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NHS DORSET CLINICAL COMMISSIONING GROUP

GOVERNING BODY

SAFEGUARDING ADULTS AND CHILDREN'S BI-ANNUAL UPDATE

Date of the meeting	20/01/2021
Author	L Plastow – Head of Safeguarding K Bland - Professional Lead Adult Safeguarding
Lead Director	V Read, Director for Nursing & Quality
Purpose of Report	This safeguarding report aims to inform the Governing Body of the safeguarding activity for Children and Adults.
Recommendation	The Governing Body is asked to **note** the report.

Monitoring and Assurance Summary

Conflicts of Interest	Members of the Governing Body should identify if they have any Conflict of Interest regarding their safeguarding practice.
Involvement and Consultation	Where relevant some members of the Governing Body may have been involved in the development of initiatives e.g. primary care dashboard.
Equality, Diversity and Inclusion	N/A
Financial and Resource Implications	There are no budgetary implications; however, the implementation of the liberty protection standards will have resource implications. This will be submitted in a business case to the governing body later.
Legal/governance	There is a legislative framework for Safeguarding practice. This paper confirms that the CCG meets its legislative requirements
Risk description/rating	Where safeguarding risks occur, these are identified and mitigated against with details in the Governing Body assurance framework.

1. Introduction

1.1 This joint Children and Adult Safeguarding report provides an overview of the safeguarding activity across NHS commissioned services. The purpose of the report is to assure the Governing Body that it is meeting its statutory functions.

1.2 The Local Safeguarding Children Boards were abolished in September 2019 and following publication of the Children and Social Work Act 2017, the new Safeguarding Partnership Arrangements were established. The Act bestows on three key partners, Local Authority, Police and CCGs, equal responsibility to safeguard and promote the welfare of children.

1.3 The lead agency responsible for Adult Safeguarding remains with the Local Authority (LA) who work with the statutory partners, the Police, and the CCG.

1.4 The Local Government Review (LGR) and subsequent OFSTED conversations have remained a major focus for the Local Authorities throughout the year but there has been assurance that the focus of the whole safeguarding agenda remains a high priority.

2 CCG Safeguarding Assurance

2.1 NHS Dorset Clinical Commissioning Group (CCG) has a statutory duty under the Children's Act (1989, 2004) and the Care Act (2014) to provide assurance that all Health Care Services commissioned, contracted and provided have robust processes in place to identify, refer and protect both adults and children from abuse, harm and neglect. The CCG also has a statutory duty to be involved in Safeguarding Adult Reviews (SAR) Serious Practice Reviews (SPR) and Domestic Homicide Reviews (DHR).

2.2 The duties of the CCG are to seek assurance that safeguarding is integral to service delivery and development across Provider services. This includes the assurance there are robust governance and reporting mechanisms in place and are effective in line with the NHSE Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (2019). Providers of NHS services are also governed and monitored on their identification and management of risk. Finally, the CCG monitors the effectiveness of their safeguarding partnership arrangements with the wider statutory partners.

2.3 To meet this duty, the CCG safeguarding team, work in close collaboration with all health providers, the local authorities and the police to provide strategic leadership and offer health advice, support and guidance to all areas of safeguarding Dorset CCG remains as an organisation compliant with its statutory requirement for children and adult safeguarding.

2.4 The Governing Body received its annual safeguarding update training in February 2020.

2.5 All high -risk health safeguarding concerns for both children and adults are escalated to the CCG safeguarding team by the Providers. High Risk safeguarding includes those cases where there is

- Wider public interest
- Media involvement
- Criminal justice processes being evoked
- Organisational abuse
- Organisational reputation is at risk
- Major workforce related issues
- Interagency threshold challenges which requires senior management discussion and decision making.
- Reduced interagency engagement which fails to identify and progress high-risk cases

This allows the CCG to liaise with statutory partners to work together to manage and mitigate risk.

2.6 The CCG has not been involved in any statutory inspections this year, although BCP Council have had an OFSTED review, for which Partner agencies were not required to participate.

2.7 This paper focuses on safeguarding assurance, an outline of multi-agency safeguarding activity can be found in Appendix 1.

3. Adult Safeguarding

3.1 The NHS providers submit quarterly safeguarding data to the CCG. This is analysed and shared as part of the Safeguarding Adults Board (SAB) Quality Assurance group as a measure to monitor the adult safeguarding health activity across the whole health landscape. Data was suspended in response to Covid 19, resulting in delays in submission, however, a revised timetable for timely submission of data has now been agreed with Providers.

3.2 The main theme of the safeguarding concerns across the whole county includes neglect and acts of omission within care providers including care homes with and without nursing.

3.3 Annual quality assurance visits have not been completed to NHS providers this year due to the global pandemic. The Adult Safeguarding Lead is working with the Head of Safeguarding to plan these visits in 2021/2022 (if government guidelines allow). NHS England and NHS Improvement (NHSEI) have developed a new Safeguarding Commissioning Assurance Tool (SCAT) that we will be implementing at the Quality assurance visits in 2021/2020.

Domestic Abuse (DA)

3.4 Dorset Police report that between 01 April 2020 and 30 September 2020 they issued 6,939 Public Protection Notices (PPN) for Domestic Abuse, this is a 10% increase on the same time last year.

3.5 Since June 2020, the CCG have received referrals for four Domestic Homicide Reviews (DHR). Due to the confidential nature of these cases further information will be available in Part 2 of this report.

3.6 It was identified during the High-Risk Domestic Abuse (HRDA) pilot that although health information was a key element of the meeting it was not possible for health to resource four meetings a week. A digital summary of System1 records are collated for each victim, perpetrator and any children involved in the case and provided ahead of the meeting. There by providing required information in a timely streamlined way.

3.7 BCP Council are reviewing their current Multi Agency Risk Assessment Conference (MARAC) model which is held weekly and can hear between 11 – 26 cases. The volume of high-risk domestic abuse continues to grow as is shown by the high numbers of cases heard at each MARAC. The CCG continue to support the review of the model.

3.8 The Adult Safeguarding Lead has completed the SafeLives MARAC Chair training.

PREVENT

3.9 PREVENT remains a high priority for the country. All NHS providers submit quarterly PREVENT data to the Home Office, which includes their training figures below for Q2.

	DCH	UHD	DHC
Q2	93.2%	98.9%	94.7%

3.10 The Pan-Dorset Prevent Partnership co-ordinates work with our partners to deliver on the PREVENT agenda and feeds into the Regional Prevent Network.

3.11 The Counter Terrorism Policing unit held a review event with Partners in August 2020, several Prevent referrals were reviewed to gain assurance that Dorset processes and protocols are robust and appropriate. All cases reviewed were handled positively and proactively.

4. Children Safeguarding

4.1 In 2020 in BCP, there were 2281 episodes of children in need and of these 1010 were for abuse, compared to in 2019 there were 1351 of which 783 were for abuse. In Dorset there were 2854 episodes of children in need of which 1354 were for abuse compared to 2712 in 2019 of which 1189 were for abuse.

4.2 This data is of relevance for it provides a more accurate indication of risk, the children of these families are vulnerable to abuse and unless preventative and early interventions are in place these are the children and young people who may come to harm.

4.3 With regard to safeguarding activity Dorset compares favourably with national and south west comparators. However, it should be noted there was an increase in families coming to the attention of children social care this year, who were not previously known.

4.4 Current data on exploitation should be considered with caution, for those reported to be at risk of significant exploitation remains static yet the emerging cases appear very low in comparison. This may be due to the risk of hidden harm and the challenge for statutory agencies in identifying risk. Both Council areas prioritise child exploitation and the CCG sit on both strategic groups. It is anticipated the South West Serious Violence Information Governance and Data group, may help to provide more accurate data regionally.

4.5 In 2019, the CCG recruited two Specialist Child Protection Nurses to improve sharing of primary care and school nursing information at Child Protection conferences, for school aged children where no health services are involved. Evaluation of these posts indicate that attendance at Conferences improved considerably, however, the role has focused on representation and has not delivered on the wider support to Primary Care. In addition, the newly developed health summaries developed in primary care can now provide information in a timely way. These posts will be reviewed when the contracts end in March 2021.

5. Children's Safeguarding Partnership

5.1 The proposed direction of travel for the Partnership is for child safeguarding to be integrated internally within both BCP and Dorset Councils and aligned with the rest of children's services in their respective local authorities. With some functions provided through a pan-Dorset Programme Office or Business Unit. These include pan-Dorset procedures, the partnership website, training and quality assurance of the Partnership though the existing Learning Hub model.

5.2 Throughout 2020, the CCG has continued to work closely with both Local Authorities supporting the Dorset Strengthening Services Plan and the Children and Young

People Strategic Alliance. In Bournemouth, Christchurch and Poole (BCP) the CCG have contributed to the Children and Young People Plan and work closely with both Local Authorities regarding the Multi-Agency Safeguarding Hubs and the now two separate front doors.

5.3 The focus for children's safeguarding throughout the pandemic has been on recognising hidden harm and providing opportunities for children and young people to be heard. A Covid safeguarding Comms group initially led by Police and now Health, had two main foci:

- children who were being targeted online and groomed /exploited
- children who were the subject of intra-familial abuse who had no means to disclose whilst in the home.

All Partners worked closely together to mitigate risk and to support a range of methods of communicating to these children throughout lockdown.

5.4 In addition, safeguarding has seen referrals of very young babies, although, this requires further exploration, it is thought this is possibly due to the cessation of home visits by universal services throughout the first lockdown, the lack of support from family and friends, resulting in increased parental anxiety.

5.5 Throughout the Pandemic, partners have worked closely to target their interventions to the most vulnerable families and there have been some excellent examples of effective partnership working e.g. targeting of most vulnerable children. The concern remains however of those families under the radar who are not already known and who have had minimal contact with services.

6. Serious Violence

6.1 Serious Violence and Exploitation is a fast-growing area of concern and is considered not only at the Children's Safeguarding Partnership but also within the Community Safety Partnerships and the Modern Slavery and Trafficking Partnership.

6.2 Following public consultation in July 2019, the Government announced that it would bring forward legislation introducing a new serious violence duty ("the duty") on public bodies, which will come into force no sooner than 2022. This will put a duty on the CCG to work together to plan, share data, intelligence and knowledge, to generate evidence-based analysis and solutions to prevent and reduce serious violence in local areas.

6.3 At the beginning of the Covid 19 pandemic, crime reduced across Dorset including County Lines activity, however although crime rates are lower than in 2019, County Lines are reported to be back up to pre-covid levels.

7. Child Sexual Abuse

7.1 The number of recorded child sexual abuse offences has increased rapidly since Operation Yewtree **(**investigation into sexual abuse allegations against Jimmy Savile and others). In the year to June 2017, there were 68,699 child sex offences, nationally, up 24% from the previous year and the numbers continue to grow.

7.2 The Covid Safeguarding Communications group was established in anticipation of the risk of sexual exploitation online and the risk of increased intrafamilial sexual

abuse. There is no evidence currently of any increase in sexual exploitation online, and the numbers of reported sexual abuse cases reduced throughout the pandemic.

7.3 Sexual Assault Referral centres remained open throughout lockdown, however the number of referrals into safeguarding of children who were sexually abused, reduced. At the moment it is not clear why this is the case.

8. Female Genital Mutilation (FGM)

8.1 There have been no reported cases of children being subjected to FGM during last twelve-month period.

9. Child Protection Information System (CP-IS)

9.1 The CP-IS project links the IT systems used across health and social care to better share information securely to protect vulnerable children.

9.2 This has been fully implemented for all key NHS providers and Local Authority partners. In response to the pandemic, NHSE mandated that CP-IS was extended to all Public Health Nursing Services.

10. Looked After Children

10.1 In January 2020 there were a total of 1009 children in care Pan Dorset, which was an increase from the previous year of 11%. In December 2020 it is recorded there are 971 in care which shows an overall increase of 7%. The most significant rise has been in the under 5 years of age population, however 25% of the caseload remains 16-18-year olds.

10.2 This year has noted an increase in the complexity of vulnerabilities and the need for health to be involved in risk management meetings as standard.

10.3 There has been a 27% increase in the number of care leavers (Dec 2020 – 852) since January 2020 which has shown a year on year increase since recording of this cohort began, this has put pressure on the commissioned care leaver nurses to meet identified need.

10.4 Initial health assessment performance has fluctuated this year with a decline noted in the latter part of the year to coincide with structure changes for both local authorities affecting notification and consent, and the paediatric service increasing their service delivery back to pre Covid times.

10.5 In response to the ongoing concerns in relation to Initial Health Assessments, a Task and Finish Group has been established with the local authorities to align processes and find a sustainable solution for the future.

10.6 Innovative practice in terms of increased use of digital platforms (WhatsApp, Attend Anywhere) has enabled the health team to recover from redeployment in April and May, performance has increased back up to 86% for review health assessments.

10.7 Anecdotal evidence is backed up by the Ofsted visits to education and social care who report that referrals to social care teams have fallen and have so far not returned to more typical levels since schools reopened, raising concern that domestic neglect, exploitation or abuse is going undetected. However, it was also noted that

relationships between carers and the children in their care improved during lockdown, as children appreciated spending quality time together.

10.8 Many children are reported missing each year and data indicates children in care are more likely to be reported missing. The data is misleading for if a child is late home from a friend and they are a child in care it will be reported, when in fact they have just stayed out late. The concerns are that vulnerable young people can be targeted by criminal gangs, however missing data alone cannot be seen as an indicator of risk.

11. Multi-Agency Safeguarding Hub (MASH)

11.1 The MASH model in place in Dorset, has undergone a transformation in 2020/21, Dorset and BCP Councils have redesigned their access to children's services which in turn has impacted on the MASH model.

11.2 The new model is truer to the original MASH prototype with all referrals being triaged at the front door and only those referrals for which additional information is required are heard in MASH.

11.3 Demand in MASH is reported to have increased significantly since the introduction of the new integrated Front Doors in both Local Authority areas.

11.4 BCP data indicates in January 2020 there were 2121 MASH contacts which reduced to 1088 in April increasing to 1519 in June. Of these between 17 and 20% were converted into referrals. This data indicates whilst in the peak of lockdown the number of referrals dropped but once restrictions eased some of the hidden harm was realised.

11.5 In Dorset the number of contacts between 01/11/2019 and 01/03/2020 was 2906 of which 1106 went onto a referral. The number reduced in April to 1058 contacts increasing to 1189 in May 2020. This again indicates a reduction in lockdown increasing as restrictions eased.

11.6 PPN referrals into MASH averaged at 563 throughout April to September with a 39% increase in September, peaking at 748, in September 2020.

11.7 In July 2020 there were 251 additional referrals to the normal average monthly number and in September, there were 873 more referrals than average. This increase in demand is not sustainable in the long term thus a Task and Finish Group has been set up by the CCG to review this. In response the MASH specification will be reviewed as the service has developed in response to demand and no longer reflects the original 2016 specification.

12. Child Death Overview Panel

12.1 Following a delay in inquests as a result of the pandemic, CDOP panels have reconvened virtually this year with two panels in Quarter 3.

12.2 There have been 26 child deaths, this year Pan–Dorset which is comparable with 24 in 2018/19 representing no sudden change in data.

12.3 The Panel use the new e-CDOP process which enables local data to be compared regionally and nationally and support the national team to identify trends. However,

the system is not practitioner friendly and requires some administrative support in the sharing of information for Panels. This will be addressed with the Partnership in 2021

13. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

13.1 Mental capacity continues to be a focus of all aspects of our work. Providers continue to make applications under the Deprivation of Liberty Safeguards (DoLs).

13.2 MCA training is still a high priority for the providers and they continue to develop an online delivery module for this. Training data is detailed below:

	UHD	DCH	DHC
Q2	93.9%	89%	81.05%

In order to be compliant training is now being delivered virtually, however in DHC, there have been several new services commissioned e.g. NHS111, with large numbers of staff to be trained which will impact on their data. DHC have developed a training programme to improve compliance.

The implementation of Liberty Protection Safeguards (LPS) has now been put back to 01 April 2022 (Appendix 2). Outlines the legislative requirements and the potential impact for the CCG and its commissioned Providers. The paper also briefly outlines the potential gaps and thus potential financial implications.

13.3 A Business Case for the implementation of LPS will be submitted to the Governing Body in Spring 2021

14. Named Safeguarding Lead GPs

14.1 Commissioning Care Local Improvement in Practice (C-CLIP) programme to improve safeguarding reports from primary care to child protection conferences continues, there has been ongoing work with practices and local authorities to address email and process issues.

14.2 Monitoring of data shows an increase in response rate from a baseline of 25-30% prior to C-CLIP, to overall in Q2, an increase to 44% and up to 56% in December. This shows good progress from the team and much appreciated buy in from practices despite the challenges of Covid-19.

14.3 Practices are contacted if negative trends are noted in response rates and these Practices are targeted for a virtual quality assessment visit, all visits are tabled for completion by end of March 2021.

14.4 Safeguarding C-CLIP has been agreed for 2021/22, to enable ongoing monitoring, embedding changes from this year and to follow up on any suggestions as a result of the quality visits. There are plans to introduce a coding element to improve accuracy and timeliness, which in turn will help facilitate the newly developed safeguarding dashboard.

14.5 Safeguarding Dashboard- a safeguarding dashboard using data from system 1 is in the final stages of its initial development. The dashboard will enable the safeguarding team to identify areas of need in different Primary Care Networks, to inform contextual safeguarding and provide evidence of which areas may need different forms of support and allocation of resource in the future.

14.6 The safeguarding CCLIP will be used to maintain accurate and current data within the dashboard. We are also hoping to use mosaic data to superimpose drug and alcohol data on top of primary care data to identify the extent of the toxic trio of domestic violence, drugs and alcohol and mental health, within the population. This has been developed with DIIS and it is hoped in the long term, data from police and local authorities can link with this Dashboard. It is anticipated the initial dashboard will be fully functional going into Q1 of 2021.

15. Safeguarding Adult Reviews (SAR)/Serious Case Reviews (SCR) Case Audits/Whole Service Reviews

15.1 Due to the confidential nature of these statutory reviews a separate report is presented in part two of the Governing Body Report.

15.2 Overall, the learning from SCR, SAR and DHR relate to domestic abuse, application and understanding of the mental capacity act, risk assessments and sharing information across agencies. There was specific learning in relation to children and parenting whilst under the influence of alcohol and the management of young people with complex mental health and care needs.

16. Serious Incident Investigations/ Managing Allegations

16.1 All serious incident investigations are triangulated with any safeguarding requirements via Ulysses. All health providers continue to take their own responsibility for managing allegations of staff, whilst the CCG report any allegations from Primary Care into NHS England for review in line with the Performers List requirements.

17. Safeguarding Training

17.1 As a result of the Covid 19 pandemic, all training this year has been delivered virtually. The safeguarding teams across the ICS, completed a Virtual Training session in April 2020 on Safeguarding and Ethical Decision Making as a result of Covid19; and in November 2020, Level 4/5 Strategic Safeguarding Training.

17.2 The CCG Safeguarding Team provided training to the Governing Body in February 2020. In addition, there has been training delivered virtually to Primary Care.

17.3 A scoping exercise has been undertaken by the CCG safeguarding team to map all CCG Staff against the revised intercollegiate documents. This has identified a number of staff specifically in Continuing Health Care who require Level 3 training, and this is being arranged with Workforce to be delivered virtually.

17.4 A bespoke safeguarding training for commissioners has been developed.

18. External Inspections and Reports

18.1 Dorset Council's, Strengthening Services Plan has identified all outstanding actions from the OFSTED/CQC/HMICFRS Joint Target Area Inspections (JTAI). All health actions are either complete or being addressed through this Plan.

18.2 A children's safeguarding focused OFSTED visit took place in November 2020, in BCP Council. No multi-agency partners were required to take part in the visit. The Report identified serious and widespread weaknesses in the quality of children's

services in Bournemouth, Christchurch and Poole (BCP). The CCG are working collaboratively with the Council to support their improvement journey.

18.3 The CCG have requested confirmation that all the Actions from the CQC CLAS (Children Looked After and Safeguarding) inspection are now complete and this will be followed up in 2021.

19. NHS England South West South Safeguarding

19.1 The CCG are represented on several streams of work being led by NHSE SW. These include :

- South West Safeguarding Steering Group
- South West Regional NHS Prevent Leads Network
- South West Regional Serious Violence and Contextualised Safeguarding Data Set & Information Governance Reference Group
- South West Safeguarding Workforce and Learning and Development Reference Group

20. Objectives for 2020 / 21

20.1 There has been significant changes in personnel within the safeguarding team this year. The focus for this year has been on building the Team, albeit virtually and to develop relationships across the Multi-Agency safeguarding partnership.

20.2 Work will continue to align the children and adult safeguarding agendas within a contextual safeguarding agenda. The table below identifies Progress with Objectives and new Objectives for 2020-21.

Objective	Date	Progress	Rag rating
Review existing systems and structures to streamline and reduce duplication	20/21	Several processes around MASH/ MARAC and HRDA have been simplified and streamlined	
Develop innovative models of safeguarding with Partners, using digitalisation	20/21	Use of digital technology across the safeguarding system has been embedded from meetings to communications to capturing data and supporting Families	
Improving intelligence and information sharing across ICS	20/21	Work has started on improving information sharing across ICS and it is planned that this will be a priority for 2020-21	
Develop safeguarding dashboard to inform future strategy	20/21	A primary care Dashboard has been developed for safeguarding and although continues to evolve shows great promise for enabling targeting of resources and informing a population focus to safeguarding	
Listening and including the voice of Service Users in safeguarding planning	20/21	Planned user event with Children In care had to be postponed due to Covid19. However, throughout Lockdown children and young people were heard via email,	

		newsletters and awareness raising via home learning packs	
Early Intervention and Prevention across the whole Health and Social Care system with a focus on preventing children coming into care.	20/21	Strengthening services Plan in Dorset and the Children and Young People Board in BCP promote the importance of early intervention and both CCG and all providers are involved with this work.	
Domestic Abuse - to ensure the recommendations from the Domestic Homicide Reviews are embedded across primary care and NHS providers	20/21	Learning from all DHR's has been collated into a single workplan and plans to audit the learning outcomes are in place for 20-21. The Domestic Abuse Bill is still going through Parliament	
Preparing for the implementation of the Liberty Protection Safeguards in partnership with PHC and Providers	21/22	Preparation meetings have taken place between CHC and Safeguarding within the CCG and also with multi-agency Partners as well as our commissioned Providers. Plans are being made and anticipated resource costs determined. The Code of Conduct is yet to be published.	
Working with Partners to strengthen safeguarding within the ICS	21/22	A small Heads group of the wider Safeguarding Team across the ICS have an established meeting monthly. There are several task and Finish groups established to carry work forward to build structures, prevent duplication, and build strong relationships	
CCLIP- Improving Quality and quantity of safeguarding reports from Primary Care.	20/21 and 21/22	The CCLIP programme is progressing well and has shown an improvement in the number and quality of safeguarding reports. the programme is being extended a further year to fully embed lessons learnt	
Serious Violence Duty - to understand the extent of the issues locally and to be assured relevant multi-agency systems and process are in place to address the risk	21/22	This is a new duty being imposed on CCG's It is to be embedded by Spring 2022 and we await further national guidance	
Strengthening relationships across commissioning and embedding safeguarding as a golden thread throughout all contracts	21/22	Safeguarding has started to work more effectively with commissioners across the CCG to embed safeguarding at the procurement stage. An example of this is with proposed new CAMHS services, safeguarding have engaged with the commissioners to embed safeguarding training and supervision into its implementation	

Ensuring all learning from Inspections and Statutory Reviews are acted on and evaluated.	21/22	All Learning has been collated and as part of the Training and Workforce sub-group of the SAB, the implementation of the learning will be evaluated.	
Review Initial Health Assessments and improve compliance within statutory timelines	20-21 and 21/22	A Task and Finish Group has been set up with both Councils with a commitment to improve rates and streamline processes by end of 20-21	

21. Conclusion

21.1 The CCG continues to maintain its statutory obligations and focus on safeguarding across Dorset's healthcare system.

21.2 Inevitably Covid 19 has impacted on safeguarding throughout this year, with increases in family tensions, domestic abuse and serious violence. However, the anticipated hidden harm is yet to be realised.

21.3 Focus for the next year will be prioritised to ensure recommendations from statutory reviews are implemented, compliance with initial health assessments is improved, developing intelligence gathering and strengthening safeguarding structures across the ICS.

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Date: **31/12/2020**

APPENDICES	
Appendix 1	**CCG Safeguarding Activity across Multi-Agency Safeguarding Partnership**
Appendix 2	**Liberty Protection Safeguards (LPS)**

APPENDIX 1: CCG Safeguarding Activity across Multi-Agency Safeguarding Partnership

This Appendix outlines some of the multi-agency working over the last 6- month period.

Adult Safeguarding

1.1 A Statutory section 42 adult safeguarding enquiry is undertaken when an individual aged 18 or over and:

- Has needs for care and support (whether the Local Authority is meeting any of these needs or not); and
- Is experiencing, or at risk of, abuse or neglect; and
- 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.

1.2 Since the beginning of the financial year both Dorset council and BCP council have implemented new front door systems for safeguarding referrals. Each council now operate a triage function as to whether a referral progresses to a section 42 enquiry, a care act assessment / social care support or no further action. It has been noted that there has been a significant increase in referrals to both councils.

1.3 The Adult Safeguarding Lead is working with both councils to understand the themes of these referrals and identify any areas for improvement in respect of the quality of the referral.

1.4 Dorset CCG and Dorset Police have worked together to ensure that any Public Protection Notice (PPN) that include a person employed by Health is notified to the CCG as well as the relevant employer. This enables the CCG to maintain oversight of risk and any themes that may emerge.

2. Domestic Abuse

2.1 The High-Risk Domestic Abuse (HRDA) model for managing high risk domestic abuse cases has been developed in the Dorset Council area. This replaces the previous Multi Agency Risk Assessment Conference (MARAC) model. The HRDA is held 4 days a week and can hear from 2-6 cases a day. Dorset Police chair the majority of the HRDA's however the CCG Adult Safeguarding Lead, also chair one HRDA each a month to support the process. Cases where the risk is not reduced through HRDA are referred to High Risk Domestic Abuse Plus (HRDAP). This is a monthly meeting where senior representatives across all multi-agency partners including mental health come together to discuss the cases and plan actions.

2.2 An increase in the complexity of domestic abuse cases has also impacted on children and young people who have been witness to the violence and the subsequent harm. There has been an increase generally in family tensions resulting in referrals of families that would have never previously come to the attention of safeguarding.

2.3 Of the 389,260 children in need, nationally at 31 March 2020, domestic violence by the parent was identified as a factor in 169,860 episodes and remains the most common factor.

3. Safeguarding Adult Boards (SAB)

3.1 The SAB has undertaken a review of Multi-Agency Risk Management (MARM) meetings across Dorset. It is anticipated that the review will be available at the end of 2020/2021. Once the review is completed it is anticipated that new guidance will be formulated to support practitioners to deliver a MARM in a person centred and effective manner

3.2 Throughout the global pandemic, partners and providers have come together to ensure that Safeguarding is integral to the Covid-19 response. Initially all agencies came together weekly to highlight any concerns and work together to achieve a collective response to mitigate risk and respond in a timely way where necessary.

4 Children Safeguarding

4.1 Children become subject to a Child Protection Plan following a Section 47 (Children Act 1989) investigation. This is undertaken when a child, under the age of 18 is identified or suspected of being at significant risk of harm.

4.2 Where a child does not require protection but is still considered *'in need'* Children's Social Care should provide planned care under Section 17 (Children Act 89). The area of early help which sit before the threshold of a Section 17 remains an area of development.

4.3 Data for the year, 2020 https://explore-education-statistics.service.gov.uk/find-statistics show there were 339 children subject to a Child Protection Plan in Bournemouth Christchurch and Poole compared to 208 in 2019 and 393 in Dorset in 2020 compared with 481 in 2019. This shows an increase in BCP and a decrease in Dorset, however the differences reflect the changes in LA boundaries, following the LGR Review.

4.4 In 2020 in BCP, there were 2281 episodes of children in need and of these 1010 were for abuse, compared to 2019 when there were 1351 of which 783 were for abuse. Whereas in Dorset there were 2854 episodes of children in need of which 1354 were for abuse compared to 2712 in 2019 of which 1189 were for abuse.

4.5 This data is of relevance for it provides a more accurate indication of risk, for the children of these families are vulnerable to abuse and unless preventative and early interventions are in place these are the children and young people who may come to harm.

5. Children's Safeguarding Partnership

5.1 The launch of the 2019 pan-Dorset Safeguarding Children Partnership signified a break with the past with one Partnership replacing the two Local Safeguarding Children's Boards. The CCG is represented at the Children's Safeguarding Partnership and it's sub-groups.

5.2 Currently despite, having one partnership, most of the functions continue to be managed by either Dorset Council or BCP Council. The partnership budget is still made up of a BCP budget and a Dorset budget rather than a single integrated budget.

5.3 Dorset Council continues to manage the training posts which commission training through external providers: the contracts for policies and procedures with TriX; and

the website. The Dorset-based business team manages the associated twitter feed and the PDSCP newsletter.

5.4 BCP provides the Partnership's data analysis function for the supply of data and analyst support to the Partnership's QA function, through a contract held by Dorset Council.

5.5 Finally, Dorset Council manages the CDOP administrator who carries out a specialist function linking into ECDOP and the national child mortality database.

5.6 However, BCP and Dorset combine in many ways in relation to other services and functions. The regional adoption agency, Aspire Adoption, and the Youth Offending Service, are both pan-Dorset services. CDOP is a Dorset/BCP/Somerset service. A regional arrangement for placing unaccompanied asylum-seeking children (UASC) is likely in the future.

6 Serious Violence

6.1.1 Children at Risk of or Linked to Exploitation (CARoLE), the CARoLE model continues as the mechanism to address children and young people at risk of exploitation in Dorset Local Authority area. The Tactical and Operational groups have continued. The CCG sit on the newly reformed Child exploitation Strategic Group.

6.1.2 In BCP, Children's Services have published a Multi-Agency Child Exploitation Improvement Plan (CEIP) 2020-2023, which focuses on four priority programmes of Prepare; Prevent; Protect and Pursue.

7. Conclusion

Partnership working has been strong throughout the last six months. The pandemic led to a strengthening of relationships and a streamlining of duplication.

Safeguarding remained a priority throughout and as a Partnership we did see increasing the numbers of complex domestic abuse and referrals into statutory services.

There has been significant learning and the period has enabled the safeguarding team to reflect on the benefits of digital working and virtual meetings as well as identifying areas for future development.

The next six months will see a realignment of the two Councils regarding children's safeguarding into a place-based model. However, the CCG are well placed to influence the transformation.

APPENDIX 2: Implementing Liberty Protection Standards, 2022

1. Background

1.1 Deprivation of Liberty Safeguards (DoLS) were introduced in England and Wales as an amendment to the Mental Capacity Act in 2007. DoLS provides legal safeguards for individuals who are deprived of their liberty and do not have the capacity to consent. They were introduced to plug the gap in safeguards identified by the European Court of Human Rights in HL v United Kingdom (2005) 40 EHRR 32 (App no 45508/99) (also known as the "Bournewood" case).

1.2 The House of Lords found that DoLS was 'not fit for purpose' in their post legislative scrutiny of the Mental Capacity Act in March 2014. Subsequent to this, the government asked the Law Commission to produce a report into mental capacity and DoLS. The Law Commission published their report in March 2017. This report introduced the proposed Liberty Protection Safeguards (LPS) which will replace the current DoLS system.

1.3 This paper outlines changes in responsibility, how prepared the CCG and Providers are for the implementation and the potential resource implication. Until the Code is published however, the full implications will not be fully understood.

2. Health Responsibility

2.1 The Liberty Protection safeguards (LPS) creates a new role for CCGs and Health providers. The CCG and Health providers become a Responsible Body.

2.2 The responsible body is the organisation in circumstances where the arrangements that result in a deprivation of liberty are being carried out. For the CCG this is for those that are found eligible and funded by Continuing Health Care.

2.3 The Responsible Body is responsible for identifying, assessing, authorising and monitoring the LPS.

3. Difference between DoL's and LPS

3.1 LPS has a wider remit than DoLS and is applicable to those within a domiciliary setting as well as those in hospitals or care homes.

3.2 In line with the Mental Capacity Act (MCA), LPS is effective from age 16.

4. Implementation

4.1 The initial date for implementation of the LPS was 01 October 2020, however due to the global pandemic this was delayed until 01 April 2022.

4.2 The draft Code of Practice is anticipated to be released for consultation in Spring 2021; followed by a 12 week consultation period prior to it being finalised.

4.3 Until the Code of Practice is released it is proving a challenge for Personal Health Commissioning and Health providers to plan. However, preparation has started for once the code is released.

4.4 The CCG sit on the BCP LPS programme board. It is anticipated there will be a Pan-Dorset approach to implementation.

5. Commissioned Services Preparation

5.1 UNIVERSITY HOSPITALS DORSET (UHD) are currently focusing on their structures, policies and procedures post the merger. The implementation of LPS is a factor in their planning for structures and service design. UHD anticipate that once the Code is released it will be able to work towards full implementation.

5.2 COUNTY HOSPITAL (DCH) have recently reviewed their initial options paper regarding the implementation of LPS. This includes a review of recent DoL's applications and some initial scoping regarding the possible impact of the LPS. Until the code of practice is published it is not possible to plan fully for its implementation.

5.3 DORSET HEALTHCARE (DHC) Due to the global pandemic DHC has been focusing on mental capacity rather than just LPS. Though some basic costings for LPS have been calculated based on what is currently known regarding training for staff, modifications to electronic systems and time for staff to undertake the assessments etc required to place a person under an LPS.

6. PERSONAL HEALTH COMMISSIONING

6.1 DoLS to LPS and cases requiring LPS assessment

6.1.1 It would be reasonable to presume that all existing DoL's cases would require LPS at the next review point or where they have been identified as requiring a DoL's application, but this has not been undertaken prior to the implementation of the LPS.

6.1.2 In totality across the service there are an estimated 170 DoL's cases that are either in place or have been identified and are going through due process having been assessed against prioritisation criteria. For clarity, the prioritisation criteria are shown in the table below:

HIGHER	MEDIUM	LOWER
• Continuous 1:1m1:2 or 1:3 care during the day and / or night • Sedation/medication used frequently to control behaviour • Physical restraint used regularly – equipment or persons • Restrictions on family/friend contact (or other Article 8 issue) • Objections from relevant person (verbal or physical) • Objections from family /friends • Attempts to leave or get out • Confinement to a particular part of the house for considerable period of time • New or unstable care plan or care arrangements • Possible challenge to Court of Protection, or Complaint	• Needs to be prevented from leaving the property unaccompanied for own health and safety. • Not asking to live elsewhere but maybe confused or disorientated about where home is. • Appears to be unsettled some of the time for example resistant to some aspects of personal care. • Restraint or medication used infrequently. • Is in the care of family for significant part of the time. • The environment has been specifically adapted to keep the person safe.	• Subject to control and supervision but may have times out of sight in own space such as bedroom. • No specific restraints or restrictions being used other than domestic environmental restrictions such as bathroom door locks. • Have been living in the same circumstances for some time (at least a year) • Settled at home, no evidence of objection etc. but may meet the requirements of the acid test. • Is in the care of family in the family home • Has strong family advocacy if not living with family • The person is end of life

6.1.3 Of the cases identified as requiring a DoLS application, 78 of these were 'green' in terms of risk rating shown above and were deprioritised to allow for more pressing cases to be progressed.

6.1.4 This was agreed through a paper to directors in December 2020. These will need to be picked up as a specific project through LPS implementation. This cohort will need to be progressed through LPS at an early stage.

6.1.5 Therefore, of the total DoLS cohort, the CCG believe that we are responsible for undertaking 170 LPS assessments.

6.1.6 The work and resource required to undertake LPS assessments was specifically excluded from the PHC restructure as the LPS Code of Practice had not been published at that time. Unfortunately, at the present time, this is still the case and therefore it is difficult to determine the exact resource requirements in terms of LPS assessments.

7. Determining Responsibility for LPS

7.1 In totality, there are 65 individuals Moving On From Hospital Living (MOFHL) / Campus cohorts. It is important that responsibilities are determined for these individuals for the completion of LPS assessments. 32 of these individuals currently appear on the DoLS tracker.

7.2 The cohorts were created on a historical basis of 'CHC eligibility'. The original dowry list was established in 2010, while the MOFHL list was established in 2011.

7.3 Currently, although each of the schedules for these make reference to CHC eligibility, there are only 13 individuals who are clearly identified as CHC eligible with supporting evidence on Caretrack. There is no formal record of CHC assessment for others.

7.4 Given that LPS responsibilities change according to CHC eligibility, the first two assessments for LPS can be incorporated into existing assessment pathways, and as the CHC Framework has been revised twice since these cohorts were determined, it would be prudent to undertake a review of all of these cases to establish whether or not they are eligible for CHC.

7.5 Additional resource will be needed to undertake this work. To undertake 52 assessments, it is anticipated that this would equate to the following resource if being undertaken over a 1 year period

New applications to 3 mth review	
Owner	**WTE**
Practitioners	0.39
Practitioner Decision	0.04
Administrators	0.11
Commissioners/Brokers	0.05
Finance	0.00

7.6 It should also be noted that the schedules for MOFHL and Dowry also make reference to changes in responsibilities and contributions with regard to CHC eligibility.

7.7 It may be that due to potential cost savings through assessment for CHC eligibility, that this work may be better compressed to a 6-month period to ensure completion within the 2021/2022 financial year.

7.8 The above resourcing figures account for the undertaking of CHC assessments for these individuals in preparation for LPS but do not account for any subsequent resource requirements to undertake LPS assessments.

7.9 Additionally, there are 31 individuals in receipt of CYPCC who are currently in the 16 / 17-year-old age group or who will be at this age at time of LPS implementation and therefore LPS assessments apply to these individuals.

7.10 It is expected that the local authority, as the lead commissioner for these individuals would be the 'Responsible Body'. This does, however, require confirmation.

8. Need for Advocacy Services

8.1 Through the work that has so far been completed for DoLS, it is apparent that the spot purchasing of advocacy services can create unnecessary delays in progressing the case in a timely fashion.

8.2 The LPS is clear that advocacy should be provided as an option to all who are going through the process and it is proposed that this is an 'opt out' function.

8.3 It is currently unclear without the LPS Code of Practice in place, whether it is the responsibility of the CCG to ensure access to Independent Mental Capacity

Advocates (IMCAs) or whether it is the role of the Local Authorities to ensure there are sufficient ICMAs for all the Responsible Bodies to instruct as per the ADASS presentation of May 2019.

8.4 PHC recognises that there is a need for advocacy services to be provided in a timely fashion and have requested their commissioning team to look at the options for commissioning this type of service for LPS.

8.5 It is important that the role of the Local Authorities in providing access to advocacy services is clarified to avoid potential duplication of effort. It is also key to ensuring the rates are commensurate with those expected for this type of service.

8.6 Regardless of the responsibility for making advocacy services available, it should be noted that this is likely to present an additional cost pressure on the PHC service.

9. Need for Approved Mental Capacity Professionals (AMCPs)

9.1 The AMCP role replaces the previous Best Interests Assessor (BIA) role within DoLS. Unlike for DoLS assessments, the AMCP role is not required for every case but only in those circumstances where there is a belief that an individual is objecting to the arrangements.

9.2 The AMCP carry out an independent check known as a 'pre-authorisation review' to provide assurance that an individual lacks capacity to consent to the arrangements giving rise to the deprivation of liberty; has a mental disorder; that arrangements are necessary to prevent harm to the person or others and are proportionate to the seriousness and likelihood of that harm.

9.3 An AMCP role could be engaged for those cases in which an individual was not thought to be objecting to their placement and this pre-authorisation review could be undertaken for those cases by a person independent of the individual's care , but who would not require specialist training or qualifications to carry out the review.

9.4 This stance has sparked concern regarding the protection of individuals who are particularly vulnerable. It is therefore recommended that, as an organisation, the CCG requires the pre-authorisation review to be undertaken by an AMCP in all cases.

9.5 Within PHC there are currently no known staff qualified as an AMCP. There are a few staff who are BIA qualified and there is interest in becoming an AMCP.

9.6 There is, however, also the consideration of conflicting priorities in terms of freeing up staff from busy operational roles to undertake the AMCP role. Additional resource, whether within or outside of the service, would be required to undertake this role.

10. LPS in Care Homes and Oversight

10.1 A registered manager within a care / nursing home, may not undertake LPS assessments where there is a financial conflict of interest.

10.2 The Responsible Body (for CHC eligible, the CCG) is responsible for deciding who completes the assessments.

10.3 It is important there is capacity within the CCG to identify where assessments are required, to identify who is undertaking these assessments (or to provide capacity to undertake them) and to provide oversight and reporting on those undertaken, those requiring review etc.

10.4 Oversight is required regardless of whether the assessment is being undertaken in a domiciliary or residential settings and processes need to be designed and implemented to ensure that all LPS assessments are tracked through from initial recommendation to assessment and review, initially at 1 year but potentially then at 3 years for some of the more stable cases – it is important therefore that risks against individual cases are fully understood.

11. Conclusion

11.1 This paper has identified the anticipated changes in moving from DoL's assessment to the implementation of Liberty Protections Standards. Without the Code of Practice it is difficult to fully appreciate the implications for the ICS. However, it has highlighted some considerations for the CCG and possible financial implications.

December 2020