Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 18 January 2023

TB2023.15

Title:	**Safeguarding Annual Report 2021-2022**

Status:	**For Information**
History:	**Annual report**

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

Executive Summary

1. This annual report covers provides an overview of activity, progress, and multi-agency participation in relation to Safeguarding of Children and Adults during 2021/22.
2. The Chief Nursing Officer has executive leadership for the OUH and is represented by the Head of Safeguarding on the Oxfordshire Children and Safeguarding Board (OSCB) Oxfordshire Adult Safeguarding Board (OSAB).
3. Safeguarding children and maternity consultations increased by 14%, to 3899 consultations, an average of 325 per month. Neglect, emotional and domestic abuse remains the main category of activity. Children presenting with self-harm increased by 60%, analysis of themes are monitored and shared at the three county self-harm forums. Complex adolescent mental health presentations and eating disorders continue to be a theme with delays in discharge. There has been joint partnership working with the LA and CAMHS to reduce discharge delays and the impact on children. The Safeguarding Liaison Service Emergency department information shares increased by 50% (n=3566). Requests for Initial Child Protection Case Conference information to support decision making was provided for 357 conferences for 691 children and 55 unborn babies.
4. Pregnancy bookings decreased by 0.9% (n=8633) this year although, 25.3% (n=2188) of all bookings were identified as either category 3 or 4 public health risk, an increase of 313. Safeguarding activity in pregnancy increased by 21% (n=1282) related mainly to mental health, drug and alcohol misuse and domestic abuse.
5. Safeguarding Adult consultations increased 22% (n=2970) an average of 247 per month and increase of 520. Themes related to neglect, self-neglect and domestic abuse. The emergency department EPR referrals decreased by 26% (n=) 3785 following streamlining the referral pathway. There was a 14% reduction of clinical incident reviews where clinical teams were concerned there may have been a safeguarding concern following a clinical incident (n=1035). There were 9 Section 42 enquiries closed during the year, two substantiated, four unsubstantiated, one partially substantiated and two inconclusive and learning was shared. There were 423 DoLS applications made during the year, an increase of 140 applications made.
6. Training compliance[1]

Adult Level 1 = 91%	Children Level 1 = 90%	Prevent Level 1&2 = 87%
Adult Level 2 = 93%	Children Level 2 = 90%	Prevent Level 3,4&5 = 90%
	Children Level 3 = 78%	Mental Capacity = 75%

7. Partnership Working continues to be strong with membership at OSAB & OSCB subgroups, multi-agency meetings, participation in the MASH for the children's team, participation in multiagency audits and processes in place to share relevant information of risks to protect children and adults.

[1] Local Safeguarding KPI is 90%: National Prevent KPI is 85%

8. **Key achievements** increase of activity and complexity of cases continued despite team challenges with sickness and vacancies to support staff with safeguarding functions. Interagency partnership working with the OSCB and OSAB and networks. The OUH achieved the full level of compliance in annual OSCB/OSAB self-assessment and peer.
   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.
   Increased activity across the MASH and partner agency requests for information to inform risk assessments.

9. Recommendation

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

Contents

Safeguarding Annual Report 2021-2022

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 and to keep safe from harm.

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 t April 2021 to March 2022 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 Trust Board received the last annual safeguarding report on the 8th September 2021.

3. Background

3.1. Safeguarding Executive Lead is Sam Foster, Chief Nursing Director. The team is led by the Head of Safeguarding (see updated structure in Appendix 2) to work across the Trust as one team to provide a family base safeguarding service.

3.2. The safeguarding team covers three domains, adults, children, and maternity.

Safeguarding System Data

4. Children and Maternity Activity

Safeguarding activity is divided into 3 main areas:

- Consultation activity
- Safeguarding Liaison
- Self-Harm presentations

4.1. There were 576 children at the end of March 2022 with a Child Protection Plan (CPP) in Oxfordshire, an increase of 124 from 2021. Neglect continues to be the predominant category of the team's activity and is comparative to the Local Authority (LA) data. The OUH continues to focus on neglect and is

represented on the OSCB Neglect Strategy Subgroup at to advise and champion work to deliver changes in families and communities. All Oxfordshire children on a CPP are flagged and uploaded to the Electronic Patient Records (EPR) to ensure information is shared to inform clinical staff assessments. There were 357 family requests for information from the OUH to inform Initial Child Protection Case Conferences (ICPCC), this involved 691 children and 55 unborn babies. The number of conferences reduced by 15 however the number of children increased by 34. Attendance is monitored by the OSCB and the LA and all applicable conferences had OUH representation to enable decision making. The number of Oxfordshire children that were 'Children We Care For' (CWCF)[2] increased by 49 to 825, this is the highest number of children for many years and includes unaccompanied asylum-seeking children.

4.2. Safeguarding children and maternity consultation activity increased by 476 to 3899 (average 325 per month). This is an increase of 14% from 2021-22 (see Figure 1). Neglect, emotional abuse, domestic abuse remains the main category of activity. Adolescent mental health, eating disorders with delays in discharge have been a theme over the year. Joint working with the LA and CAMHS to reduce delays and the impact on families has been a priority to reduce the impact on children and families.

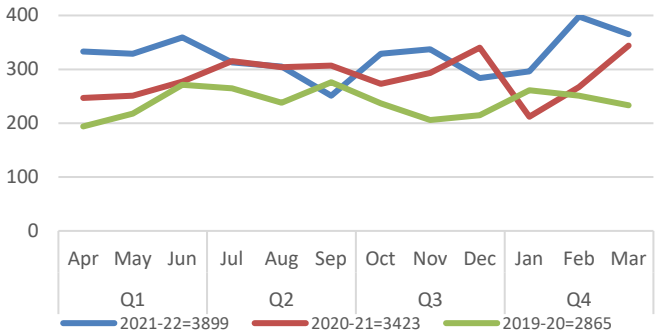
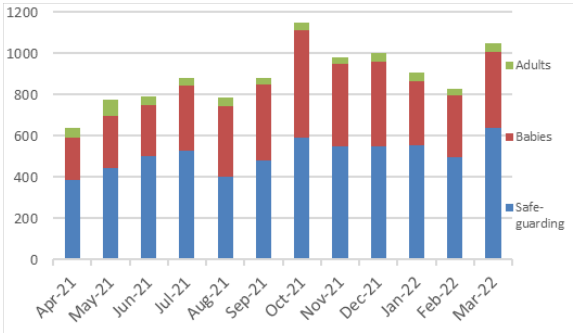


Fig. 1: Children and Maternity Consultations Activity 2019-2022

4.3. The Safeguarding Liaison Service shares information with primary care and children social care for open cases when children present to the Emergency Department (ED) in relation to set criteria (see Appendix 3). Attendances are broken down into three areas; children safeguarding presentations, all babies under 1-year of age due to their vulnerability, and parent or carer attendances to ED where their presentation raises a safeguarding concern and potential risk to a child. Oxfordshire Children's Social Care received notifications for children on a CPP or for CWCF[i].

4.4. Presentations to ED increased by 3566 (n=10622) which is a 50% increase over the year (see fig.3). Figure 4 demonstrates the increase in attendances over four years to compare pre and post Covid 19 pandemic attendances.

[2] Looked After Children (LAC) is the statutory term, locally the children in care requested the term 'Children We Care For'



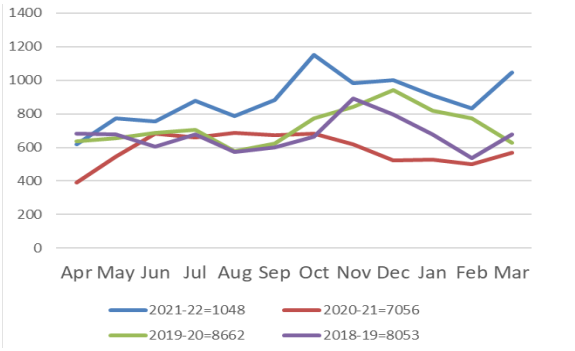
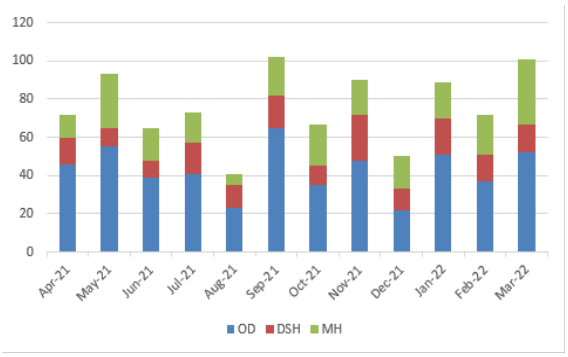


Fig. 2 Safeguarding Liaison Service Year Attendance

Fig.3 Safeguarding Liaison Service over 4 years

This service ensures information of potential vulnerability is available to professionals working with families to inform any risk assessments. The Trust invested in an additional full-time administrator to support information sharing.

4.5. Complex cases related to adolescent mental health and eating disorders continued to be a significant concern this year. Attendance to ED's for self-harm increased by 60% over the year with overdoses being the main presentation (see figure 5 and 6). Analysis of themes were closely monitored and shared with the three county self-harm forums to put in plans to support families, schools, and professionals. Delays of discharge due to placement availability has been a significant issue.



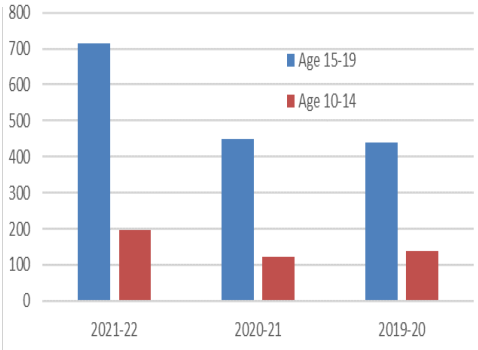


Figure 4. OUH ED year attendances with DSH, OD and MH

Figure 5. Three-year ED attendances (CSU data)

4.6. The Home Office funded Hospital Navigator project commenced in the JR ED this year. Connections Support manage the project and volunteers working with the Community Safety Practitioners. The aim of the project is to support the police Violence Reduction Unit (VRU) working with children and young

adults to reduce reattendance at emergency care settings. The project is in all Thames Valley Trusts. The project in the OUH has been slow to start and plans are in place to increase the number of volunteers and presence in ED. Oxford Brookes university are undertaking an evaluation of the project across all sites.

Maternity Activity

4.7. Maternity pregnancy bookings decreased by 0.9% (n=8,633) this year, however 25.3% (n=2188) of all bookings were identified as either category 3 or 4 public health risk[3], an increase of 313. Safeguarding activity in pregnancy saw an increase of 21% (n=1282) with maternal mental health, drug and alcohol misuse and domestic abuse being the main category of concern. There were 192 unborn babies with LA involvement and 25 interim care order obtained by the courts. Figure 6 and 7 demonstrates the maternity safeguarding team activity in relation to safeguarding cases identified at pregnancy booking. This increases during pregnancy when concerns are identified.

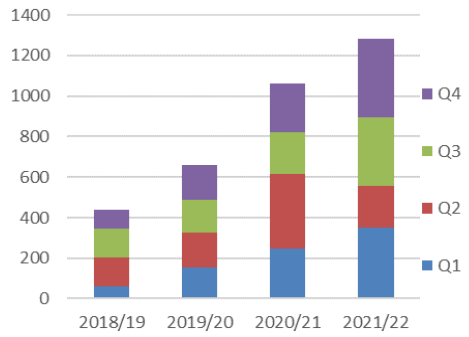


Fig.6: Safeguarding Maternity Team Consultations

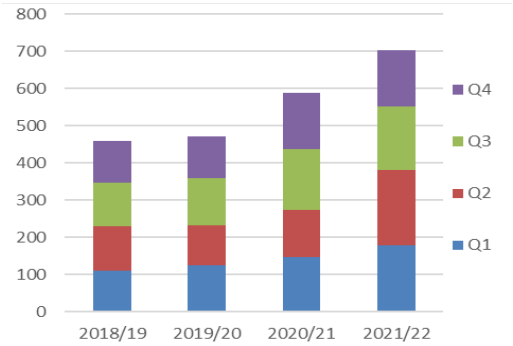


Figure 7: Safeguarding Cases at Booking

4.8. The team monitor any delay in discharge awaiting social care placements for mothers and/or babies following either care orders or section 20, voluntary agreement for care. There were 20 days where there was a delay beyond clinical need involving 11 maternity cases, this is a small increase of 5 days from last year. Preplanning is in place by the team to ensure plans are in place to reduce delays for court attendance coupled with joint requests from OUH and the LA to the court for virtual hearings.

4.9. The team supported community maternity services by attending 59 strategy meetings and 16 ICPCC's to participate in identifying risk to protect a mother and unborn baby and inform decisions.

5. Safeguarding Adult Activity

Safeguarding activity is divided into four main areas:

- Safeguarding consultation activity

- Section 42 (Care Act 2004) investigations of safeguarding concerns Trust services including investigations and Safeguarding Adult Reviews (SARS)
- Deprivation of Liberty Safeguards (DoLS) applications for the Trust

5.1. There were 5,934 safeguarding concerns raised over the year to Oxfordshire County Council (OCC), an increase of 21% with 1,738 going on to be safeguarding enquiries which is a reduction of 33%.

5.2. The safeguarding adult consultations increased by 22% (n=2970) over the year, averaging 247 per month, an increase of 520 from 2020-21 (see fig. 8). Figure 9. shows the source of combined activity to include EPR referrals and Ulysses reports. In September 2021 ED EPR referral pathway was streamlined to ensure appropriate referrals received and saw a 26% reduction in referrals (Table 1.). This pathway ensured the ED High Intensity User team and the ED Community Safety Practitioners received the necessary referrals to manage patient need.

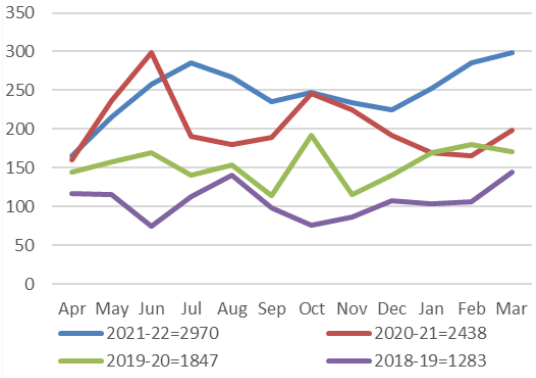


Fig. 8: Safeguarding Adult Team Consultations 2018-2022

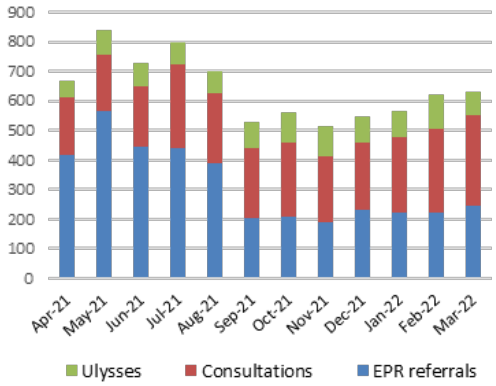


Fig. 9: Safeguarding Adult Combined Activity 2018-2022

	2020/21	2021/22	Difference	% Difference
Consultations	2438	2970	↑ 532	↑22%
EPR Referrals	5135	3785	↓ 1,350	↓ 26%
Ulysses	1198	1035	↓ 163	↓ 14%

Table.1: Safeguarding Adult Combined Activity

5.3. The main consultation category related to issues of neglect, self-neglect and domestic abuse (see Fig 10.). The team ensured completion of domestic abuse

DASH[4] forms and referrals to MARAC for high-risk domestic abuse cases. Advise on safeguarding to support safe discharge, confirming capacity assessments are undertaken to ensure compliance of the Mental Capacity Act (MCA) and support the accurate Deprivation of Liberty Safeguards (DoLS) process informing the LA to undertake an assessment. The team participate in best interest meetings to support clinical teams.

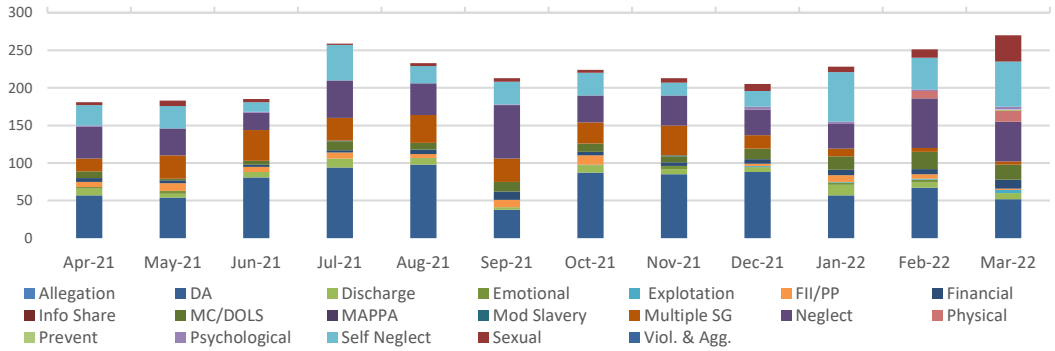
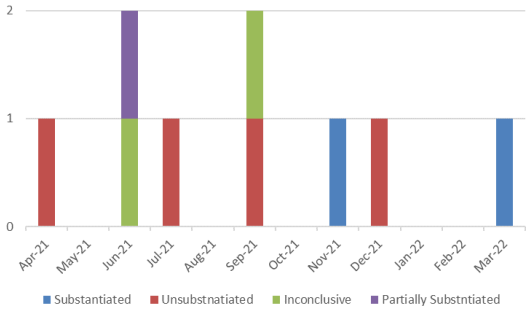


Fig. 10: Safeguarding Adult Consultation Activity

5.4. The team liaise with the LA to ensure appropriate process is followed for Section 42 (Care Act 2004) enquiries and support the divisions with completion to manage safeguarding concerns. This is shown in Figure 7 below.

5.5. The Trust received 9 Section 42 investigations over the year and related to discharge issues, neglect, and allegations. There were two found to be substantiated, four unsubstantiated, one partially substantiated, and two inconclusive (Fig. 8). Responses were all shared with divisions involved. The LA are changing the outcome notification process and will only sharing lessons to be learnt. Figure 9 indicates the divisional location involved with the investigations.

[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/.



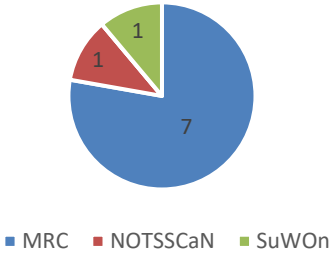


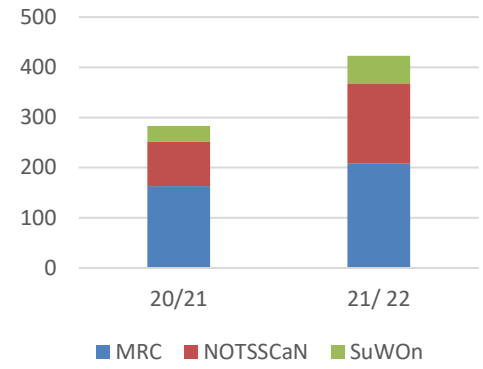
Fig. 11. Sc.42 investigation outcome

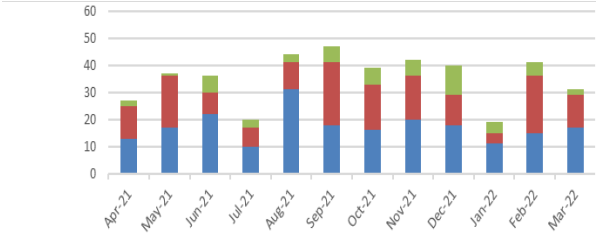
Fig. 12. Divisional Sc.42 Investigations

5.6. The adult safeguarding team review and manage and administer the DoLS process for the Trust. Each application is reviewed and sent to the patients LA and notifies the Care Quality Commission (CQC). The team review applications prior to submission to ensure:

- a relevant mental capacity assessment is documented
- accurate, appropriate and comprehensive DoLS application
- 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.

5.7. There were 423 DoLS applications made during the year, an increase of 140 from the previous year (Figure 9). Figure. 10 shows the DoLS applications per division varied over the year. The majority were received from MRC division. The team supported clinical areas in identifying, documenting capacity, and making applications.





	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
SuWON	2	1	6	3	3	6	6	6	11	4	5	2
NOTSSCaN	12	19	8	7	10	23	17	16	11	4	21	12
MRC	13	17	22	10	31	18	16	20	18	11	15	17

Fig. 13 DOLS applications submitted

Fig. 14 DOLS by Division during 2021/22

5.8 There remains a significant delay in LA's undertaking DoLS authorisation the team review the applications and escalate to the local authority if a mental health doctor and best interest's assessor needs to review urgently or if there has been a delay to their assessment.

5.9 The Trust's mental capacity assessment documentation template is embedded within the Electronic Patient Record System (EPR) to ensure consistent recording and allows easy access to the assessment. The team provide area specific guidance and training on capacity assessment and completion of DoLS applications. The introduction of the Rule of Thumb (see appendix 4) awareness tool to support staff in assessing capacity. This was rolled out across the Trust with posters, pocket cards as well as on the intranet to raise aware to provide clinical staff information on the implementation and statutory responsibilities for MCA.

6. Partnership working to improve outcomes for children and adults

6.1. The Head of Safeguarding represents the Chief Nursing Officer on both Oxfordshire Children and Adult Safeguarding Boards. The safeguarding team are members of 13 sub-groups for the OSCB and OSAB (see table 2). The Chair of the training Subgroup is the Operational Children Manager and is shared with Oxford Health Adult Safeguarding Manager.

OSCB sub groups	OSAB sub groups
Joint Training subgroup (OUH/OH Share the Chair)	
Performance Audit and Quality Assurance (PAQA) (OUH Deputy Chair)	Performance Information and Quality Assurance (PIQA)
Case Review and Governance (CRAG)	Safeguarding Adults Review (SAR)
Policies and Procedures	Mental Capacity Forum
Child Exploitation Subgroup	Vulnerable Adult Mortality Group (VAM)
Neglect Subgroup	Homelessness Mortality Review Group
Child Death Overview Panel (CDOP)	
Health Advisory Group	
OSCB Business Group	

Table 2: Membership of OSCB/OSAB sub-groups

6.2 The safeguarding team continue, in partnership with Oxford Health to work in the MASH to provide health information. Contact into the MASH increased by 33% (n=23,920) over the year, there have been delays in providing health information due to the increased workload. Additional temporary health resource was redeployed over the year to manage risk. Monitoring of MASH activity continues, and resource remains a challenge. The focus for the coming year is to build on early help to assessments

6.3 The safeguarding team contribute two days a week to support the functioning of the Multi-Agency Safeguarding Hub (MASH). This function is shared with Oxford Health to ensure health information is shared to inform assessment of need. Joint resourcing has been reviewed and additional support is still required to support the MASH partnership as contact to the MASH increased by 33% over the last year. The team have supported, when possible, to manage backlogs in health information requests.

6.4 Information requests from the LA to inform decision making for Initial Child Protection Case Conference (ICPCC) under section 47 of the Children Act (1989) reduced by 15 (n=357). This involved sharing information for 691 children and 55 unborn babies.

6.5 The Trust participate in multiagency meetings for the Oxfordshire Community Safety Partnerships, Modern Slavery Forum, the Oxfordshire Domestic Abuse Strategic Group, Serious Concerns group and the multiagency Partnerships in Practice group.

6.6 The team attended all of the three-area 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. The team attended the majority of the 3 county Multi-Agency Task and Coordination (MATAC) group to share information and support perpetrators of domestic abuse to reduce risk.

6.7 Participation at the multi-agency Berkshire, Oxfordshire & Buckinghamshire (BOB) reediness for the Liberty Protection Safeguards (LPS) group following the Mental Capacity Act amendment in 2019. The implementation date is expected to be 2023. The main changes in the legislation will make the OUH a responsible authority to ensure completion of assessments and will need to have qualified assessors in place. The other main change to the Act is that it includes 16 -17-year-old children.

6.8 There have been 23 requests from the Oxfordshire Channel process and share relevant information to inform the risk assessments.

6.9 The safeguarding team have participated in the Homeless Mortality group to contribute to reviewing the homeless pathway and identify any learning. There were 11 deaths reviewed, all were male, 10 were living in homeless accommodation and one street homeless and half were under 45 years of age and alcohol addiction was the main feature and most were known to the OUH.

7. Designated Safeguarding Officer

7.1 The Designated Safeguarding Officer (DSO) works 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.

7.2 From April 2021 to March 31st, 2022, the DSO's were involved in 60 safeguarding cases involving members of OUHFT staff, including our third party contractors and NHSP staff members. There has been a significant increase in the complexity of safeguarding cases.

8 Case Reviews

8.1 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 is interagency learning. There were five reviews undertaken over the year related to six children, one child died. Learning has been discriminated through learning events, learning summaries and lessons are included on safeguarding training. There are no outstanding actions for the Trust.

8.2 The Child R historical children Serious Case Review (SCR) Report[5] and Learning Summary[6] was published in December 2021. Child R was a young person who died in an out of county secure placement in 2013. Concerns related to neglect, physical harm and sexual harm. The Trust contributed to the review.

8.3 The Trust in two Safeguarding Adults Reviews (SARs) and one Domestic Homicide review:

'Adult Ian' review related to the death of a homeless man with addictions, self-neglect and mental health issues. There are no actions outstanding for the Trust.

[5] Child R Report 2021-12-09-Child-R-Serious-Case-Review-Report.pdf (oscb.org.uk)
[6] Learning summary 2021-12-09-Child-R-Learning-Summary.pdf (oscb.org.uk)

'Rhonda' who was a vulnerable adult that died. There were concerns of care when in a nursing home hub bed and issues of clarity regarding responsibilities and escalation process. A further review of the case was undertaken to review accuracy of the published report. The OUH outstanding action is under review by OCC commissioners around guidance for care homes and responsibilities.

9 Training

9.1 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%.

9.2 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 2022
Adults Level 1 (KPI 90%)	91%
Adults Level 2 (KPI 90%)	87%
Children Level 1 (KPI 90%)	91%
Children Level 2 (KPI 90%)	84%
Children Level 3 (KPI 90%)	70%
Prevent Level 1&2 (KPI 85%)	84%
Prevent Level 3,4 &5 (KPI 85%)	92%

Table 3: Trust Safeguarding Training Compliance

9.3 Online training remains the main route to deliver Level 1 and 2 safeguarding adult and children training. Level 3 face to face children safeguarding training safeguarding training ceased during the Covid-19 pandemic and delivery via Microsoft teams commenced. This has continued as it has been well evaluated and can target larger groups. Bespoke safeguarding training face to face has restarted to support teams and provide 'at the elbow' training.

[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/

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

9.5 The Trust new My Learning Hub platform has improved over the year to accurately record compliance and glitches have been remedied.

9.6 The implementation of the following training as been delayed

- Level 3 Adult Safeguarding training
- Advanced Mental Capacity Act training for clinicians

10 Audit

10.1 The Trust submitted the annual OSCB/OSAB self-assessment of compliance with Section 11 of the Children Act and the Care Act 2014. There was a positive peer review of the Trusts compliance and evidence provided.

10.2 A joint OUH and Oxford Health audit has been undertaken as part of an OSCB action plan following the JP partnership review. This audit provided assurance that children who frequently attended both ED and Minor Injury Units had information shared with primary care of attendances. The results were positive as all the children identified as having attended both services had appropriate follow up in primary care.

11 Impact

11.1 The increased level of activity across safeguarding with the number of consultations related to complex cases to support the multiagency partnership and staff to support. This level of increased activity on the team has been impacted by sickness absence and recruitment to vacancies. The Trust has invested further resources over the year to expand the team.

11.2 The impact at a strategic level has been in regard to working across the Safeguarding partnership to support the activity of the OSCB and OSAB. This has involved contributing to the Boards, Board subgroups, audits,

11.3 Information sharing for child protection cases conferences, case reviews and SARs, MARACs and MATACs has been high and impacting on risk assessments.

11.4 The impact of the team involvement at the MASH to share health information and participate in the analysis of risk. There have been significant backlogs in sharing health information due to resources that have been challenging to manage

11.5 The teams review of all DOLs applications to maintain a consistent standard, ensure follow up and documentation on EPR. The team have worked with clinical areas to ensure the implementation of the MCA and need for DOLs applications.

11.6 The review of the s42 process to work with OCC to ensure relevant S 42 investigations are processed. The team support clinical teams to complete Sc. 42 enquiries. There were 9 reviews over the year, a reduction of 15 and all

were submitted within the agreed timeframe. The team closely linked with the LA to ensure closure and responses are received in a timely manner.

12 **Key Challenges:** This also demonstrates the impact of the team

- The continued increase in activity with referrals and consultations across the Trust and all sites in both children and adult safeguarding that is reflected locally and nationally
- Resource into the MASH to process health information to inform risk, this is a shared responsibility with Oxford Health to ensure adequate resources to meet the increase of 33% activity
- The number of children presenting with complex safeguarding mental health self-harming behaviours who have 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
- Working with multi-agency partners to recognise and reduce neglect experienced in families and increase use of child development tool
- Timely mental capacity assessment and documentation
- The length of time to assess and authorise DOLs applications
- The challenges in achieving or maintaining compliance for safeguarding children and adults training; including implementation of Level 3 adult safeguarding.
- The introduction of the Hospital Navigator programme
- Safeguarding is a demanding role and getting recruitment right has been a challenge.

13 The Key achievements

- Positive multiagency partnership working to safeguard children and adults
- Increased effective safeguarding advice to protect vulnerable adults and children and support to staff as demonstrated by activity
- Active participation at OSCB and OSAB board and subgroup meetings
- Promote mental capacity assessments and developing the Rule of Thumb guide to improve understanding and documentation
- 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

14 Conclusion

14.1 The Safeguarding Team continues 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.

14.2 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.

14.3 All of 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.

15 Recommendation

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

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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.

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

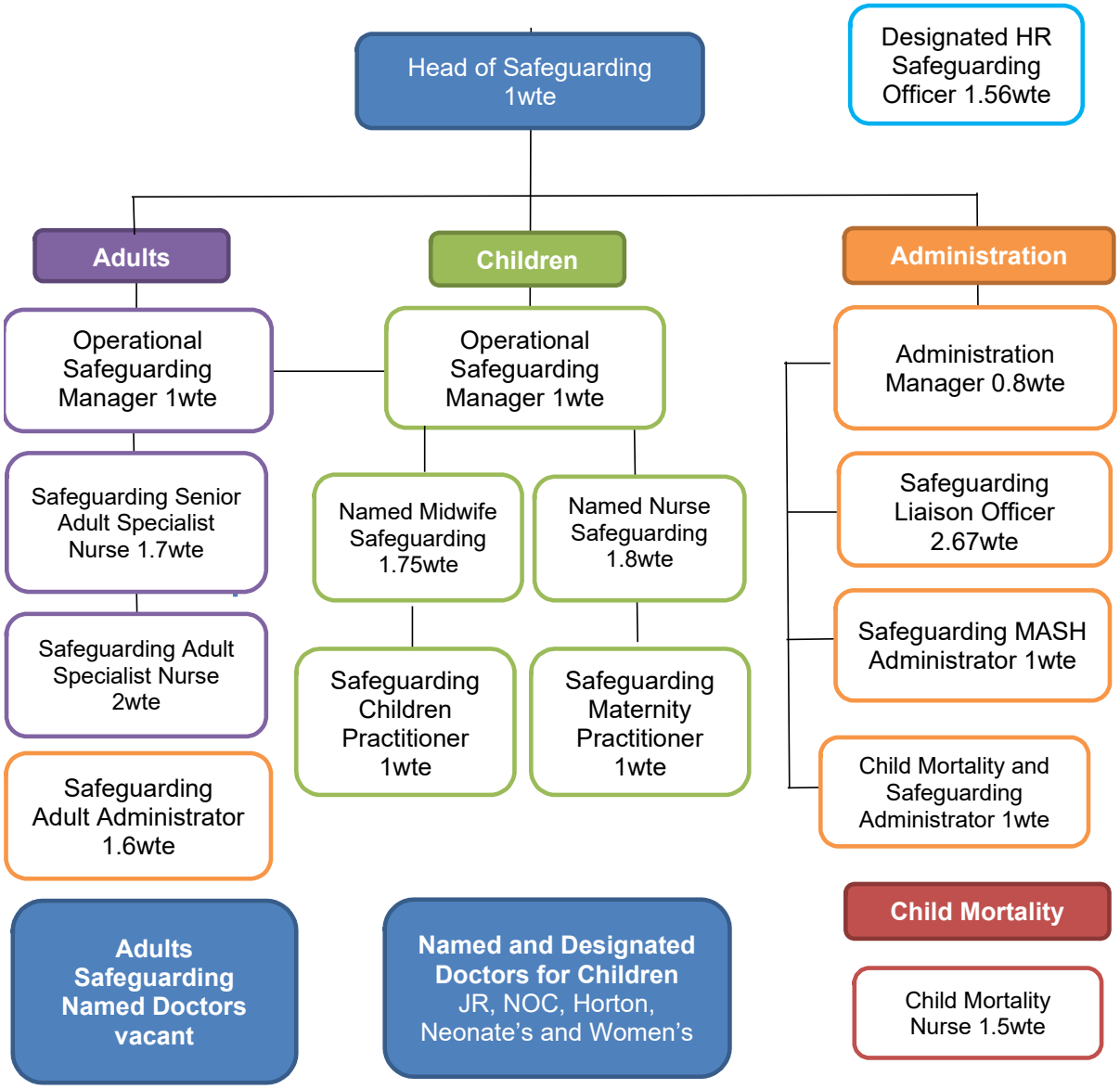
Section 42: Section 42 Enquiries

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.

Appendix 2.

Safeguarding Team Structure



Appendix 3.

Safeguarding Children Liaison Referral Criteria

Referral Code	OUH Children's Safeguarding Liaison Criteria
A	Children / young people subject to CPP & LAC
B	Unaccompanied by adult with parental responsibility (Expect 17 years)
C	Drugs & Alcohol
D	Alleged Assault
E	Vulnerable Adult with dependent children where there are safeguarding concerns
F	Frequent attendances - more than 3 in 3 months or 10 in past year
G	Not registered with GP
H	Did not wait to see medical staff (except 16-18)
I	Parenting/ supervision (< 5years)
J	Development / weight / hygiene concerns
K	Child not in school / school issues
L	0 - 18yrs - Concerns re nature of injury / presentation / NAI
M	Delayed presentation
N	Overdose / self-harm/ mental health
O	Death 0 -18yrs
P	Dog bite
Q	Burns
R	Other - Any safeguarding concerns not listed above

Nov 2021

Appendix 4.
Rule of Thumb

NHS
Oxford University Hospitals
NHS Foundation Trust

5 key principles of the Mental Capacity Act (MCA)

MCA is also applicable to 16 and 17 year old children

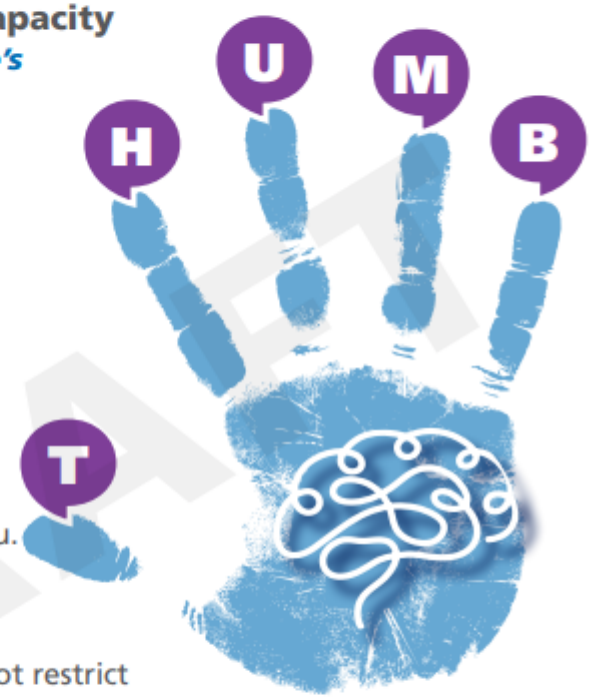
Think presume mental capacity
REMEMBER: *this is everyone's responsibility*. Consider I can make a decision.

Help your patient to maximise capacity
Do all you can to help me make a decision.

Unwise decisions don't mean lack of capacity
You must not automatically say that I lack capacity when my decision seems unwise to you.

Make sure you take the least restrictive option
Check that your decision does not restrict my freedom, unnecessarily.

Best interests of your patient at all times
Use a *Best Interests Checklist* if I am unable to make a decision.



Empower and support your patient. REMEMBER the rule of THUMB.

FOR FURTHER INFORMATION CONTACT SAFEGUARDING ON:
01865 234 565 / ext 34565 / bleep 8080 or
http://ouh.oxnet.nhs.uk/MentalCapacityAct/Pages/Default.aspx

REF: OMI 66971 - MARCH 2021: