MILTON KEYNES SAFEGUARDING BOARD

Annual Report
2017/18

High Challenge, High Support
Worried about a child?
If you are concerned a child or a young person is at immediate risk of harm please call Thames Valley Police on 999.

If you require advice from Thames Valley Police, or to report a crime, please dial 101.

If the child you are concerned about is not in immediate danger you should report your concern by completing a Multi-Agency Referral Form.

Contacts:
Multi-Agency Safeguarding Hub (MASH)
Monday to Thursday from 9am to 5pm & Friday 9am to 4:30pm
T: 01908 253169 / 253170
In an emergency, outside of these hours
T: 01908 265545
E: children@milton-keynes.gov.uk

Worried about an adult?
If you have a concern about an adult at risk of abuse and they are in immediate danger you should contact the relevant emergency services by ringing 999.

If the adult you are concerned about is not in immediate danger you should report your concern by completing an Adult Safeguarding Alert. If you know or believe a crime has been committed you should also contact the Police. If you are not sure whether abuse is happening you can telephone the Access to Adult Health and Social Care Team to discuss your concerns.

Contacts:
Safeguarding Adults
Monday to Friday from 8:30am to 5:00pm
T: 01908 253772
In an emergency, outside of these hours (incl Bank Holidays)
T: 01908 725005
E: ascat@milton-keynes.gov.uk
Introduction to the 2017/18 annual report

Local Safeguarding Adult and Children Boards are required (under the Care Act 2014 and Section 14A of the Children Act 2004) to publish an annual report on the effectiveness of safeguarding and promoting the welfare of children and adults at risk of abuse and neglect in the local area and identify areas for improvement.

Working Together to Safeguard Children 2015 sets out details of how this report should be provided in relation to children and young people. We are required to provide a rigorous and transparent assessment of the performance and effectiveness of local services, and ensure the report identifies areas of weakness, the causes of those weaknesses and the action being taken to address them.
**Foreword**

**Welcome to our 2017-2018 annual report.**

This year we have made a promising start to our new and very different arrangements for safeguarding the communities of Milton Keynes. I am delighted that despite all the complexities and challenges arising from that transition, front line staff across all our agencies continued to focus on delivering good services to vulnerable children, adults and families, whilst safeguarding those most vulnerable or at risk of harm effectively.

Our improved data and performance systems give us assurance that overall safeguarding practice is reasonably effective, and that there is much that is at times innovative and at times extremely good. Inevitably there is room for improvement, as there always will be, and practitioners and managers are increasingly learning and focussed on improvements.

Over the year we have delivered the majority of the projects and pieces of work we set out to, and in doing so ensured those areas of weakness in our services or emerging areas of concern are not only identified but also addressed.

I am very proud of everyone involved in the work of the board, for everything they have done to ensure we delivered real improvements and made a difference to the lives of many as a result. It has not been easy and at times the burden has rested on fewer shoulders than is ideal, but by the end of the year there is an overall consensus that real, robust and sustained improvement in the leadership of the partnership safeguarding system, strategic focus, and strong, supportive and robust challenge between partners is the result. There is also a much clearer focus on areas for development, such as working with multi-factorial vulnerability and exploitation, as well as managing complexity, and on mental ill-health and homelessness. We know that whilst awareness of adult safeguarding is growing significantly, we receive far too many alerts and need to develop more proportionate responses, and we know financial pressures remain a significant risk for us all.

There is also consensus that the biggest change has been at the Board level, and the impact is still insufficiently strong at programme board or group level. It has made things harder for middle managers and leaders and raised new expectations for some people. There have been some negative changes.

Despite the few areas for improvement this has been a good year. We are stronger and increasingly more effective as a board. I am delighted that as a foundation year, 2017/18 has been so good.

We lost impetus in our work to involve and engage with children and young people and made limited progress with work to engage adults. We have not progressed with the key shifts we need to make in workforce development and standards terms, and we have still not “cracked” the issue of coherent multi-agency partnership working in providing preventative interventions or early help.

*Jane Held*
Independent Chair 2018
What is safeguarding?

Safeguarding means protecting people’s right to live in safety, free from abuse and neglect.

It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the individual’s wellbeing is promoted.

Safeguarding adults

Safeguarding duties apply to an adult who:

- Has care and support needs (whether or not the local authority is meeting any of those needs);
- Is experiencing, or at risk of, abuse or neglect;
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

The aims of adult safeguarding are to:

- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs.
- Stop abuse or neglect wherever possible.
- Safeguard adults in a way that supports them in making choices and having control about how they want to live.
- Promote an approach that concentrates on improving life for the adults concerned.
- Raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect.
- Provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult.
- Address what has caused the abuse or neglect.

Safeguarding children

Safeguarding and promoting the welfare of children is defined as:

- Protecting children from maltreatment;
- Preventing impairment of children’s health or development;
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care;
- Taking action to enable all children to have the best outcomes.
Key principles

Six key principles underpin all adult safeguarding work:

Empowerment – people being supported and encouraged to make their own decisions and informed consent.

Prevention – it is better to take action before harm occurs.

Proportionality – the least intrusive response appropriate to the risk presented.

Protection – support and representation for those in greatest need.

Partnership – local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability – accountability and transparency in delivering safeguarding.

Key principles for effective safeguarding of children:

Safeguarding is everyone’s responsibility – For services to be effective each professional and organisation should play their full part.

A child-centred approach – For services to be effective they should be based on a clear understanding of the needs and views of children.
**Demographics of Milton Keynes**

**261,750**

Estimated population 2015
mkinsight.org/mk-basics

**26%**

from an ethnic minority background
mkinsight.org/mk-basics

**23%**

of the MK population were aged under 16
Milton Keynes continues to have a younger than average population
https://bit.ly/2Pdy6P1

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**What do we know about vulnerable adults in Milton Keynes?**

<table>
<thead>
<tr>
<th>Reason for concern</th>
<th>Total alerts</th>
<th>Gender bias</th>
</tr>
</thead>
<tbody>
<tr>
<td>In cases where action was taken</td>
<td>Safeguarding alerts this year</td>
<td>Abuse against each gender</td>
</tr>
<tr>
<td>34% neglect</td>
<td>15% on last year</td>
<td>65% against women</td>
</tr>
<tr>
<td>25% physical abuse</td>
<td></td>
<td>35% against men</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Where abuse took place</th>
<th>Nationality</th>
</tr>
</thead>
<tbody>
<tr>
<td>22% in the person’s own home</td>
<td>78% from a British background</td>
</tr>
</tbody>
</table>

**Child protection in numbers**

<table>
<thead>
<tr>
<th>Child Protection Plans</th>
<th>Main reason</th>
<th>Age of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of new plans this year</td>
<td>Category for Child Protection Plans</td>
<td>subject to Child Protection Plans</td>
</tr>
<tr>
<td>160</td>
<td>Neglect</td>
<td>42.1% under four years old</td>
</tr>
<tr>
<td>¥ 33 from last year</td>
<td>As it was in previous years</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discontinued plans</th>
<th>Total looked after children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stepped down to Family Support Plans</td>
<td>1 April 2017 - 31 March 2018</td>
</tr>
<tr>
<td>98 (66.2%)</td>
<td>391 (excludes short breaks)</td>
</tr>
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</table>
The Milton Keynes Safeguarding Board is a joint statutory body fulfilling the objectives, functions and responsibilities set out for adults and children’s safeguarding boards in the Care Act 2014, the Children Act 2004, and Working Together 2015.

Following extensive consultation we have created a single Milton Keynes Safeguarding Board (MKSB) to strengthen our multi-agency work, bringing together the three key agencies (health, police and local authority) to support, coordinate and monitor effective multi-agency safeguarding arrangements.

MKSB’s strategic goal is high support and high challenge – to provide a safeguarding lens on the system.

**High support through:**
- Engaging with people
- Support with coordination
- Resolving and unblocking problems
- Learning from good and poor practice

**High challenge through:**
- Assurance
- Scrutiny
- Diagnosis
- Holding to account
- Identifying gaps and blockages
- Reviewing practice

The Board is responsible for supporting the coordination of multi-agency arrangements to protect and safeguard children and adults in Milton Keynes and for monitoring their effectiveness at a multi-agency strategic level and to assure that:

- Local safeguarding arrangements are in place as defined by the Children Act 2004 and the Care Act 2014 and all relevant statutory guidance.
- Safeguarding practice is person-centred and outcome-focused.
- Safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

The Board meets bi-monthly. MKSB is supported by dedicated Children’s and Adult Programme Boards, responsible for the statutory functions specific to children’s and adults safeguarding. The Child Death Overview Panel, which meets quarterly, reports into the Children’s Programme Board. In addition, the board has three all-age groups:

- Reviews and Learning
- Performance, Quality and Improvement
- Workforce Development and Standards
MK Together is the partnership umbrella under which the Safeguarding Board operates. This new set of partnership arrangements was designed to bring together the core ‘people partnerships’ (The NHS, Local Authority and Police) to work as effectively and efficiently as possible.

MK Together is characterised by:

- Simple partnership arrangements that are easily understood
- Flexible arrangements that can adapt to future needs, changes to legislation or emerging local issues
- Streamlined and well co-ordinated planning and action
- Joined up, system-wide partnerships and cross partnership working
- A single support team able to work across partnerships and multiple issues relieving pressure on limited resources
Lifelong Wellbeing -
A new Health and Wellbeing Strategy

OVERARCHING STRATEGIC PRIORITIES

Staying well
– a strong focus on prevention

Closing the gap
– reducing inequalities in life chances

One MK
– an integrated, innovative approach to health and wellbeing
| Holding to account | Established a robust performance analysis structure for the partnership agencies that identified risks and issues for further scrutiny and escalation.  
Refreshed and increased our membership at the Adult Programme Board and Performance, Quality and Improvement Group (PQI) to ensure varied and effective discussion and commitment to the board’s activities across the key partners and stakeholders. |
|---|---|
| Engaging | Engaged with partners to consult on and promote the new MK Together vision.  
We worked with Milton Keynes College to deliver an annual conference, which gave students the opportunity to develop their event management skills. |
| Challenging and changing | We have challenged practice within the secure training centre to support their improvement of safeguarding practice and promote a change of culture within the establishment. |
| Growing and Learning | We facilitated our first joint children’s and adults safeguarding conference that raised awareness of modern slavery, online grooming and radicalisation across both sectors.  
We have disseminated learning from one Safeguarding Adults Review (SAR) and one thematic children’s learning review to improve systems and practice across Milton Keynes for vulnerable adults and children.  
We have recruited to the new MK Together posts, further embedding our new safeguarding partnership arrangements and leading the way in innovation. |
| What we will do in 2018/19 | • Maintain and review a performance dashboard, escalating issues of concern as required.  
• Complete a review of audit practice across Milton Keynes.  
• Co-ordinate Section 175 audits.  
• Refresh how we conduct the Section 11 audit so that it captures and promotes both compliance and improvement.  
• Carry out two ‘rapid reviews’ including the views of residents and practitioners, one on emerging areas of vulnerability, and one on neglect, plus any other reviews that are triggered by issues of concern.  
• Respond to relevant policy and legislative changes.  
• Develop a multi-agency pathway for self-neglect.  
• Develop and adopt a levels of need tool taking account of existing national and local frameworks.  
• Explore the extent to which ‘missing’ is an issue for adults services.  
• Establish a task and finish group with Safer MK to address exploitation.  
• Create multi-agency pathways to prevent emerging gang activity and associated exploitation.  
• Examine the effectiveness of arrangements and preparation for children transitioning between children’s and adults’ services.  
• Develop an overarching framework and toolkit for undertaking incident, case and learning reviews.  
• Establish and embed a local safeguarding Competency Framework for the Milton Keynes workforce.  
• Use the Competency Framework to set the curriculum for and develop updated safeguarding training.  
• Monitor and evaluate the effectiveness of single-agency training and compliance with the Competency Framework.  
• Develop and oversee the mechanisms for the dissemination from audits and reviews, and research material.  
• Carry out multi-agency learning reviews including Serious Case Reviews and Safeguarding Adult Reviews, and disseminate learning from these and national case review activities. |
The Safeguarding Board is supported by dedicated Children’s and Adults Programme Boards, responsible for the statutory functions specific to adult or children’s safeguarding. The Adult Programme Board is also concerned with a range of issues which can contribute to the wellbeing of its community and the prevention of abuse and neglect, such as:

- The safety of people who use health services, including mental health services.
- The safety of adults with care and support needs in residential settings.
- Effective interventions with adults who self-neglect, for whatever reason.
- The quality of local care and support services.
- The effectiveness of prisons in safeguarding offenders.
- Making connections between adult safeguarding and domestic abuse.
- Modern slavery and associated issues.

The Adult Programme Board is responsible for leading and co-ordinating programmes of work (through groups, projects and task-and-finish groups) designed on a multi-agency basis to ensure:

- Practitioners work collaboratively to prevent abuse and neglect where possible.
- Agencies and individuals give timely and proportionate responses when abuse or neglect have occurred.
- Agencies make enquiries, or request others to make them, when they think an adult with care and support needs may be at risk of abuse or neglect.
- Agencies arrange for an independent advocate to represent and support a person who is the subject of a safeguarding enquiry or review, if required. The Programme Board is assured that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.
- Safeguarding Adult Reviews are carried when the criteria are met.

**What have we done?**

- We undertook a governance review, and rationalised our membership and groups, and introduced a new logo for the Safeguarding Board. During this process the Adult Programme Board received updates regarding transition from the previous arrangements to the new ones.
- A Performance and Quality Assurance Framework was developed as well as an overarching Learning and Improvement Framework.
• We received multi-agency performance data, and exceptions reports.
• Adult Programme Board members contributed to discussions about future Business Plan priorities.
• As well as receiving regular updates in relation to the Adult A SAR, which had been commissioned in 2016, an internal Learning Bulletin was disseminated within MKSB partner agencies. Local guidance on involving the police was incorporated into procedures as a result of the Adult A SAR.
• New multi-agency service guidance on vulnerable families was presented to the Programme Board.
• A new SAR—was commissioned by the Safeguarding Board and contact was made with relatives of the subjects - as part of the Board’s continuing commitment to gaining the views of family members as appropriate.
• In December Programme Board members received a briefing from MK Council on progress that has been made in the management of DoLS. The briefing reported a substantial improvement since the audit in September 2016. The Programme Board was sufficiently assured of progress that it agreed there was no further need for the MCA/DoLS group to meet.

How well have we done it? What difference have we made?

• The new Safeguarding Partnership structure – MK Together - enabled us to release capacity and focus on priorities.
• All Reviews of cases, whether they meet the statutory criteria for a SAR, or it is decided to conduct a Learning Review, include as part of the process the offer to family members and/or subjects of reviews, the opportunity to share their views.

Next steps

• We will be reviewing Milton Keynes safeguarding thresholds for alerts and enquiries and working with colleagues to improve the quality of alerts.
• We will strengthen the way we manage safeguarding referrals through more effective and efficient processes by developing a single front door process in the Multi- Agency Safeguarding Hub (MASH).
• We will develop a multi-agency response to self-neglect and risk management.
The Children’s Programme Board is responsible for delivering the functions of the Local Safeguarding Children Board (LSCB) Regulations 2006 including:

- Developing policies and procedures for safeguarding and promoting the welfare of children in Milton Keynes.
- The action to be taken where there are concerns about a child’s safety or welfare, including thresholds for intervention.
- Supporting the training of people who work with children.
- Oversight of appropriate recruitment and supervision of people who work with children.
- Investigations of allegations concerning people who work with children.
- The safety and welfare of children who are privately fostered.
- Ensuring the Board is sighted on the work of affiliated sub-groups, task and finish groups, forums etc as necessary.
- Communicating to people and organisations in Milton Keynes the need to safeguard and promote the welfare of children, raising their awareness and encouraging them to do so.
- Participating in the planning of services for Milton Keynes.
- Undertaking reviews of serious cases, learning reviews or other cases and advising the Council and their board partners on lessons to be learned.
- Publishing an annual report on the effectiveness of child safeguarding and promotion of welfare of children in Milton Keynes.
- Providing challenge to ensure that there is a comprehensive, effective and adequately resourced system-wide approach to safeguarding children and promoting their welfare.

What have we done?

- The Children’s Programme Board met five times during the year, which was a period of change as local safeguarding partnership arrangements and governance were reviewed.
- Received the report of a thematic learning review into three deaths of very young children where there were common features. As a result the CPB commissioned the Early Help project on behalf of MKSB.
- Received the MKSB report on the review of restraint at Oakhill STC and agreed a number of actions, including Programme Board members attending Oakhill’s use of force meetings to take joint ownership and responsibility for oversight of safeguarding at Oakhill STC.
- Considered the findings of a number of audits including the Multi-Agency Case File Audits and the Section 175 audit of safeguarding arrangements in schools.
- Received an update on the Young People’s Participation Strategy and received reports from various MKSB groups on their activity and business plan progress.
How well have we done it? What difference have we made?

• The Children’s Programme Board received regular updates from Oakhill STC on safeguarding practices within the STC. Regular meetings between the MKSB Independent Chair and the management of Oakhill STC have allowed for further assurance.

• The Children’s Programme Board oversaw the Early Help project which included several focus groups with practitioners and managers from various agencies in Milton Keynes to gain their views on current early help provision. The feedback from this work will inform further work in 2018 – 2019 that will be taken forward by an MKSB Early Help task-and-finish group.

Next steps

• We will work with Safer MK to create multi-agency pathways to prevent emerging gang activity and associated exploitation through a Predictive Harm Task and Finish Group.

  Take forward the recommendations from the Early Help project and develop an early help strategy, protocols, procedures and toolkit.

• Examine the effectiveness of arrangements and preparation for children transitioning between services.

• Support a joint task and finish group with the Adult Programme Board and Safer MK focusing on exploitation.

• Take forward participation work.
The remit of CDOP panels is to provide an overview of cases and identify learning that seeks to reduce future deaths, as well as being assured that support is being provided to bereaved families. Milton Keynes Child Death Overview Panel (CDOP) reviews child (excluding those babies who are stillborn) of children up to the age of 18 years who are normally resident in Milton Keynes. This includes neonatal deaths, expected and unexpected deaths in infants and in older children. The Panel membership included representatives from the Coroner’s Office, Milton Keynes Council Milton Keynes Clinical Commissioning Group, Milton Keynes University Hospital NHS Foundation Trust, Public Health, and Thames Valley Police.

During meetings members consider the child’s background and events leading to the child’s death and are required to classify each death reviewed. This classification is hierarchical: where more than one category could reasonably be applied, the category highest on the list is assigned. Figure A shows the distribution of child death reviewed by the category assigned by the Panel.
What have we done?

• The panel met three times in the period 1 April 2017 – 31 March 2018. In total 22 child deaths were reviewed, a slight decline from 2016/17 as fewer meetings were held. A further 21 child death reviews were ongoing as at 31 March 2018. Neonatal deaths (children aged 0–27 days) accounted for 58% (11) of the child deaths reviewed. Nine (47%) were male and 10 (53%) were female and 50% (11) were of black and minority ethnic background (ethnicities of four cases were unknown).

• One case was referred by MKSB CDOP to the Serious Case Review (SCR) subgroup and a report is due to be published in early 2018/19. One case was referred to the LeDeR (Learning Disability Mortality Review) process, responsible for reviewing deaths involving a child with learning disabilities.

How well have we done it? What difference have we made?

• During 2017/18, only one review had an identified modifiable factor, compared to nine last year. This factor was consanguinity (or the effects of having parents who are second cousins or closer), in line with in previous years.

• The Panel identified that extreme prematurity was a feature in 11 (48%) of the deaths reviewed in 2017/18 (as defined by the World Health Organisation as less than 28 weeks gestation). Two (18%) of these deaths were deemed ‘not viable’ (i.e. less than 22 weeks gestation). Five (45%) of these cases involved one or both of a set of twins. Modifiable factors were not identified in any of these cases.

• MKSB CDOP reviewed provision of awareness-raising initiatives for parents about the risks associated with first-cousin marriages offered in other areas. The quality of these was felt to be high; however MKSB CDOP noted that a greater understanding of the local population would help target communications.

• Ante-natal services continue to proactively promote the smoking cessations services, as shown by smoking at time of delivery rates.

• The Chair of MKSB CDOP wrote to Milton Keynes Council to seek assurance on the safety of one location of a death due to a road accident. There have been no further deaths due to road accidents in 2017/18.

• The Panel liaised with the Royal College of Pathology to assist it to improve the protocols for pathologists to work with the treating clinician at the time of death, with the support of the local Coroner’s office.

Next steps

• CDOP chair should continue to review opportunities to work across the STP with other CDOP arrangements.

• Recommend that MKSB consider working with local community leaders in ‘at risk’ populations to develop awareness of their understanding of the risks of consanguinity to better inform awareness raising activities of partner agencies.

• Complete an in-depth study of deaths due to extreme prematurity/not viable births in order to provide any lessons to be learned from the finding and make recommendations for health and social partners to address the issue, including consideration of the additional risk of multiple pregnancy (e.g. twins). This work fits into the remit of the Local Maternity Services group and it is recommended that they lead a review across the STP area.

• Partner agencies should review opportunities for the improving the access to specialist skills across the palliative care pathway.

• Strengthen the focus on identifying modifiable factors and ensure that adequate action to address them is identified by partners.
The purpose of the group is to assess the quality and impact of our individual and collective safeguarding work and how can we bring about further improvement. The PQI group meets bi-monthly to review multi-agency performance data and audits. Members are encouraged to professionally challenge practice and performance, identify good practice and take learning back to their agencies.

What have we done?

- Created a performance and assurance framework with a robust model for sharing and analysing multi-agency safeguarding information which includes external partners.
- Extended the membership of the group to include a wider range of partners.
- Introduced a new method for presenting data to encourage professional debate, challenge and learning.
- Identified and escalated potential risks to the Safeguarding Board for robust monitoring and improvement.
- Supported the bi-annual Section 175 audit and completed a full Section 11 audit.
- In the latter part of the year, we have started to move away from solely relying on data and audit to assess the effectiveness of multi-agency safeguarding practice and piloted a new model for thematic reviews.

How well have we done it? What difference have we made?

- The collation of multi-agency data has been a success and a full year’s data has been collected for final review from partners including police and Milton Keynes University Hospital NHS Foundation Trust (MKUHFT). This has given us a good foundation on which to continue to improve the impact of this group.

Group membership has extended and improved, demonstrating multi-agency commitment to striving for continuous improvement.

- Members have agreed the new model for presenting data, plus the new reporting cycle and thematic review arrangements for the coming year evidencing effective evolution of the group in line with developing needs.
- Exception reporting has highlighted areas of concern to the Board.

Next steps

- We will continue to improve the impact of this group. During the first part of 2018/19 we have already reviewed and rebuilt our multi-agency performance dashboard, and extended it further to ensure better multi-agency coverage. The new performance dashboard includes a wider data set than the board has had access to previously – which was social care dominated. For example the dashboard now contains indicators around child and adolescent mental health.
- We will continue to embed the ‘rapid review’ model in order to incorporate public and practitioner perspective into the work of the MKSB. The first of our new style themed reviews focusing on gangs was a success, offering an opportunity to triangulate data and organisational views with feedback from the community.
- Co-ordinate a Section 11 and Section 175 audit and report findings to the Safeguarding Board.
- Continue with spotlight presentations and discussion on cross-cutting issues that have been introduced for 2018/19, for example presentations on street homelessness and hoarding.
The function of the Reviews and Learning Groups (RLG) is to ensure compliance with the Care Act 2014 requirements (Safeguarding Adult Reviews) and LSCB Regulations 2006 and Working Together 2015 (Serious Case Reviews and Learning Reviews). This group holds the overarching quality assurance role for the work produced by the Adult Case Review Panel (ACRP) and Children’s Case Review Panel (CCRP) and has responsibility for ensuring that learning from local and national reviews is shared and implemented.

The group, including representatives from both panels, have worked on overarching policies and processes over the year including a new joint toolkit, terms of reference, new referral pathway and improved quality assurance procedures for external report writers.

**What have we done?**

- Revised the MKSB Review Procedures and Toolkit to align the processes used by both the Panels.
- Adopted a new learning review model moving away from traditional written reports towards a more interactive multi-agency learning forum which encourages open and honest discussion and reflection thus providing richer narrative for the report.
- The CCRP met seven times during the year. Monthly meetings have been scheduled for the financial year with flexibility to allow for increased or decreased need and also incorporate virtual discussions in-between with panel members, agencies and the Independent Chair to progress actions.
- Following three separate infant deaths with similar features, we published a thematic learning review in August 2017. Outcomes included an agreement with housing not to place vulnerable young parents in accommodation outside of MK away from their sources of support. The learning fed into the MKSB review of Early Help and prevention pathways.
- We have commissioned and progressed one Serious Case Review due for publication by the end of 2018.
- In addition we considered five new referrals, four of which led to local learning or single-agency reviews.
- Identified learning opportunities for a number of cases via further consideration of information provided by agencies.
- Referrals have included concerns about gang-related activity, mental health treatment for under 18s and safe sleeping practices for young babies.
- The CCRP also supported and quality-assured the health review process for a case of fabricated and induced illness.
**ACRP Panel**

- The ACRP met four times during the 2017 – 2018 financial year (June, November, January, and February).
- The Panel dealt with the publication of the Adult A Safeguarding Adult Review (SAR) and the dissemination of a Learning Bulletin.
- The group commissioned one SAR due to be completed later in 2018. The SAR relates to concerns for the care of elderly residents in a residential home. Reports relating to SARs are published on the MKSB website on completion.
- The Panel also considered a further three referrals by exploring information provided by a variety of agencies, two of which have precipitated local learning reviews and made a contribution to learning via the LeDeR process.
- We considered referrals which included concerns for self-neglect and care in a supported housing facility.

**How well have we done it? What difference have we made?**

- A Signs of Safety methodology continues to be effectively used by the CCR Panel when considering SCR referrals and has been adopted by the ACR Panel.

**We have implemented a new system for tracking communication with key stakeholders including family and referrers.**

- Feedback to referrers is now timelier and we have included visits to referrers to explain decisions in person to improve the quality of referrals. Feedback has suggested this is helpful and has been well received.
- Our latest learning review report demonstrates that the new model is successful due to the insight gained during the multi-agency discussion.
- Panels meet face to face or virtually with consistent membership to facilitate timely and thorough consideration of all referrals and progressing actions.
- We have identified themes and patterns across practice in key agencies which have prompted further review and improvement in practice across the whole system.
- We have initiated a new learning review model that has improved joint working and shared responsibility across statutory and voluntary organisations.
- There is now more focus on keeping families involved in reviews and incorporating their views, perspectives and information, reflecting these in the final outcomes and recommendations.

**Next Steps**

- To review and refine the referral process and review systems, including meeting changed requirements detailed in new Working Together guidance (in case of SCRs).
- Work with Milton Keynes Council to improve the process for commissioning SCRs and SARs.
- Introduce a new system for sharing information that is best practice for data protection.
WORKFORCE DEVELOPMENT AND STANDARDS

This group ensures that the requirements of the Care Act 2014 and Working Together 2015 (or any successor regulations and guidance arising from the Children and Social Work Act 2017) in relation to multi-agency workforce development, training, knowledge and practice competence are met. This group has undergone a number of changes during the financial year including change of chair and focus, however it has continued to work with other groups to improve workforce competency across the sector.

What have we done?

• The initial focus of the work was merging the two separate ‘training-focused’ groups – Milton Keynes Safeguarding Adults Board (MKSAB) Training, Education & Development sub-group, and Milton Keynes Safeguarding Children Board (MKSCB) Learning and Development sub-group – into one joint adult and children’s Workforce Development & Standards Group. The group met three times during this reporting period - May 2017, September 2017 and January 2018.
• We oversaw the introduction of a charging policy for MKSB safeguarding children training.
• We agreed the focus of the MKSB annual conference in November 2017 – Trafficking and Exploitation – which was the first joint adults and children’s conference held by the Board, and was attended by around 300 delegates from across the Milton Keynes workforce.
• We oversaw the revision of training materials for MKSB children’s safeguarding training.
• The Workforce Development and Standards Group also agreed the introduction of a four-stage evaluation process for MKSB’s safeguarding children training.
• The group was unable to conduct a training needs analysis however a mapping exercise was completed which has led to a change in the way children’s safeguarding training is delivered.
• The Group produced a first draft joint Adult and Children’s Competency Framework.

How well have we done it?

What difference have we made?

• Our conference welcomed local and national experts who gave insightful talks on topics including online child exploitation, modern slavery and radicalisation. It was well received by those who attended. Over 90 per cent of participants stated that they would change their practice based on what they had learnt at the conference.
• Feedback from MKSB training was positive and participants found it to be value for money. The introduction of a charging policy reduced the level of non-attendance on MKSB training courses.
• Adult safeguarding compliance has continued to improve meaning more professionals will have greater awareness of the Care Act, Mental Capacity and how to prevent abuse of vulnerable adults.

Next steps

• To continue working with the Council who will be delivering training on behalf of the Board from April 2018.
• To finalise and agree the joint Adult and Children’s Competency Framework and then distribute and embed the final version across the workforce in Milton Keynes.
• Review and refresh group membership to improve effectiveness.
What have local partners done to contribute to the safeguarding of adults and children in Milton Keynes?

MILTON KEYNES CLINICAL COMMISSIONING GROUP

The Milton Keynes Clinical Commissioning Group (MKCCG) is the clinically-led statutory NHS body responsible for the planning and commissioning of health care services in Milton Keynes. The MKCCG has responsibilities to continually seek to improve the quality of care. The MKCCG safeguarding duties include ensuring safeguarding is integral to all our commissioning functions; assuring and supporting commissioned services to deliver effective safeguarding practice, and work with our partnership in accordance with the Care Act 2014 and Children Act 2004. The MKCCG Safeguarding Team works to ensure a cohesive approach to safeguarding with partners, providers, commissioners and our safeguarding networks.

What have we done?

• Our Safeguarding and Quality Teams have developed a safeguarding assurance matrix to ensure consistency and proportionality across providers.
• Our Safeguarding Leads review safeguarding data submitted on a quarterly basis by providers (CNWL MK, MK UHFT and Urgent Care) and areas of concern are raised through Clinical Quality Review meetings.
• We offer specialist support to GP Practices to help ensure robust safeguarding measures are in place; including advice, supervision, training and audit.
• The Designated Leads have worked with Public Health to provide safeguarding supervision.
• The MKCCG Quality Monitoring Nurse provides nursing input into the Adults MASH one morning a week with the aim of improved communication between the MKCCG and the Council’s safeguarding teams. This is in addition to a part-time funded Health practitioner for the Children’s MASH.
• We lead work on Female Genital Mutilation (FGM) on behalf of the Board. The Designated Nurse in her role as chair of the FGM Panel has done some targeted awareness-raising with the local travel clinic around FGM, and delivered multi-agency specialist training which has been very well attended.
• We have continued to complete quality monitoring visits of care homes and domiciliary care in partnership with the Milton Keynes Council contract monitoring team.
• We have a new Designated Doctor in post and a new locally based Named Safeguarding GP to support the safeguarding work.
• Work to support Primary Care included quarterly training and a joint safeguarding event attended by over 200 Primary Care staff.
• Our Safeguarding Team continue to support the work of Milton Keynes Safeguarding Board (MKSB) with representation at the Safeguarding Board and various MKSB groups. Our safeguarding team has supported the work carried out on behalf of the MKSB by chairing the adults and children’s case review panels and facilitating local learning reviews.
• We have supported statutory reviews through Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews.
How well have we done it? What difference have we made?

- Quarterly training for GP Practices in safeguarding adults and children has been in place for a year; leading to a reduction in practices seeking basic safeguarding advice and an increase in practices identifying more complex hidden issues such as trafficking and fabricated and induced illness (FII).
- Over 200 practitioners attended a safeguarding protective learning event which received positive feedback from those who attended.
- Our Designated Nurse was nominated for a National General Practice Award 2017, finalist in the category of Clinical Team of the Year – Improving Safeguarding Services for developing a safeguarding children template for GP Practices to use within their electronic record keeping system.
- Milton Keynes has the lowest number of care homes and domiciliary providers that require improvement or are rated as inadequate in the East Midlands region. The role of our Quality Monitoring Nurse is a significant contributory factor in this rating.
- The FGM Multi-Agency Panel receives high numbers of referral, demonstrating that professionals are appropriately identifying risks of FGM and taking appropriate action to safeguard children and support women who have experienced FGM. The quality of conversations that professionals are having with women and families has improved. We secured funding for our community engagement project ‘Be Bold’. Somalian outreach workers have been engaging with affected communities, local faith groups and using social media to change attitudes towards FGM and support those affected.

Next steps

- Continuing our work with MKSB and across the Sustainability and Transformation Partnership footprint to make most effective use of resources.
- Building on the success of the GP Children’s safeguarding template and developing a template for GPs to use in regard to adult safeguarding.
- Provision of further training for primary care.
- Prioritisation of Modern Slavery.
- Increase the number of people with a learning disability who receive an annual health check.
- Meet and maintain our transforming care for people with a learning disability trajectory.
- Work with partners to improve the pathway for people who are self-neglecting.
- Strengthen and embed a Health-wide approach where children ‘Were Not Brought’ to appointments to ensure safeguarding concerns are identified.
- Support the MKSB to embed the newly developed tools, guidance and training in response to fabricated or induced illness.
- Review current pathways and provision of Child Protection Medicals.
- Establish peer supervision for Paediatricians.
- Continue to formalise and strengthen the governance assurance for primary care as part of our wider delegated commissioning arrangements.
THAMES VALLEY POLICE

Thames Valley Police (TVP) is the largest non-metropolitan police force in England and Wales. We police the counties of Berkshire, Buckinghamshire and Oxfordshire, serving a diverse population of more than two million, plus the six million visitors who come to Thames Valley area each year. The TVP force area is divided up into 12 Local Policing Areas (LPAs) including the Milton Keynes LPA.

We are committed to working together to make our communities safer. We will do this by preventing and thoroughly investigating crime, supporting victims, and bringing offenders to justice. With our people, public and partners we will build stronger, more resilient communities, and will provide a modern police force which meets the needs of the public we serve. View the full Force Commitment on our website www.thamesvalley.police.uk

The Police and Crime Commissioner has published the full Police and Crime Plan for Thames Valley, which outlines the priorities for the area and how we will work with partners to achieve them. View the full Police and Crime Plan, Thames Valley Police Delivery Plan on our website (as above).

Local Policing Area teams are responsible for response and deployment, community engagement, problem-solving, early help, anti-social behaviour, hate crime, gangs and problem crime groups, Multi-Agency Public Protection Arrangements (MAPPA), and mental health.

The Protecting Vulnerable People Team take care of investigations into child abuse, domestic abuse, vulnerable adults, missing people and the management of violent and sexual offenders.
What have we done?

- We have continued to make a full contribution to the Milton Keynes Safeguarding Board, the Programme Boards and groups.
- We have supported the work of Case Review Panels by contributing to the preparation, commissioning and publication of Serious Case Reviews.
- We have rolled out our single-agency SaVE (Safeguarding, Vulnerability, Exploitation) programme to frontline staff, specialists, and senior leaders.
- We have worked together with the SaferMK Partnership to conduct a partnership-wide analysis of what we need to tackle domestic abuse effectively.
- We have continued to work to increase diverse communities’ confidence in the police and in doing so identify hate crimes.
- Development of Problem Solving Teams who work within neighbourhoods with residents to solve short and medium term problems.
- We have continued to support mental health triage and a new health care worker (funded by Central and North West London NHS Foundation Trust - CNWL) in custody.
- We have supported the development of ELPIS, a multi-agency risk assessment tool for missing people.
- More of our staff are now trained as Dementia Friends.
- Neighbourhood Officers have been trained in Sign Language.
- We now have dedicated Schools officers.
- Police and Crime Act training has been completed by all staff.
- Continued leadership in the Multi-Agency Risk Assessment Conference (MARAC) process.
- We are working in the MK MASH to use the multi-agency data to predict which children would be subject to greater harm and to get a better comprehension of the networks of exploitation.

How well have we done it? What difference have we made?

- The focus by the problem-solving team on under 18 year old repeat missing episodes has increased partnership working and significantly reduced the number of repeat cases.
- A problem-solving approach to repeat victims of Domestic Abuse improved our ability to intervene early and has allowed us to make effective changes in victim’s lives at an early stage.
- TVP officers are now supporting other agencies in delivering healthy relationship training, changing how the police are seen and increasing confidence that we will support victims.
- Operation Retreat. Modern Slavery operation and investigation, which safeguarded a number of foreign nationals and identified new ways of working in partnership to manage hidden harm.
- We have used social network analysis using social care and police data to understand how children across MK are being exploited, particularly in relation to gangs. On a tactical level this has allowed us to have a greater understanding of the current risk and guidance on who to take action against as exploiters and the exploited. Strategically, it has given us a different perspective on how gangs are operating in the city, giving us a platform to reframe as a partnership to reduce the level of risk our young people face and to reduce harm.

Next Steps

- Develop our use of predictive analytics and use multi-agency data to better understand risks and to take action in partnership.
- Roll out of ELPIS across TVP.
- Review of Multi-Agency Risk Management Meeting to include all forms of exploitation against children, not just CSE.
- Review the multi-agency response to domestic abuse; have more effective meetings to also focus on tackling the offenders as well as supporting the victims. Move towards dynamic MARACs so the risk is being managed every day, not just monthly.
- SaVE safeguarding training phase three to further enhance officer and staff skills.
- Support the upcoming changes to Working Together statutory guidance.
- Further enhance partnership working to ensure that we use collective resources effectively.
We provide information and advice, short term support to help people stay independent, and longer term support for people with more complex needs. The Care Act 2014 sets out the legal framework for how local authorities should protect adults at risk of abuse or neglect. Our Safeguarding Adults Team has the lead responsibility for making enquiries, or to request others to make them when they think an adult with care and support needs may be at risk of abuse or neglect, and they need to find out what action may be needed.

What have we done?

- We have delivered training to key partners including Thames Valley Police, South Central Ambulance Service and local providers and introduced an electronic referral form to improve quality of safeguarding alerts.
- We have integrated adult safeguarding into the Milton Keynes MASH which was previously for children only. This has allowed better integration with children and adult social care and enhances our approach to “think family”. We have a new management team for the service in 2017 and have a programme of work aimed at improving the service.
- We continued to transform our learning disability services following public consultation in 2015/16. We commissioned an independent advocacy service to work with service users, family carers and providers to support people throughout the period of change.
- We transferred the Community Occupational Therapy (COT) service from the NHS into MKC Adult Services. The COT service is now closely aligned to the adult social care teams and will be used to enhance the assessment offer to vulnerable individuals.
- The Contracts Team has strong links with the safeguarding team and ASC reviewing team. Both teams work together to ensure that concerns are addressed, trends identified and followed up. Providers’ establishment meetings are conducted jointly with representatives and monitoring teams.
- We have written and are implementing a new screening process that utilised the Care Act’s three stage test. This will improve consistency within decision-making across the team.
- We have changed the internal reporting system and refreshed our forms to provide better accuracy of reporting and improved assurances of making safeguarding personal.

**Commissioned new MKC approved home care providers across the city.**

**All home care service-users have been reviewed and either transferred to the new care provider or been assisted to set up a direct payment so that they can maintain their existing home care in a timely effective manner.**

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How well have we done it?
What difference have we made?

- Our partners and providers have told us that they are benefiting from improved response time and communication.
- There is better joint working with adult and children’s social care via the integrated MASH and this will be demonstrated in the upcoming evaluation.
- ASC staff are reporting that they feel more supported by the new management structure that has removed the responsibility of Deprivation of Liberty, and therefore allowed management more time to focus specifically on safeguarding and provide advice and guidance to team members.
- In-house services have all achieved either Good or Outstanding ratings with CQC, illustrating the Council’s commitment to delivering high quality services that meet the needs of individuals through the provision of well-managed services.

**The DoLS team completed a total of 936 assessments over the course of 2017-18, an increase of exactly 100 on the previous year, and increase of 11%.**

- We have invested in our services supporting people coming out of hospital, and social care delays in hospital discharge have fallen significantly in the last year making sure people get home or to the most suitable destination to meet their needs as quickly as possible.
- There has been a continued effort to support most people in their own homes.

Next steps

- Following the updated electronic referral form, we will introduce a monitoring system to ensure the right referrals are getting through to the team.
- We are creating a new set of guidance documents for our team to tighten up processes and enable staff to identify their own solutions/actions.
- We are in the process of replicating the current children’s levels of need documents for use in adult services to provide consistency across the services, make transition from children’s to adult services less complicated, and provide a clear criteria for professionals and public to understand safeguarding adult criteria.
- Utilising the COT service in the assessment process to provide an enhanced and more holistic approach.

- Service re-design to be undertaken with the aim of making the service provision more efficient for service users.
- We will work closely with partners to establish a care pathway for adults who self-neglect by developing a Vulnerable Adults Risk Management panel.
- Recruitment and use of Occupational Therapists within the reablement process with the aim of ensuring a through and innovative reablement experience that maximises the individual service-users potential for independence.
Throughout 2017/18 the Children’s Social Care service in Milton Keynes has grown in its resource and capacity to meet the demand challenges that continue. In January 2017 the Safeguarding Adults Service joined the Multi Agency Safeguarding Hub (MASH) to further enhance the working together of the services and this has been a helpful and positive development.

A new Service Director for Children’s Services started in January 2018 and is progressing a programme of improvement work including a focus on: maintaining operating stability, targeted improvement activity, greater focus on practice quality. This work includes a strengthened focus on systems leadership, led by the Children’s’ Heads of Service, through a new forum of the Children and Families Leadership Team (CFLT).

What have we done?

- We have recognised our social work workforce is a key strength in our system. Vacancy rates remain low and the retention is good as we provide strong professional development and supervision. Alongside this we have retained low usage of Agency staff.

- We have strengthened our family support approach and with our Children and Family Practices (CFPs) being managed within the Children’s Social Care Family Support Service we have provided continuity of decision making and a good consistency in regard to thresholds.

- We have progressed a change within our Fostering and Placement Service through creating separate Fostering Recruitment and Support Teams to enhance the support given to carers and to improve the Placement opportunities for our Looked After Children.

- We have made changes to our internal performance and reporting systems and data set to ensure an improved understanding and accuracy of our key performance indicators and ensuring we know ourselves well.
• We have, and continue, to deliver a range of training and to progress innovative programmes of delivery, e.g. Healthy Relationships programme to reduce Domestic Abuse referrals, to ensure responsive services and focus on delivering good outcomes for children and their families.

How well have we done it? What difference have we made?

In March 2018 we published a Children’s Social Care self-evaluation for our Ofsted Annual Conversation. We were able to demonstrate the progress that had been made across the service since our Ofsted Inspection in 2016. We evidenced:

• The success of our workforce stability, with the majority of our social workers recognised as being ‘Highly Effective’ in their work.

• We have moved our audit activity from purely one of compliance to a more analytical approach including case file audit days and ‘deep dive thematic’ audits covering areas such as Strategy meetings, Missing Return Interviews and Permanency. We therefore know:

• 83% of children engaged in the Return from Missing Interview process.

• Permanent foster placement matches are considered for all children under the age of 14 with an increase in Special Guardianship Orders.

• We know we have good volumes and through flow through our support services, with 92% of successful interventions recorded in CFPs and only 7% of cases escalating to requiring Children’s Social Care (CSC) support.

• We have reduced the number of open cases within the service by 4.8%, retaining social care contacts and referrals in line with expectations.

• Our numbers of Children in Care are not going up, with fewer children coming into care and a reduction in the average age that a child enters our care to eight years old.

• Placement stability has shown to be improving with 66% of our children remaining in the same placement for two years or more.

Over the last year we have focussed on ensuring we understand our successes well and are clear where our outcomes aren’t as successful as we would like them to be and the actions we need to progress.

Next Steps

In line with our targeted improvement activity and greater focus on practice quality we are:

• Strengthening our leadership, management and governance arrangements to ensure whole system approaches across Children and Family Services to ensure children in social care services are receiving the best support available across a range of services.

• Reviewing our policies and processes to ensure they support and enable social workers to progress good outcomes for children, particularly in the case of permanency.

• Progressing cross-regional arrangements for adoption alongside the Government’s drive to create Regional Adoption Agencies.

• We are reviewing our ‘offer’ to Children Looked After and Care Leavers to ensure we are effective and ambitious Corporate Parents and ensure they achieve well and secure good outcomes.
Central and North West London (CNWL) NHS Foundation Trust provides community health and mental health services in Milton Keynes. Our community health services are: Community Nursing, Universal Children’s Services, Podiatry, Intermediate Care, Dental Services and other Specialist Therapies (such as Speech and Language Therapy and Neurological Rehabilitation, amongst others).

Our mental health services comprise acute mental health wards at the Campbell Centre, older adult and rehabilitation in-patient services and a wide variety of community-based services, which support, care for and treat people with a wide range of mental health disorders. The teams within these services are supported by the Trust’s local safeguarding team to deliver their safeguarding responsibilities to both adults and children.

What have we done?

- We have developed a financial abuse leaflet on the same pattern as our sexual safety leaflet
- We have established a task and finish group to develop a more effective Mental Capacity Act assessment tool
- We have worked with Standing Together to develop Domestic Abuse awareness training which has been rolled out across the Trust
- We have continued to monitor Prevent training attendance figures to ensure we meet trust compliance targets
• We have implemented safeguarding information alerts on our electronic record system.

• We have developed ‘Supervision Skills for Safeguarding and Child Protection Supervisors’ training and a ‘Train the Trainer’ approach, to support our safeguarding children leads.

• We have worked closely with Milton Keynes University Hospital Trust to ensure effective joined-up working with cases involving suspected fabricated or induced illness (FII), to encourage early identification and joint early intervention.

• We have continued to develop our training provision – refreshing content to reflect learning from new cases and Milton Keynes Safeguarding Board (MKSBB) priority areas. For example, we arranged sessions on Child Sexual Exploitation (CSE) facilitated by the MKSB CSE lead, and specialist training on safeguarding children of parents who misuse substances, developed in response to learning from recent cases of baby deaths involving co-sleeping and substance misuse.

• We continue to monitor the incidents reported by our staff for any safeguarding issues and, to support this further, we have threshold exercises with senior staff from various teams to review the consistency of our approach in reporting safeguarding concerns.

• We have developed our systems to prompt staff to record mental capacity decisions and our systems for recording Deprivation of Liberty Safeguard authorisations have also been made more robust to ensure they comply with Care Quality Commission requirements.

• The Trust has been well represented on the Board and sub-groups.

How well have we done it? What difference have we made?

The safeguarding children alerts on electronic patient records have assisted in identifying children with additional needs and vulnerabilities.

• Learning from case reviews along with targeted support from the safeguarding team, has led specialist teams to develop further skills in identifying and responding to complex cases. Learning has been incorporated into training and is shared across the organisation.

• Compliance with training has remained at a very high level; as a result we have seen a greater understanding amongst the staff of their role and responsibilities in regard to safeguarding. This is reflected in safeguarding referral numbers and incident reporting, suggesting that staff now have the knowledge to protect their patients and service users on a more consistent basis.

• Despite personnel changes in a number of key roles, we have maintained our attendance at key meetings, and training and assurance processes have continued unaffected.

• Where there is learning from incidents occurring in our services outside of Milton Keynes, they have been shared with all parts of the Trust, leading to improved systems and wider knowledge.

Next steps

• To deliver Trust safeguarding objectives for 2018/19 as detailed in the CNWL Safeguarding annual report.

• To further integrate safeguarding adults and children teams and processes in Milton Keynes.

• To further develop mechanisms to ensure the service user’s voice is heard in safeguarding processes in line with Making Safeguarding Personal requirements and ‘hearing the child’s voice’. To ensure compliance with the Safeguarding Assurance Framework action plans for 2018/19.

• To increase our representation at and contribution to the MKSB delivery by attending and providing local data to the Performance, Quality and Improvement group.

To continue to contribute to strengthening partnership working in Milton Keynes.
The preventative role of Fire & Rescue Services is well embedded and at a national level prevention initiatives have contributed to the significant decrease in the number of people dying in fires over the last decade. Within the Buckinghamshire Fire & Rescue Service area, the number of fire fatalities each year since 2011 has remained broadly constant at three or below, with dwelling fires in the same period decreasing by one fifth. This may be a reflection of the efficacy of prevention activities along with the work that has been undertaken over the same period to ensure that domestic dwellings have working smoke alarms.

In order to maintain this trend in reducing dwelling fires, Buckinghamshire Fire & Rescue Service is utilising its knowledge of the main causes of fire in combination with national statistics and risk modelling tools to provide preventative advice to those statistically more at risk, such as the elderly, people who are socially isolated, or who have alcohol or drug issues. Buckinghamshire Fire & Rescue Service is able to draw upon its position as an organisation which is trusted by the public to support access to those communities at risk and to safeguard adults and children.

What have we done?

- Following a national consensus for Fire & Rescue Services to increase their collaboration with health and social care, the Home Fire Risk Checks (HFRCs) we have used to reduce the risk of fire have evolved to a pilot model of Safe & Well visits which encompass a focus on the wider health and well-being of the vulnerable people we come into contact with.

- Close collaboration with partner agencies is integral to improving the outcomes for people with identified risk factors and we have increased the number of agencies with whom we have Information Sharing Agreements in place, to aid in ‘Making Every Contact Count’.

- Those people who aren’t mobile are at greater risk from fire, therefore the Service has worked with the NHS to gain a better understanding of falls prevention, and how to refer those at risk from falling to the relevant organisations.

- In working to serve the communities we are based in, we are making our premises available to partners from the health sector to run targeted programs from. This collaborative approach is part of the ‘Fire as a Health Asset’ model and is helping us to reach a wider social demographic to reduce the risk of fire, impact on health and well-being and improve outcomes, whilst reducing costs to the NHS.

- To reassure the public and our partner organisations, all of our frontline staff have Disclosure and Barring Service clearance.

- We have delivered our education engagement programme, which provides structured education to improve the safety awareness of children. The service also delivers a range of activities to children, which are designed to improve physical activity and nutritional awareness, increase self-esteem, widen young people’s employability or form part of wider diversionary programmes.

- We have maintained our attendance and contribution to the Safeguarding Board and working groups in order to understand local societal risks and to support safeguarding children and adults and when requested, information has been submitted to Safeguarding Adults Reviews. A representative of the Service has also attended Multi-Agency Risk Assessment Conference (MARAC) meetings.
How well have we done it? What difference have we made?

- We have improved the way in which we track the education we offer to children and young people to enable us to target provision to those with an identified increased risk of incidence of injury from fire.

- We are working to improve the ways in which we evaluate our progress. Currently, we ask for feedback from young people and teachers on our course, which in turn improves the delivery of future courses.

- We feel we make a difference, but we cannot always prove it. By its very nature, effective prevention education should reduce the risk of incidence of fire but the reduction in overall domestic dwelling fires cannot be statistically linked to this. Nonetheless, by using our data and risk modelling capability in a more analytical way we can start to evaluate whether our activities improve outcomes, based on predictive risk.

Next steps

- Refine how we interrogate our own data and utilise national data to improve how we target those at risk from fire.

- Roll out and refine the Safe & Well visit model to ensure that our referral pathways are identifying the right people to offer support to and ultimately contribute to making people safer.

  Work with partners to reduce overall risk through effective joint working, joint intervention visits etc.

- Improve the mechanisms in place for members of the public and partner agencies to provide feedback on how well we have worked with them to reduce risk.

- Review our safeguarding policy to ensure it complies with current legislation, reflects newly developing issues and identifies how we will ensure that staff across the organisation are conversant in current issues and processes.

- Increase our attendance and participation at MKSB groups and use our service level data to enhance the knowledge of certain trends we experience across the multi-agency partnership, including hoarding and cuckooing.
We are an active member of the Milton Keynes Safeguarding Board (MKSB) and as such have specific responsibilities and duties in respect of safeguarding adults and children.

The Trust’s Safeguarding Adults, Children and Midwifery teams work in collaboration to safeguard all ages. Through investigating safeguarding concerns, action plans are produced and monitored within the Trust’s Safeguarding Committee. Learning is shared as appropriate across agencies.

Safeguarding performance, compliance and improvements are monitored through the adult and children safeguarding assurance frameworks by the organisation and the local clinical commissioning group (CCG).

The Trust is represented on the safeguarding board’s groups including chairing the Workforce Development and Standards group.

The Trust has contributed to Serious Case Reviews and Safeguarding Adult Reviews from which learning outcomes are shared within the organisation.

The Trust has had two Prevent referrals in 2017 both raised with the Emergency Department, with staff working in collaboration with both adult and children’s safeguarding leads and in collaboration with other agencies.

Compliance of safeguarding children within the Trust is also maintained within safeguarding assurance framework monitoring in collaboration with the CCG in addition to internal mechanisms.

We promote joined up working across maternity and paediatric areas to ensure the Trust has a clear and measured approach to safeguarding children.

The Trust has a safeguarding lead forum which meets monthly to share good practice, learning, offer supervision and review themes and performance.

The safeguarding board and Trust safeguarding committee have supported collaborative working between MKUHFT and Oakhill secure training centre to produce a Memorandum of Understanding document. This will improve a young person’s experience of attending hospital and also facilitate appropriate information being shared regarding the care required.

With the key themes proposed from the MKSB such as child exploitation and gangs, the Trust has been active in inviting external agencies such as the police into A&E to discuss their data. This shared approach will help improve knowledge and understanding of potential safeguarding risks within the local area.
How well have we done it? What difference have we made?

- MKUHFT adult safeguarding is in a positive transition. Learning is being demonstrated by the variety of adult safeguarding alerts and concerns being raised demonstrate staff learning as they are distinguishing between an alert and a concern, demonstrating their ability to use professional curiosity, asking critical questions.
- Themes have been identified from safeguarding alerts, for example self-neglect and domestic abuse, which the organisation has shared within the relevant boards. An example of a learning outcome is the development of a see-saw diagram to assist staff within Department Of Critical Care to understand when to apply a Deprivation Of Liberty Safeguarding (DoLS). This has since been included in the organisation’s DoLS training to aid decision making and it has been noted that there has been an increase in medics appropriately completing DoLS forms. Safeguarding Adults training (Level 1 & 2 and Mental Capacity and Deprivation of Liberty Safeguards) maintains compliance at above 90%.
- The designated doctor for safeguarding children has been instrumental in assisting engaging stakeholders to produce a toolkit for identifying fabricated or induced illness; a positive outcome following a previous health professionals learning review.

Next steps

- Move forward with Tissue Viability Nurses (linking with community) to design, implement and embed the Department of Health and Social Care safeguarding adult protocol for pressure ulcers and the interface with a safeguarding enquiry (January 2018).
- Continue collaboratively working with external agencies who attend MKSB to understand and utilise intelligence around emerging safeguarding themes.
- Enhance collaborative working with safeguarding children’s and maternity; promote safeguarding, share learning and good practice.
- The Trust is aiming to adopt collaborative ways of working with Woodhill prison and Chadwick Lodge.
- Level 3 children training will be a focus for the Trust, as compliance is below 90%. A review of training is being undertaken, proposal is due (Sept 18).
- Looking forward, the Trust is supportive of the new MKSB structure and the focus in collaboration between agencies with MK Together. Consideration will be required in relation to expectations of attendance and contribution to safeguarding groups to ensure effectiveness of the groups.
The Buckinghamshire and Oxfordshire Local Delivery Unit (LDU) is one of ten LDUs in the South West South Central National Probation Service Division. We are a statutory criminal justice service tasked with the supervision of those assessed as posing a high risk of harm to others who have been convicted of violent and sexual offending recognised under the Multi-Agency Public Protection Arrangements and subject to Community Orders, prison sentences or post release licence in the community across Oxfordshire and Buckinghamshire. We work with courts, victims and a variety of partnership agencies, including Local Safeguarding Boards, to achieve our aim of protecting the public, preventing victims, reducing re-offending and the successful rehabilitation of offenders.

Our practice teams are divided into three areas: Courts, Prisons and Community. We currently manage approximately 200 service users who live in the Milton Keynes area and manage approximately 230 Milton Keynes residents currently in custody. We have a Court Team offering a direct service to the Milton Keynes Magistrates Court and have a team based at HMP Woodhill.

What have we done?

- Members of the management team have attended the Children’s Programme Board to support its work based on the premise of ‘high support and high challenge’.
- We work collaboratively with local agencies through a variety of processes including through the joint chairmanship of the local Multi-Agency Public Protection Arrangements, timely and effective information sharing with the local MASH, consistent attendance at Child Protection Case Conferences, Core Groups and Child in Need meetings. We welcome and foster collaborative partnership relationships and share our knowledge and experience, as well as learning from our colleagues working in other agencies.
- A full mandatory training gap analysis has been undertaken across our whole staffing establishment.
- Through the Chairmanship of the Reducing Re-offending and Integrated Offender Management Steering sub group under the Local Criminal Justice Board, we have been influential in placing the needs of some of our most vulnerable adult service users at a high priority. These include those being released from prison after serving an Indeterminate Public Protection sentence and those facing homelessness on release from prison.
- We have undertaken a full, cross-Division Domestic Abuse and Safeguarding audit of our training, processes and practice.

How well have we done it? What difference have we made?

- We have begun a programme of nationally developed e-Learning and classroom training delivery to ensure that all staff have successfully undertaken the mandatory Adult Safeguarding and Domestic Abuse and Child Safeguarding training. Additionally, we have developed, and are due to begin delivering, staff engagement workshops on Neglect and Preparation and Effective Attendance at Child Protection Case Conferences, particularly focusing on building staff professionalism and confidence in appropriate and meaningful professional challenge.
Our work in partnership with agency members of the Criminal Justice Board has led to us working with our police colleagues to provide improved, collaborative and innovative intensive support to service users who have been assessed as posing a high risk of harm and re-offending. The effectiveness of this work against measures that will include reduction in offending and recall rates will be undertaken next year.

We have worked closely with our Criminal Justice Board colleagues to actively seek financial resources to provide accommodation support for some of our communities hardest to house, vulnerable service users.

Following on from the Divisional DA and Safeguarding Audit, team performance has been RAG-rated and managers have produced Action Plans to demonstrate gaps and what they will be doing to improve practice. These will be reviewed in the summer before a full divisional peer audit is to take place in the autumn.

Next steps

- To play an active role as a member of both the Adult and Children’s Safeguarding Programme Boards.
- To continue to deliver NPS Adult and Children safeguarding objectives.
- To continue to listen to our staff for the need for continual professional development, providing the opportunities, in partnership with others.
- To continue to embed quality assurance processes regarding Child Safeguarding Referrals.
- To ensure compliance with Probation Instruction 2014-02 - Safeguarding of Children and Vulnerable Adults.
- To continue to contribute to strengthening partnership working in Milton Keynes.
The Thames Valley Community Rehabilitation Company (TVCRC) is one of 21 CRCs created as part of the Ministry of Justice’s Transforming Rehabilitation agenda in 2014. We are a statutory organisation managing low and medium risk individuals aged 18 or over and subject to Community Orders, prison sentences or post release licence in the community across the Thames Valley region (Berkshire, Buckinghamshire and Oxfordshire).

In 2017 we amalgamated our young adult male and working age male cohorts. We now divide our practice teams between two cohorts, working with male and female service users respectively. This has reduced staff and service user travel and enabled staff to work predominately in a single office base improving their local partnership working. We manage approximately 560 service users in Milton Keynes cohort teams and an additional 135 service users undertaking standalone unpaid work.
What have we done?

- Our pilot project to increase the number of Mental Health Treatment Requirements given to vulnerable individuals sentenced in court, has now been expanded and re-launched to five sites including Milton Keynes.
- We continue to offer employment, training and education support to all the adults we work with across the region.
- We chair/attend the Integrated Offender Management scheme, which has a focus on intensive support for those prolific offenders wanting to make positive change.
- We deliver ‘Heal’ for female service users, which is a programme that supports those who have gone through trauma.

How well have we done it?
What difference have we made?

The analysis of serious further offence data highlighted the need to upskill our Responsible Officers in relation to working with sex offenders, in particular in the areas of assessment and supervision, specifically with those that commit domestic violence offences. Our Responsible Officers have received training from Circles of Support and Accountability. We are now in the process of quality-assuring our risk management to evidence the impact of this work.

Next Steps

- We have had some changes to our Senior Management Team and middle managers in 2017, the next steps will be for new staff to contribute to the work of the Board and ensure an appropriate level of attendance at relevant meetings and groups.
- Piloting ‘Heal’ for male service users.
Oakhill Secure Training Centre (STC) is one of three purpose-built secure training centres in the country and is situated in Milton Keynes. It is currently managed by G4S Care and Justice Services Limited. The STC offers secure accommodation for up to 80 young people aged between 12 and 18 years who have been sentenced or remanded to custody. Healthcare is provided by G4S Health under a service level agreement, with appropriate access to community-based services. Education is provided on-site by G4S. Oakhill endeavours to provide young people with the support they need whilst operating within the contractual requirements.

What have we done?

- Our Director and Head of Safeguarding have met regularly with the MKSB Independent Chair for assurance purposes. We also participate in a quarterly professionals meeting with the Police, Council and Oakhill Safeguarding.
- Oakhill accepted the recommendations of the report of the Review of Restraint conducted by MKSB
- A refurbishment programme has commenced of all living accommodation for young people which will be complete by November 2018.
- Oakhill implemented a new multi-disciplinary meeting ‘Team Around the Child’ (TAC) which meets weekly to review Young People’s Care Plans.
- A new admission pack has been developed with young people for when they arrive at the Centre.
- Implemented a new admission and assessment tool.
- Implemented Asset-plus; this is a case management system, which includes revised systems of risk assessment and information sharing. The bullying policy has been reviewed and investigations are now be completed and managed by the Behaviour Support Team.
- Searching risk assessments and procedures for all young people have been reviewed. This reflects the need for all searching to be proportionate to risk and be fully recorded by staff.
- All uses of force and restraint are now reviewed by an MMPR Co-ordinator to ensure appropriate use of force and incident management and any issues identified are submitted to the Use of Force meeting for further reviewing in a multi-agency forum.
- An incentive scheme for young people has been developed and implemented rewarding positive effort and challenging negative behaviour.
- Feedback and discussions are sought from young people through the new Xchange meeting.
- Skills4U 12 week Gangs Programme has been commissioned and introduced.
- Co-commissioned a substantial substance misuse project, bringing in spoken word artists and researchers from Guys Hospital enhanced young people’s understanding of the science of addiction. Young people have confidently shown their work and led in peer activities and facilitated workshops with adults as part of this project; the project involved eight young people from five units and spanned 30 hours.
- Revised education timetable includes life skills. A new role of Education Behaviour Support Manager has been introduced, who, with Senior Residential Managers, has developed a set of expectations for attendance and behaviour.
- A plan to introduce a Forensic Psychology service in addition to the introduction of CAMHS was completed and resourced.
How well we have done it?  
What difference have we made?

• The centre has placed a significant emphasis on planning effectively and ensuring a multi-disciplinary approach to decision-making and planning. As a result teams are working less in silo; For example, the Substance Misuse Team has worked alongside community specialists from Kings College, Science Gallery London, Community Youth Engagement Workers, London based Gang’s programmes. The projects have drawn support from other teams within the centre and have clear outcomes linked to current legislation and the Substance Misuse Service Specification.

• Education and chaplaincy teams are providing more group work, allowing a range of services targeted at the criminogenic needs of the young people.

• Upward trend of referrals for the MASH and LADO, reflect the robust operational pathways eg staff awareness of sexually inappropriate behaviour between different ages of the young people. Feedback with the young people on the outcomes of referrals is more robust and consistent.

We continue to have to manage large numbers of incidents involving challenging behaviour leading to restraint. As a result the focus of our training plan is entirely centred on equipping and empowering staff to manage incidents confidently and assertively without the need for physical restraint.

• The centre has historically struggled with a high level of churn amongst its operational staffing group. This volatility has reduced significantly with dramatically reduced staff attrition and levels of sickness. All of which supports a more consistent group of staff who build strong and consistent relationships with the young people in our care. The voices of the young people in the centre is now stronger, with revised complaints procedures and an ‘X-change meeting’ with senior staff to share ideas and thoughts about how we can improve the centre. Anti- Bullying systems and monitoring systems for sexualised behaviours have also improved to ensure a safer community.

Next Steps

• The development of a new strategic plan with contributions from all staff and young people which will include standards of practice thus evidencing ‘What good looks like’.

• Support a Quality Assurance team who are new in post to regularly benchmark our performance against that plan alongside our Ofsted actions.

• The introduction of a Youth Council to enhance the voices of the young people.

• Young people’s Exit Interviews to use as a ‘distance travelled tool’ to evidence change.

• A full time targeted worker will be employed to continue developing and facilitating group intervention in a more joined up and holistic way.
South Central Ambulance Service NHS Foundation Trust (SCAS) was formed in 2006 and covered four counties, which increased in 2017 to seven counties delivering patient transport for non-emergency hospital appointments covering a population of seven million. We employ over 3,600 clinical and non-clinical staff and are supported by over 1,300 volunteers.

SCAS understands and promotes the importance of safeguarding children and adults across all areas of its services. This will include any person that could potentially come into contact with the general public either face to face or via the telephone, preventing harm to the patients that are cared for in the pre hospital environment. SCAS has taken measures to ensure that policies and processes comply (adhere) with the requirements and performance outlined by legislation and policies and procedures of partner agencies.
What have we done?

• Carried out a full review of safeguarding training at all levels with the production of new training packages.
• Reviewed and updated the Prevent policy.
• Completed development of a chaperone policy.
• Designed and drafted a web-based safeguarding referral form for our 111 and emergency centre, ready to go live later in 2018.
• Upgraded the safeguarding server due to improve storage capacity and update security settings. This upgrade was completed in February 2018.
• SCAS safeguarding team are virtual members of the various MASH teams in the different counties and provide information when requested.
• Delivered safeguarding level 2 to all staff groups. Training is audited by the Head of Safeguarding to ensure the courses that are running are compliant with legislation and the Intercollegiate document 2014 (roles and competencies for healthcare staff).
• SCAS has contributed to a number of serious case reviews in the MK area.
• SCAS has developed any highlighted weakness into a joint action plan with partner agencies.
• Produced a weekly staff magazine called Staff Matters that cover a range of safeguarding topics such as FGM, Modern Slavery, Prevent and Bruising.
• Advised and supported other organisations with safeguarding training and processes, for example working with Fire and Rescue to develop a fire risk assessment for vulnerable persons.

How well have we done it? What difference have we made?

• The Trust’s safeguarding training compliance for level 1 children and adults is 95%, and for level 2 children and adults is 95%.
• Prevent training compliance is at 92% for basic awareness.

Next steps

• Develop a new safeguarding adults policy and a separate safeguarding children’s policy.
• To review and update the domestic abuse policy.
• To review and redesign the safeguarding form on the electronic patient record.
• Work with NHS England Digital to develop a solution to implement CP-IS (child protection information sharing) in ambulance and 111 services.
• Develop a level 1 safeguarding booklet and safeguarding guidance pamphlet for contracted taxi firms and Patient Transport Service volunteer car drivers.

Build closer links with the various MASH teams and continue to support partners when asked.

• To make Making Safeguarding Personal and Voice of the Child a priority.
• To test and rollout of the web based safeguarding referral form to both 111 and emergency call centres.
What have we done?

- We consider safeguarding an essential element of the health and wellbeing of the public we aim to represent. We ensure the staff and volunteers of our organisation follow safeguarding procedures in their contact with the public.
- Healthwatch Milton Keynes launched our ‘Enter and View’ programme in 2018. Our ‘Enter and View’ authorised representatives are trained to recognise and escalate safeguarding issues by referring them to the appropriate agencies.
- We have provided a monitoring and oversight role on the Adults Programme Board and the Performance, Quality and Improvement Group of the Board.

How well have we done it?
What difference have we made?

- We have appropriately trained our staff and volunteers to identify and escalate safeguarding concerns.
- We have worked with MK Together to review and monitor how we can best contribute and discharge our statutory responsibilities and ensure the role of Healthwatch Milton Keynes is effective on relevant boards.
Next steps

To continue to strengthen our relationships with MK Together.

- In line with our strategic objectives to Engage, Empower, Influence and Inform, we will support MK Together to enhance patient, servicer user and carer involvement with regards to safeguarding practice, reflection and oversight.
Attendance at MKSB Meetings 1 April 2017 – 31 March 2018

Summary of Representation at MKSB meetings
(six business meetings were held during the financial year, + a Development Day)

Local Authority – 100% attendance/representation

Police – 100% attendance/representation

Health Commissioner - CCG – 85% attendance/representation
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+ Development Day 29 September
Appendix B

Financial position

2017/18 End of Year Position
### Table 1 – Summary of 2017/18 end of year forecast

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<tr>
<td>Training costs (including conference)</td>
<td>8,922</td>
<td></td>
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<tr>
<td>FGM community work</td>
<td>4,500</td>
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<tr>
<td>Miscellaneous costs</td>
<td>6,097</td>
<td></td>
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<tr>
<td>Total</td>
<td>-73,181 (to be carried forward)</td>
<td></td>
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<tr>
<td>Glossary of terms</td>
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<tr>
<td>ACRP Adult Case Review Panel</td>
<td>LDU Local Delivery Unit</td>
<td></td>
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<tr>
<td>A&amp;E Accident and Emergency</td>
<td>LPA Local Policing Area</td>
<td></td>
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<tr>
<td>ASC Adult Social Care</td>
<td>LSCB Local Safeguarding Children Board</td>
<td></td>
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<tr>
<td>CAMHS Child and Adolescent Mental Health Service</td>
<td>MAPPA Multi-Agency Public Protection Arrangements</td>
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<tr>
<td>CCG Clinical Commissioning Group</td>
<td>MARAC Multi-Agency Risk Assessment Conference</td>
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<tr>
<td>CCRP Children’s Case Review Panel</td>
<td>MASH Multi-Agency Safeguarding Hub</td>
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<tr>
<td>CDOP Child Death Overview Panel</td>
<td>MCA Mental Capacity Act</td>
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<tr>
<td>CFP Children and Family Practice</td>
<td>MK Milton Keynes</td>
<td></td>
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<tr>
<td>CFLT Children and Families Leadership Team</td>
<td>MKCCG Milton Keynes Clinical Commissioning Group</td>
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<tr>
<td>CJB Criminal Justice Board</td>
<td>MKSAB Milton Keynes Safeguarding Adults Board</td>
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<tr>
<td>CNWL MK Central and North West London NHS Foundation Trust Milton Keynes</td>
<td>MKSB Milton Keynes Safeguarding Board</td>
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<tr>
<td>COT Community Occupational Therapy</td>
<td>MKSCB Milton Keynes Safeguarding Children Board</td>
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<tr>
<td>CPB Children’s Programme Board</td>
<td>MK UHFT Milton Keynes University Hospital NHS Foundation Trust</td>
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<tr>
<td>CP-IS Child Protection Information Sharing</td>
<td>MMPR Minimising and Managing Physical Restraint</td>
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<tr>
<td>CSC Children’s Social Care</td>
<td>NHS National Health Service</td>
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<tr>
<td>CSE Child Sexual Exploitation</td>
<td>NPS National Probation Service</td>
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<tr>
<td>CQC Care Quality Commission</td>
<td>OFSTED Office for Standards in Education, Children’s Services and Skills</td>
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<tr>
<td>CuSP Custody Support Plan</td>
<td>PBS Positive Behaviour Support</td>
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<tr>
<td>DCI Detective Chief Inspector</td>
<td>PQI Performance, Quality and Improvement Group</td>
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<tr>
<td>Divisional DA Divisional Domestic Abuse</td>
<td>RAG (rating) Red, Amber, Green rating</td>
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<tr>
<td>DoLS Deprivation of Liberty Safeguards</td>
<td>RLG Reviews and Learning Group</td>
<td></td>
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<tr>
<td>ED Emergency Department</td>
<td>SAR Safeguarding Adults Review</td>
<td></td>
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<tr>
<td>ELPS Police ‘missing’ data system</td>
<td>SaVE Safeguarding, Vulnerability, Exploitation</td>
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<tr>
<td>FGM Female Genital Mutilation</td>
<td>SCAS South Central Ambulance Service NHS Foundation Trust</td>
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<tr>
<td>FII Fabricated or Induced Illness</td>
<td>SCR Serious Case Review</td>
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<tr>
<td>GP General Practitioner</td>
<td>STC Secure Training Centre</td>
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<tr>
<td>HFRC Home Fire Risk Checks</td>
<td>STP Sustainability and Transformation Partnership</td>
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<tr>
<td>HMP Her Majesty’s Prison</td>
<td>TAC Team Around the Child</td>
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<tr>
<td>LADO Local Authority Designated Officer</td>
<td>TVCRC Thames Valley Community Rehabilitation Company</td>
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<tr>
<td>LeDeR Learning Disability Mortality Review</td>
<td>TVP Thames Valley Police</td>
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