Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board: Wednesday 08 November 2023

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Title:	**OUH FT Safeguarding (Children and Adults) Report 2022-2023**

Status:	**For Information**
History:	**This Safeguarding Children and Adults Annual Report was presented at the Trust Management Executive 28th September 2023**

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

Executive Summary

1. This annual report provides an overview of activity, progress, and multi-agency participation in relation to Safeguarding of Children and Adults during 2022/23.
2. The Chief Nurse has executive leadership for the OUH and is represented by the Head of Safeguarding on the Oxfordshire Children and Safeguarding Board (OSCB) Oxfordshire Adult Safeguarding Board (OSAB).
3. Safeguarding children and maternity consultations increased by 50%, to 5,869 consultations, an average of 489 per month. Neglect, emotional and domestic abuse continue to be the main theme of activity. Children presenting with self-harm reduced by 8% however the complexity of mental health and eating disorder presentations continues related to delays in discharge. Themes are monitored and shared with partner agencies. The partnership working with the LA and CAMHS had reduced discharge delays and the impact on children. The Safeguarding Liaison Service Emergency department information shares increased by 2606 (n=3566) and increase of 50%. Requests for Initial Child Protection Case Conference information to support decision making was provided for 404 conferences, (↑47) for 764 children (↑73) and 64 unborn babies (↑9).
4. In maternity the pregnancy bookings decreased by 1.3% (n=8,521) this year although, 26.3% (n=2,238) of all bookings were identified as either category 3 or 4 public health risk. Safeguarding activity in pregnancy increased by 79% (n=2,289) related mainly to maternal mental health, drug and alcohol misuse, domestic abuse and this year homelessness has been a recurring theme and leads to delays in discharge. Maternity have recognised the increase in activity and have supported the team with additional resource. There continues to be significant multi agency working to ensure risks and safety plans are in place.
5. Safeguarding Adult consultations increased 34% (n=3,985) an increase of 1,921 which is an average of 332 per month. Themes related to neglect, self-neglect, and domestic abuse. The number of Ulysses requests for a safeguarding review increased by 12% (n=1155). There were 11 Section 42 enquiries and 8 have been closed with two being partially substantiated, four inconclusive and one unsubstantiated. OCC have moved away from these categories and moved to learning points. There was one case with learning points related to discharge and communication. Themes related to neglect and discharge issues. There were 610 DoLS applications made during the year, an increase of 187 applications made.
6. Training compliance[1]

Adult Level 1 = 92%	Children Level 1 = 92%	Prevent Level 1&2 = 91%
Adult Level 2 = 92%	Children Level 2 = 91%	Prevent Level 3,4&5 = 91%
	Children Level 3 = 83%	Mental Capacity = 76%

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

7. Partnership Working continues to be strong across the system with participation at multi-agency meetings, working in the MASH for the children’s team, involvement in OSAB & OSCB subgroups, participating in audits and good systems in place to share relevant information of risks to protect children and adults.
8. **Key achievements** continue to be the increase of activity and complexity of cases. The team have had challenges to manage the increasing activity and complexity alongside staff vacancies and sickness, this especially relates to administration roles. There has been good Interagency partnership working and involvement with the OSCB and OSAB and subgroups. The OUH achieved the full level of compliance in annual OSCB/OSAB self-assessment and peer. Increase of DoLS applications and support to clinical team to ensure the mental capacity assessments undertaken and documented.
9. **Key challenges** increased activity and complexity across all areas of safeguarding most significantly in maternity. The number of complex adolescent children presentations and delays in discharge. Resourcing for the MASH. Timely mental capacity assessments and documentation. Retention and recruitment of staff and specifically administrators.

Recommendations

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

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OUH FT Safeguarding (Children and Adults) Report 2022-2023

1. Definitions

1.1. Safeguarding children

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

1.2. Safeguarding adults

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

2. Purpose

2.1. This paper presents the annual report for safeguarding children and adults for t April 2022 to March 2023 in line with 'Working Together to Safeguard Children' 2018, the Children Act 2004 and the Care Act 2014.

2.2. This report sets out the requirement for Trust Boards to produce an annual report with an analysis of the effectiveness of local safeguarding arrangements. The Trust Board received the last annual safeguarding report on the 8th of September 2021.

3. Background

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

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

4. Safeguarding System Data

Children and Maternity Activity

4.1. Safeguarding activity is divided into 3 main areas:

- Consultation activity
- Safeguarding Liaison
- Self-Harm presentations

4.2. There were 560 children at the end of March 2023 with a Child Protection Plan (CPP) in Oxfordshire, a reduction of 16 from 2021/22. The predominant category continues to be neglect, this reflects the OUH data. There has been a focus in the OUH to recognise neglect and staff are directed to OSCB assessment toolkits on training. The OUH is represented on the OSCB Neglect Strategy Subgroup at to advise and champion work to deliver changes in families and communities. Oxfordshire children are flagged on the Electronic Patient Records (EPR) when there is a child protection plan to ensure information is shared to inform clinical staff assessments.

4.3. There were 404 family requests for information from the OUH to inform Initial Child Protection Case Conferences (ICPCC), an increase of 47 that involved 764 children, an increase of 73, and 64 unborn babies and increase of 9. The OUH have participated and shared information for initial child protection case conferences over the year. The number of Oxfordshire children that were 'Children We Care For' (CWCF)[2] increased by 44 to 869.

4.4. Safeguarding children and maternity activity saw a 50% increase over the year (Figure 1). There were 5,869 contacts, an increase of 1,970 (average of 489 per month). The themes continue to be related to neglect, emotional abuse, domestic abuse.

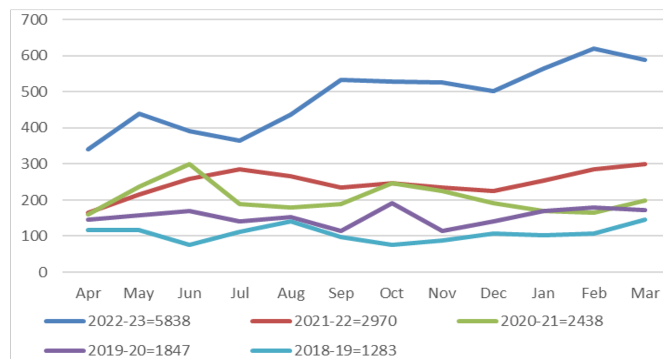

Figure 1:Children and Maternity Consultations Activity 2019-2022

4.5. The safeguarding liaison service share information with primary care and children social care for open cases when children present to the Emergency Department (ED) in relation to set criteria. The three areas are children safeguarding presentations, babies under 1-year due to vulnerability of age, and parent or carer attendances to ED where their presentation raises a

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

safeguarding concern and potential risk to a child (Figure 2). There was an increase of 2606 attendances (n=13228) over the year which is a 25% rise (Figure 3).

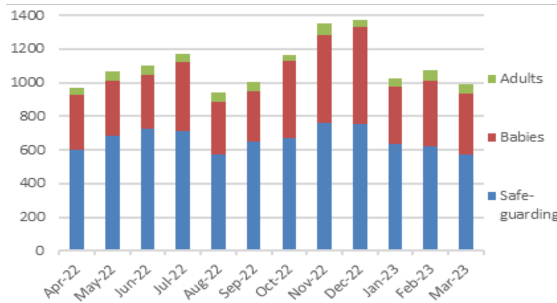

Figure 2: Safeguarding Liaison Service year attendance

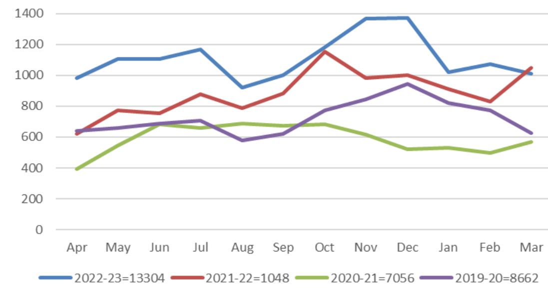

Figure 3: Safeguarding Liaison Service over 4 years

4.6. Adolescent complex mental health and eating disorders have continued to require significant liaison and planning. Attendances to ED's have decreased by 8% however, 21/22 had an unprecedented increase of 56% from the previous year (Figure 4). Admissions for self-harm stabilised although again were 44% higher than 20/21 and an increase of 60% since 2018/19. The number of younger children attending ED's with mental health concerns increased and there is added complexity in managing these cases (Figure 5). Attendances continue to be analysed monthly and shared with primary care, CAMHS, school health nursing service, children social care and education. The three county self-harm forums have discontinued, however, the OUH share themes and escalate any concerns patterns to ensure support is in place for families, schools, and professionals. Despite the decrease in attendances last year the complexity of cases increased, often requiring escalation. The partnership working with the LA and CAMHS had reduced discharge delays and the impact on children. There is continued liaison with other agencies and disciplines to ensure robust plans are put in place to support the young person, family, and professionals working with them.

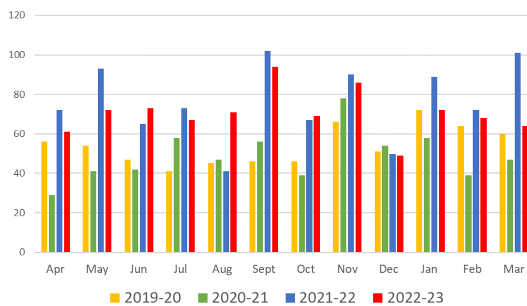

Figure 4: ED attendances over 4 years

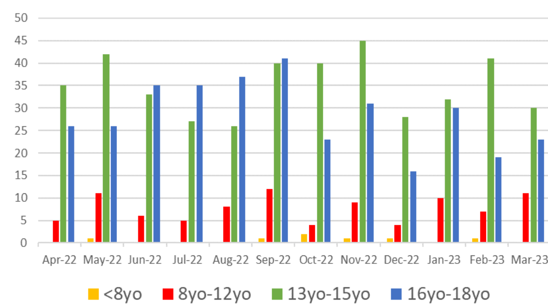

Figure 5: OUH ED attendances with DSH, OD and MH

4.7. The Home Office funded Hospital Navigator project commenced in the JR ED during 2021 managed by Connections Support working with the ED Community Safety Practitioners. The aim of the Thames Valley ED project in is to support the police Violence Reduction Unit (VRU) working with children

and young adults attending hospital with injury from violent or criminal activity to reduce reattendances and support. The project in the OUH has remained problematic and is currently awaiting a new provider to manage. Oxford Brookes university are undertaking an evaluation of the project across all sites.

Maternity Activity

4.8. Maternity pregnancy bookings decreased by 1.3% (n=8,521) this year, there were 26.3% (n=2,238) of all bookings that were identified as either category 3 or 4 public health risk[3], an increase of 1%. Safeguarding activity in pregnancy increased by 79% (n=2289) (Figure 6) Themes related to maternal mental health, drug and alcohol misuse, domestic abuse and this year homelessness has been a recurring theme and leads to delays in discharge. Maternity have recognised the increase in activity and have supported the team with additional resource.

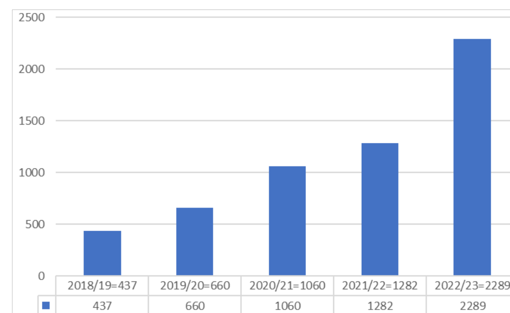

Figure 6: Maternity Safeguarding Activity

4.9. The number of safeguarding cases at booking increased by 37% (n=965) (Figure 7). There were 197 unborn babies with LA involvement and 18 interim care orders obtained by the courts.

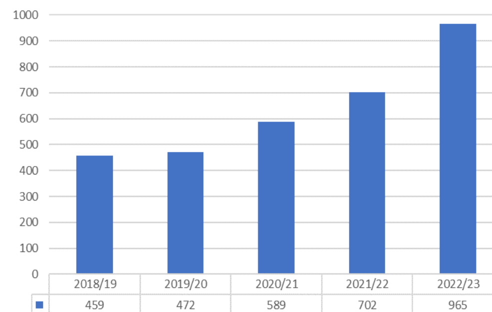

Figure 7: Safeguarding identified at booking

4.10. The team monitor any delay in discharge awaiting social care placements for mothers and/or babies following either care orders or section 20 (Children Act 1989), voluntary agreement for care. Delays in discharge beyond clinical need were low, 6 days over the year for 3 cases. This is a reduction of 14 from

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

2021/22. Preplanning is in place by the team to ensure plans are in place to reduce delays for court attendance coupled with joint requests from OUH and the LA to the court for virtual hearings.

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

Safeguarding Adult Activity

4.12. Safeguarding activity is divided into four main areas:

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

4.13. Oxfordshire County Council (OCC) had 6,770 safeguarding concerns raised over the year, an increase of 14% with 1,921 that went on to be safeguarding enquiries which is an increase of 11%.

4.14. There have been 3,985 safeguarding adult consultations, an increase of 1,015 which is a 34% higher than 2021-22 (see Figure 8). This is an average of 332 per month. Figure 9. shows the source of combined activity to include EPR referrals and Ulysses reports. The number of Ulysses request for a safeguarding review increased by 12% (n=1155). This is in addition to safeguarding participation in the harm free meeting for HAPUs and falls in hospital, this is now across all the divisions and is highlighting the importance of assessing mental capacity for consent to care and treatment and vigilance in ensuring there have been no safeguarding concerns during the episode of care.

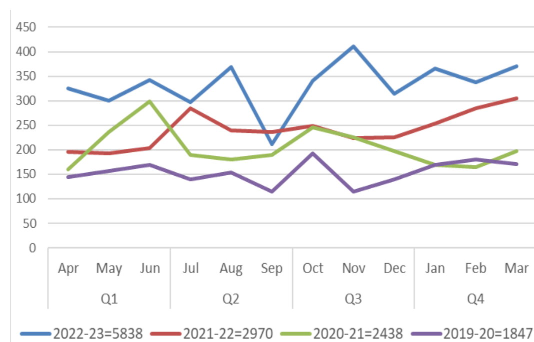

Figure 8: Adult Safeguarding Consultations

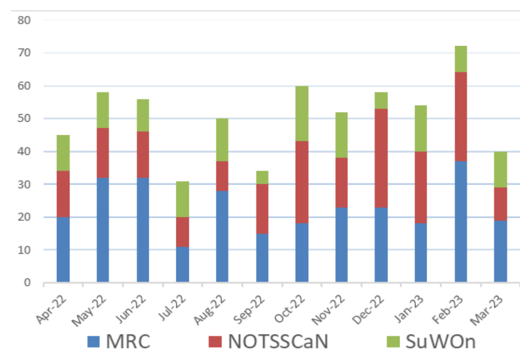

Figure 9: Adult Combined Activity 2022-23

4.15. The main consultation themes related to issues of domestic abuse, neglect, and self-neglect. The team support clinical teams when there are complex discharge cases where there are safeguarding concerns and with best interest

decision making. A best interest template and checklist have been developed for guidance to support clinical staff.

4.16.The Trust received 11 Section 42 investigations over the year that related to neglect and discharge issues. There are three reviews remain open awaiting closure notices. There were two reviews found to be partially substantiated, four were inconclusive, and one unsubstantiated (Figure 10). The OCC changed their closure notice process during the year and moved away from giving a category and now provide learning points which aligns with the Patient Safety Incident Response Framework (PSIRF). One case had learning points related to discharge and information sharing. The teamwork with OCC to scope potential s42 enquiries to ensure appropriate enquires are issued to the OUH.

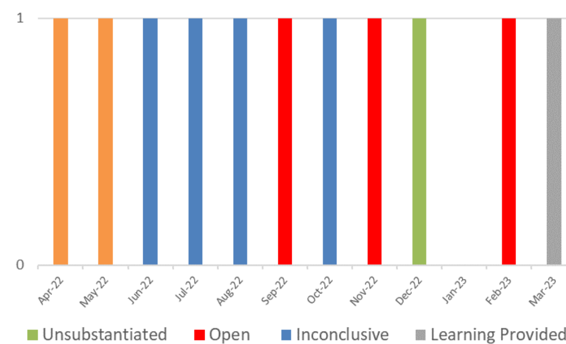

Figure 10: Sc.42 investigation outcome

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

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

4.18.There were 610 DoLS applications made during the year, an increase of 187 from the previous year (Figure 11). Figure. 12 shows the DoLS applications per division varied over the year. MRC division submit the majority of DoLS applications. There has been a focus this year on mental capacity training to support clinical areas in ensuring assessment are undertaken and capacity is documented and support the applications process.

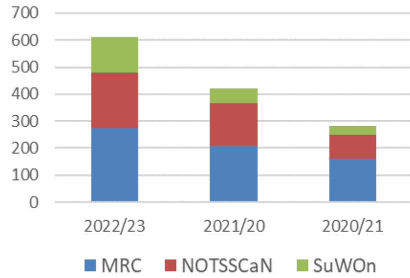

Figure 11: DoLS Applications over 3 years

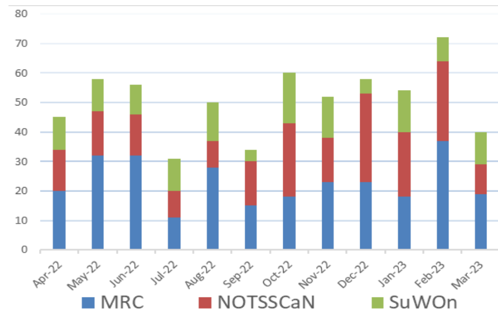

Figure 12: DOLS Applications 2022/23

5. Partnership working to improve outcomes for children and adults.

5.1. The Head of Safeguarding represents the Chief Nursing Officer on both Oxfordshire Children and Adult Safeguarding Boards. The safeguarding team are members of 13 sub-groups for the OSCB and OSAB (see Table 1). The Chair of the training Subgroup is the Operational Children Manager and is shared with Oxford Health Adult Safeguarding Manager.

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

Table 1: Membership of OSCB/OSAB sub-groups

5.2. The OUH and Oxford Health safeguarding team share the health function in the Multi-Agency Safeguarding Hub (MASH) two days a week. Contact into the MASH increased again this year by a further 18% (n=2,8262). Delays in providing health information due to the increased activity continued during part of the year. The OUH team provided additional resource, when possible, but this has been limited due to capacity issues. Oxford Health have resourced additional staff to the MASH to manage risk. OCC have increased staffing into the MASH to manage the demand.

5.3. Information requests from the LA to inform decision making for Initial Child Protection Case Conference (ICPCC) under section 47 of the Children Act (1989) increased by 47 (n=404). This involved sharing information for 764 children and 64 unborn babies. Information is added to all children's EPR records.

5.4. The Trust attends multiagency meetings: Oxfordshire Community Safety Partnerships, Prevent Strategic Board, Oxfordshire Domestic Abuse Strategic Group, Serious Concerns group and the multiagency Partnerships in Practice group.

5.5. The safeguarding team attended the three-area monthly Multi-Agency Risk Assessment Conferences (MARAC) to share relevant information in high risk domestic abuse cases. Information is recorded on the electronic patient record to inform practitioners involved with patients of when they attend the Trust. The team also attended all of the 3 county Multi-Agency Task and Coordination (MATAC) group to share information and support perpetrators of domestic abuse to reduce risk.

5.6. The implementation of Liberty Protection Safeguards (LPS) has been delayed and will not be implemented during this government, therefore the ICB readiness group ceased to meet.

5.7. The Head of Safeguarding is the Trust Prevent lead and attended the Prevent Board. There have been 9 requests from the Oxfordshire Channel panel to share relevant information to inform risk assessments.

5.8. The safeguarding team have completed scoping for 22 Homeless Mortality Review (HMR) reviews an increase of 50%. We have participated in the rapid review process as part of the OSAB subgroup, which takes learning from the cases to improve practice and multi-disciplinary working.

6. Designated Safeguarding Officer

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

6.2. From April 2022 to March 2021 the DSO's were involved in 69 safeguarding cases involving members of OUHFT staff, including our third-party contractors and NHSP staff members.

6.3. Since April 2022 there has been a significant increase in the complexity of safeguarding cases involving staff members involving the DSO's. Of the 69 cases open in 22/23; 20 of these required Local Authority Designated Officer (LADO) discussion or involvement as they involved harm, or potential harm to children.

7. Case Reviews

7.1. Child Safeguarding Practice Reviews (CSPR) are commissioned by the OSCB when a child or young person dies or experiences serious harm or injuries and there is interagency learning. There were two reviews commissioned over the year. Learning has been discriminated through learning events, learning summaries and lessons are included on safeguarding training.

7.2. Child A related to self-harming, at risk of suicide and accommodated in residential placements out of county.

7.3. Child G related to adolescent sexual exploitation. A learning event took place to inform on trauma informed practice following this review.

7.4. There were 7 child rapid reviews undertaken, two related to non-mobile babies, one died. The other 5 were for children aged between 10-16. Themes of the reviews related to intrafamilial sexual abuse, chronic neglect, parenting capacity, homelessness, non-accidental injuries in a small baby, elective home education and domestic abuse.

7.5. Safeguarding adults team scoped for 12 Serious Case Reviews (SARS) in the last year and taken part in the SAR sub-group and been part of the multi-agency discussions as to which cases should be taken for consideration as a full SAR. The learning from these meetings is a valuable way to explore how changes can be achieved across agencies.

8. Training

8.1. The Key Performance Indicator (KPI) for safeguarding training is locally agreed by the Berkshire, Oxfordshire, Buckinghamshire Integrated Care Board. This is set at 90%. The nationally agreed KPI for Prevent Level 3 training is 85%.

8.2. The Adult and the Children Safeguarding Training comply with the Intercollegiate guidance[4] [5]. Online safeguarding training is provided by e-Learning for Health (Health Education England)[6]. Prevent radicalisation online training is provided by the UK Home Office.

Safeguarding Level	KPI	Compliance % March 2022
Adults Level 1	90%	90%
Adults Level 2	90%	89%
Children Level	90%	92%
Children Level 2	90%	86%

[4] https://www.rcn.org.uk/professional-development/publications/pub-007069
[5] https://www.rcn.org.uk/professional-development/publications/pub-007366
[6] https://www.e-lfh.org.uk/

Children Level 3	90%	70%
Prevent Level 1&2	85%	85%
Prevent Level 3,4 &5	85%	90%

Table 2: Trust Safeguarding Training Compliance

8.3. Online training remains the main mode of delivery for Level 1 and 2 safeguarding adult and children training. Level 3 face to face children safeguarding training is delivered either face to face or via Microsoft Teams and both are well evaluated. The implementation of level 3 safeguarding adult training has been delayed; however, the level 2 adult safeguarding training includes additional modules to provide a higher level of training. Bespoke mental capacity training to support teams and provide at the elbow' training has been well received and improved the number of DoLS applications.

8.4. There is a plan to achieve and maintain compliance in all levels of safeguarding and radicalisation training in both adult and children safeguarding.

9. Audit

9.1. The Trust was compliant in all areas of the annual OSCB/OSAB self-assessment to meet the requirements set out in Section 11 of the Children Act 1989 and the Care Act 2014. This was reviewed at the OSCB/OSAB partner agency peer review to evidence compliance and agreement of the assessment was afforded.

9.2. A NICE CG110 repeat maternity audit of complex social factors in pregnancy. The original audit was requested by the Oxfordshire Clinical Commissioning Group and OUH to understand the relationship between antenatal care and the primary social factors concentrating on specific vulnerabilities related to substance misuse, language difficulties for migrant/refugee women, under 20 age group and women who experience domestic abuse. The audit evidenced an improvement in most areas. An action plan is in place to ensure the recommendations from the audit are monitored.

9.3. A multi agency deep dive into difficulties in discharging children with complex presentations to understand reasons for delays in discharge from the OUH. This related complexity to return children to placements due unavailability of their 4 in-patient mental health beds or appropriate residential or foster care placements. Th impact of trauma was identified pre and post admission and positives were that the voice of the child strongly came through. Training needs for staff were identified to manage complex behaviours and neuro diverse presentations. There were many findings with 13 recommendations, of which many have been completed and continue to be reviewed.

9.4. A DoLS Audit reviewing DoLS over the previous financial year led to a focus week on Complex Medical Unit is (CMU) ward areas to support applications made for DoLS which led to an increase. This led to improved knowledge on mental capacity assessment and when to apply for a DoLS authorisation to protect vulnerable patients. There has been a continued focus on mental capacity and DoLS in this area which has been supported by the area Matron. was undertaken to review CMU. There is a focus on new staff to ensure support and training in place.

10. Key Challenges

10.1. This year saw again an increase in activity and cases across the Trust and all sites in both children and adult safeguarding. There is recognition nationally and locally that safeguarding, and complexity is increasing. Maternity safeguarding activity has seen a significant increase in activity.

10.2. Recourse for the MASH to process health information to inform risk to meet the increased activity.

10.3. Ongoing complexity of safeguarding cases related to mental health, drug and alcohol, perplexing presentations, domestic abuse and neglect and self-neglect.

10.4. Timely mental capacity assessment and documentation.

10.5. The length of time to assess and authorise DoLS applications.

10.6. The implementation of Level 3 adult safeguarding.

10.7. The issues related to the Hospital Navigator programme.

10.8. Safeguarding is a demanding role and retention and recruitment challenges.

10.9. Increased legal activity and court reports request.

11. Key Achievements

11.1. Increased effective safeguarding advice to protect vulnerable adults and children and support to staff as demonstrated by activity.

11.2. Multiagency partnership working to safeguard children and adults.

11.3. Active participation at OSCB and OSAB board and subgroup meetings

11.4. Increase in DoLS and mental capacity assessments.

11.5. Safeguarding is further embedded across divisions and is demonstrated in the activity.

11.6. Evidence of good practice at the annual OSCB and OSAB self-assessment.

11.7. Effective patient centred collaboration when working alongside multidisciplinary clinical teams to safeguard patients with evidence of the patient voice.

12. Conclusion

12.1. 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.

12.2. 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.

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

13. Recommendations

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

Appendix 1 – Definition of vulnerable adults according to the Care Act 2014.

The Care Act 2014 describes an adult with care and support as:

- an older person
- a person with a physical disability, a learning difficulty, or a sensory impairment
- someone with mental health needs, including dementia or a personality disorder.
- a person with a long-term health condition
- someone who misuses substances or alcohol to the extent that it affects their ability to manage day-to-day living.

People with care and support needs are not inherently vulnerable, but they may come to be at risk of abuse or neglect at any point due to:

- physical or mental ill-health
- becoming disabled
- getting older
- not having support networks
- inappropriate accommodation
- financial circumstances or
- being socially isolated

Section 42: Section 42 Enquiries

A. When a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)
    i. has needs for care and support: (whether or not the authority is meeting any of those needs),
    ii. is experiencing, or is at risk of, abuse or neglect, and
    iii. as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

B. The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by who.

Appendix 2 – Safeguarding Team Structure.