Oxford University Hospitals
NHS Foundation Trust

Trust Board Meeting in Public: Wednesday 12 September 2018

TB2018.82

Title	**Oxford University Foundation Trust (OUHFT) Safeguarding (Children and Adults) Report 2017-2018**

Status	Annual Report
History	The previous Safeguarding Children and Adults Annual Report was presented at the OUH Trust Board on 9 November 2017

Board Lead(s)	Mrs Sam Foster, Chief Nurse			
Key purpose	Strategy	**Assurance**	Policy	Performance

Executive Summary

1. This report is comprised of two sections which provide a summary of the key issues and activity in relation to Safeguarding of Children and Adults during 2017/18. This is an annual report.

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

3. Safeguarding children consultations increased to 1819 (↑12% n=199) averaging 151 per month. The main issue remains neglect which reflects county and national statistics. There has been an increase in complex cases, young people with mental health difficulties and maternity safeguarding concerns requiring on-going support from the team*.*

   Emergency department cases referred to the Liaison Service totalled 8,252, this is an increase of 16.9% (n=1,190).

   Requests for information were provided to support decision making at 423 Initial Child Protection Case Conference involving 848 children.

4. Safeguarding Adult consultations increased to 1270 (44% increase). There were 26 safeguarding adults concerns raised about the Trust's care and 28 Section 42 enquiries. Of these, 11 enquiries were substantiated, eight were unsubstantiated and nine remain open investigations.

5. Training compliance[1] – Safeguarding Adults 87.3%, Level 1 children: 85%, Level 2 children: 91.6%% and Level 3 children: 84.2%.

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

7. **Key achievements** The significant amount of partnership working to safeguarding children and adults. Audit activity both Trust and multiagency has evidenced good practice. The OUH achieved a high level of compliance in the annual OSCB/OSAB self-assessment and peer review.

   Key challenges are the ongoing increase in consultations with both children and adult safeguarding, children and pregnant women presenting with mental health difficulties, complex cases requiring ongoing support, increase requests for child protection information and participation at conferences due to high numbers of children with plans, documentation surrounding Mental Capacity Assessment, DOLS applications, the length of time taken to open and close section 42 investigations and Patient Falls.

8. **Recommendation**

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

[1] KPI 90%

1. Definitions

1.1 Safeguarding Children

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

1.2 Safeguarding adults

- An adult is an individual aged 18yrs or over.
- Appendix 1 gives the definition of vulnerable adults according to the Care Act 2014.

2. Purpose

2.1 This paper presents the annual report for safeguarding children and adults for April 2017 to March 2018 in line with 'Working Together to Safeguard Children' 2015, the Children Act 2004 and the Care Act 2014.

2.2 This sets out the requirement for Trust Boards to produce an annual report with an analysis of the effectiveness of local safeguarding arrangements. The last annual safeguarding report was received by the Trust Board on 13 September 2017.

3. Background

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

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

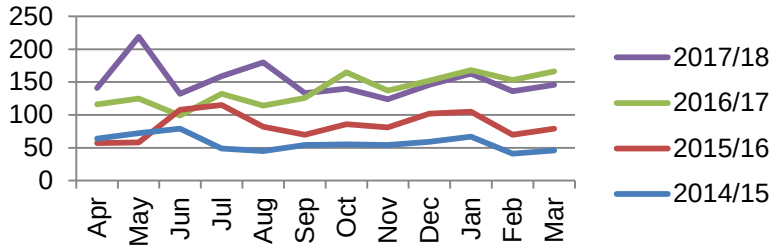
4. Safeguarding Children Activity

4.1 Safeguarding activity is divided into 3 main areas:

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

4.2 There have been 1819 consultations (average 151 per month) with the safeguarding children team. This is an increase of 12% (n=199) from 2016-17 (see Figure 1)

Safeguarding Children Consultations

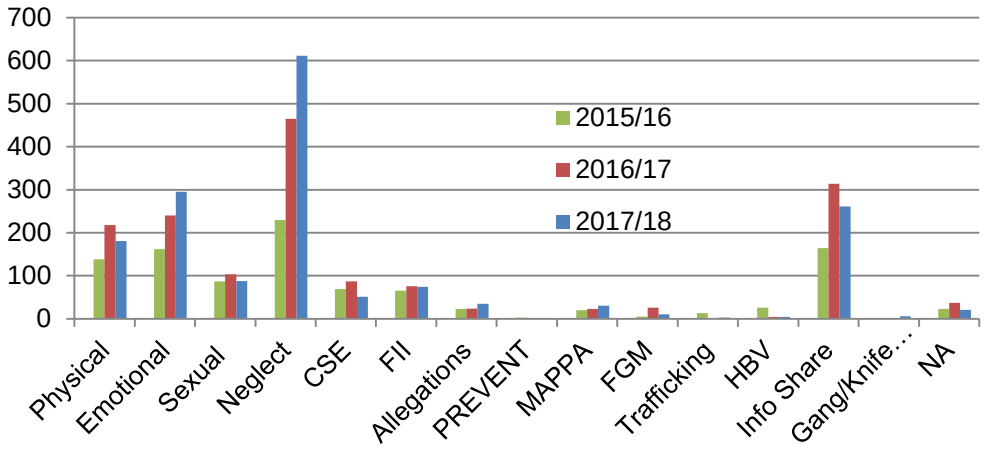


4.2 There were 730 children with a child protection plan (CPP) in Oxfordshire at the end of March 2017. This was an increase of 28% from 2016/17. The main reason children were placed on a plan continues to be for neglect (65%). The number of children that were 'Looked After[2]' rose a further 6% to 691.

4.3 OUH safeguarding children activity rose significantly the first part of the year, (see fig.1) and there continue to be a number of complex cases requiring ongoing support to practitioners from the team, senior managers and legal services.

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

Fig 2. Consultation categories for the previous three years



4.5 The number of complex cases has increased, mainly related to adolescent mental health, non-accidental injury and fabricating induced illness. There have been a number of children that have this year required admission under the mental health act with difficulties securing a bed which has been recognised as a national issue. This has been escalated via the OSCB to NHS England and local councillors and MPs. There have been a number of cases involving large numbers of staff to support attending court to give evidence.

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

[2] A L**ooked After Child** may either be accommodated (which **means** that the council is looking **after** them with the agreement, at the request or in the absence of their parents) or subject to a Care Order made by the Family Courts.

4.7 Emergency department cases referred to the Liaison Service totalled 8,252 as presented in Figure 3. This is an increase of 16.9% (n=1,190).

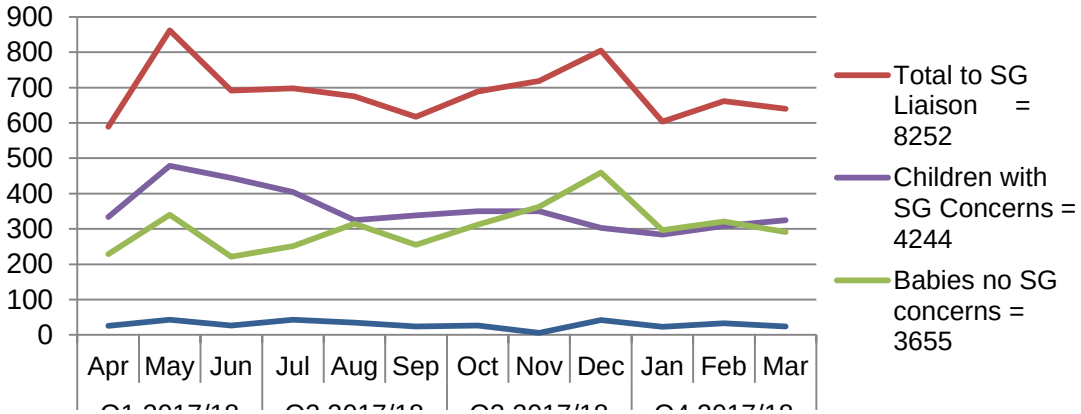


Fig. 3 Liaison Service ED Attendances April 2017 – March 2018

4.8 There has been an increase of 291 12-17 year olds attending ED with drug, alcohol or having self-harm behaviours (n=1315). The safeguarding team are working closely with the Oxfordshire multi-agency self-harm strategy to monitor and ensure support and treatment is targeted to reduce presentations.

4.9 In maternity there were 8,223 bookings, 442 less this year. However, 16.5% (n=1288) were identified as either category 3 or 4 public health risk[3], an increase of 258. As in previous years the dominant category of concern remains maternal mental health issues. The Trust works closely with mental health services within the OUH to support maternal mental health needs. There has been a reduction in delays to discharge when court proceedings are needed. This continues to be monitored.

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

4.11 The JR hospital children social care team provide support to manage cases on-site for maternity and the children's hospital. There were 125 strategy meetings, 75 Initial Child Protection Case Conferences and 39 court care orders to place children in local authority care. Cases at the Horton hospital are managed by the North Assessment team.

Strategy Meetings	Children's	49	125
	Maternity	74	
ICPCC	Children's	17	75
	Maternity	58	
Care Order	Children's	14	39
	Maternity	*25*	

4.12 The children safeguarding team attend strategy meetings working with practitioners and children's social care to ensure information is shared to help with the assessment of risk to protect a child. Support and debrief sessions for staff are

[3] Maternal Health & Social Score Level 3 = low obstetric/high public health risk Level 4 = high obstetric/high public health risk

provided as needed in these difficult situations either by the safeguarding team or psychological medicine.

4.13 The OUH reported 100% compliance with the NICE NG76 Child Abuse Neglect guidance.

5 Safeguarding Adult Activity

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

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

5.2 Consultations*:* Figure 4 shows the number of consultations over the previous two financial years. The 1270 (44% increase on the previous year) consultations during the year, compares with 297 for 2015/16 and 882 (197% increase) in 2016/17. Please note the number of consultations recorded was 18 in December 2017, this was due to reduced capacity because of staff sickness and vacancies.

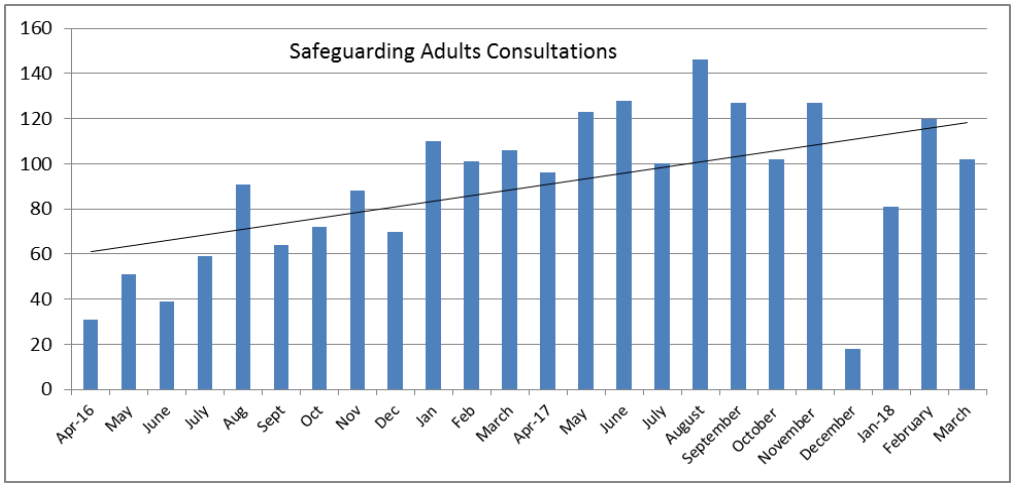


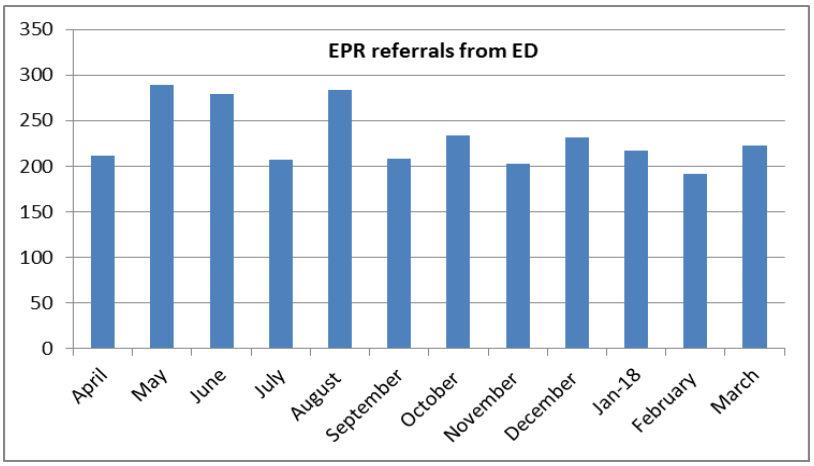
Fig.4 Safeguarding Adults Consultations during 2016/17 and 2017/18

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

[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/.

[5] Multi-Agency Public Protection Arrangements. It is the process through which the Police, Probation and Prison Services work together with other agencies to manage the risks posed by violent and sexual

5.4 Figure 5 shows the Safeguarding Adult referrals from the Trust's Emergency Departments (ED) throughout the year. The 2954 referrals were made via the Trust's electronic patient record (EPR). These referrals will include concerns about domestic abuse, drug and alcohol dependency and vulnerable and frail adults admitted from home or care homes. Fig. 5 shows the peak of referrals in May, June and August.



5.5 Figure 6 shows that there were 26 safeguarding adults concerns raised and 28 Section 42 enquiries into the Trust's care[6]. Appendix 1 gives the definition and criteria for Section 42 enquiries according to the Care Act 2014.

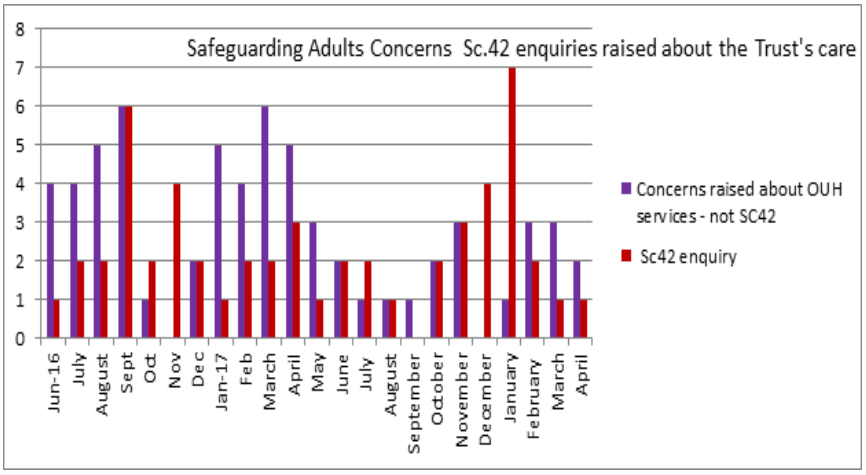


Fig.6 The Section 42 Enquiries and Safeguarding Concerns

Figure 7 shows the number of substantiated and unsubstantiated enquiries. During this period 11 enquiries were substantiated compared to 15 in 2016/17, eight were unsubstantiated compared to nine in 2016/17. At the time of reporting nine are open and current investigations.

offenders living in the community in order to protect the public.
https://mappa.justice.gov.uk/connect.ti/MAPPA/groupHome

[6] An enquiry is any action that is taken (or instigated) by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect them because of those needs. http://www.scie.org.uk/care-act-2014/safeguarding-adults/adult-safeguarding-practice-questions/

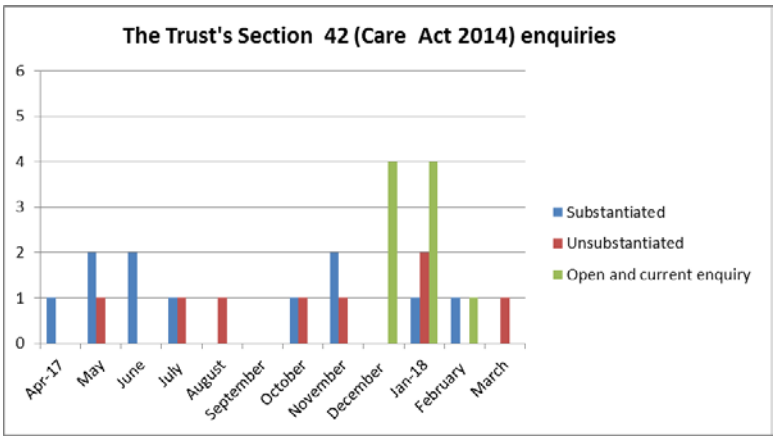


Fig.7 The Section 42 enquiries with outcome

5.6 The team has been under significant pressure during the year. This led to TME recommending and increase in the number of specialist nurses within the team. These posts have been recruited and at the time of writing have been in post for six months, making a significant impact on the team's ability to respond to requests for support and guidance.

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

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

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

6 Partnership working

6.1 The Government Wood review (March 2016) of arrangements of LSCBs, serious case reviews and child death overview panel has been agreed in Oxfordshire and the OSCB will continue to function in its current format. The safeguarding team are members of five sub-groups for the OSCB and five for the OASB working in partnership to improve outcomes for children and adults.

6.2 The safeguarding children team continued to participate in the daily functioning of the Multi-Agency Safeguarding Hub (MASH). This function, in conjunction with Oxford Health NHS FT, ensures appropriate health response to concerns raised.

6.3 The OUH participates at the three area Multi-Agency Risk Assessment Conferences (MARAC) to share relevant information in high risk domestic abuse cases.

Information is recorded on the electronic record so that practitioners are aware of these risks when patients attend the Trust.

6.4 Information is requested for all Initial Child Protection Case Conference (ICPCC) under section 47 of the Children Act 1989. There were 423 ICPCC involving 848 children where relevant health information was provided to support decision making. This is a reduction of conferences however, an increase in the number of cases (table 2). Participation at ICPCC by OUH staff is monitored by the OSCB and had improved to 100% participation.

		2016/17	2017/18	Difference	% Change
ICPCC Invites		447	434	-13	-3%
Information shared	Unborn	83	73	-10	-12%
	Child	823	848	25	3%

Table 2. ICPCC information requests

6.5 **Domestic Abuse:** There have been considerable concerns relating to families living with the medium risk of domestic abuse. The pilot Multi-agency Domestic Abuse Repeat Perpetrator meeting (MARDAP) will be held on 16th August 2018 for the South Oxfordshire and the Vale of White Horse Local Police Area (LPA). It is envisaged that Oxford city and Cherwell and West LPAs will be held during the autumn. This is important collaborative work and will particularly assist the Trust's emergency departments (EDs) in the assessment, treatment and support of patients at a standard or medium risk of domestic abuse. The Trust's Domestic Abuse strategy for patients, visitors and staff will be completed by 31st August 2018. The Trust's Head of Adult Safeguarding has recommended that Oxfordshire Safeguarding Children' Board (OSCB), Oxfordshire Safeguarding Adult's Board and Oxfordshire Community Safety Partnerships (OSCPs) convene a joint sub Domestic Abuse group to coordinate Oxfordshire's activity.

6.6 **Modern Slavery and Human Trafficking:** Trafficking and modern slavery is a local, national and international issue. The four types of slavery are criminal, domestic, labour and sexual[3]. The Modern Slavery Act 2015[4] outlined the statutory duty to report all suspected instances of modern slavery to the Home Office using the National Referral Mechanism (NRM). The Trust's clinical areas who have recently supported patients who are suspected victims of modern slavery are ED, Trauma, Sexual Health, Oncology and Maternity services. Oxfordshire Community Safety Partnership has recently implemented the Oxfordshire Modern Slavery Partnership and Network, to coordinate support activity for people at risk of slavery and trafficking. Elmore Community Services[5] is undertaking a research project, commissioned by Oxford City Council, to investigate the nature and extent of Modern Slavery and Trafficking within Oxford. The project will run from May 2018 – July 2019. Oxfordshire's modern slavery multiagency work is in early development. The Trust will be a key partner in this development.

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/649906/Transparency_in_Supply_Chains_A_Practical_Guide_2017.pdf

[4] https://www.gov.uk/government/collections/modern-slavery-bill

[5] http://www.elmorecommunityservices.org.uk/

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

7.1 The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It applies to individuals aged 16 and over[7].

7.2 Deprivation of Liberty Safeguards (DOLS) form part of the Mental Capacity Act 2005. DOLS were introduced in 2009.

7.3 The Trust ward nursing teams are responsible for the DOLS application and management. There were 271 applications for Deprivation of Liberty Safeguards (DOLS) during the year. Figure 8 shows the comparison with the previous two years. This is a 38% in 2016/17 and 88% increase in 2017/18; and represents considerable work on behalf of ward and the safeguarding adults' teams. Each application is reviewed by the safeguarding adults' team prior to sending to the appropriate DOLS supervisory office.

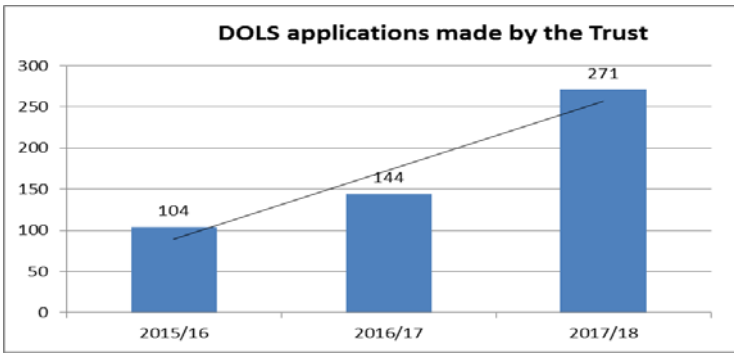


Fig 8 DOLS applications with outcome

7.4 Despite this increase considerable risks became evident during the year. These were:

7.4.1 Applications for patients who are not Oxfordshire residents. It is logistically more complicated for DOLS Supervisory offices to organise Section 12 Doctors and Best Interest Assessors. This is being mitigated by weekly review telephone calls with the relevant offices and escalation to the respective Director of Adult Social care where appropriate

7.4.2 The Cheshire West judgement in 2014[8] continues to significantly impact on the number of applications assessed and subsequently granted

7.4.3 Documentation for MCA; identified in the CQC inspection of Oxford Centre for Enablement (OCE) and KPMG audit during October 2017

7.4.4 Clinical understanding of MCA and DOLS identified during the inspection and audit detailed above

7.5 As part of the CQC action implementation plan developed following the OCE inspection during August 2017 and KPMG audit in November 2017, a consultant trainer who previously worked as the MCA advisor for the Care Quality Commission (CQC) will be working with the Trust and clinical divisions for 15 days during this financial year (2018/2019) to increase knowledge and clinical application of the act in practice. Each division will have access to 3.5 days of the consultant's time to

[7] https://www.england.nhs.uk/ourwork/safeguarding/our-work/mca/
[8] http://www.communitycare.co.uk/2014/03/19/supreme-court-ruling-heralds-sharp-rise-deprivation-liberty-safeguards-cases/

develop sustainable clinical practice within the division. This approach has been adopted to reflect the particular needs of different specialities.

7.6 The complexities following the Cheshire West judgement were reported by a House of Lords Select Committee in 2014. The Care Quality Commission' serious national concerns surrounding the practical implementation of the Mental Capacity Act have led to the Department of Health commissioning the forthcoming publication, on 7th August 2018, of the NICE guideline[9] (GID-NG10009) '*Decision making and mental capacity'.*

7.7 The Safeguarding Adults Peer Review, identified as an action following the CQC inspection, will be undertaken in the coming six months. This will be the first thematic review the Trust has undertaken. The first meeting of the Review team was held on 26th July. The team presented the data pack for the team to confirm the key lines of enquiry (KLOE).

8 Case Reviews

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

8.1.1 The Trust participated in three children's reviews across Oxfordshire and one in Wiltshire.

8.1.2 All actions from SCRs have been completed and learning has been disseminated in training and through the 'At a Glance' learning documents and participation at OSCB learning events.

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

8.2.1 During 201/18, one SAR was concluded. This related to a man who lived alone in Oxford who died in an explosion in his flat which demolished the building. He had mental health problems and was supported by Oxford Health NHS Foundation Trust. Whilst the Trust was not involved in the investigation, the recommendations are transferable

1. Accurately record contact information
2. Clear proactive referral processes between team of different agencies to mitigate risk
3. Document changes to a plan when supporting someone to ensure the team are aware
4. Actively support people if a team is worried about them and ensure the know the concerns

9 Training

9.1 The Key Performance Indicator (KPI) for safeguarding training is 90% and continues to be a challenge to achieve. Table 2 presents the level of compliance. The KPI was achieved for level 2. The Trusts Safeguarding Children and Adults Teams and Learning and Development are meeting with the Trust's Electronic Learning Management system provider (e-LMS) to resolve the longstanding issues with the system. It is envisaged this review will

[9] https://www.nice.org.uk/guidance/indevelopment/gid-ng10009

- Resolve reporting problems which will increase the number of staff who are compliant with training
- Clarify the process by which external training can be hosted on the system. This is particularly important for Prevent Level 3 training and Level 1, 2 and 3 children's and adults training.

Safeguarding Level	Compliance %
Adults	87.3%
Children Level 1	85%
Children Level 2	91.6%
Children Level 3	84.2%

Table 2. Safeguarding Training compliance

9.2 The contributory factors to this are:

- The Electronic Learning Management System (ELMS) does not directly link to Electronic Staff Record (ESR). This is expected to be resolved over the coming year to ensure when staff leave OUH the learning platform will be accurately updated.
- The learning platform is altered to reflect joint adult and child safeguarding training that has been streamlined[10].

9.3 Actions taken to increase compliance:

- In order to align with national requirements, the training requirements were reviewed and included in the safeguarding training strategy.
- Where compliance was below the key performance indicator, this was brought to the attention of the Divisional Management Team to follow up with individuals and names of staff requiring training provided.
- Trust weekly Induction training is now being included as level 1 training and ensures that all staff receive a basic level of understanding of safeguarding and know who to contact for support.

9.3 Level 3 safeguarding children training is delivered face to face and evaluated well, with 87% evaluating training as excellent and 13% good. Practitioner follow up 3 months after attending training is being implemented to ascertain impact training has on practice.

[10] All level 1 and 2 Safeguarding training is now combined children and adults to ensure there is a think family focus

9.4 Prevent is included in all Safeguarding training programmes. Figure 9, below shows the number of staff trained in Basic Prevent Awareness Training (BPAT) to date

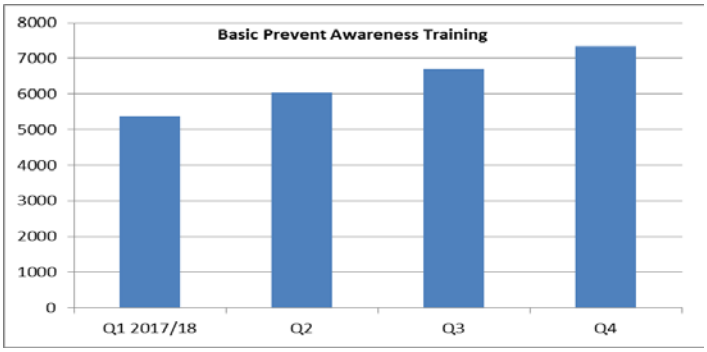


Fig. 9 Basic Prevent Awareness Training (BPAT)

9.5 A total of 29 members of staff have been trained in Prevent Level 3 training. This has been face to face training. The Home Office have produced on line Level 3 training which the Trust will be delivering instead of face to face training.

10 Services for People with Learning Disabilities

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

10.2 The Oxfordshire Clinical Commissioning Group (OCCG) has commissioned the Trust to deliver:

10.2.1 acute liaison services to people with learning disabilities and additional complex physical health needs

10.2.2 an epilepsy specialist nurse for people with learning

10.3 Three joint projects commenced during the year and are planned to become established practice during 2018/19. These are:

- Epilepsy project
- Physical health Strategy. This will encompass the complex health project to define the needs of and the pathway for people with learning disability and complex health needs
- Oxfordshire system wide experience and engagement project

10.4 Two nurses (Band 6 liaison nurse and Band 7 epilepsy specialist nurse to lead the epilepsy project) were recruited during the year to facilitate the work outlined above.

11 Audit

11.1 The OSCB/OSAB joint annual safeguarding declared compliance with S11 of the Children Act 2004 and Care Act 2014 against the 10 standards measured. The peer review concurred a rating of Green for the training standard as no follow up to evidence impact of training had been implemented and Blue[11] for all other areas.

11.2 Participation in the OSCB multiagency young people's Domestic Abuse (DA) audit highlighted the need to embed the pathway into practice. The OUH demonstrated the voice of the child is captured and is supporting the implementation of the multiagency action plan.

[11] compliant and able to provide evidence

11.3 The safeguarding children team undertook an audit to ascertain the level of knowledge of OSCB toolkits available to assess risks, awareness of recourses available and confidence in reporting concerns in relation to neglect. Recommendations from the audit are being implemented and the team are participating in the multiagency neglect strategy and peer review process.

11.4 An audit was undertaken re compliance with children self-harm guideline and proforma. The audit highlighted there was a delayed discharge from hospital in nearly half the cases. This is being monitored and escalated at a multi-agency placement meeting for complex cases.

11.5 The OUH participated in the OSCB Children with a Disability audit and evidenced strong multi agency working. There were no recommendations for the OUH. There is a need to move to record 'was not brought' and cease the use of 'did not attend' when children miss appointments. There was good evidence that the voice of the child and parents was documented.

11.6 The KPMG audit of MCA/DOLS practice included the review of 13 patients for whom DOLS applications were made during Quarter 3. The results of the audit were presented to the Trust's audit committee earlier this year.

12 The safeguarding adults' delivery priorities were developed following a series of workshops with the team to review the day to day working practices. The plan is focusing on five areas of delivery and is shown in Figure 10.

Fig. 10 Safeguarding Adults Delivery priorities

13 Impact including key achievement and challenges

13.1 At an operational level, the impact of the teams can be seen in the level of clinical activity, particularly the number of consultations, over the year. The challenges with capacity over the autumn were considerable and this has significantly eased following the recruitment of additional team members. The introduction of the safeguarding adults' daily duty rota and on call has enabled the team to be more proactive and support clinical teams during the weekends and evenings.

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

13.3 The number of consultations undertaken has enabled teams to support patients and their families in challenging circumstances. The teams have contributed to the level of safeguarding children and adults knowledge across the Trust and in the county. The increase in capacity in the safeguarding adult's team towards the end of the year enabled the teams to support patients and their clinical teams in extremely complex situations.

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

13.5 At the joint OSCB/OSAB annual self-assessment and peer review the OUH attained highest level in all but one area in the self-assessment and peer review. There is a plan in place to review training 3 months following to evidence impact.

13.6 The team have supported the Trust's clinical teams to complete 28 Sc. 42 enquiries and reviewed prior to submission. The impact of this has been to raise the importance of this statutory function.

13.7 The key challenges this year also demonstrate the impact of the teams

- There have been a significant increase in consultations in both children and adult safeguarding
- The number of complex children's and adults' cases requiring ongoing support from the safeguarding teams
- Documentation surrounding Mental Capacity Assessment
- The increase in DOLS applications and the length of time to assess
- The increase in patients and staff affected by domestic abuse
- The challenges in achieving the KPI of 90% for safeguarding children and adults training

13.8 OCC Safeguarding Team has previously highlighted the limited Trust oversight into the safeguarding concerns raised about Liaison Hub[12] and Home Assessment and Re-enablement Team (HART). To date, during 2018, there have been three enquiries (two unsubstantiated and one current enquiry) for Hub and OUH care and six for Hub patients receiving nursing home Hub care. Additionally since 1st January 2018, 16 safeguarding adult concerns have been raised about HART services. These related to six medication errors, four episodes of neglect, one fall, one missed visit and four described as other. To this end, MRC and the Trust's Adult Safeguarding Adults Team have put in place a system to confirm, monitor and audit safeguarding concerns raised in relation to the Liaison Hub and HART. The Trust's Safeguarding Adults Policy will be amended accordingly and presented at the August Clinical Policy Group on 7th August 2018. The Trust's Assurance and Safeguarding Adults Teams are providing training and support to the Trust's Liaison Hub Team to strengthen their knowledge and skills in clinical assurance.

[12] **Liaison Hub:** The Trust is collaborating with Oxford Health NHS Foundation Trust and Oxfordshire County Council (OCC) to develop the 'Liaison Hub'. The Hub provides an important service to reduce delays in patients discharge and ensures that patients who are medically fit are transferred appropriately and in a timely way to the right environment to meet their on-going needs. As the Hub is an outsourced service, it is important that the Trust is assured of the quality and safety of the service provided. OCC Safeguarding Adults Team shares the details of the Sc. 42 enquiries for Hub patients' beds.

14 Conclusion

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

14.2 The multiagency joint working demonstrated the Trust commitment to work together to improve the identification and protect children and vulnerable adults within the Trust.

15 Recommendation

15.1 TME is asked to note and approve the content of this report

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Chief Nurse

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