

Cover Sheet

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Title: Safeguarding Annual Report 2024-2025

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Board Lead: Chief Nursing Officer

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Key Purpose: Assurance, Policy, Performance.

Executive Summary

1. The Oxford University Hospitals Foundation Trust (OUH) Safeguarding Annual Report 2024-2025 presents a detailed account of the Trust's safeguarding work across children, adults, and maternity from April 2024 to March 2025.
2. During 2024–2025, the safeguarding team managed 13,006 cases, reflecting a slight reduction in volume but an increase in complexity. Children's safeguarding continued to focus on neglect and abuse, with targeted actions to address discharge delays. Maternity safeguarding saw a significant 26.2% increase to 4,601 cases, driven primarily by issues related to substance misuse, mental health, and domestic abuse. Enhanced discharge planning and the introduction of new support platforms provided improved care pathways for vulnerable women. For adults, key concerns remained neglect, self-neglect, and domestic abuse, particularly affecting older people, prompting strengthened multi-agency responses and risk management strategies.
3. There were ten Section 42 safeguarding adult investigations conducted, mainly relating to discharge planning and medication concerns. All were handled in line with statutory and Trust procedures, with key learning shared via governance forums. Improvements in discharge coordination and medication safety have been actioned, ensuring lessons are embedded to enhance patient safety.
4. The number of Deprivation of Liberty Safeguards (DoLS) applications increased to 1,627 during the reporting period, highlighting both heightened awareness and a rising need for robust oversight in this area. Comprehensive audit findings identified gaps in documentation and compliance, spurring a Trust-wide initiative for targeted training and a scheduled re-audit. These actions are designed to ensure not only that all statutory requirements are met, but also to embed a culture of continuous improvement and accountability in DoLS processes.
5. Partnership working has consistently emerged as a key strength for the Trust, demonstrated by proactive and sustained engagement in the multi-agency safeguarding adult board, children's safeguarding partnerships, their respective subgroups, and a broad spectrum of collaborative multi-agency forums. Even in the face of increasing demand, the Trust has maintained a clear focus on timely information sharing and effective risk management. These priorities have been advanced through the cultivation of stronger, more integrated relationships with partners, enabling prompt responses to complex safeguarding concerns and fostering a culture of mutual support and accountability across all agencies.
6. Safeguarding training compliance across the Trust consistently met or exceeded targets, demonstrating a strong commitment to staff development. While most areas showed high adherence, divisional managers are addressing outstanding requirements, particularly for Adult and Children Level 3 safeguarding training, to ensure full compliance.
7. Key achievements during the reporting period are considerable and reflect a Trust-wide commitment to safeguarding excellence. The introduction of the Ulysses

safeguarding IT module has improved case management and documentation. Expanding the Hospital IDVA role has strengthened the Trust's domestic abuse response. Ongoing multi-agency collaboration and high training compliance reinforce the Trust's commitment to safeguarding, as reflected in positive audits and the embedding of best practice across all divisions.

8. Key challenges remain in improving mental capacity documentation, managing increasing complexity and volume of safeguarding cases, addressing discharge planning issues, and meeting the growing demand for multi-agency reviews and information sharing requests.
9. Given the increasing complexity and volume of safeguarding cases detailed in this report, a comprehensive review of resourcing for the Multi Agency Safeguarding Hub (MASH) function is recommended. This review should assess current staffing levels, resource allocation, and operational capacity to ensure the Hub is fully equipped to respond effectively to the evolving safeguarding landscape.
10. Enhanced resourcing will be essential to maintain the Trust's high standards of timely information sharing, robust risk management, and collaborative multi-agency working—especially considering rising demand and the need for prompt responses to complex safeguarding concerns. This proactive approach will further embed a culture of excellence and accountability across all safeguarding services.

Recommendations

11. The Trust Board is asked to:
 - Note and approve the content of this report.

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Safeguarding Annual Report 2024-2025

1. Introduction

- 1.1. This report provides a comprehensive overview of the Trust's safeguarding activities between April 2024 and March 2025 across adult and child safeguarding.
- 1.2. This year, the Trust improved safeguarding practices, tackled new challenges, and promoted safety. The report covers achievements, areas for growth, and future goals in protecting vulnerable people.

2. Purpose

- 2.1. The Trust Annual Safeguarding Report summarises safeguarding activities and progress from the past year. It aims are to:
 - Assure the Board that statutory safeguarding responsibilities for children and adults have been met.
 - Highlight achievements, outline developments, and pinpoint areas for improvement and future priorities in safeguarding practices.

3. Background

- 3.1. The Trust is responsible for incorporating safeguarding into its core functions and must protect children, young people, and adults in its care. This obligation is required by law as outlined in:
 - The Children Act (1989), the Children Act (2004)
 - The Care Act (2014) and Health and Social Care Act (2022)
 - The Mental Capacity Act (2005)
- 3.2. In addition, the Trust incorporates safeguarding into its core operations and adheres to the responsibilities outlined in CQC Regulation 13: Safeguarding service users from abuse and improper treatment.
- 3.3. The Berkshire, Oxfordshire, Buckinghamshire Integrated Care Board (BOB ICB) oversees the Trust's compliance with the Safeguarding requirements specified in the NHS Contract, in accordance with the Safeguarding Accountability and Assurance Framework (July 2022).

4. Safeguarding System Data

- 4.1. The Trust acquired the Ulysses safeguarding module in January 2024 to record cases and related activities. Safeguarding is now separated into child and adult cases, and maternity activity has moved out of the children's safeguarding data as in previous years. All three teams, children's, adult and maternity and neonatal, work closely together following a Think Family approach to safeguard children and adults.

- 4.2. There were 13,006 cases across the Trust, a decrease of 390 from last year. Case complexity led to 24,370 recorded activities. This year marks the first time activity and cases can be recorded with the new safeguarding Ulysses module. Monthly averages are 1,083 cases and 2,030 episodes of activity (Figure 1).

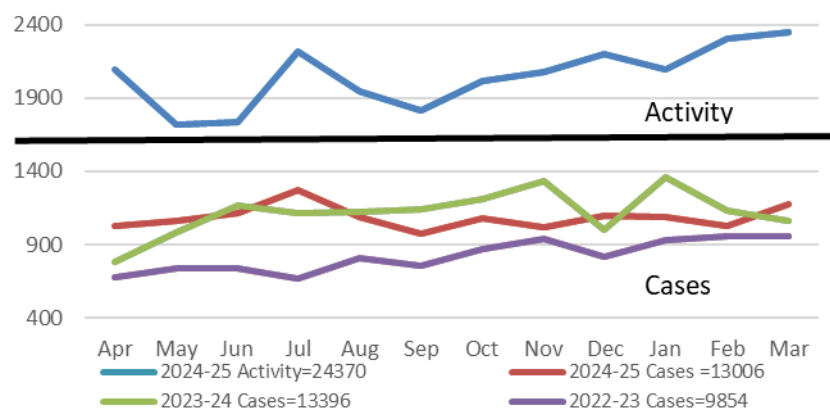


Figure 1: Safeguarding cases 2022-23 and total activity over 2024-25

- 4.3. There were 17,331 episodes of adult safeguarding activity related to 8,523, which equates to an average of 1,444 episodes a month and includes the maternity and data is included in adult data (Table 1).

Division	Adult		Child		Overall Total
	Cases	Activity	Cases	Activity	
Corp	1083	699	269	143	2194
CSS	156	304	43	17	520
MRC	4133	4181	2499	1158	11971
NOTSSCaN	696	1003	1119	1072	3890
SuWOn	2455	2621	627	92	5795
OUH Total	8523	8808	4557	2482	24370

Table 1: Divisional safeguarding activity

- 4.4. The Ulysses safeguarding module can measure the number of safeguarding episodes of involvement for each case. The majority of cases (n=7,563) had a single episode of involvement, whereas 5,517 cases required between 2–46 episodes of involvement. This highest number of cases needing between 21–46 interventions related to just 16 cases.
- 4.5. The main themes for children safeguarding related to cases of neglect (n=1,033), emotional abuse (n=779) and physical abuse (n=682) (Figure 2). Delays in discharge often occurred due to concerns raised by parents regarding the safety of taking their children home when self-harming, emotionally dysregulated, or aggressive behaviours are present. ED had six cases where there had been a delay in discharge, up to three days due to parents or carers declining to take a child home. A process to reduce multiple meetings that do not have senior decision makers in attendance to support a plan for discharge is being supported by the Integrated Care Board (ICB), Child and Adolescent Mental Health Service (CAMHS) and Children Social Care (CSC) to ensure there is a timely escalation process

to an appropriate senior level decision maker in place early to improve a timely safe discharge.

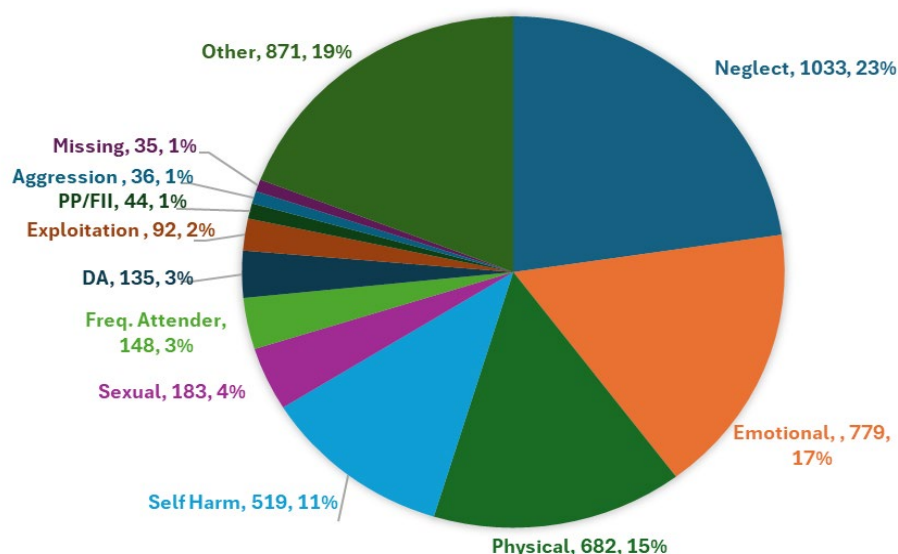


Figure 2: Child categories of activity

- 4.6. The safeguarding liaison service shares information with primary care and children's social care for open cases when children attend the Emergency Department (ED). The focus is on three groups: children with safeguarding presentations, babies under one year old with no safeguarding concern due to vulnerability, and cases where a parent or carer's ED visit raises child safeguarding concerns (Figure 3). There was a reduction of 1,142 cases over the year (n=12,041), an average of 1,000 information shares a month that followed a similar trend to the previous years (Figure 4). Escalations related to trends have been reported to primary care and the safeguarding network to raise awareness and plan any actions required. These related to children self-harming themes, assaults, babies sustaining injuries following falling from surfaces and sustaining injuries.

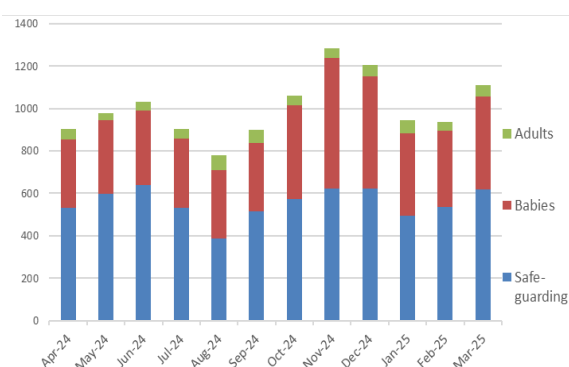


Figure 3: Safeguarding Liaison Service year attendance

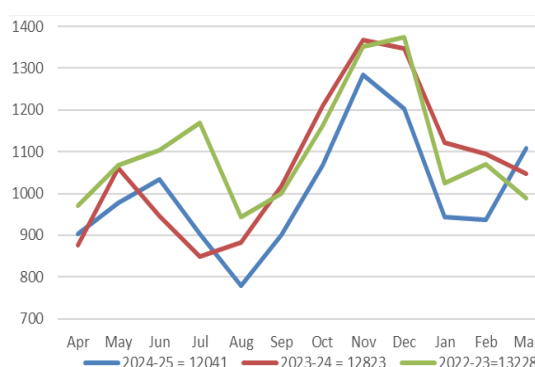


Figure 4: Safeguarding Liaison Service over 3 years

- 4.7. The Thames Valley Hospital Navigator project, relaunched in July 2024 with Home Office funding and Oxfordshire Youth charity support, worked with

Thames Valley Police VRU to mentor young people attending hospital due to violence or crime. The project ended in March 2025 when Home Office funding ceased, and the Trust could not continue its support. An evaluation of the scheme was completed.

5. Maternity

- 5.1. Maternity safeguarding activity increased by 26.2% to 4,601 in 2024/25 compared to 3,646 in 2023/24 (Figure 5). Since 2020/21, this represents a 334% overall increase in safeguarding activity.
- 5.2. Themes involve complex cases related to substance misuse, mental health, and domestic abuse.
- 5.3. Discharge delays have significantly reduced from 65 days in 2023/24 to 15 days this year, largely due to improved coordination of pre-birth planning with multi-agency partners and ensuring discharge plans are established before delivery. The proactive, multi-agency approach led by the maternity safeguarding team has been instrumental in minimising delays caused by social or safeguarding issues, allowing for safe discharge as soon as clinically appropriate. However, some delays persist when a maternity safeguarding team member is not on site, particularly outside the Monday to Friday working schedule.

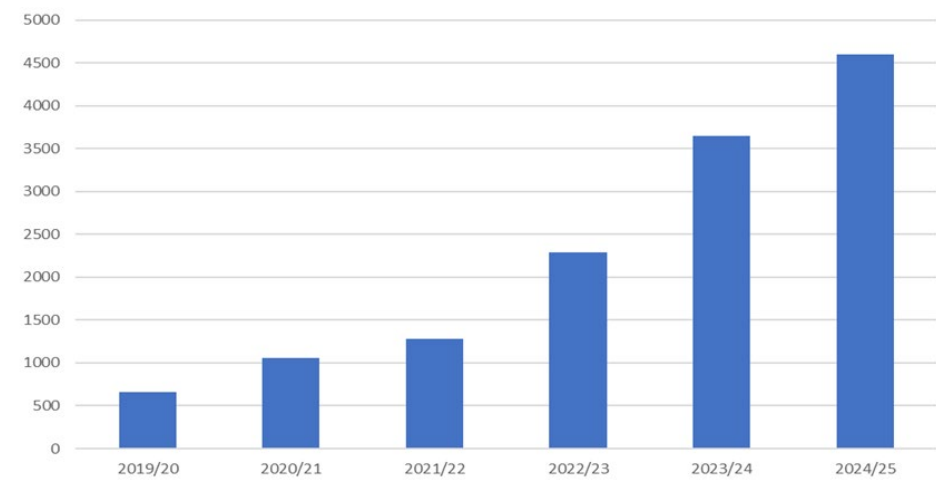


Figure 5: Maternity Safeguarding Activity over Six Years

- 5.4. There were 198 unborn babies involved with Children’s Social Care, and following birth, 15 Interim Care Orders were granted by the court to facilitate the separation of mother and baby. Additionally, three babies were placed under police protection at or shortly after birth due to meeting the threshold for immediate significant harm. Thames Valley Police provided positive feedback on the maternity safeguarding team’s calm, organised, and efficient handling of the police protection orders. Despite the challenging and distressing nature of these situations, minimal disruption to staff and other inpatients was achieved in all cases.
- 5.5. The Royal Courts of Justice commended the team’s clear, well-prepared, and patient-focused multidisciplinary approach in a complex maternity case

involving significant mental health concerns. Effective collaboration among OUH maternity, the legal team, and partner agencies highlighted the advantages of integrated working and the value of specialist midwives for mental health, substance misuse, and safeguarding when managing sensitive, legally complex cases.

- 5.6. Housing issues and homelessness at birth have prompted collaboration with the local authority homeless team to identify pregnant women at risk of being homeless. This often involves multi-occupancy housing that excludes infants, as well as women without access to public funds who are homeless at admission.
- 5.7. The Maternity Safeguarding and Mental Health team completed a quality improvement project by launching a Padlet platform for maternity staff and service users. This resource provides geographically organised information on available services, including housing, domestic abuse support, food banks, baby banks, mental health services, and NHS resources, along with details on how to contact or refer to them. The Padlet has been well received by both staff and service users and is regularly updated with new information on a weekly basis.
- 5.8. The 12-month pilot of a Hospital Independent Domestic Violence Advisor (HIDVA) in the OUH maternity safeguarding team proved highly successful, securing continued funding from Oxfordshire County Council. The HIDVA offers specialist support to domestic abuse victim-survivors during hospital stays and appointments, improving safety, engagement, and discharge planning. The role will now expand to all four hospital sites, ensuring ongoing support as individuals return to the community and strengthening safeguarding across maternity and acute care.
- 5.9. Confidential safeguarding information was inadvertently made available to patients on the national maternity BadgerNet system due to documents being placed incorrectly. Ninety-two breaches were identified. The safeguarding team acted promptly to secure those affected, remove the data, and implement permanent changes. The incident was escalated to NHS England for review.

6. Adult

- 6.1. The main themes for adult safeguarding related to neglect, self-neglect and domestic abuse (Figure 6).

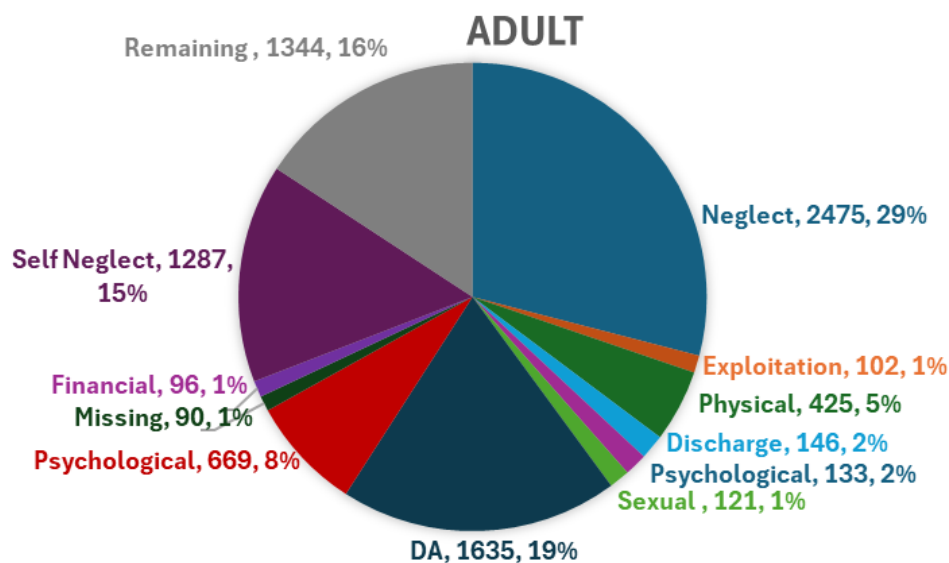


Figure 6: Adult Safeguarding Themes

- 6.2. The Trust received ten Section 42 (Care Act 2014) investigation requests over the year where there were safeguarding concerns about Trust services. There were six related to concerns around discharge process, two for medication concerns on discharge and two related to pressure damage. Learning was provided for two cases. There were four s42 cases scoped and returned as not applicable for investigation by the Trust.
- 6.3. The safeguarding team are part of the Trust discharge assurance programme to improve processes and experiences of patients around discharge. Learning from s42 investigations was shared and disseminated at Divisional Clinical Governance meetings and Patient Safety and Effectiveness Committee (PSEC).
- 6.4. Domestic abuse, neglect, and self-neglect continue to be the main themes of activity over the year. An increase in domestic abuse in the elderly has been noted. There continues to be high numbers of complex cases requiring ongoing safeguarding involvement and includes difficulties with discharge.
- 6.5. The team attend Harm Free meetings when incidents are reviewed, and mental capacity continues to be a focus to ensure learning is embedded when reviewing cases.

7. Deprivation of Liberty Safeguarding (DoLS)

- 7.1. The adult safeguarding team manages the DoLS process for the Trust. Each application is reviewed for accuracy then sent to relevant Local Authority (LA) and notification are sent to the Care Quality Commission (CQC). The review process, prior to submission ensures:
- A documented relevant mental capacity assessment
 - Accurate, appropriate, and comprehensive DoLS application

- The appropriate use of Sections 5 and 6 of the Mental Capacity Act

7.2. There were 1,627 DoLS applications this year, up 415 from last year (Figure 7), with most requests coming from the MRC division (Figure 8). Nine escalation requests for urgent DoLS authorisation were submitted to the LA during the year for complex cases. The adult safeguarding team training to support clinical areas in the competition of mental capacity assessments and DoLS applications and the implementation of the Enhanced Care and Close Observation (ECCO) Policy has resulted in the increase in applications.

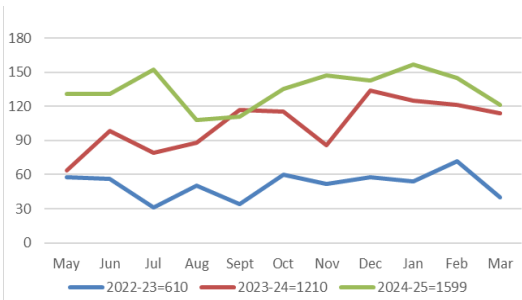


Figure 7: DoLS Applications over 3 years

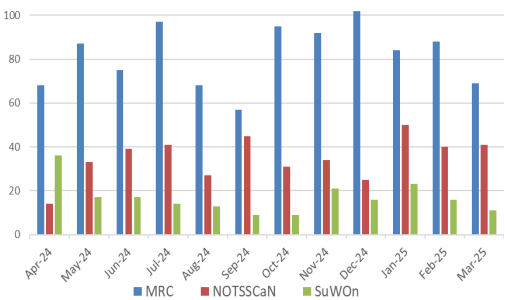


Figure 8: Divisional DOLS Applications 2024/25

7.3. A DoLS audit was completed on 23 wards, involving 513 patients. This identified 146 patients were known to have an impairment of brain (28%) with 111 patients lacking capacity to consent to care and treatment. There were 36 patients on enhanced observation. The audit identified that a third of our adult inpatients have an impairment of mind and brain, 40% did not have documented capacity assessments and 54% did not have a DoLS in place. Audit findings have been disseminated to the PSEC, Divisional Clinical Governance Committees, Safeguarding Steering Group and presented at the Safety, Learning & Improvement Conversation. Divisions have put in plans to improve these results with additional training from the practice development nurses and the adult safeguarding team and a re-audit is planned for November 2025.

8. Partnership working to improve outcomes for children and adults

8.1. The Head of Safeguarding represents the Chief Nursing Officer on the Adult Safeguarding Board (OSAB) and the newly formed Oxfordshire Children Safeguarding Partnership (OSCP). The OSCP have restructured the partnership and subgroups. The Trust is represented at the below partnership groups (Table 2).

OSCP	OSAB
Executive Group	Business Group
Business Delivery Group	Safeguarding Adults Review (SAR) (inc. Homeless Mortality Reviews (HMR))
Child Safeguarding Practice Review (CSPR)	Performance Information and Quality Assurance (PIQA)

Performance Audit and Quality Assurance (PAQA)	Learning, Development and Training
Children Learning Development, Training and Procedure subgroup	Policy, Procedure & Practice Subgroup
Twice Yearly Summits and Practitioners Forums	Engagement Group
Children	Adult
Child Death Overview Panel (CDOP)	Mental Capacity Forum
Health Advisory Group	Prevent Board
Domestic Abuse Strategic Board	
Multi-Agency Risk Assessment Conferences (MARAC) (3 x per month North, City, South)	
Multi-Agency Task and Coordination (MATAC) group (3 x per month North, City, South)	

Table 2: Multi-agency Partnership Groups

- 8.2. The safeguarding team are part of the Multi-Agency Safeguarding Hub (MASH) team that jointly manage the health information sharing process alongside Oxford Health (OH) safeguarding team to identify any known risks. The MASH activity has increased leading to backlogs in providing health information. OUH and OH have where possible increased resource and reviewed ways of working to ensure information is shared in a timely way.
- 8.3. Information requests for Initial Child Protection Case Conference (ICPCC) under section 47 of the Children Act (1989) increased by (n=347) over the year. This involved sharing information for 647 children and 57 unborn babies. All records of Oxfordshire children on a plan or who are in the care of the LA are flagged on EPR and information recorded on all children's EPR records by the liaison team.
- 8.4. The team attended most of the three-monthly Multi-Agency Risk Assessment Conferences (MARAC) to share relevant information in high-risk domestic abuse cases involving adults and children. The team were unable to attend some meetings due to capacity issues, so relevant information was shared ahead of the meeting. Documentation of risk is entered on EPR to inform clinical staff involved with patients of when they attend the Trust. The team attended most of the three county Multi-Agency Task and Coordination (MATAC) group to share information involving perpetrators of domestic abuse.
- 8.5. The Head of Safeguarding is the Trust Prevent lead and attends the Prevent Board. There were 18 requests from the Oxfordshire Channel panel to share relevant information to inform risk assessments, this is an increase of four this year.

9. Designated Safeguarding Officer (HR)

- 9.1. The HR Designated Safeguarding Officer (DSO) works closely with the safeguarding team with allegations and liaising with the Local Authority

Designated officer (LADO) to manage risks and ensure support for staff and managers is in place.

- 9.2. The Sexual Safety at Work Charter and The Worker Protection (Amendment of the Equality Act 2010) Act 2023, have become embedded in the Managing Allegations against Staff and Persons in a Position of Trust, Respected and Dignity at Work, Disciplinary Procedure policy and the Freedom to Speak Up practices. Training for all staff on Understanding Sexual Misconduct in the Workplace was implemented in February 2025.
- 9.3. From April 2024 to March 2025 the DSOs were involved in 76 safeguarding cases involving members of OUHFT staff, including our third-party contractors and NHSP staff members.
- 9.4. There were 18 cases that required Local Authority Designated Officer (LADO) discussion or involvement.

10. Case Reviews

- 10.1. There have been two serious incident notifications submitted to the National Panel by the OSCP Child Safeguarding Practice Reviews (CSPR) with one leading to a CSPR following the death of a child. The OUH participated in the review. A summary will be published on the OSCP site and learning will be shared.
- 10.2. The team have participated in eight Safeguarding Adult Reviews (SARS) of which four have concluded. There were no specific learning or actions for the OUH.
- 10.3. Responses have been provided for nine Homeless Mortality Reviews (HMR), there were no specific learning points or actions for the OUH.
- 10.4. The team have participated in two new Domestic Abuse Related Death Reviews (DARDR) (this was previously called Domestic Homicide Reviews (DHR). There are currently ten reviews ongoing in Oxfordshire.

11. Training

- 11.1. The adult and the children safeguarding training complies with the Intercollegiate guidance^{1 2}. Online safeguarding training is provided by e-Learning for Health (e-LFH) from Health Education England³. Bespoke training continues to be provided where possible.

Safeguarding Level	KPI	Compliance % March 2024
Adults Level 1	90%	91% 
Adults Level 2	90%	92% 
Adults Level 3	90%	87% 

¹ <https://www.rcn.org.uk/professional-development/publications/pub-007069>

² <https://www.rcn.org.uk/professional-development/publications/pub-007366>

³ <https://www.e-lfh.org.uk/>

Children Level 1	90%	92%	~
Children Level 2	90%	89%	↓
Children Level 3	90%	88%	↓
Prevent Level 1&2	85%	92%	↑
Prevent Level 3,4&5	85%	94%	↑
Mental Capacity Act	85%	87%	↑
Identifying Victims of Mod. Slavery	85%	87%	↑

Table 3: Trust Safeguarding Training Compliance

- 11.2. Online training is provided by the e-LFH platform for level 1 and 2 safeguarding adult and children training. Children level 3 training is available also as an e-LFH course or face to face Trust training. Trust produced e-learning for level Adult Level 3 safeguarding training, this is being reviewed. Compliance improves over the year following the appraisal window and at time of writing this report all areas are at or above the KPI. Table 3 shows levels of compliance.
- 11.3. Prevent radicalisation online training is provided by the UK Home Office and is above the ICB contracted KPI at 92% for awareness training and 94% for the basic level of compliance at end of year (Table 3).
- 11.4. Mental capacity training is via e-LFH and additional bespoke training for teams is delivered as requested. Trust compliance was at 87%.

12. Key achievements

- 12.1. The increase in the number of DoLS applications has been maintained following the 100% increase the previous year.
- 12.2. Close working with the LA to review DoLS to escalate cases needing authorisation due to difficult behaviours in patients.
- 12.3. Successful implementation of the Ulysses Safeguarding IT module to record cases and added activity to show the level of activity for many cases. This module records all the DoLS application data directly to enable visibility for wards.
- 12.4. Overall compliance of Trust wide safeguarding training.
- 12.5. The implementation of the HIDVA role was positively evaluated which led to further funding for a year. This role supports victims of domestic abuse that come into the Trust.
- 12.6. The team have effectively provided safeguarding advice to protect vulnerable adults and children despite the increase in activity to support staff across the Trust.
- 12.7. Multiagency partnership working to evidence safeguarding.
- 12.8. Active participation at OSCB and OSAB board and subgroup meetings.

- 12.9. Evidence of safeguarding being embedded across divisions and is demonstrated in the activity.

13. Key challenges

- 13.1. Improve the documentation of mental capacity assessments and completion of DoLS for all patients on ECCO.
- 13.2. The need for all patients admitted to hospital with care and support needs that do not have mental capacity have DoLS applications submitted
- 13.3. Complexity of cases and discharge planning across all safeguarding areas continues to be a challenge. This has related to homelessness, issues with care packages to discharge both adults and children and families declining to take the adults or child home.
- 13.4. Activity has increased slightly to 1,083 cases a month which has led to 2,030 episodes of activity a month. This is the first year activity for cases has been recorded using the new Ulysses safeguarding system.
- 13.5. There continues to be an increase in multi-agency safeguarding reviews and requests for information to be shared.
- 13.6. The MASH activity has increased and led to back logs in health information being shared. The health desk is a shared function with Oxford Health safeguarding team and the OUH has been requested to increase OUH resource to mirror the Oxford Health increase in support the MASH. However, with increased financial pressures on the Trust this has not been possible.

14. Conclusion

- 14.1. The Safeguarding Team continues to develop across the OUH and partner agencies to meet the requirements set out in section 11 of the Children Act 2004 and the Care Act 2014.
- 14.2. Significant multiagency joint working has demonstrated the Trust's commitment to work together to improve the identification of concerns, and to protect children and vulnerable adults within the Trust.
- 14.3. The work across the Trust and partnerships would not be possible without the commitment of our front-line staff and the safeguarding team who have the professional curiosity and commitment to safeguarding our patients. I would like to thank all of them for their professionalism, dedication, and continued support to safeguarding our patients across the Trust.

15. Recommendations

- 15.1. The Trust Board is asked to:
- Note and approve the content of this report.