Oxford University Hospitals NHS
NHS Trust

Trust Board Meeting: Wednesday 13 November 2013

TB2013.129

Title	**Safeguarding Children and Adults Annual Report**

Status	For information
History	This is the annual report which spans the period 1June 2012 to 31 May 2013

Board Lead(s)	**Ms Liz Wright, Acting Chief Nurse**			
Key purpose	Strategy	**Assurance**	Policy	Performance

Executive Summary

Children

1. This report provides a summary of the key issues and activity in relation to Safeguarding Children in the past year and is presented annually identifying areas of development and challenge.
2. The safeguarding children definition is as follows:

"A child is anyone under the age of 18. 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."

3. The Acting Chief Nurse for OUH is represented on the Oxfordshire Childrens' Safeguarding Board by the Lead Nurse, Safeguarding Children.
4. The Oxfordshire Safeguarding Children Board has set its business priorities for 2013-2015. The OUH contributes to these priorities both internally and through interagency work. The priorities are:
    a. To be assured that there is a continuum of safeguarding support for children, young people and families.
    b. To improve the quality assurance work of the OSCB.
    c. To improve how we engage and act on views of children and young people and frontline practitioners.
    d. To maintain an interagency focus on key safeguarding risk for groups in Oxfordshire.
5. The safeguarding children training figures are reported against all eligible multidisciplinary staff for training:
    a. Safeguarding children Level 1 = 84.7%
    b. Safeguarding Children Level 2 = 79.6%
    c. Safeguarding Children Level 3 = 80%

    The safeguarding children training has been updated and revised and will be in use by January 2014, using a blended learning approach. This has been commissioned through Oxford Brookes University for all disciplines.
6. The safeguarding children's activity mainly involves assessment and consultation around children's care provision by families. This is in contrast to safeguarding adults' activity, which relates to services provided by OUH. There are currently 470 children with child protection plans in Oxfordshire with active alerts on hospital records requiring staff to share information about attendances and health related issues. To date in 2013 there have been 43 child protection strategy meetings and 31 child protection case conferences on trust sites. A bi-monthly Safeguarding Children's Strategy Group with representation from all divisions across the Trust, meets to review and discuss actions and activities related to safeguarding children.
7. A number of local safeguarding cases have been of national interest recently including the case of sexual exploitation, known as the Bullfinch case and the investigations following the Jimmy Saville allegations. The Trust's safeguarding team has contributed to the care management and protection of these vulnerable young people. There has been internal and inter-agency activity, to put in place safeguards for children and young people in the future, raising staff awareness and providing tools to assist in assessments. This case is currently the subject of a serious case review which is due to be completed in January 2014.

8. The safeguarding children team are currently actively involved in four serious case review investigations two involving young children and two involving teenagers. Three commissioned by Oxfordshire Safeguarding Children's Board and one commissioned by Northamptonshire Safeguarding Children's Board.

Adults

9. This report provides a summary of the key issues and activity in relation to Safeguarding Adults in the past year is presented annually and identifies areas of development and challenge.

10. *No Secrets* (2000) defined the a vulnerable adult or adult at risk as an adult

"*who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".*

The guidance defines abuse as
'*The violation of an individual's human and civil rights by any other person or persons'***.**

11 The Acting Chief Nurse for OUH is represented on the Oxfordshire Adults' Safeguarding Board (OSAB) by the Safeguarding Adults and Patient Services Manager.

12 The safeguarding adult training figures are 81.2% and are reported against all eligible multidisciplinary staff for training.

A review and update of training resources has been developed in conjunction with Oxford Brookes University. This training will be competency based and will be implemented from January 2014 and has been validated by the OSAB.

Oxford Brookes University is also developing further introductory training for OUH on the Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS) and introductory training in Safe Restraint Practice.

13 There are three distinct elements of internal safeguarding adults' activity in the Trust.

- Safeguarding concerns about vulnerable people raised by OUH staff.
- Requests for information about vulnerable people.
- Safeguarding alerts made about OUH services.

There have been 18 safeguarding alerts made about OUH care by external agencies. Five alerts were closed to Safeguarding procedures with no further action by the Local Authority Safeguarding Team.

The main theme of safeguarding alerts relates to poor and unco-ordinated discharge, communication and handover.

14 The Mental Capacity Act (2005) provides a statutory framework for acting and making decisions on behalf of individuals who lack mental capacity.

To safeguard individuals who sometimes lack mental capacity, it can become necessary to restrict their liberty. Deprivation of Liberty Safeguards (DOLS) protect the human rights of people who are 18 or over; *and* are in a registered care home or a hospital; *and* lack capacity to consent to arrangements proposed for their care and/or treatment; *and* for whom such arrangements amount to deprivation of liberty; *and* are not detained (or liable to be detained) under the Mental Health Act 1983.

The Trust has made 14 DOLS applications and 7 have been authorised
15 **Recommendation** The Trust Board is asked to note the annual safeguarding children's and adult's report and approve the recommended areas of activity for the coming year.

Oxford University Hospitals NHS
NHS Trust

Safeguarding Children and Adults Annual Report 2012/13

Chief Executive's Foreword

I am pleased to present Oxford University Hospitals NHS Trust's Safeguarding Children and Adults Annual Report for the period 01 June 2012 to 31 May 2013. This joint report will be presented in two parts to reflect the extensive safeguarding activity for both children and adults.

Safeguarding children

The Trust has a statutory responsibility to safeguard children and young people under the Children Act, section 11, (1989, 2004). The CQC essential standard 7 requires the Trust to ensure that suitable arrangements are in place to ensure that all service users are protected from the risk of abuse and internal processes are in place to reduce the potential of abuse.

Safeguarding services and practices in Oxfordshire over the past year have been influenced by the publication of the revised guidance 'Working Together to Safeguard Children' (published in March 2013), which clarifies the responsibilities of organisations and professionals for safeguarding children and reinforces the focus on to the needs of the child, rather than the formal processes.

A number of local safeguarding cases have been of national interest over the last year. The Trust's safeguarding team has contributed to the care management and protection of the vulnerable young people involved in these cases. There has been internal and inter-agency activity to strengthen safeguards for children and young people, to raise staff awareness and to provide improved tools to assist in assessments. The child sexual exploitation case is currently the subject of a formal multi-agency serious case review which is due to be completed in early 2014.

Staff across the Trust have shown their commitment to ensure that children and young people are safely and effectively cared for within all services provided by the Trust.

Safeguarding adults

The important reports from Sir Robert Francis, Professor Don Berwick and Sir Bruce Keogh that were published during 2013 highlighted the importance of working with, and listening to, patients and carers in the delivery of safe and compassionate care. This partnership with patients and families is particularly important in planning care, in the maintenance of good nutrition and hydration, the support for carers, and the provision of information and advice. It is essential to have effective policies and procedures covering; how to raise matters of concern; safe and well co-ordinated discharge arrangements; the maintenance of privacy, respect and dignity for patients; the importance of listening to

patients and families and resolving any concerns quickly and learning from these issues to change practice.

The investigation and report into the care provided at the Winterbourne View Home, published in 2012, highlighted the vulnerability of people with learning disability who are supported in health and social care funded placements. The care of people with learning disability who happen to require hospital care is a particular challenge for acute hospitals. All staff must be alert to the needs of people with a learning disability admitted under our care, and to the needs of their families and carers. The Trust is continuing its work to ensure full compliance with the recommendations of “Healthcare for All”.

The work across the Trust to safeguard children and vulnerable adults has significantly increased this year. As an organisation our ability to protect and care for the most vulnerable amongst our patients will be a valuable yardstick of how well we look after the totality. This is an important measure of how we are “delivering compassionate excellence” to our patients.

Signed

Sir Jonathan Michael FRCP

Chief Executive

Annual Safeguarding Children Report

1. Purpose

1.1. The Trust has a statutory responsibility to safeguard children and young people under the Children Act, section 11, (1989, 2004).The CQC essential standard 7 requires the Trust ensure that they are making suitable arrangements to ensure that all service users are safeguarded against the risk of abuse and processes are in place to effectively to reduce the potential of abuse.

1.2. This is a report summarising the activity and developments in Safeguarding Children within the Oxford University Hospitals NHS Trust (OUH) over the past year from June 2012-June 2013. This is to provide assurance to the Trust Board in relation to compliance with its statutory requirements and obligations.

1.3. The report draws on and, where appropriate, uses data shared with all other agencies across Oxfordshire taken from the OSCB performance report.

2. Overview

2.1. Safeguarding services and practices in Oxfordshire over the past year have been influenced by the publication of the revised 'Working Together to Safeguard Children' guidance (published in March 2013), which sets down the statutory responsibilities for child protection practice and organisational changes. This new guidance streamlines previous guidance to clarify the responsibilities of professionals towards safeguarding children and strengthen the focus on to the needs of the child rather than the processes in place.

2.2. Most of the responsibilities and procedures in the new 2013 Working Together document remain the same as in the 2010 guidance, but the guidance is presented in a much more succinct and less detailed way.

2.3. The guidance seeks to emphasise that effective safeguarding systems are those where:

2.3.1. the **child's needs are paramount**, and the needs and wishes of each child, should be put first, so that every child receives the support they need before a problem escalates;

2.3.2. **all professionals who come into contact with children and families are alert to their needs** and any risks of harm that individual abusers, or potential abusers, may pose to children;

2.3.3. **all professionals share appropriate information in a timely way** and can discuss any concerns about an individual child with colleagues and local authority children's social care;

2.3.4. **high quality professionals are able to use their expert judgement** to put the child's needs at the heart of the safeguarding system so that the right solution can be found for each individual child;

2.3.5. **all professionals contribute to whatever actions are needed to safeguard and promote a child's welfare** and engage in regularly reviewing the outcomes for the child against specific plans and outcomes;

2.3.6. **local areas innovate** and changes are informed by evidence and examination of the data.

2.4. Effective safeguarding arrangements in every local area should be underpinned by two key principles as stated in the Children Act 1989, 2004:

2.4.1. **safeguarding is everyone's responsibility**: for services to be effective, each professional and organisation should play their full part; and

2.4.2. **A child-centred approach**: for services to be effective they should be based on a clear understanding of the needs and views of children.

2.5. The OUH is an active member of the Oxfordshire Safeguarding Children Board (OSCB) and attendance at board meetings in the past year has been 100%. In partnership with Oxfordshire County Council, Oxford Health Foundation Trust, commissioners and the OUH NHS Trust, all inter-agency practices and policies have been reviewed to ensure they are compliant with the statutory responsibilities.

2.6. The Executive lead for Safeguarding Children within the Oxford University's Hospitals NHS Trust is the Chief Nurse. Strategic responsibility for Safeguarding Children is delegated to the Divisional Director of Children's and Women's Division. OSCB attendance has been delegated to the Lead Nurse, Safeguarding Children.

2.7. A bi-monthly Safeguarding Children Strategy Group, with representation from all divisions across the trust, meets to review and discuss actions and activities related to safeguarding children. To ensure a clear coordination between safeguarding children and adults there is a standing agenda item for feedback and discussion about adult safeguarding issues. The Clinical Governance Committee receives monthly quality reports from each division and within these reports there is a section related to safeguarding.

2.8. The Safeguarding Children's team sits within the Children's and Women's Division. In April 2013 the resources for safeguarding children were increased to enhance the team following additional funds being made available by Oxfordshire Clinical Commissioning Group. This team now consists of a full time Lead Nurse; a Named Nurse, a Named Midwife, an Associate Named Midwifed an administrator and Named Doctors with dedicated PA's within their job plans[1] for safeguarding children responsibilities.

2.9. Professional support for staff at the Churchill, Horton and Nuffield Orthopaedic hospital sites is also provided by nominated site based professionals including

[1] [1] Named roles are defined in Working Together the as Safeguarding Children (2010) as staff with key roles in promoting good safeguarding practice, providing advice and expertise to fellow professionals. Job Descriptions and Roles and responsibilities have been detailed by the Royal College of Paediatrics and child health in an intercollegiate paper (http://www.rcpch.ac.uk/sites/default/files/Safeguarding%20Children%20and%20Young%20people%202010_0.pdf)

nurses, therapists and doctors, within their existing roles. These key link professionals facilitate site based meetings to enable staff to address local issues. Link professionals are supported by the safeguarding children team.

2.10. With the exception of referrals to social care, this year there has been a large increase in activity levels compared to the same period last year

2.10.1. Table 1 Interagency Activity Levels over the last two years

2.10.1.1. .

Activity - April to August	2012	2013	Change
Referral	2606	2413	-7%
Initial Assessment	1372	1487	8%
Core assessment	811	1084	34%
S47 investigation	364	548	51%
Initial CP Case Conference	162	257	59%
Children placed on a plan	149	242	62%
Became looked after	88	126	43%

2.11. Oxfordshire's safeguarding service for children and young people was graded as good overall in the biannual joint area inspection of safeguarding services and children in looked after services within Oxfordshire undertaken by CQC and Ofsted and completed in March 2011. The action plan resulting from this inspection was completed in May 2012. Inspection processes have been revised in the past six months and an inspection is anticipated imminently.

2.12. Locally the shadow Health and Wellbeing Board, which was established as a result of changes in the Health and Social Care Act 2012, began to operate. The relationship with the OSCB and precise accountability arrangements for monitoring and reviewing Oxfordshire's safeguarding activity are currently under review and will be a focus for the OSCB. The new national Safeguarding Performance Information Framework was published in June 2012 by the Department for Education. The Oxfordshire dataset for 2013/14 is based on the national dataset and additional indicators inform the local questions that need to be asked about the impact and quality of care addressing any local areas of concern that have been raised through other intelligence including inspection, audit and serious case reviews.

2.13. The OSCB performance dataset is structured under the following themes from the national framework:

2.13.1. **Outcomes for children and young people and their families**; including issues related to educational attainment.

2.13.2. **Child protection activity** including providing early help; including activity related to early assessments and universal services planning

2.13.3. **The quality and timeliness of decision making and planning**; focusing on referral processes and the effectiveness of planning

2.13.4. **Child protection planning** including reporting on attendance of different agencies at core groups and case conferences. From August 1st 2013 onwards there will be records kept of who was invited and who attended core groups and case conferences including individual agency reports

2.13.5. **Workforce**; identifying issues related to safer recruitment, staffing levels and allegation management.

3. Oxfordshire Safeguarding Children's Board (OSCB) Priorities

3.1. The Oxfordshire Safeguarding Children Board's (OSCB) priorities provide strategic direction and challenge across the relevant local agencies in Oxfordshire. The OUH contributes and reports into the OSCB including areas of work undertaken and completed

3.2. Following the 2011/12 annual report the OSCB redefined its priorities for 2014:

3.2.1. **Improving the understanding of parental risk factors**: Domestic abuse, substance misuse and poor mental health are identified parental risk factors. The combination of these factors has been highlighted as a recurring theme in serious case reviews. It is known that they can be common problems affecting parents and carers and can provide challenges to family life.

3.2.2. The Board set the priority of improving professional awareness and understanding of these issues and the risks that they present to children. This priority overlaps with the work of the Oxfordshire Safeguarding Vulnerable Adults Board, which aims to improve responses for vulnerable victims of domestic abuse.

3.2.3. The Trust reported the following related to this priority:

3.2.3.1. 'Think family" training sessions including the distribution of prompt cards for teams and professionals have been completed. This training is now incorporated in to current safeguarding classroom training and will become part of a revised on-line training package.

3.2.3.2. A' 'safeguarding snapshot audit' evidenced improved knowledge amongst professionals. This audit was created by the MARS division for local use and has now been undertaken in a number of divisions. It provides a review of staff knowledge about safeguarding based on the CQC Standard 7 criteria. Divisional audit results should be available via Health assure.

3.2.3.3. The OUH trust reported increased and improvements in referral and consultation in relation to family factors influencing childcare and welfare. Internally all divisions are now raising concerns about children and young people appropriately to the safeguarding team and external partners.

3.3. **Developing work on child sexual abuse:** Oxfordshire, like many other areas of the country, has identified an issue of children being abused through child sexual exploitation (CSE), known as the 'Bullfinch' case. There have also been investigations following the Jimmy Savile allegations that have led to a health service review of processes that ensure the protection of patients from possible abuse from official visitors. As a result there has been a renewed inter-agency focus on the development of inter-agency procedures, training and a tool kit to recognise and assess child sexual exploitation.

3.3.1. Within the OUH targeted training has been undertaken to raise awareness, improve knowledge and develop greater understanding.

3.3.2. The trust's genito-urinary medicine (GUM) services received update training, have improved their vulnerable young person assessment process and are contributing to case reviews

3.3.3. Maternity, Gynaecology, GUM, Children's and Emergency Department staff have been provided with the details of the Kingfisher Team, a new specialist multi agency referral team. This is also available to all other staff via the trust's intranet.

3.3.4. The trust has also developed an official visitors protocol that is currently in the approval process

3.3.5. **Developing performance information to promote improvement and accountability** The OSCB recognises the importance of scrutiny and sharing performance information across agencies and have through a subgroup worked on developing quality assurance and audit. This sub group has commissioned audits to review frontline inter-agency working; receive feedback from individual agencies on their safeguarding audits; review the range of data produced by agencies to analyse if there are key themes; In addition they track the implementation of actions set out in serious case reviews, which state where agencies could learn some lessons and better safeguard children.

3.3.6. The Trust's contribution to this priority over the past year has included:

3.3.6.1. To establish a data set that enables the Safeguarding Team to monitor and assess activity and effectiveness. This basic information enables the team to contribute to and challenge interagency data as appropriate.

3.3.6.2. To ensure that activity and performance is now reported monthly within divisional quality reports

3.3.6.3. To develop an audit plan including safeguarding health checks for colleagues that regularly review activity and performance.

3.3.6.4. To confirm that midwifery teams are completing a health and social scoring in all booked appointments and the assessment of women with the safeguarding lead in order to improve information to support vulnerable families

3.3.7. **Monitoring and challenging agencies' self-assessment of safeguarding arrangements:** An important function of the OSCB is to evaluate and challenge what is done by Board partners individually to safeguard and promote the welfare of children, and advise them on ways to improve. This is done through the 'Section 11[2] safeguarding audit'.

3.3.7.1. In 2012-13 the Trust reported compliance against all 12 standards, an improvement on the previous year in which outstanding work was required in relation to ensuring staff were trained and that workforce procedures included robust allegation management process, and rechecks on key staff groups.

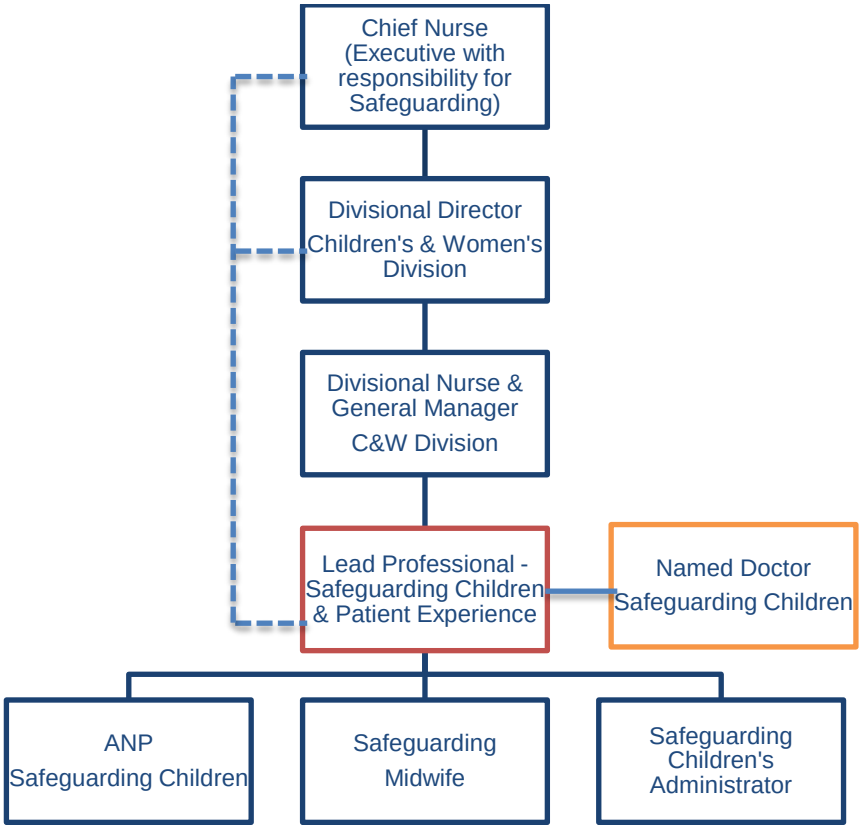
3.3.7.2. A peer review event linked to the Section 11 assessment resulted in the trust being asked to provide additional data and documentation. Following this review process, the trust was commended and its assurance process and was used as an exemplar for other organisations.

[2] Section 11 is the Section of the children act that identifies the core standards required of all organisations to safeguarding children and young people against which the trust is monitored annually.

4. Roles and responsibilities:

4.1. The Acting Chief Nurse is represented by the Lead Nurse, Safeguarding Children on the Oxfordshire Safeguarding Children's Board.

4.1.1. The organisational structure for Safeguarding Children's Team is illustrated below:



4.2. Strategic responsibility for Safeguarding Children is delegated to the Divisional Director, Children's and Women's Division.

4.3. The Lead Nurse Safeguarding Children coordinates the operational and strategic safeguarding children's work for the Trust and attends the Oxfordshire Safeguarding Children Board (OSCB) on behalf of the Chief Nurse.

4.4. The Divisional Director for Children's and Women's Division and Lead Nurse for Safeguarding Children are supported by the Divisional General Manager and Divisional Nurse for Children's and Women's Division in discharging their responsibilities in relation to safeguarding children.

4.5. The Lead Nurse for Safeguarding Children has direct access to the Chief Nurse for safeguarding children as necessary to ensure line of sight directly to Board level where required.

4.6. Each clinical division has a nominated representative who is required to link with the safeguarding children team and provide assurance that there

division is safeguarding children. These divisional representatives are required to report back at the Safeguarding Children Strategy Group bi-monthly. This Group is chaired by the Divisional Director for Children's and Women's Division.

4.7. The Trust is represented on, and actively involved in, the work of all OSCB sub-groups, contributing to strategic and operational safeguarding developments across the county. The Trust's contribution has been acknowledged and commended by the OSCB business team.

5. The OUH Trust's Internal Activity:

5.1. Safeguarding Children's activity is divided into six distinctive areas of work involving acute, community and maternity services.

5.2. Acute paediatric services assess and treat children with acute injuries and illnesses including regularly caring for those whose illness or injury is thought to be linked to a safeguarding issue. There are on average 3 cases under assessment in the service at any time.

5.2.1. Referrals from hospital staff to the children, young people and family assessment teams were audited in April 2013 and found to be appropriate and adequate during an audit.

5.2.2. Referrals to the social work team based at the John Radcliffe hospital site remain less formal and involve much greater consultation and face to face meetings. This has resulted in less written referral information from health practitioners in the initial phase of assessment. Staff in both acute services and social care believe this is efficient however it has led to challenges when social care staff have presented cases to their legal team. New guidelines for staff include time scales in which reports are expected to be completed for police and social care staff to resolve this issue. Medical reports are required by social care services for initial assessments within three working days and in the snap shot audit in March 2013 this was found to be compliant.

5.2.3. Acute paediatric consultations are reviewed within a monthly case review meeting and summary learning is shared across the directorate and with the safeguarding Strategy Group. A database of all cases is now maintained for children and young people where safeguarding concerns have been raised and these have proceeded to strategy meetings. In the year 2012-2013 there have been 94 formal child protection investigations undertaken by the acute paediatrics team.

5.2.4. There are currently 470 children with child protection plans in Oxfordshire with active alerts on hospital records requiring staff to share information about attendances and health related issues. There is an active and supportive child and family assessment team enabling and supporting child protection and child welfare support. To date in 2013 there have been 43 child protection strategy meetings and 31 child protection case conferences on OUH sites.

5.2.5. The community paediatricians' complete regular medicals of children cared for by the local authority. There are currently 438 children looked after by the local authority all of whom require the completion of regular medicals

5.2.6. Community Paediatrics team receives referrals from all children's agencies, who require a child protection medical assessment. This year to date there has been 43 full child protection medicals undertaken in the community paediatrics.

5.2.7. During the year 2012-2013 96 formal assessments and 106 telephone consultation episodes were completed within the Community Paediatric Child Protection and Child Sexual Abuse Assessment service. These assessments are mainly referrals from Social Workers and police however far more GP requests to review and assess safeguarding concerns have been received. Community Paediatrics, based in the John Radcliffe Hospital, delivers a duty Paediatrician service 8-5pm Monday to Friday, for Oxfordshire residents, with clinics available on Monday and Fridays. Urgent referrals of children (normally infants) likely to need admission for acute medical management, out of hours and weekends are managed by the acute on-call paediatrician.

5.2.8. Health assessments are also completed for children with 'patient at risk' alerts in place due to their on-going health, social care and safeguarding concerns. These children are monitored and assessed by a lead clinician. There are 32 children with such patient at risks alerts in place that have not yet led to child protection planning.

5.3. Within maternity services a health and Social Score Process is used to identify Vulnerable Families and safeguard the needs of the unborn child and it is now established practice in Midwifery care.

5.3.1. Information is held on women who are identified as vulnerable and have a score of 3 or 4 on the health and social assessment score (H&S),

5.3.2. Table identifying the numbers identified in 2012-2013 within OUH services:

H&S 3&4	Teenage Pregnancy	Safeguarding	Mental health	Domestic Abuse	Substance Misuse
243	68	61	69	41	22
4.86% (of all pregnancies)	27%	25%	28%	16-8%	9%

5.4. This year figures were reported to the OSCB for the first time on Oxfordshire children who attended Accident and Emergency and those who became inpatients due to unintentional and deliberate injuries. These figures show a large increase form figures recorded last year; however definitions have changed and been expanded. The national definition now includes 'assaults',

'deliberate self-harm' and 'other accidents and 'includes non-emergency admissions alongside emergency admissions. Reports for last year will be rerun based on the new criteria to review the caseload and identify any changes in activity.

5.5. Multi agency data identifies that despite the increase in activity, timeliness of decision making remains high and has improved on last year with the exceptions of: completing Child Protection Reviews; completing Core Assessments and undertaking Initial Case Conferences. OUH teams are to be commended for their contribution to this work.

Timeliness - April to August	2012	2013	Change
Child Protection reviews on time	97.4%	94.3%	-3.1%
LAC reviews on time	91.0%	93.3%	2.3%
CP visits on time	58.8%	82.9%	24.1%
LAC visits on time	72.9%	91.6%	18.7%
Initial Assessments < 10 days	90.1%	92.0%	1.9%
Core assessment < 35 days	83.7%	82.0%	-1.7%
S47 investigation < 15 days	37.4%	40.0%	2.6%
Initial CP Case Conference < 15 days	87.5%	85.2%	-2.3%
Initial core group < 10 days	75.3%	86.8%	11.5%
Subsequent core group < 30 days	56.3%	58.5%	2.2%

5.6. Attendance at case conferences and core groups by all organisations outside social care is reported as low by Oxfordshire County Council. The percentage of meetings recorded as having a full attendance was 21.7% for the primary meeting and 19.3% for review and follow up meetings. Records held by Oxfordshire County Council reported that there was only a 32% attendance at core group meetings. This has been reviewed and found to be related to staff missing 4 meetings in the year to date. The OUH NHS Trust Safeguarding Children Team has requested that the records be updated to reflect Trust representation rather than service representation. A monitoring process has been agreed internally to ensure all meetings are appropriately attended in future.

6. Allegations Management and Risk Assessments:

6.1. Risk assessments are undertaken when a patient or staff member is known to have a criminal caution or conviction that may impact on the safety or welfare of others. All such assessments are the responsibility of the police, probation and judiciary services that may include health services where required. In the past year fifteen such assessments have been undertaken by the Lead Nurse Safeguarding Children.

6.2. Situations involving staff members that require further investigation are managed using the allegation management process. In the past year there have been seven investigations involving the Lead Area Designated Officer (LADO) at Oxfordshire County Council. These are all cases in which child protection issues had been raised. One case remains open and all other cases have been concluded. Divisional and Executive teams have been involved in all cases in accordance with the allegation management procedures.

7. Training

7.1. Generic and targeted training opportunities have been increased over the previous six months. Improvements have been noted in practice settings, audits of staff knowledge show improvements and all staff training compliance figures reported by workforce's learning and development team have significantly increased The table demonstrate training percentages against eligible numbers of staff as reported in September 2013 to the Oxfordshire Clinical Commissioning Group:

	2013
Safeguarding Adults	81.2%
Safeguarding Children Level 1	84.7%
Safeguarding Children Level 2	79.6%
Safeguarding Children Level 3	80%

7.2. A review of training resources is due to be completed by the end of November 2013. The new safeguarding children and safeguarding adults' introductory training has been developed in conjunction with Oxford Brookes University. This training will be competency based and will be implemented from January 2014 and has been validated by both safeguarding boards.

7.3. Oxford Brookes University is also developing further introductory training for OUH on the Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS) and introductory training in Safe Restraint Practice. This is important to ensure staff are confident and have sufficient knowledge of the principles of the Mental Capacity Act when treating and caring for their patients.

7.4. The Lead Nurse, Safeguarding Children and Safeguarding Adults and Patient Services Manager are actively engaged with multiagency training through the Safeguarding Childrens' and Safeguarding Adults Boards.

8. Serious Case Reviews

8.1. A serious case review is required by government when a child or young person has been seriously harmed as a result of abuse, and a number of different organisations have been involved. The case must meet the criteria as set out in Working Together 2013.

8.2. The Trust is currently contributing to four serious case reviews for children, three commissioned by Oxfordshire Safeguarding Children Board and one by Northamptonshire Safeguarding children board. There are also two case reviews completed but awaiting the closure of criminal proceedings before

they are published. In all cases the terms of reference and time scales are determined by statutory guidance and Local Safeguarding Childrens Board.

8.2.1. One completed case review involves a toddler aged 22 months fatally injured by impact to head in November 2010. Publication of this report is this due imminently, following completion of criminal court case.

8.2.2. The active case reviews are:

8.2.2.1. A review of six young females (Child A, B, C, D, E, F) from a larger cohort following sexual abuse incidents in Oxfordshire. The overview report expected in January 2014.

8.2.2.2. A review of care provided to a thirteen year old girl who died by hanging. She was in the care of the local authority at an out of county therapeutic placement. First draft of the Overview report to be submitted mid-October 2013.

8.2.2.3. A review of a toddler who was found dead in her home. The OUH Internal Management Report (IMR) was completed and signed off 25th Sept 2013 and send to Oxfordshire Safeguarding Childrens Board (OSCB).

8.2.3. A review of a baby subject to a child protection plan due to neglect. At four months the baby was left sleeping on a sofa and later found dead due to natural causes – sudden unexpected death in infancy. A full report was completed and signed off internally 27th Sept and sent to OSCB to forward to Northamptonshire LSCB.

9. Service and Practice Developments:

9.1. Policies and procedures which have been developed during this year include:

9.1.1. An updated flagging system for children at risk and with child protection plans within EPR for maternity services including the ability to import other documents e.g. social care memos to EPR making them more accessible to all staff caring for mother and baby

9.1.2. A Resident Parent protocol and a review of the guidelines for carers within the children's service

9.1.3. Parenting Assessment processes as part of the OSCB Neglect Strategy

9.1.4. A screening tool has been made available to staff if they have concern about possible child sexual exploitation and links made with the specialist referral team at Cowley Police station for key staff groups.

9.1.5. Multi-agency escalation processes for staff concerned that cases are not being resolved safely have been shared and used in complex cases by paediatric staff.

9.1.6. Midwives handover to a named Health Visitor has been added to the discharge documentation and is mandatory.

9.1.7. EPR is improving record keeping and our ability to communicate with Doctors and Midwives. Through EPR we can request updates and information and provide information in return, creating clear documentation of information shared.

9.2. Service developments include:

9.2.1. Having an identified Obstetric Consultant for Vulnerable groups: provides care for high risk vulnerable groups and works closely with named midwife for safeguarding and specialist midwife for teenage pregnancy.

9.2.2. An Obstetric and Gynaecology Consultant has developed and is leading on care of women who have suffered female genital mutilation. A care pathway has been developed and is being linked to the pathways required to protect vulnerable children.

9.2.3. A new teenage pregnancy bay is running on level 5, to improve targeted working for teenage pregnancy.

9.2.4. Saplings group was set up in East Oxford targeting and engaging vulnerable women. It provides antenatal care combined with antenatal education for pregnant women who have a health and social assessment score 3or 4.

10. Partnership work

10.1. The Oxford University Hospitals NHS Trust in 2012-2013 had 100% attendance at the Oxfordshire Safeguarding Children Board and good representation within all sub groups.

10.2. The Trust provided active contributions to the policies developed during the year, assisted in the multi-agency training programmes, developing resources developed and contributed safeguarding activity through the health advisory group, quality assurance group and executive committee.

10.3. Active partnership and care pathways exist and are monitored between acute and mental health support to children and young people with safeguarding needs. These have been enhanced with revised protocols during this year. A liaison paediatric psychiatrist has been employed to work with teams to improve mental health support and intervention. This provision is being expanded to offer specialist support to vulnerable children, children who self-harm, and those with complex mental health issues.

10.4. The joint working between emergency services, ambulance services, social care and the liaison health visitor service is supported and monitored quarterly with minutes learning and actions presented to the Safeguarding Strategy Group.

10.5. Information sharing protocols are now formally established between the Multi-Agency Public Protection Agency in Thames Valley and the OUH to

enable proactive assessment to be undertaken to ensure the safety and security of individuals managed within MAPPA and all trust patients, visitors and staff.

10.6. Named Midwives for Safeguarding Group was set up by Named Midwives in the Thames Valley Region, including named Midwife for Oxford to act as support and share good practice. They meet on alternate months with each area acting as host.

10.7. Multiagency relationships have been established with social work teams, mental health teams and substance misuse teams.

10.8. The OUH safeguarding team facilitates the training of contracted service staff within the trusts training programme. The contractor is responsible for managing and monitoring compliance with training requirements.

11. Conclusion for Safeguarding Children

11.1. Staff have shown their commitment to ensuring children and young people are safely and effectively cared for within OUH services. Significant safeguarding activity has been within all areas of the trust.

11.2. The Safeguarding Strategy group has been able to actively safeguarding agendas across the organisation due to the development of a more representative cross divisional membership.

11.3. The Trusts' continued commitment to partnership shown by the high levels of active involvement in the OSCB and partnership developments.

11.4. The development of new and revised polices that support practitioners to effectively safeguard children while within our services.

11.5. The increased awareness of staff responsibilities to safeguard children through increasing compliance to complete training has led to earlier identification and support being provided to both individuals and families.

12. Recommendations for Safeguarding Children

12.1. The Trust will remain responsive and proactive in ensuring safeguarding remains a core trust priority. The safeguarding team will support this by developing and reviewing practice across the trust. Specific areas of focus which will form the basis of work plans are outlined below:

12.1.1. Over the next year the safeguarding team will continue to monitor and improve on the quality of assessment, referral and planning for families and individual in need of support and protection.

12.1.2. Safeguarding training will continue to be a key focus to ensure that the organisation meets its mandatory responsibility to ensure all staff in the organisation has been trained, at the appropriate level, to contribute to safeguarding children. This will be developed and offered in a range of formats to ensure optimal opportunities for all staff groups.

12.1.3. Joint work with the Community and Social Care teams will remain a priority to promote partnership working and the sharing of key safeguarding resources.

12.1.4. Other specific areas of work will include: ensuring staff engagement with pregnant teenagers, early access to postnatal contraception, early intervention and identification of families in need, identification of young carers, safeguarding resources and information for children and young people; Increased awareness and intervention associated with parental risk factors including Domestic Abuse; and improved understanding of child sexual exploitation.

12.1.5. There will be a clear audit programme to monitor and review the effectiveness of policies and procedures focusing on the outcome of service involvements for children and families in our care.

Safeguarding Adults Annual Report

1. **Purpose**

1.1. This paper presents the annual report for safeguarding and adults at risk for June 2012 to June 2013.

2. **Background**

2.1. Safeguarding adults at risk is a key component of Trust values and responsibilities to vulnerable groups.

2.2. The important reports from Sir Robert Francis, Professor Don Berwick and Sir Bruce Keogh, that were published during 2013, and these have highlighted the importance of safe clinical practice, working with and listening to patients and carers. This is particularly in relation to

- involving patients and their families in care planning
- clinical teams working in partnership with patients and families
- good nutrition and hydration
- support for carers, information and advice
- whistle blowing policy and practice
- safe and well coordinated discharge
- listening to patients and families concerns and resolving them quickly
- responsive and humane complaints practice and learning from these issues to change practice
- privacy, respect and dignity.

2.3. The investigation and report into Winterbourne View (2012) highlighted the vulnerability of people with a learning disability who are supported in out of area placements. This has particular relevance for the acute sector in being alert to the needs and vulnerabilities of people with a learning disability admitted from a health or social care placement as an emergency. It is therefore critical that Emergency Departments are confident in recognising institutional abuse and reporting processes to local authority safeguarding teams and the police.

2.4. The OUH is a partner agency of the Oxfordshire Safeguarding Adults Board (OSAB). The aims of OSAB are to ensure that all incidents of suspected harm, abuse or neglect are reported and responded to proportionately to:

2.4.1 Enable people to maintain the maximum possible level of independence, choice and control.

2.4.2 Promote the wellbeing, security and safety of vulnerable people consistent with his or her rights, capacity and personal responsibility and to prevent abuse occurring wherever possible.

2.4.3 Ensure that people feel able to complain without fear of retribution.

2.4.4 Ensure that all professionals who have responsibilities relating to safeguarding adults have the skills and knowledge to carry out this function.

2.4.5 Ensure that safeguarding adults is integral to the development and delivery of services in Oxfordshire.

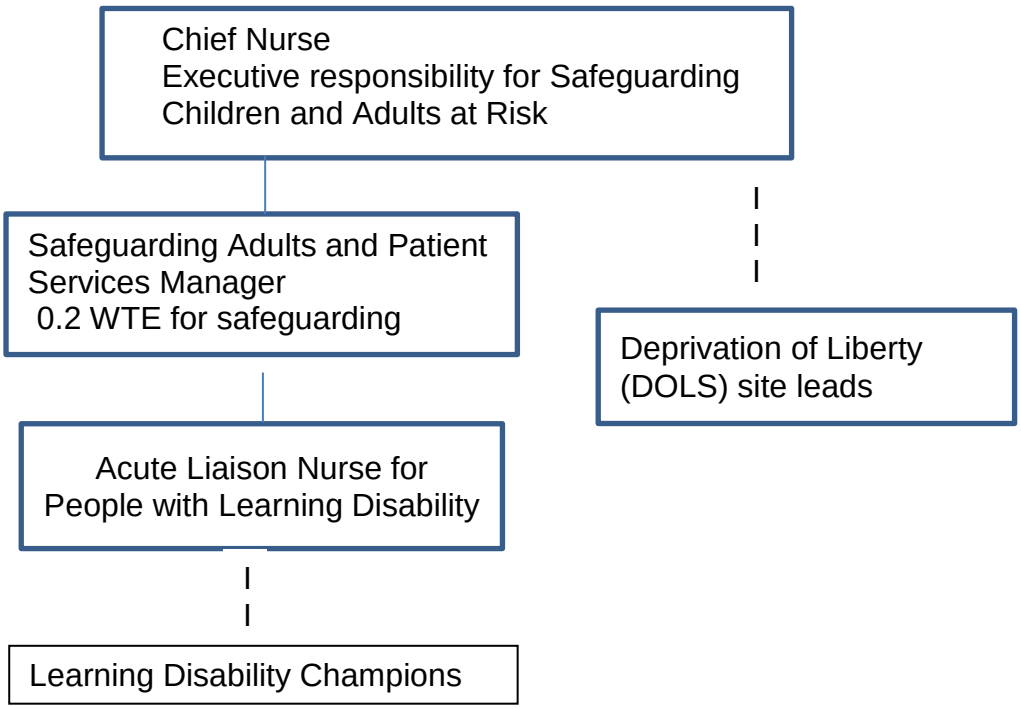
2.5 These aims, are underpinned by the following key principles:

- **Empowerment**: Providing people with support, assistance and information, and enabling them to make choices and give informed consent.
- **Protection:** Support and representation for those in greatest need.
- **Prevention:** It is better to take action before harm occurs.
- **Proportionality:** Proportionate and least intrusive response appropriate to the risk presented.
- **Accountability: Partnership:** Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability and transparency** in delivering safeguarding.

Statement of Government Policy on Adult Safeguarding
Department of Health 2011

3 The OUH safeguarding adults' at risk structure

3.1 Figure 1 presents the safeguarding structure within the Trust. The safeguarding adult lead is incorporated within Patient Services within the Chief Nurse, Patient Services and Education directorate.



(Please note: The dotted line - - - denotes no line management responsibility)

Fig.1

4 National guidance and regulation

4.1 The Care Quality Commission (CQC)

4.1.1 **Outcome 7: Safeguarding people who use services, from abuse,** is the main essential standard for quality and safety. This standard states :

'*People should be protected from abuse and staff should respect their human rights'*

4.1.2 There are 15 further CQC essential standards for quality and safety which also have key relevance for safeguarding adults at risk. Please refer to Appendix 1 for a list of these relevant essential standards and outcomes.

4.2 *No secrets:* Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (2000).

4.2.1 *No Secrets* defined the a vulnerable adult or adult at risk as

"*who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".*

4.2.2 The guidance defines abuse as
'*The violation of an individual's human and civil rights by any other person or persons'***.**

4.2.3 The following main different forms of abuse.

- Physical abuse
- Sexual abuse
- Psychological abuse
- Financial or material abuse
- Neglect and acts of omission
- Discriminatory abuse
- Institutional abuse

These types of abuse may be as the result of deliberate intent, negligence or ignorance:

No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (2000).

4.3 The purpose of the NICE guidance (QS24) Quality standard for nutrition support in adults is to improve the effectiveness, safety and experience of care for people who need nutrition support. The quality standard therefore aims to safeguard adults at risk by protecting them from avoidable harm.

5 Local Guidance

5.1 Local Trust and Oxfordshire safeguarding adults guidance is available for all Trust staff on the Trust intranet and includes information about

5.1.1 Types of abuse

5.1.2 Making a safeguarding referral

5.1.3 Domestic abuse

5.1.4 Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS)

6. Safeguarding Adults

6.1. There are three distinct elements of internal safeguarding adults' activity in the Trust.

6.1.1 **Safeguarding concerns about vulnerable people raised by OUH staff**. This includes alerts raised about older people in care, people with a learning disability, people with mental health problems and domestic abuse. The reporting of these alerts has increased during the previous 12 months due to improved training and awareness.

6.1.2 **Requests for information about vulnerable people**. This includes information about an adult at risk when there may be safeguarding concerns externally. This information is shared using the Six Information Management Principles.

6.1.3 **Safeguarding alerts made about OUH services**.

6.2 In the previous 12 months there have been 18 safeguarding alerts made about OUH care by external agencies. Five alerts were closed to Safeguarding procedures with no further action by the Local Authority Safeguarding Team.

6.2.1 The main theme of safeguarding alerts relates to poor and unco-ordinated discharge, communication and handover. The root causes of these safeguarding alerts are:

- The lack of understanding about the system of referral of patients to social care.
- The lack of understanding of the health and social care needs of adults at risk particularly older patients when they are discharged.
- The lack of clear and robust detailed documentation about patients' treatment and healthcare in patients' records.
- Insufficient information about pressure ulcer care

- The poor handover and communication to a receiving care provider including contacts when there is a concern.

6.2.2 The additional alert themes included

- Medication errors or information about medication
- Allegations of assault and inappropriate behaviour by members of staff.

6.3 There have been 184 incidents raising potential safeguarding concerns logged on Datix by OUH clinical teams in the previous 12 months. On review, not all of these incidents have been validated as safeguarding alerts. The actual safeguarding alerts have related to pressure ulcers on admission, OUH medication errors, financial abuse in other care settings and concerns about the care and neglect of elderly patients in care homes. Clinical staff raise the safeguarding alerts to the Oxfordshire Safeguarding Adults Team.

7 Deprivation of Liberty Safeguards (DOLS) and the Mental Capacity Act 2005

7.1 The Mental Capacity Act (2005) provides a statutory framework for acting and making decisions on behalf of individuals who lack mental capacity. The Independent Mental Capacity Act Service (IMCA) provides an independent advocate for people who are not able to make certain important decisions and who, at the time decisions need to be made, have no-one to support them.

7.2 Under the Mental Capacity Act, it is lawful to restrict the liberty of people who lack capacity, provided that the restrictions are proportionate to the risk of harm to that person, and the seriousness of this harm. This must not however amount to a deprivation of the person's liberty.

7.3 To safeguard individuals who sometimes lack mental capacity, it can become necessary to restrict their liberty. Deprivation of Liberty Safeguards (DOLS) protect the human rights of people who: are 18 or over; *and* are in a registered care home or a hospital; *and* lack capacity to consent to arrangements proposed for their care and/or treatment; *and* for whom such arrangements amount to deprivation of liberty; *and* are not detained (or liable to be detained) under the Mental Health Act 1983.

7.4 A DOLS referral should be made if a patient does not have mental capacity and one of the following restrictive practices apply:

- Physically restraining or sedating a person resisting admission or to prevent him/her leaving
- Refusing to discharge a person to the care of family members
- Any other restrictions on the person's liberty or freedom of movement that are frequent, on-going or cumulative.

7.5 A patient must have been assessed as to whether they have specific mental capacity before Trust staff proceed with a DOLS application. There are two stages to the DOLS application process. These are urgent and standard applications. The Trust has managing authority to authorise urgent DOLS applications. These are valid for seven days. The patient is then assessed by

a Best Interest Assessor and a Medical Assessor as part of the standard DOLS application process.

7.6 The lead responsibility for DOLS transferred from primary care services to the local authorities in April 2013.

7.7 There have been 14 DOLS applications, between June 2012 and June 2013, seven of which have been authorised. There were no DOLS applications between 24 August 2012 and 1 February 2013. This figure is low, however, OUH DOLS applications and authorisations have significantly increased since March 2013 which indicates that staff have a much better understanding of the implications of the Mental Capacity Act and DOLS in relation to the assessment of patients with decreased mental capacity.

7.8 The Trust needs to improve practice in the following areas

- Comprehensive documentation of a mental capacity act assessment prior to a DOLS application
- When an authorised DOLS is due to expire
- Develop more robust practice for reviewing individual DOLS authorisations against the patient's need for continuation

The improvement in this practice will be reported in the OUH Safeguarding Adults Annual Report 2013/14.

8 Risks for OUH escalation and mitigation of issues relating to Safeguarding Adults

8.1 Safeguarding adults

8.1.1 The majority of safeguarding adults' activity and referrals is within Emergency Medicine, Therapies and Ambulatory Services and Neurosciences, Trauma and Specialist Surgery because of the vulnerability of older patients, patients with cognitive impairment and a learning disability.

8.1.2 There has been significant increase in referral and reference activity and bench marking indicates that this is a national trajectory relating to increased public and staff awareness. This escalation of awareness, generation of alerts and investigations and coordination of mandatory training has challenged the current level of resources; which is being reviewed. This has been identified as a risk on the Acting Chief Nurse' risks register.

8.1.3 A benchmarking exercise has been undertaken with Trusts with comparable services and patient groups. This has identified varying structures within both corporate and clinical directorates. The indications for best practice are for embedded clinical expertise as well placed resources, supported by experts lead clinicians at corporate level. This has highlighted a need to review the resource of expertise and administration support.

9. Training June 2012 – May 2013

9.1 The safeguarding adult training figures are reported against all eligible multidisciplinary staff for training

9.1.1 Safeguarding adults = 81.2%

9.2 A review of training resources is due to be completed by the end of November 2013. The new safeguarding children and safeguarding adults' introductory training has been developed in conjunction with Oxford Brookes University. This training will be competency based and will be implemented from January 2014 and has been validated by the OSAB.

9.2.1 Oxford Brookes University is also developing further introductory training for OUH on the Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS) and introductory training in Safe Restraint Practice. This is important to ensure staff are confident and have sufficient knowledge of the principles of the Mental Capacity Act when treating and caring for their patients.

9.3 The Lead Nurse, Safeguarding Children and Safeguarding Adults and Patient Services Manager are actively engaged with multiagency training through the Safeguarding Childrens' and Safeguarding Adults Boards.

10 The strategic plan for Safeguarding practice development June 2013 – June 2014

10.1 Safeguarding Adults

10.1.1 *The training will be reviewed and updated to include*

- Introductory Safeguarding Adults awareness training
- Introduction to Mental Capacity Act and DOLS
- Introduction to safe restraint practice
- Multiagency Safeguarding Leaders training in partnership with Oxford Health

10.1.2 *Governance*

Each safeguarding adult's investigation will be presented at the monthly divisional review of complaints and incidents and at the monthly Trust Safeguarding Adults Review meeting.

10.1.3 *Audit*

The Trust peer review will include safeguarding children, safeguarding adults, learning disability and MCA/DOLS.

Oxfordshire Safeguarding Adults Board is developing a multiagency safeguarding audit for all Board agency members. This will be piloted during 2013/14 and will be reported to both clinical Governance Committee and OSAB.

10.1.4 *Partnership working*

10.1.4.1 Oxfordshire will be developing a Multiagency Safeguarding Hub (MASH). The MASH will support children initially and will plan to

include adults in the future. The Trust services and particularly Emergency Departments, discharge planning teams and children and women's services will be key partners in the development and implementation of the MASH.

10.1.4.2 The Dementia Steering Group, led by the OUH Dementia Lead, Divisional General Manager for EMTA and Deputy Chief Nurse, is leading the Trust wide co-ordination to improve services for people with Dementia. The steering group includes carers, Age UK and Guidepost. This work includes:

- Coordination of the Dementia CQUIN
- Dementia Training Strategy including the Dementia Leaders training delivered by the University of Worcester.
- The recruitment of volunteers to support older patients and patients with dementia.
- Dementia cafes (these are 'pop up' cafes to provide support and information for carers).
- 'Knowing me' document developed by the Oxford Health and OUH Dementia leaders

10.1.4.3 The Safeguarding Leaders Training is being developed in partnership with Oxford Health and the first training will commence March 2014 and will be aimed at senior clinical leaders. The training will include leading safeguarding practice within a team, domestic abuse, working with the police, Mental Capacity Act /DOLS and working across the health and social care system to safeguard vulnerable people. This is designed to safeguard patients across healthcare boundaries along patient pathways.

10.1.4.4 The Discharge Oversight Group is led by the Deputy Director of Clinical Services. This cross trust group is standardising discharge processes and using the learning from complaints, incidents, patient experience, carer experience and safeguarding to improve patient discharge across the Trust.

10.1.4.5 The Tracking and Flagging project for people with a learning disability is a joint project between OUH, Southern Health, Oxford Health and South Central Ambulance Service (SCAS) and Oxfordshire County Council. This includes SCAS developing an anticipatory care plan for vulnerable people.

10.1.4.6 Oxfordshire Independent Mental Capacity Advocates (IMCA) will hot desk in the PALS office in the West Wing for one day a week from January 2014.

11 Conclusion for Safeguarding Adults at Risk

11.1 Staff have shown their commitment to ensuring adults at risk are safely and effectively cared for within OUH services. Significant safeguarding activity has occurred within all areas of the Trust.

11.2 The increased awareness of staff responsibilities to safeguard adults at risk through increasing compliance to undertake training, has led to earlier identification and support being provided to both individuals and their families.

11.3 The number of DOLS applications for the previous year (2012/2013) was low, however OUH DOLS applications and authorisations have significantly increased since March 2013 which indicates that staff have a much better understanding of the implications of the Mental Capacity Act and DOLS in relation to the assessment of patients with decreased mental capacity.

11.4 However, the main theme of safeguarding alerts relates to poor and uncoordinated discharge, communication and handover to external health and social care agencies.

11.5 The Trust's continued commitment to its partnership are demonstrated by the high levels of active involvement in the OSAB and partnership developments.

11.6 The development of new and revised polices will support practitioners to effectively safeguard adults while within our services, through improved information and guidance.

12 Recommendations for Safeguarding Adults at Risk

12.1 The Trust will remain responsive and proactive in ensuring safeguarding adults at risk, is considered a core trust priority. The specific areas of work will include:

12.1.1 Improve the routine and systematic analysis of the themes from safeguarding adults alerts, incidents and complaints to inform service improvement and patient care within OUH.

12.1.2 To review the safeguarding adults' resource and administration support. This will include increasing the knowledge resource within divisions, supported by expert lead clinicians at corporate level.

12.1.3 To implement the OUH Safeguarding Adults Coordination Group chaired by the Chief Nurse.

12.1.4 To further embed clinician's robust knowledge of DOLS and domestic abuse.

12.1.5 To further embed partnership working with the Community and Social Care teams at both clinical and corporate level to safeguard adults at risk.

12.1.6 To develop and implement an audit programme to monitor and review the effectiveness of safeguarding adults at risk, the practices, policies and procedures focusing on the outcome of service improvements for adults at risk in the Trust's care.

12.1.7 To further develop and implement safeguarding training with divisional safeguarding adult leads.

13 Actions

13.1 The Trust Board is asked to acknowledge the extensive activity undertaken by both Safeguarding teams and the national guidance influencing changes in practice, the key issues highlighted and risk factors.

14 References

14.1 Guidance about compliance: Essential standards of quality and safety. Care Quality Commission March 2010

14.2 Quality standard for nutrition support in adults: QS24 National Institute for Health and care Excellence

14.3 Oxfordshire Safeguarding Adults Board: Safe from Harm website http://www.safefromharm.org.uk/wps/wcm/connect/occ/Safe+From+Harm/Home/

14.4 No Secrets: guidance on protecting vulnerable adults in care**:** Department of Health: March 2000 https://www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care

14.5 Winterbourne View Hospital: Department of Health review and response. June 2013. https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response

14.6 The Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis QC. February 2013. http://www.midstaffspublicinquiry.com/report

14.7 Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. Professor Sir Bruce Keogh KBE July 2013 http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

14.8 A promise to learn – a commitment to act: improving the safety of patients in England. August 2013 Professor Don Berwick. https://www.gov.uk/government/publications/berwick-review-into-patient-safety

14.9 Statement of Government policy on Adult Safeguarding. Department of Health. May 2011 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215591/dh_126770.pdf

Authors

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November 2013

Appendix 1

- **Outcome 1: Respecting and involving people who use services**
  People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run.
- **Outcome 2: Consent to care and treatment**
  Before people are given any examination, care, treatment or support, they should be asked if they agree to it.
- **Outcome 4: Care and welfare of people who use services**
  People should get safe and appropriate care that meets their needs and supports their rights.
- **Outcome 5: Meeting nutritional needs**
  Food and drink should meet people's individual dietary needs.
- **Outcome 6: Cooperating with other providers**
  People should get safe and coordinated care when they move between different services.
- **Outcome 8: Cleanliness and infection control**
  People should be cared for in a clean environment and protected from the risk of infection.
- **Outcome 9: Management of medicines**
  People should be given the medicines they need when they need them, and in a safe way.
- **Outcome 10: Safety and suitability of premises**
  People should be cared for in safe and accessible surroundings that support their health and welfare.
- **Outcome 11: Safety, availability and suitability of equipment**
  People should be safe from harm from unsafe or unsuitable equipment.
- **Outcome 12: Requirements relating to workers**
  People should be cared for by staff who are properly qualified and able to do their job.
- **Outcome 13: Staffing**
  There should be enough members of staff to keep people safe and meet their health and welfare needs.
- **Outcome 14: Supporting workers**
  Staff should be properly trained and supervised, and have the chance to develop and improve their skills.
- **Outcome 16: Assessing and monitoring the quality of service provision**
  The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care.
- **Outcome 17: Complaints**
  People should have their complaints listened to and acted on properly.
- **Outcome 21: Records**
  People's personal records, including medical records, should be accurate and kept safe and confidential.