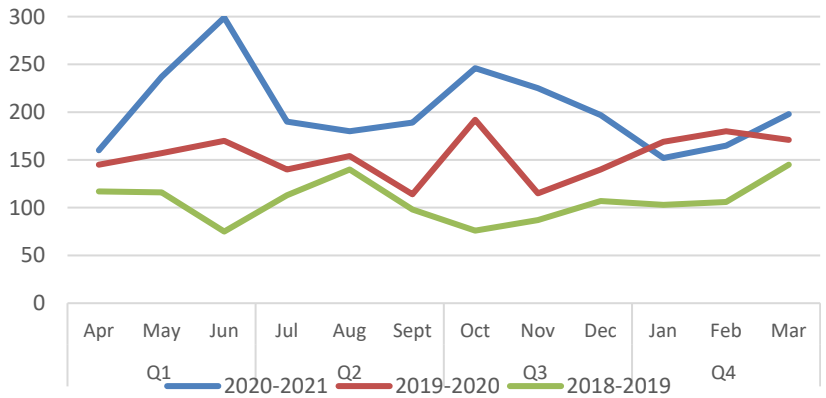
4.15 MASH activity has increased by 37% over the year, this has led to delays in health information sharing. A review of health resource has been undertaken and escalated to the CCG as there has been no increase since its implementation in 2014. The OUH and Oxford Health provide the health information for the MASH and have committed an additional full-time administrator. Additional support has been required over the year by the safeguarding children team to reduce delays in providing health information. This continues to be monitored and is a priority to review resourcing.

5. Safeguarding Adult Activity

Safeguarding activity is divided into four main areas:

- investigation of safeguarding concerns surrounding Trust services including Section 42 investigations[4] and safeguarding Adult Reviews (SARS)
- consultations relating to safeguarding
- training and education reviewing and processing the DOLS applications for the Trust
- supporting the safeguarding partnership working.

5.1 The safeguarding adult team received 2438 consultations over the year, averaging 203 per month. This is an increase of 24% (n=591) from 2020-21 (see fig 5).



[4] Care Act 2014

Fig. 5: Safeguarding Adult Team Consultations 2018-2021

5.2 There were 5135 Emergency Department (ED) EPR referrals, an increase of 9%, and 1198 incident reviews, a 29% reduction from 2019-2020. The safeguarding team review incidents raised when there are safeguarding concerns by the clinical team (see table 1).

	2019/20	2020/21	difference	% difference
Consultations	1847	2438	↑ 591	↑ 24%
ED EPR Referrals	4677	5135	↑458	↑ 9%
Incident Reviews	1699	1198	↓ 501	↓ 29%

Table.1: Safeguarding Adult Team Referral 2018-2021

5.3 Figure 6 demonstrates the monthly combined referrals that average 730 a month.

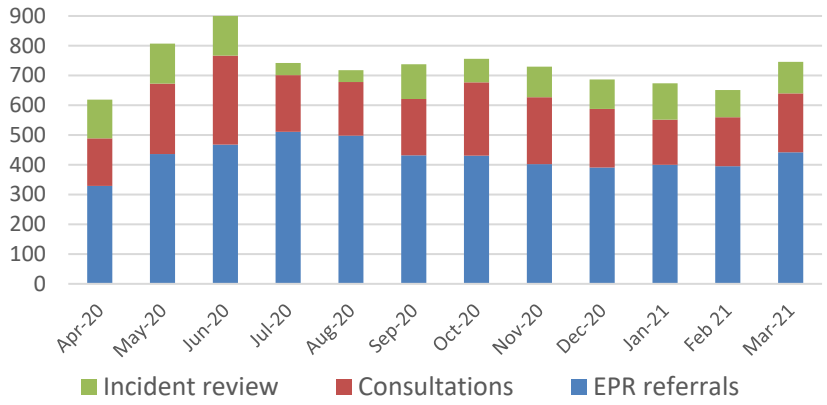


Fig.6: Safeguarding adult monthly referrals

5.4 The consultation categories mainly related to issues of neglect and self-neglect, domestic abuse, multiple safeguarding concerns, and perplexing presentations. Consultations include advice on discharge eligibility, completion of Deprivation of Liberty Safeguards (DoLS), the implementation of the Mental Capacity Act (MCA), completion of domestic abuse DASH[5] forms and advice regarding completion of Section 42 enquiries to support staff managing safeguarding issues. This is shown in Figure 7 below.

[5] 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/.

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

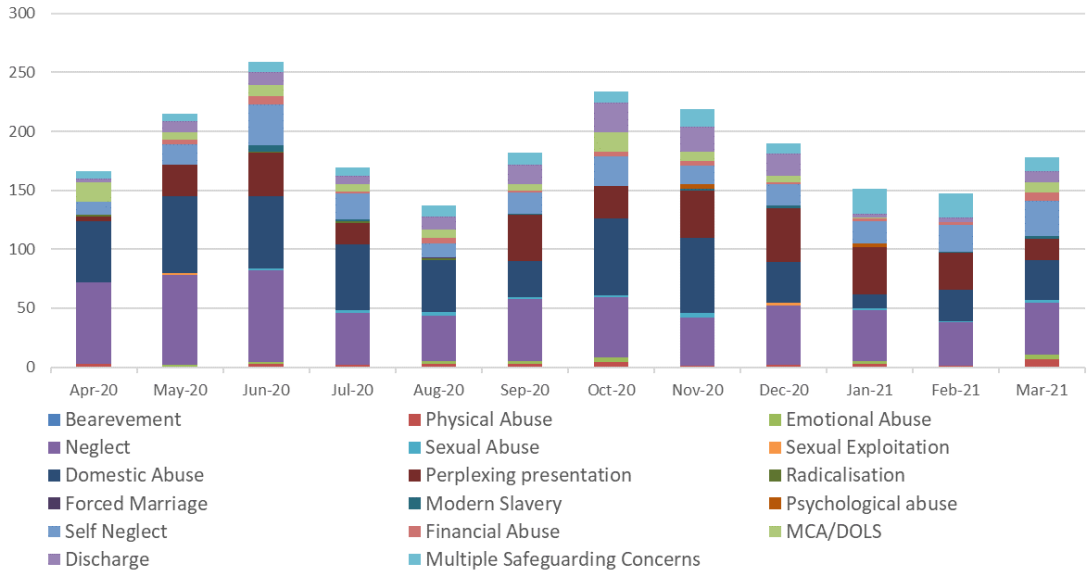


Fig. 7: Consultations Categories

5.5 Figure 8, below, shows the Section 42 enquiries during the year. The Trust received requests for 23 investigations. There were 11 partially or completely substantiated, 10 were unsubstantiated, one inconclusive, and one remains open due to complexities and needing a repeat review by the LA. Figure 9 indicates the divisional location involved with the investigations.

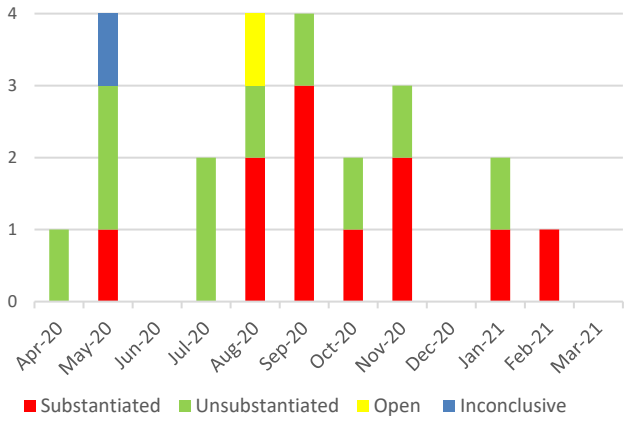


Fig. 8. Sc.42 investigation outcome

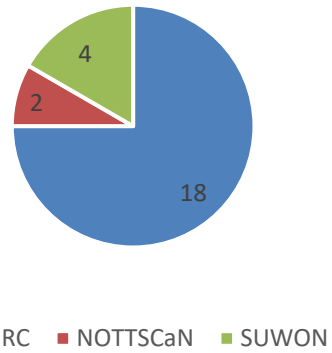


Fig. 9. Divisional Sc.42 Investigations

5.6 The themes for the Sc. 42 investigations mainly relate discharge issues and neglect with two cases involving physical abuse that was unsubstantiated and another sexual assault that was inconclusive.

6. Partnership working to improve outcomes for children and adults

6.1 The safeguarding children team are members of nine sub-groups for the OSCB. The adult safeguarding team are members of five subgroups for the OASB. This is shown in Table 2, below. The Head of Safeguarding represents the Chief Nursing Officer on both Safeguarding Boards.

OSCB sub groups	OSAB sub groups
Training sub group	Training sub group (TSG)
Performance Audit and Quality Assurance (PAQA)	Performance Information and Quality Assurance (PIQA)
Case Review and Governance (CRAG)	Safeguarding Adults Review (SAR)
Policies and Procedures	Mental Capacity Forum
Child Exploitation Sub Group	Vulnerable Adult Mortality Group (VAM)
Neglect Task and Finish Group	Homelessness Mortality Review Group
Child Death Overview Panel (CDOP)	
Health Advisory Group	
Business Group	

Table 2: Membership of OSCB/OSAB sub groups

6.2 The Trust participate at the Oxfordshire Community Safety Partnerships, Modern Slavery Forum, the Oxfordshire Domestic Abuse Strategic Group and the multiagency Partnerships in Practice meetings.

6.3 Both the children adult safeguarding teams contribute to the OSCB and OSAB training pool.

6.4 The safeguarding children team to contribute to the functioning of the Multi-Agency Safeguarding Hub (MASH) 2 days a week. This function, in conjunction with Oxford Health NHS FT to ensure health information is shared to inform assessment of need. Additional nurse and admin resource has been required to support the MASH partnership due a 38% increase in referrals to the MASH over the year.

6.5 The safeguarding team attend the three area and monthly Multi-Agency Risk Assessment Conferences (MARAC) to share relevant information in high risk domestic abuse cases. Information is recorded on the electronic patient record to inform practitioners involved with patients of when they attend the Trust.

6.6 The team participate in the Oxfordshire Channel process and share relevant information to inform the risk assessments.

6.7 The OSAB commissioned a reported to review the deaths of 9 homeless people. In November 2020 the thematic review report set out recommendations and led to the Homeless Mortality Review group being set up. The safeguarding team have participated in this group, and it is in its infancy to scrutinise performance and share learning across the partnership.

6.8 Due to systems changing related to the Covid-19 pandemic a multi-agency meeting took place to identify and share risks and information and provide support. This has continued and highlights the strong working relationships across the partnership and ability to respond to safeguarding themes identified. Issues around domestic abuse, adolescent mental health and increased MASH activity led to wider discussions and additional services to support being provided.

6.9 Information to inform decision making is requested by the LA for all Initial Child Protection Case Conference (ICPCC) under section 47 of the Children Act 1989. There were 372 ICPCC invites, a decrease of 1.8% (n=7) involving 657 children and 67 unborn babies. There was an overall slight reduction as shown in Table 3, below.

		2019/20	2020/21	Difference	% Change
ICPCC Invited		379	372	↓7	↓1.8%
Information Shared	Unborn	70	67	↓3	↓4%
	Children	693	657	↓36	↓5%

Table 3 ICPCC information requests

7. **COVID-19**.

7.1 The team's activity was monitored as the usual expected patterns of attendances changed over the year as a result of the COVID 19 pandemic.

7.2 There was initially a reduction in Domestic Abuse referrals and the usual ED activity reduced. The Police, Oxford Health and the county's Domestic Abuse services noted that there was not a local increase as nationally reported domestic abuse. The safeguarding team are part of the county wide domestic abuse strategy and information was regularly updated on the intranet safeguarding pages to support staff to support patients and colleagues.

7.3 The referrals for neglect increased in relation to patients identified as shielded or patients who were carers who contracted COVID-19.

7.4 This was shared with the Oxfordshire CCG and the OCC Adult Safeguarding team; the local COVID support groups developed during the 2nd half of March and the OCC Community Support Hubs were developed by 9th April. This in part helped with the response to the concerns for isolated and vulnerable people in this situation and the potential for neglect/ harm from a reduction in statutory services.

7.5 Carers Oxfordshire, Oxford Family Support Oxford Health and the Trust's Learning Disability Services network held a successful and well received virtual on-line seminar on 9th April 2020 for family carers worried about the impact of COVID-19 on their relative with a learning disability. This was instrumental in family carers feeling more confident about the Trust's care for people with learning disability.

7.6 Safeguarding teams have continued to support staff during the changes to working providing advice, supervision and support with case management.

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

8.1 The correct implementation of The Mental Capacity Act 2005 (MCA) is pivotal to patient centred healthcare. This important legislation protects and empowers individuals who may lack the mental capacity to make their own decisions about their care and treatment. It applies to individuals aged 16 years and over.

8.2 Mental Capacity is time and decision specific which safeguards against assumptions and decisions being made about the patient.

8.3 The Trust's MCA assessment is embedded within the Electronic Patient Record System (EPR). The Trust's MCA site gives clinical staff current information on the implementation and statutory responsibilities for MCA. The site was recently reviewed in light of the COVID- 19 pandemic.

8.4 The Deprivation of Liberty Safeguards (DOLS) form part of the Mental Capacity Act 2005. DOLS were introduced in 2009. The Trust's ward nursing teams are responsible for the DOLS application and management on the ward. The adult safeguarding team manage and administer the DOLS for the Trust.

8.5 Each DOLS application is reviewed by the safeguarding adults team prior to the safeguarding administrator sending to the appropriate DOLS supervisory office. This process is shown in Appendix 4 and includes the statutory responsibilities to inform the Care Quality Commission (CQC).

8.6 An administrative and clinical review is undertaken prior to the submission of the DOLS application form. This ensures

- a relevant mental capacity assessment is documented
- accurate, appropriate and comprehensive DOLS
- the appropriate use of Sections 5 and 6 of the Mental Capacity Act. For example if a patient is experiencing acute delirium and it is likely they will recover mental capacity.

8.7 During the year, 283 DOLS applications were made an increase of 83. Figure 9 shows the comparison with the previous four years and shows a reduction for the second consecutive year, although in March eight DOLS applications were made because of the emphasis of preparations for COVID - 19. Please note figures for the last two years have been broken down by division.

8.8 Figure. 10 shows the DoLS applications varied over the year during Covid-19. The levels varied during periods of lockdown. The majority were from MRC division.

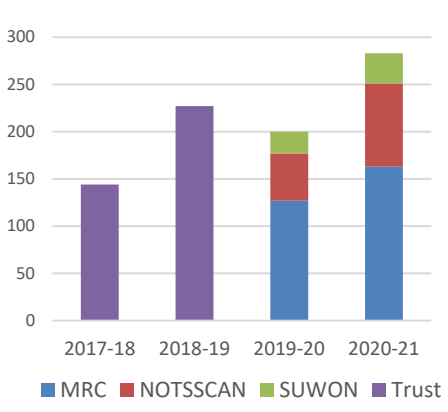


Fig. 9 DOLS applications submitted

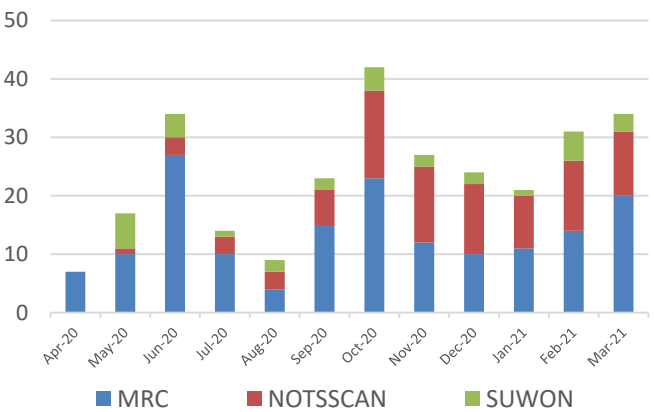


Fig. 10 DOLS by Division during 2019/20

8.9 The Mental Capacity Amendment Act (2019) gained Royal Assent on 16th May 2019. The Act was drafted following the House of Lords Select Committee in

2014 and the Care Quality Commission' (CQC) concerns surrounding the national implementation of the Mental Capacity Act. In the Act, DOLS will be replaced by Liberty Protection Standards (LPS). Due to Covid-19 pandemic there is a delay in the national implementation, the code of practice is due implementation delayed 2022.

8.10 The risks and mitigations in association with the implementation of DOLS are shown in Table 4 and are carried over from last year.

Risk	***Mitigation***
Lack of clarity regarding the implementation of Liberty Protection Standards in the Mental Capacity Assessment Act 2019.	The national implementation has been postponed due to the continued delay in the publication of statutory guidance and the COVID-19 pandemic.
Continued impact of Cheshire West judgement in 2014[6]	Escalation for Trust's patients ensuring timely clinical and Best Interest assessment when needed during the DOLS application process.
Documentation for MCA	Update of Mental Capacity Act assessment forms and advice on the Electronic patient Records (EPR). OUH Rule of Thumb literature and training on MCA guidance being developed.
Clinical understanding of MCA. Particularly nurses and Allied Health Professionals (AHPS) understanding that they can assess mental capacity.	MCA module included in the suite of training for Level 2 Adult Safeguarding. Planned implementation of the Health Education England (HEE) 11 modules on MCA
Collection of all activity relating to DOLS applications	The DOLS spreadsheet has been expanded to include the status of a DOLS application. This enables more accurate recording of the number of DOLS reviewed. 1. Waiting for DOLS authorisation 2. Transferred - DOLS application not submitted 3. Sadly died - DOLS application not submitted 4. Using Sc. 5 and 6 of MCA – DOLS not required

Table 4: Implementation of MCA/DOLS

9. Designated Safeguarding Officer

9.1 The Designated Safeguarding Officer (DSO) function has moved into the safeguarding team to manage cases involving staff to support when involved with partner agencies when concerns or allegations have been raised. There have been 125 cases over the year.

9.2 The DSO and Head of Safeguarding work closely with the Local Authority Designated officer (LADO) team when allegations have been raised to manage risks and ensure support for staff and managers is in place.

10. Case Reviews

[6] http://www.communitycare.co.uk/2014/03/19/supreme-court-ruling-heralds-sharp-rise-deprivation-liberty-safeguards-cases/

10.1 Children Serious Case Reviews (SCR) and Child Safeguarding Practice Reviews (CSPR) are commissioned by the OSCB when a child or young person dies or experiences serious harm or injuries and there are concerns that interagency working could have been more effective to safeguard them.

10.2 The children safeguarding team participated in five CSPRs across Oxfordshire, one SCR in Berkshire and one in Buckinghamshire and 2 local reviews. Learning events for practitioners took place to disseminate learning themes.

10.3 There are no outstanding actions, learning is disseminated in safeguarding level 3 training; through the 'At a Glance' learning documents, and participation at OSCB learning events.

10.4 Safeguarding Adults Reviews (SAR): the OSAB commissioned two reviews. One review relates to nine homeless people who died in Oxford during 2018-2019. There is national concern relating to homeless people. This has been published. The team participate in the Homeless Mortality review meeting as part of the action plan for this review.

11. Training

11.1 The Key Performance Indicator (KPI) for safeguarding training is locally agreed with the CCG and is 90%. The nationally agreed KPI for Prevent Level 3 training is 85%.

11.2 The Adult and the Children Safeguarding Training Intercollegiate guidance[7] [8]are used to inform the Trust training. The online safeguarding training is provided by E-Learning for Health (Health Education England)[9]. The online Prevent training is provided by the UK Home Office.

Safeguarding Level	Compliance % March 2020
Adults Level 1	84%
Adults Level 2	79%
Children Level 1	84%
Children Level 2	78%
Children Level 3	73%
Prevent Level 1&2	91%
Prevent Level 3,4 &5	88%

Table 5: Trust Safeguarding Training Compliance

11.3 *Tables 5and 6, below, present the Trust and Divisional level of compliance.*

	Adult Level 1 %/gap	Adult Level 2 %/gap	Children Level 1 %/gap	Children Level 2 %/gap	Children Level 3 %/gap	Prevent Level 1&2 %/gap	Prevent Level 3,4 & 5 %/gap
Corporate	92%/60	85%/29	92%/67	82%/24	88%/16	91%/74	89%/16

[7] https://www.rcn.org.uk/professional-development/publications/pub-007069
[8] https://www.rcn.org.uk/professional-development/publications/pub-007366
[9] https://www.e-lfh.org.uk/

MRC	84%/149	79%/614	83%/119	77%/591	83%/314	83%/340	84%/263
NOTTSCaN	78%/218	80%/596	78%/213	79%/484	81%/398	81%/398	83%/314
SWUON	92%/62	91%/320	93%/58	87%/307	92%/143	92%/143	90%/160
CSS	94%/71	88%/133	94%/77	88%/132	90%/834	94%/94	90%/83

Table 6: Divisional Safeguarding Training Compliance

11.4 Compliance with training dropped as face to face training ceased due to NHS England and Government advice on social distancing a result of the Covid-19 pandemic. Online training remained available Microsoft teams virtual training was developed and well evaluated. Due to staff clinical pressures reminders were not sent to allow staff to manage the pandemic. Training remains available on line and the OSCB and OASB developed a suite of training accessible online and through webinars to support agencies.

11.5 The plan to achieve compliance in safeguarding and radicalisation training continues in both adult and children safeguarding.

11.6 The Trust move to the new My Learning Hub platform took place in April 2021 with an expectation to provide a passport programme to enable staff to transfer their previous Statutory and Mandatory Training to their Trust account and any additional CPD, webinar attendance, updates to provide evidence of compliance with the Intercollegiate guidelines for both adult and children. This is included on Trust induction.

11.7 The implementation of the following training as been delayed due of COVID-19 pandemic.

- Level 3 Adult Safeguarding training
- Advanced Mental Capacity Act training for clinicians
- Online ACT (Action Counter Terrorism) training

12. **Audit**

12.1 The Trust submitted the annual OSCB/OSAB self-assessment of compliance with Section 11 of the Children Act and the Care Act 2014. This again was positively peer reviewed and commended on the quality of the return. The Trust responses to the practitioner audit was lower than the previous year which was considered likely to be due to increased clinical pressures due to the pandemic.

12.2 An audit has been undertaken to look at ED attendances for children known to the police on the Recency, Frequency & Gravity (RFG) data to ascertain if the correct safeguarding pathway was followed. The results are positive and will be presented at the next safeguarding strategy meeting. A request for ED to mandate that all under 18 year olds have the children assessment completed as this age group often follow use adult assessment documentation.

12.3 An audit of practice was undertaken of skeletal surveys to investigate possible non accidental injury, and the results mostly positive. The small number of action points arising have been completed.

13. **Impact**

13.1 At an operational level, the impact of the teams can be seen in the level of clinical activity, particularly the number of consultations, complexity of cases and changes to working over the year.

13.2 The challenges with capacity have been considerable again this year due to staff changes and sickness. The establishment was reviewed, and a decision has been made to merge both teams into a single all age family based safeguarding team. This is in line with national practice.

13.3 The impact of the teams at a strategic level has predominately been with the partnership work to support the activity of the OSCB and OSAB. This has involved contributing to subgroups, serious case reviews and SARs, the development of county wide domestic abuse service, contribution to MARAC, Community Safety Partnerships, Channel and Prevent.

13.4 The number of consultations undertaken has enabled teams to support patients and their families in challenging and extremely complex circumstances. The teams have contributed to the level of safeguarding children and adult's knowledge across the Trust and in the county.

13.5 The adults' team's review of each DOLS application continues to maintain the standard of the DOLS applications. Although considerable challenges surrounding the implementation of the MCA have been established, the adults' contribution to improving the Trust's compliance through training and the development of MCA within EPR has been significant.

13.6 The team have reviewed the s. 42 process to work with Trust's clinical teams to complete Sc. 42 enquiries. There were 24 reviews over the year and the team have closely linked with the LA to ensure closure and response received in a timely manner. The impact of this has been review jointly submit within initial timescales set out by the LA and ensure finding are shared with teams.

14. **Key Challenges:** This also demonstrates the impact of the team

- There continues to be a significant increase in consultations across the Trust and all sites in both children and adult safeguarding that is reflected locally and nationally.
- Number of adolescent children presenting with complex safeguarding mental health needs and prolonged stays in hospital due to delays identifying appropriate placements by children social care or CAMHS
- Ongoing increases in complexity of safeguarding cases related e.g., mental health, maternity, perplexing presentations, domestic abuse and neglect. These often require ongoing support from the teams
- Timely mental capacity assessment and documentation
- The length of time to assess and authorise DOLS applications

- The challenges in achieving the KPI of 90% for safeguarding children and adults training; including the introduction of training passports via the new learning platform My Learning Hub

15. **The Key achievements**

- Significant daily interagency partnership work to safeguarding children and adults
- Continuity of effective safeguarding advice and support despite staffing challenges and changes to working over the Covid -19 pandemic.
- Active participation at OSCB and OSAB board and subgroup meetings
- Evidence of good practice at the annual OSCB and OSAB self-assessment
- Effective patient centred collaboration when working alongside multidisciplinary clinical teams to safeguard patients
- Development of MS teams safeguarding training during Covid that has been well evaluated
- The merge of the adult and children safeguarding team in January 2021 to provide an all aged, family-based service.

16. **Conclusion**

16.1 The profile of Safeguarding Children and Adults Teams continue to develop across the OUH and partner agencies to meet the requirements set out in section 11 of the Children Act 2004 and the Care Act 2014.

16.2 Significant multiagency joint working has demonstrated the Trust's commitment to work together to improve the identification of concerns, and to protect children and vulnerable adults within the Trust.

16.3 All the work across the Trust and partnerships would not be possible without the commitment of our front-line staff and the safeguarding team who have the professional curiosity and commitment to safeguarding our patients. I would like to thank all of them for their professionalism, dedication, and continued support to safeguarding our patients across the Trust.

17. **Recommendation**

17.1 The Trust Management Executive (TME) is asked to note and approve the content of this report

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 Team