MK Together | Safeguarding Partnership

SAFEGUARDING ANNUAL REPORT 2021-2022

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Contacts

If you have a concern about an adult or child and they are in immediate danger you should contact the relevant emergency services by ringing 999.

If the adult or child you are concerned about is not in immediate danger you should report your concern to Milton Keynes Council.

Safeguarding Adults
Monday to Friday from 8:30am-5:00pm
01908 253772
Out of hours: 01908 725005
Access.Team@Milton-Keynes.gov.uk

Safeguarding Children
MASH - Monday to Thursday 9-5pm and Friday 9-4.30pm
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Independent Scrutineer's Assessment

I am pleased to introduce the MK Together Partnership Annual Report for 2021/2022. This report covers the second part of the major Covid-19 response period and the transition since the national lockdown periods ended. As with the previous year partner agencies were all fully stretched, maintaining services and coping with multiple challenges and pressures. The MK Together Partnership remained robust and active, changing and adapting as necessary, and maintaining a degree of momentum and improvement despite the pressures. However, it has become clear that over this period the relentless focus on maintaining front line services whilst continuing to maintain good practice standards has taken a toll, particularly for the front line work force. It will become clearer over 2022/23 what impact that has had, but I remain assured that overall safeguarding practice has continued to be both effective and well-managed.

Policy changes, and new legislation both had an impact over the year requiring partnership adjustments and membership changes. This has not affected the strength or quality of the Partnership, which is both robust and mature, dealing well with matters of concern as well as overseeing ongoing service improvement and new service developments. The affiliated Boards have all continued to drive forward their priorities, as have all the agencies in the Partnership. The speed of progress is perhaps the most noticeable change resulting from the Covid-19 period as daily service pressures impact on strategic and managerial capacity. All the Boards have continued to improve their own internal approaches to their responsibilities, and our processes and systems are maturing as a partnership, especially in terms of inter-board relationships and the transfer of relevant business. Our application of learning from reviews and audits continues to improve and the focus is as much on impact as it is on action planning.

Nationally driven strategic changes in the NHS have at times presented the Partnership with some challenging issues and questions over the year, and the partnership footprint has had to be carefully considered, as a drive towards larger NHS commissioning bodies has been balanced with responding effectively to locally differentiated needs and priorities. It is reassuring as the scrutineer to see the constructive nature of the discussions that have taken place. It is also reassuring to know that these big strategic issues are not negatively impacting on a local focus and local improvements, nor is it an issue for the people of Milton Keynes, whose focus is on their own experiences of health care, support, care services, and community safety.

The priorities for the Partnership remain clearly identified, although the focus on the quality of frontline safeguarding practice needs to continue to be centre stage, like a stick of rock through all we do. This does require clear assurance processes in each agency, to make sure the pressures do not divert from a consistent level of scrutiny and assurance of safeguarding quality. Whilst this has not been a major concern it is easy to allow our attention to move away from the 'business as usual' activity, and in safeguarding practice a relentless focus on business as usual is required. The challenge ahead will be to balance recovery from the last two years, new developments and improvements and a focus on everyday practice.

Introduction

We are pleased to present the annual safeguarding report of the MK Together Partnership for 2021-22. This is presented on behalf of the three statutory partners and the local multi-agency safeguarding partners. The three safeguarding partners have a shared and equal duty to make arrangements to work together to safeguard and promote the welfare of all children and adults at risk of abuse and neglect in Milton Keynes. The safeguarding partners - Milton Keynes Council; Thames Valley Police, Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group (now known as BLMK ICB) - work together with other key agencies as the MK Together Partnership.

This MK Together Partnership annual report overs the period from 1st April 2021 to 31st March 2022. The annual report outlines the key activities and achievements of the Partnership over the last year. You will see in the report that we have worked through our priorities through the year as well as deliver on those areas identified during the last reporting period.

Agencies have continued to face challenges brought about by Covid 19 during the reporting period with restrictions only being eased in March 2022. The Partnership has continued to keep abreast of the challenges and the mitigations to ensure robust safeguarding systems have kept pace with the changes and will continue to do so as we move into the living with Covid stage. The Partnership will also support agencies to adapt to changing needs of Milton Keynes residents with new and emerging challenges including the cost-of-living crisis and war in Ukraine.

Strong partnerships are at the heart of the way we do things in Milton Keynes. The strength of our partnership was noted by Ofsted Inspectors when they visited Children's Services in September 2020. In their November 2020 letter, Ofsted recognised that "The Partnership has planned and delivered a well-coordinated and effective response to the pandemic. Its actions have been swift and well considered, with an appropriate focus on supporting the most vulnerable".

Partnership arrangements have been underpinned by the following principles:

- **Improve outcomes for residents** – partnership working should have a direct impact on the lives of the people living in Milton Keynes
- **Maximise value for the Milton Keynes pound** – streamlined partnerships which minimise duplication and help partners work together efficiently
- **Flexible and agile** – partnerships which adapt as needed in order to keep up with the ever-changing world
- **Facilitate system-wide working** – a space for open and honest conversations, further enhancing relationships across the system
- **Safeguarding as a golden thread** – it is front and centre in everything we do

Moving forward, the MK Together Partnership will continue to build on the work it started in 2019-2020 with early identification and analysis of new safeguarding issues and emerging threats. We will ensure learning is promoted and fully embedded in a way that supports the achievement of positive outcomes for children, young people and adults.

Finally, we would like to say thank you to all agencies and front line staff for the incredible work that they do to keep children and adults safe from abuse and neglect.

Michael Bracey – Chief Executive, MKC
Anne Murray – Chief Nurse, BLMK ICB
Supt Marc Tarbit – LPA Commander, Milton Keynes

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 both the risks and experience of abuse or neglect, while at the same time making sure that the individual's wellbeing is promoted.

The legal framework

Safeguarding both adults and children is about preventing the risk of harm from abuse or exploitation or having the ability to reduce it by raising awareness and supporting people in making informed decisions.

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 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.

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 experiencing 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.

Six key principles of adult safeguarding:

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

The MK Together Partnership

The work of the Partnership is delivered by the following Affiliate Boards.

Assurance monitors performance against partnership plans and organises thematic reviews, audits and data review as appropriate. This board is responsible for providing oversight of the statutory safeguarding responsibilities.

Review manages statutory case reviews, ensuring they are appropriately commissioned, meet quality expectations, are delivered in a timely fashion, and that actions are taken forward and learning shared.

Risk identifies new and emerging areas of risk and exploitation. This Board maintains oversight of case-based panels including Channel, Multi-Agency Risk Management Group, and CR-MARAC.

Tasking develops and delivers multi-agency activities in response to specific problems or issues, including awareness-raising campaigns and joint disruption or enforcement operations.

Child Death reviews deaths of children normally residing in Milton Keynes, recording modifiable factors and making any recommendations for preventative action.

Voice and Workforce Boards have been permanently deleted from the MKT structure. We will instead carry out an annual listening exercise and workforce is now a standing agenda item at MKT Management Board: https://www.mktogether.co.uk/wp-content/uploads/2021/04/MK-Partnerships-Handbook-2021.pdf

Our Priorities 2021/22

- Domestic Abuse
- Hate Crime
- Violent Crime
- Mental Health
- Child Poverty/Reducing Inequalities

Duties of the Safeguarding Partnership

- To seek assurance that partner agencies are delivering on their statutory safeguarding responsibilities.
- To make arrangements to work together to safeguard and promote the welfare of all children in a local area.
- To coordinate and ensure the effectiveness of agencies in supporting vulnerable adults.
- To publish arrangements, including arrangements for independent scrutiny.
- To carry out Child Safeguarding Practice Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews, and implement local and national learning.
- To have arrangements in place to review child deaths.
- To publish a strategic plan (adults) and an annual report on the work of the partnership.
- To carry out a review of the use of restraint at Oakhill Secure Training Centre.

Sponsor's Annual Highlight Report – Assurance Board

Sponsor – Bedfordshire, Luton & Milton Keynes Clinical Commissioning Group

Assurance Board is responsible for overseeing strategic compliance across the Partnership by seeking assurance and addressing any areas of concern in collaboration with the other affiliated boards.

What has the board done?

Assurance Board keeps track of all actions arising from statutory reviews including Child Safeguarding Practice Reviews (CSPRs), Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs). Evidence is required to assure board members that the appropriate activities have taken place to improve practice across the system and learning is embedded in all agencies. Assurance Board is now chaired by the Independent Scrutineer Jane Held.

Between April 2021 and March 2022, the Board:

- Held regular monthly meetings, throughout the year. Attendance has been good, with limited change in attendees. Agendas set for meetings continue to reflect strategic overview of all priorities.
- Increased the focus on overall safeguarding assurance over the year and safeguarding in relation to MKT Priorities.
- Several projects are currently underway, delivery of these have been delayed by resource pressures related to Covid-19.
- Continued to monitor case review tracker to ensure actions from reviews are completed.
- Taken overview of post inspection responses and action plans in relation to Children's Services and Oakhill Secure Training Centre.
- Continuously forward planned scheduled activities to 'revisit' key action plans to seek assurance on the impact of changes to practice.
- Shared section 11 process and outcomes with partners.
- Focused on voice of the child and the acknowledgement of further work that needs to be completed.

What assurance do you have that learning from reviews has been embedded into practice?

Assurance Board project plan for the year continues to schedule reviews of action planning and key projects to assess impact. This includes detailed attention to identified areas of concern.

Specific deep dive projects during 2021/22, include:

- Looked After Children
- Carers Assessment Task and Finish Group
- Impact of Domestic Abuse Strategy
- Impact of Covid

What will the board do next?

- The Assurance Board's key function is to consistently seek assurance on improvement and to drill down into areas of limited progress. This is achieved through regular monthly reviews of action plans and projects.
- Our Independent Scrutineer has identified three priority areas, for further scrutiny; 1) CAMHS Services, 2) Vulnerable, criminal and sexually exploited and missing young people 3) Transition services, particularly for high dependency/ neuro-diverse/ highly vulnerable/ seriously ill young people and adults. Three scrutiny exercises will be completed over the 2022/23 period, reporting via Assurance Board to MKTSP.
- Continue to review Assurance Board project plan, whilst identifying areas requiring multi-agency attention and/or key improvement projects. We will deliver a more robust audit programme and work with colleagues across all the affiliated boards to progress the multi-agency projects required to deliver on our priorities.

Sponsor's Annual Highlight Report – Review Board

Sponsor – Milton Keynes University Hospital Foundation Trust

The Review Board manages local statutory case and practice reviews, ensuring they are appropriately commissioned, meet quality expectations and are delivered in a timely fashion, and that actions are taken forward and learning shared.

What has the board done?

Between April 2021 and March 2022:

- Four Adult rapid reviews were carried out by the Local Case Review Panel.
- Five rapid reviews were carried out relating to children. One met the threshold for a Child Safeguarding Practice Review (CSPR).
- Published four reviews (2 Children and 2 DHRs)
- Five reviews from the reporting year 2020-2021 that were protracted due to delays in criminal trials during the Covid-19 pandemic, are now underway.

Learning continues to be identified at earlier stages through the embedding of a refreshed rapid review process for both adults and children reviews.
The Board continues to follow vigorous processes to agree and monitor action plans, reflecting recommendations from reviews to ensure timely implementation and monitoring through Assurance Board.

The Board continues to identify themes for improvement and ensure these are reflected within action plans in order to promote system-wide learning.

The management of DHRs has been integrated within Review Board and partnership links with AAFDA (Advocacy After Fatal Domestic Abuse) have been embedded.

What assurance do you have that learning from reviews has been embedded into practice?

The board manages a live tracker of actions from reviews, which are regularly shared and monitored through Assurance Board. A review of learning bulletin is distributed to all professionals involved, in order to ensure learning messages are easily received.

The chair of review board is now a member of assurance board, where on-going actions from reviews are progressed and can feedback to review board.

What will the board do next?

- We will continue to progress all outstanding reviews, ensuring identified learning is reflected within SMART action plans in order to continually improve system practice.
- We will work closely with AAFDA and the Home Office to ensure production of robust DHRs, focus on capturing walking in victims/family shoes/experience.
- We will continue to focus on embedding a robust process where cases do not meet safeguarding threshold but where learning is evident.
- We will review and disseminate Review governance timeframes to ensure learning is not delayed.
- We will actively link with national consultations regarding safeguarding review processes e.g. Knife crime ,involving families using a similar approach to DHRs.

Sponsor's Annual Highlight Report – Risk Board

Sponsor – Thames Valley Police

Risk Board has strategic oversight of operational groups that co-ordinate care for vulnerable children and adults in Milton Keynes and seeks to understand and address emerging themes and vulnerabilities.

What has the board done?

- The Community Safety Strategic Assessment was completed, and the new strategy signed off at SaferMK.
- Consultation on our community safety strategic priorities was done in conjunction with the annual community safety survey.
- We assessed an emerging risk of vulnerable adults who are perpetrators of high level ASB which led to a Community Trigger in two very complex cases. We viewed a draft Vulnerable Adults ASB pathway which was produced by ASC and the community safety team.
- We reviewed the issue of suicide. The Suicide Prevention Programme Board is responsible for the Suicide Prevention Action Plan. Domestic Abuse and suicide was to be included within this programme of work.
- Focussed on improving the response to drug related deaths. Risk Board advised that a full review is carried out whenever Public Health is notified of the death of a service user in the substance misuse service and learning to be shared across agencies.
- Risk Board facilitated several multi-agency briefings in response to murders linked to knife crime.
- Following a murder outside MK College, Risk Board identified that improvements could be made to the Child Death Joint Agency Response Pathway when there is a death involving contextual safeguarding. This involves Public Health being invited to the strategy meeting so that protocols for information sharing and signposting support services with schools can be shared. Ownership of this recommendation to sit with the Child Death Board.

What assurance do you have that learning from reviews has been embedded into practice?

- Learning from two complex Community Triggers led to the implementation of the Vulnerable Adult Pathway which was signed off by Assurance Board and put into practice. The impact will be reviewed in autumn of 2022.
- The Strategic Exploitation Panel reports to Risk Board. This was introduced due to learning from incidents where children were criminally exploited and seeks to address criminal as well as sexual exploitation.
- The Strategic Exploitation Panel provides a governance structure to the operational groups which allows new emerging risks and vulnerabilities to be reported to Risk Board for multi-agency discussion and planned response. The impact of this is a more proactive and partnership response to risk.

What will the board do next?

- Continue to focus on contextual safeguarding risks such as exploitation and knife crime generated through children's missing episodes.
- Risk Board has initiated a review by the Independent Scrutineer to see where improvements can be made and will use the Integrated Care System to improve opportunities for collaboration and co-location.
- Currently reviewing the pathways for children who witness domestic abuse in the home so that more co-ordinated early intervention can be provided to prevent ongoing trauma and harm.

Sponsor's Annual Highlight Report – Tasking Board

Sponsor – Milton Keynes Council

The Tasking Board develops and delivers multi-agency activities in response to specific problems or issues, including awareness-raising campaigns and joint disruption or enforcement operations. Tasking Board is responsible for carrying out medium to long term projects that are either brought by partners, referred by other boards or are part of our strategic plan.

What has the board done?

- In the reporting period of 2021-2022 Tasking Board had a significant focus on reducing serious violence.
- In preparation for the new Serious Violence Duty, Tasking Board has had oversight of the work being carried out through the Serious Violence Strategy Delivery Group.
- Taksing Board agreed the projects funded by MKC's £350,000 investment into reducing knife crime and ASB, managing the implementation of these projects that focus on prevention and diverting children away from crime.
- We are working with the Thames Valley Violence Reduction Unit (VRU) to use a data informed approach to targeting our most vulnerable children at risk of criminal exploitation to ensure interventions are provided at the earliest opportunity.
- We have also completed work to improve the multi-agency pathways for modern day slavery to ensure a holistic approach is taken to support these vulnerable individuals.
- We have worked with Risk and Assurance Board to implement a new pathway for vulnerable adults who are perpetrators of ASB. The aim is to provide support to de-escalate the behaviour and avoid enforcement actions such as closure orders.
- We have reviewed local area hotspots for anti-social behaviour and/or poor community cohesion and worked with partners and the community to improve public realm and engage with communities to improve these areas for the residents.

What assurance do you have that learning from reviews has been embedded into practice?

- Tasking Board carries out projects that come about from recommendations from reviews. This included oversight of the carers assessment project to ensure parents of adult children with complex needs are assessed as carers and an ongoing desktop exercise into joined up care of vulnerable adults with complex needs.
- Following learning from national and local reviews into weapon enabled murder we will continue to develop on this action plan to ensure partners use a trauma informed approach to identifying and addressing risk and promoting positive outcomes
- We have progressed work on a multi-agency pathway for concealed pregnancy which will be launched in 2022. We know that adolescents and women with learning disability or mental health concerns are more likely to conceal or deny their pregnancy. The pathway is designed to equip front line professionals with the skills to identify a concealed or denied pregnancy and support the individual, bringing in appropriate agencies to ensure the safety of both mother and child.

What will the board do next?

- We will deliver on our first-year actions for the community safety strategy and develop a serious violence strategy.
- We will engage the public to raise awareness of modern-day slavery.
- We will launch the concealed pregnancy multi-agency guidance.
- We will track the outcomes of projects receiving council funding to produce an evidence base for interventions.

Sponsor's Annual Highlight Report – Child Death

Sponsor – Milton Keynes Council

The Child Death Board reviews deaths of children normally resident in Milton Keynes, recording modifiable factors and making any recommendations that may prevent future child deaths.

What has the board done?

A systematic review of all child death in MK – considering underlying risk factors that include social and environmental factors (e.g. domestic abuse, mental health of parents, deprivation) – to monitor and identify underlying patterns.

2020-2021 saw the lowest number of deaths reviewed by MK Child Death Board (13 deaths) – the number of child deaths was reduced across the UK over the same time period, most likely due to a reduction in the incidence of infectious diseases (as a result of changes during the pandemic).

Actions identified from the 2020-2021 report and in the past 12 months that directly relate to these include:

- Identified the need (and written to commissioners) for commissioning of responsive and flexible palliative care services for children to consider the needs of whole family
- Identified parental smoking as a risk factor; reducing high prevalence of smoking amongst more deprived communities is a now priority for MK HWB, led by public health
- Identified a high rate of premature birth amongst mothers with obesity and Black African mothers; currently seeking to understand how other areas have responded
- Given the low numbers of deaths in MK, we have agreed to undertake analyses over a larger geographic footprint (BLMK) with a single report for the whole area, including a sub-section for MK

What assurance do you have that learning from reviews has been embedded into practice?

- Relevant learning from reviews is fed back to teams.
- CNWL and MKUHFT recently fed back that their agencies have done some work on highlighting and embedding across the workforce the importance of checking the family composition – particularly in respect of identifying and recording details of fathers and also recording who has parental responsibility.

What will the board do next?

The Child Death Board will continue to consider learning gained via other forums or processes – such as CSPRs and Health Serious Incident notifications – to ensure any learning identified there contributes to the discussion during the child death review process.

There has been little or no progress in reducing high smoking prevalence, particularly amongst parents living in more deprived areas or who are employed in routine or manual occupations. This is now a priority for the MK HWB – and a full strategy to address this is being developed.

Agency Annual Highlight Report – Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group

What actions has your agency taken to advance the MKT priorities?

- The Chief Nurse, The Director of Transformation and Delivery, The Designated Nurse for Safeguarding A dults (DNAS) and the Designated Nurse for Safeguarding Children and Looked after Children (DNSCLAC) continue to take an active leadership role within the MK Together partnership in Milton Keynes.
- **MK Together** - BLMKCCG is represented on the Community Safety Partnership, the MK Together Board and all Affiliate Boards.
- **Section 11** The DNSCLAC chaired the multi-agency Self-Assessment Assurance Peer Challenge event.
- **FGM** - DNSCLAC continued to chair the panel and updated the FGM toolkit to support identification of more specific risks of FGM.
- **Domestic Abuse** – the CCG have commissioned further Domestic Abuse Champion Training for GP practices We are members of the Domestic Abuse strategic and operational partnership boards.
- **Training** – Delivered online training for GPs and practice staff in safeguarding which includes domestic abuse, modern day slavery, hate crime, MCA and learning from reviews. Commissioned further Domestic Abuse Champions training and offered opportunities for provider and GP safeguarding leads to attend Level 4 Clinical Leadership in safeguarding training.
- **Guidance, policy and procedure** – The Designated nurses have led on the development and implementation of a pathway for covid testing for unaccompanied asylum-seeking children, the health safeguarding response to the quarantine hotels, members of and chaired working groups and task and finish groups, S136 information sharing processes between health agencies and police, carers' assessments and updated the child death pathway. The CCG safeguarding people policy has been reviewed and updated.

What assurance do you have that learning from reviews has been embedded into practice?

Contract monitoring arrangements with health providers includes support to resolve system issues and embed learning identified in reviews. As members of Assurance Board, we ensure providers report on their actions and assess evidence of change and impact.

- Following the work around Multi Agency professionals' meetings, we are now seeing more professionals' meetings taking place.
- CCG commissioned Domestic Abuse Champion Training and we now have 53 domestic abuse champions trained across BLMK. Domestic Abuse Partnership reported they have noticed an increase of referrals from GPs.
- Assurance of safeguarding activity from statutory and third sector providers in line with the section 11 framework has been achieved.
- Safeguarding training data (level three) has achieved exceptional feedback and demand for the training has increased.

What will you do next?

- Continue our work around domestic abuse
- Ensure Learning from current and future statutory reviews is shared, incorporated into training and is being considered within commissioned services.
- Ensure the Integrated Health Care Partnership is prepared for implementation of the Liberty Protection Safeguards.
- Lead on a Looked after Children deep dive audit for children placed in Milton Keynes and out of area, to examine current processes, and identify potential areas where changes to processes are needed.

Agency Annual Highlight Report – Milton Keynes Council (Children's)

What actions has your Agency taken to advance the MKT priorities?

- During 21/22 MK CSC has formed an additional Family Support Team to create to increase in social work capacity as well as additional management oversight.
- Primary Mental Health support has continued to be offered by MKC mental health workers across the Specialist Assessment & Intervention Team (SAIT), Healthy Relationships Project (HRP) and Supporting Teenagers Empowering Parents (STEP). This has been well received by children and their parents who continue to benefit from initiatives such as the "lets talk" programme, 1:1 sessions and the "being me" group.
- HRP provides a number of preprogrammes and initiatives that support children and parents who have been affected by domestic abuse. This work is delivered in a variety of settings i.e. Children/Family Centre, Schools and social care venues both on a 121 basis. Group includes: The Freedom Programme, Recovery Toolkit, Let's Talk, Escape the Trap and 121 support. This year has seen the introduction of a dedicated schools Family Support Worker to support schools directly with the promotion of healthy relationships.
- CSC has offered significant support for Food Poverty, by offering emergency food at outreach Food bank serving stations, issuing food bank vouchers, sharing faith group donations weekly, providing hot meals in the summer and arranged holiday food for those on low incomes, supported Holiday Activity Fund (HAF) and started a new Community Larder along with cascading St Marks Meals. We have supported 8000 families with this offer, along with 2000 meals for low income families in the half-term holidays and 9000 meals for the Holiday Activity Fund. Feedback from parents to say that they would not be able to support their children without our help and the half-term meals and HAF in term time has been a lifeline. Parents shared that the activities were just as needed as food as they could not afford this and it really supported mental health for their children.
- We have provided support to over 50% of target families over the last year (Workless, Lone and Young parents), through activity sessions. This support has ensured that children have attended sessions, including resilience to improve confidence, speech and language, and parents have benefitted from family support and gained new skills. This has been observed and been recorded by the team and parents have shared how both their children's and their confidence has increased.
- Centres have helped 60 parents take up employment, with three also using the new Childcare deposit scheme. 144 parents completed training and 62 attendees completed Distance Learning.

What assurance do you have that learning from reviews has been embedded into practice?

- End of course evaluation client forms allows us to quality assure our service to influence and inform best practice.
- Client feedback tells us...
  "it's like my eyes have been opened, I can now see what is happening to me"
  "I now feel able to move on in my life, my confidence has grown, I look forward to the future for me and my children".
  the freedom programme has changed my life, I am no longer living in fear"
- We invite colleagues such as Head of service, team manager and Domestic Abuse Coordinator to attend our end of programme session. Ensuring our children and families have an opportunity to have their voice heard.
- Quality control ensures consistent practice is delivered across the whole service.
- Ofsted report commented the positive impact HRP has in supporting those affected by domestic abuse.

What will you do next?

Children's Centres

- Exploring introducing more Community Larders in all family centres. We are also going to offer more holiday hunger support to low-income families.
- We need a minimum of 60% target families accessing all centre sessions, to engage with those most in need
- Will endeavour to increase a greater take up of the Childcare deposit for next year to support more families in securing employment.
- CSC is looking into the expansion of our Exploitation Hub to incorporate a Contextualised Safeguarding Team, to increase the approach to contextualised safeguarding.

HRP

- Expand our work within Milton Keynes secondary schools by applying for additional funding.
- Devise a programme to support young males within schools.
- Focus on early intervention by delivering Domestic Abuse awareness training to all children and family centre staff (booked for inset day 9th May)
- Working alongside the suicide prevention officer once in post

SAIT

- Further funding secured to offer more targeted support to child identified as known to the child exploitation hub.

Agency Annual Highlight Report – Milton Keynes Council (YOT)

What actions has your Agency taken to advance the MKT priorities?

- Increased focus on addressing the overlap between serious youth violence and criminal exploitation of children through improved partnership information sharing and coordinated planning and delivery of individual and systemic solutions. This included the outcome of a restructure of the wider Children's Services that brought the Youth Offending Team into a closer partnership alignment alongside Children's Social Care and created a Youth Offending Service that encompassed the Youth Offending Team; The Multi-Agency Missing and Exploitation Hub (ME Hub); the Young People's Drug and Alcohol Service (YPDAS) and the Stay Safe Team (specialist Youth Workers/Youth Support Workers and Young People Advice and Guidance Workers).
- Ensured that the additional resources available from the NHS funded Health and Justice 'Early Support Project' (ESP) have continued to enable more targeted work around prevention/early intervention. This has included ongoing evaluation of the ESP's effectiveness and 4 positive outcomes, and the identification of opportunities to share the effective practice and learning both regionally (YJB South East Regional Practice Development Forum) and locally (HMCTS Youth Panel) as well as with the partnership and across other services.
- Developed and implemented a solution to effectively capture the voice of children who have offended and their experiences of involvement in the YJS and working with the YOT and its partners. Combined with the effective feedback approaches for both post court and Diversion outcomes over the next 12 months, development of the work in this area has enabled the voice of children and families involved in the YJS, alongside that of staff and volunteers, to more meaningfully contribute to a holistic co-production model of both the vision of the service going forward and also the way, how and where it is delivered.
- Strengthened the YOT's work in restorative justice, through collaborative work with the police and Youth:MK to increase the level of victim information and engagement and to ensure direct and indirect restorative approaches are both available and meet the requirements of a service structured around Child First principles and approaches.

What assurance do you have that learning from reviews has been embedded into practice?

- Work to protect children was the strongest area, with interventions delivered to reduce risks. All children are screened for potential exploitation.
- Well-informed, balanced assessments are improved by the use of specialist speech, language and communication assessments.
- Reviewing is ongoing and active. When changes are identified, these are acted on quickly.
- The child's strengths and protective factors are identified alongside structural barriers. Planning builds on the child's strengths and actions are taken to try and reduce the effects of barriers.
- Children benefit from a wide range of interventions delivered with skill and speed.
- Building trusting relationships is the core of the YOT's work, and staff show persistence and flexibility in engaging children and their parents and carers.
- The Early Support Project continues to have very positive results in relation to its interventions with only 2.94% of children engaged being involved in offending in the 2 years following the support they received.
- Overall results for reoffending for the Youth Offending Team for children on statutory cases also remain very positive with a reoffending rate within 2 years of 27.9% (compared to a national figure of 34.2%)

What will you do next?

- Development of a contextual safeguarding team to support the needs of young people who are at risk of or being exploited.
- Continue to support and develop ESP.
- Integrate and develop youth work provision in the YOT.

Agency Annual Highlight Report – Milton Keynes Council (Adults)

What actions has your Agency taken to advance the MKT priorities?

- During the last year Adult Social Care has increased the staffing within the Council's safeguarding adults' team, adding two additional social workers and two social work assistants. This equates to a 57% increase in staffing capacity. As a result, there has been a significant improvement in the screening of, and response to, safeguarding contacts received.

- The PIPOT policy has been revised as a result of a Safeguarding Adult Review. Advice and guidance on PIPOT can be found on the MKC website at: https://www.milton-keynes.gov.uk/social-care-and-health/safeguarding/concerns-about-a-person-in-a-position-of-trust-pipot The policy has been followed on five occasions since the revisions were made and has been shown to work effectively. A designated adult safeguarding manager (DASM) inbox is in place and is monitored on a daily basis by the safeguarding team; appropriate referrals are acted upon and managed in line with the policy.

- The Council's Decision-Making Tool (DMT) has been revised, updated and implemented. The key changes to the DMT have been cascaded to all key partners. A significant change is the introduction of a consultation line, so that agencies can directly consult with the safeguarding adults team with regards to perceived safeguarding issues. The Council's performance monitoring is illustrating that the conversion rate of safeguarding contacts to Section 42 safeguarding enquiries is rising (25% for 2021/22). It is forecast to be 35% in 2022/23. This indicates that the consultation line is operating effectively and that appropriate contacts are being formalised, while issues that are not safeguarding matters are dealt with elsewhere.

- The post of Domestic Abuse Co-ordinator was introduced in 2021/22 as part of the improved governance to support MKC meet its duties under the Domestic Abuse Act. The role brings together multiple agencies involved in domestic abuse locally to deliver the MK Domestic Abuse Strategy 2020-25 and support the Domestic Abuse Partnership Board and Operations Group.

What assurance do you have that learning from reviews has been embedded into practice?

- The revision of the PIPOT procedure in response to a SAR has been followed on five occasions and has been shown to work well.

- The Council developed its Community Support Team (CST) in response to a number of SARs that were undertaken. The team has since been expanded and continues to respond to those vulnerable individuals who do not fit easily into any of the traditional adult social care categories of support.

What will you do next?

- Continue to monitor performance of the safeguarding adults team; ensuring that they continue to respond appropriately to cases.

- Continue to monitor the activity of the Community Support Team.

- Monitor and review the activity of the Domestic Abuse Co-Ordinator.

- Engage positively and proactively in all SARs and ensure that action plans are followed and implemented to improve practice.

Agency Annual Highlight Report - CNWL

What actions has your Agency taken to advance the MKT priorities?

- CNWL held the 4th Annual White Ribbon virtual conference to talk about how we keep domestic violence on the agenda. We have also over 100 'Domestic Violence Champions' who have opportunities for Continued Professional Development (CPD) each month and are supported with outside speakers to enable sharing and the promotion of good practice.
- The Trust QI project to reduce violence on Mental Health Wards has resulted in reduction in violence and aggression and self-harm at the Campbell centre. There has been a sustained improvement in the use of restrictive interventions such as seclusion, restraint and rapid tranquillisation.

Violent Crime

- We are also working in partnership with Thames Valley Police (TVP) to reduce violent and hate based crime and are at the forefront of Multi Agency Public Protection Arrangements (MAPPA) and Criminal Justice in Mental Health Panel meetings; reducing violence and outcomes for our patients.

Mental Health

- This year there has been a drive to improve access to psychological therapies including crisis and home treatment teams; giving opportunities for patients to express their thoughts and explore positive thinking and coping strategies. The Crisis Café with MK MIND offers people additional support in a safe environment out of normal working hours.

Child Poverty/Reducing Inequalities:

- CAMHS service, have changed the Single Point of Access (SPA) to ensure children receive a full mental health assessment on acceptance to the service; reducing waiting for further assessment and to prevent children from repeating their 'story' to multiple professionals.

What assurance do you have that learning from reviews has been embedded into practice?

- Governance systems oversee improvement work following safeguarding reviews. Findings from reviews inform our annual safeguarding audit plan and the portfolio of audits ensure learning and standards relating to safeguarding are met.
- Outcomes of audit are reported in Named Nurse quarterly reports, and this is shared at the Quarterly Divisional Safeguarding meetings, the Clinical Quality Indicators Meetings and Clinical Oversight Groups (COG).
- There are a range of dashboards, reports and data which provide our services with a range of information to help inform practice. In MK Mental Health services, new weekly reports and monthly dashboards have also been developed to include data to improve triangulation of quality, performance and HR indicators. This has improved oversight and the management of risk to spot themes around self-harm or use of restrictive interventions quickly. Weekly complex case reviews are also undertaken for all complex patients on the ward and twice weekly MDT meetings have been developed at the Hub community treatment team to improve oversight of referrals and daily performance data for urgent referrals needing crisis intervention.
- This year, the MK Early Intervention into Psychosis Team (EIPN), also achieved an improvement in rating from the previous years national audit to 'performing well'. The team have recently been informed that they have provisionally achieved the 'Top Performing' rating following a subsequent audit during October 2021. The audit is based on a number of criteria which measure evidence based practice.

Agency Annual Highlight Report - CNWL

What will you do next?
Following the relaxing of Covid restrictions we have started re-engaging with our local communities, attending events in participation with Healthwatch. This included a successful event at Fishermead to identify awareness of local needs and to promote health information and mental health services and a event at the Xcape MK, to promote services to meet the need of women and women of ethnic minorities and their families.

A steering group has been established at the Campbell centre, to implement the 'See, Think and Act' programme to develop good relationships and awareness of safety on the ward. Workstreams include improving communication, handover and developing 'safety huddles' using discussions about risk and plans of care. Following learning from an incident on the ward; we have also commissioned additional training to support staff to consider patients physical health needs while they are mentally unwell. This work has included a simulation event in which the team were given the opportunity to attend to a 'sickle cell crisis' for their learning.

As normal service delivery resumes following Covid; data shows an increase in safeguarding work in our universal 0-19 service. Compounded by demand for the 0-5 Universal Plus (UP) pathway, an increase in child protection and nearly 1,500 children on the non-universal pathways. This is monitored via the service risk register and weekly meetings to prioritise safeguarding. We also utilise the shared safeguarding record with live information. Recruitment of Health Visitors is a National issue discussed at CNWL and BLMK forums.

Agency Annual Highlight Report – Milton Keynes University Hospital Foundation Trust

What actions has your agency taken to advance the MKT priorities?

- We have worked in partnership with community agencies MKAct through attendance at Domestic Abuse Strategic Partnership Board and have facilitated the recruitment of a Hospital Independent Domestic Violence Advisor (HIDVA).
- The HIDVA has been integrated into the safeguarding team at MKUH and has secured relationships within Emergency Department and Maternity footprint. An internal referral process has been agreed and good practice of professional curiosity and sign posting has been noted. This will be expanded across the organisation over the coming 12 months, including the impact of role evaluation early 2023.
- Partnership links with other acute trusts who are also hosting HIDVAs have been made and MKUH will continue to strengthen these.
- MKUH continues to host Hospital Navigators as part of a regional violence reduction scheme led by Thames Valley Police. The Navigators are integrated within the Emergency Department and won the National Crimebeat award in March 2022.
- The Hospital Navigators are integrated within the hospital safeguarding team and have demonstrated positive service user experiences through shared case studies.
- There continues to be a focused approach to embedding a mental health workstream within the Trust through joint interface meetings and the recruitment of a Mental Health Education Facilitator. Bitesize mental health training has been facilitated online, as well as support and supervision in clinical practice.
- Continued support and active leadership in multi-agency meetings to support individuals with complex physical and mental health care needs. This has involved the chairing of daily escalation meetings to discuss/review risk assessments, criteria for bed searches and application of mental health sections.
- The role of Learning Disability Nurse within the Trust has been further developed in providing a liaison function, linking with community partners to support admission and transition of discharge. Focused work benchmarking against National Learning Disability standards continue to enhance internal improvements.
- Head of Nursing Quality and Safeguarding with Safeguarding Leads attend Health-wide safeguarding meetings where annual board priorities are discussed.

What assurance do you have that learning from reviews has been embedded into practice?

- Action plans related to health are reviewed and learning is disseminated internally through safeguarding leads forum.
- Active attendance at LeDeR Assurance panels where action plans are reviewed for learning
- A Hospital Safeguarding Committee is chaired by the Chief Nurse and meets quarterly with external designated leads attending for assurance and transparency of Trust safeguarding processes. Escalation concerns from the committee report to the Quality and Clinical Risk Committee and seen at Trust Board.
- A Safeguarding hub with a focused Think Family approach is in place with Leads representing 3 core services –Adults, Paediatrics and maternity.
- Assurance provided through annual SAAF and Section 11 frameworks.
- Assurance meeting with Independent Scrutineer has been held providing update on safeguarding team structure and training compliance and assurance was received.
- Signs of Safety training has been delivered with children services.
- Internal debriefs and table-top learning events have been developed to promote reflective practice and open facilitated discussions post incidents.
- Continuation of online safeguarding training across all levels which will allow provision of facilitate multi-agency workshops.

What will you do next?

- Liberty Protection Safeguards implementation is anticipated to come into effect from October 2022 and we will work in partnership across BLMK to ensure this change is seamless.
- Ensure all learning from statutory adult and children reviews is shared and incorporated into training, internal audit programme.
- Review safeguarding training provision to enhance multi-agency approach.
- Focus on readmission of attendance of vulnerable persons to emergency department through Hospital Navigator scheme contributing to regional and national data profiling for violence reduction.
- Progress mental health workstreams with partners.

Agency Annual Highlight Report – National Probation Service

What actions has your agency taken to advance the MKT priorities?

The Probation Service has recently introduced a new Staff Appraisal process and annual salary increment progression is linked to the completion of mandatory training which has provided a better tracking process and improved incentive for completion.
Mandatory training includes:

- Child Safeguarding e-learning
- Adult Safeguarding e-learning
- Domestic Abuse e-learning
- Safeguarding and Domestic Abuse classroom training
- Adult Safeguarding classroom training
- Hate Crime Staff Briefing
- Diversity and Inclusion

The details of all victims of Hate Crime are now automatically forwarded to the local Adult Safeguarding Teams. This allows for the opportunity for improved data collection and the offer of support to those in need. The local Probation Service works closely with TVP, particularly through MAPPA, the IOM Scheme and Community Safety Partnerships which have had a focus on reducing violent crime.

As the National Probation Service (NPS) manages adults over the age of 18, staff will have limited contact with children, however we:

- Ensure that they have a voice - there is an expectation that all MAPPA meetings note anything in relation to the children's voice when that child is subject to MAPPA (there are cases managed by the Youth Justice Service who are discussed at MAPPA and Probation are one of the core members of MAPPA).
- Maintain an NPS child protection case monitoring database by Senior Probation Officers.
- Undertake quality audits on all safeguarding referrals utilising a National Performance Improvement Tool.
- Senior Probation Officers must countersign all risk assessments for individuals posing a high risk against practice quality standards.
- Share information promptly when requested.

What assurance do you have that learning from reviews has been embedded into practice?

- Whenever an offender under probation supervision is charged with a serious sexual or violent offence the need for a Serious Further Offences (SFO) review is considered. A review is always undertaken if the SFO charge is murder, manslaughter, or other specified offence involving loss of life, rape, or a sexual offence against a child.
- The purpose of a review is to provide an objective assessment of the quality of practice in the management of an individual case up to the point of the SFO. Actions are identified if needed to improve practice in the management of future cases and/or update relevant policy or guidance to assist with wider improvements.
- There is a clear focus on safeguarding. Safeguarding children, family members, vulnerable adults and partners of those we supervise, and the public at large is always our priority. As an individual's period under supervision progresses, we must remain acutely aware of potential victims and what action is required to protect them from harm.
- SFO Action Plans are signed off and overseen by the local Head of Probation Delivery who is mandated to provide evidence to the Investigations and Review Team that progress has been made and actions are completed.
- The Probation Service had a particular cluster of SFOs related to serious organised crime in the Milton Keynes area which led to an overarching themed PDU action plan with several areas that required the implementation of extensive additional staff training. This was completed to schedule.
- Subsequent local and national audits/HMIP inspections focusing primarily on review of risk management plans and offender supervision during the Covid pandemic have been encouraging in that access to safeguarding and public protection information was assessed as good overall, finding the ease of obtaining information from children's social care services had either remained the same or improved since March last year.
- The quality of the case supervision was also assessed as good, and consistency was indicative of an overall improvement. Assessments have been found to focus sufficiently on keeping people safe, evidencing good liaison with partner agencies, and, in particular, police and children's social care services.

Agency Annual Highlight Report – National Probation Service

What will your agency do next?

Continue to:

- Be active members of all current safeguarding partnership forums.
- Provide NPS staff resource to local DHR Panels.
- Seek opportunities for joint training, networking and awareness raising.
- Quality assure partnership safeguarding, specifically responses to MASH enquiries and all safeguarding referrals against practice guidance, expectations, SLAs and local thresholds.

Additionally there will be a focus upon improving:

- Recruitment and retention of staff.
- Service users' involvement and engagement in supervision planning and review.
- Liaison between victim liaison officers and officers responsible for case management.

Agency Annual Highlight Report – Oakhill Secure Training Centre

What actions has your agency taken to advance the MKT priorities?

- The Resettlement Team deliver Healthy Relationships Work Packs to children convicted of or with identified domestically abusive behaviours.
- Approximately 70% of the children at Oakhill are documented to have witnessed domestic abuse and continue to be supported on site and by their external professional YOTs and CSC teams using a multi-disciplinary approach.
- Oakhill has continued to see an increase in children remanded for violent crimes many of whom are gang affiliated. The Centre is being supported by the YCS to reduce levels of violence and over recent months this reduction has been prominent. This has been achieved through interventions delivered by the Forensic Psychology Team, Resettlement Team, Conflict Resolution Team and Enhanced Support Team as well as the development of a Behaviour Management Strategy and a review of the EIS Policy.
- The Centre also utilises the support of third sector organisations to divert children from gangs and violence e.g. Hackney Music Trust, Exodus.
- Staff who experience high levels of violence within the centre are supported with a new trauma informed practice model utilising specially trained peers for support and an in-house care team.
- Any violent crimes committed within the centre are referred to Thames Valley Police and information is shared through the monthly 'Crime Clinics'. For less serious discriminatory behaviours we have a Discriminatory Incident Reporting Process managed by the safeguarding team. This helps challenge and identify emerging discriminatory behaviours and attitudes with young people.
- Mental health intervention is provided by secondary healthcare service – CAMHS Team. They provide MH screening, diagnosis and treatment plans for young people who experience MH concerns. This work is also supported by the Child and Adolescent Psychiatrist who will direct young people to an alternative establishment if necessary. There is further support provided by Forensic Psychology interventions, Speech and Language Therapy and Special Educational Needs Teams.
- We care for a high proportion of Care Experienced children and our Resettlement and Safeguarding Social Workers play an integral role in managing the Looked After Children Reviews and information sharing with external agencies.
- Those children being released into care are supported by the residential team and resettlement team to prepare for their transitions, this includes interventions to develop their life skills.
- Oakhill has also successfully managed to challenge local authorities on their responsibility and care provision for care experienced young people. The Centre also refers to Barnardos, The Howards League and the Children Commissioner through Help At Hand to reduce inequality and support re-integration into the community.

What assurance do you have that learning from reviews has been embedded into practice?

- Oakhill STC has not been involved in any National or Local Learning Reviews during this or the previous reporting period. However, the Centre has continued to deliver learning from Child Safeguarding Practice Reviews as part of the safeguarding training package for staff. This includes learning on serious self-harm and suicide, criminal exploitation and CSE.
- The Centre also engaged with Local Authority for the 2020/21 annual review of restraint. There was an amended format to the review due to the COVID Pandemic and as a result of this review changes were made to the 'Child's Debrief' following incidents of restraint. This is now utilised to capture the Child's voice at the most appropriate time and by the most appropriate person rather than expecting engagement straight after the incident and accepting the refusal to engage from the child.
- Oakhill STC has received two OFSTED Inspections/Assurance Visits within the last year and these unfortunately led to the Centre receiving an Urgent Notification and also Rectification Notices for a number of key areas including Safeguarding, Safety/Violence, Staffing, etc. The Centre continues to face challenges however huge steps forward have been made with this being acknowledged by a number of key partners also. Overall, OFSTED and Her Majesty Inspectorate of Prisons (HMIP) noted that children felt safe in the Centre despite some of these challenges. An initial cap in the numbers of children at the Centre was enforced, however this has since continued to increase. The Centre is undergoing a significant refurbishment to improve the living environment of children accommodated with us.

Agency Annual Highlight Report – Oakhill Secure Training Centre

What will you do next?

- Implementation of a new behavior management strategy to reduce the need for physical intervention.
- A review of the centre's Safeguarding and Child Protection Policy to be undertaken
- Assess the impact and learning from new Young Person Debriefs as part of the Restraint Minimization Meeting.
- Assess the impact of TRim Model to better support staff involved in serious incidents of violence.
- Develop relationships with third sector organizations to continue to support children in the community on release eg Hackney Music Trust, Ride High initiative.
- Monitor recommendations from National and Local Learning Reviews to improve outcomes for children in the care of Oakhill STC.

Agency Annual Highlight Report – Thames Valley Police

What actions has your agency taken to advance the MKT priorities?

- Thames Valley Police contributed to the annual Community Safety Strategic Assessment and strategy through Risk Board.
- Domestic Abuse continues to be a priority in Milton Keynes. There is a dedicated Domestic Abuse Investigation Unit that focusses on high-risk incidents of abuse and provides tactical advice to local policing team.
- Repeat Domestic Abuse offenders are managed through MATAC which is led by our Problem-Solving Team.
- Repeat Domestic Abuse victims are managed through our Problem-Solving Team.
- In line with the Force and National position the LPA has developed a plan to tackle Violence Against Women and Girls (VAWG). This includes a focus on targeting VAWG offenders and creating safer spaces. Op Vigilance (Night-Time Economy) and Op Vocal (DA offenders).
- Drug lines – increase in disruptions recorded, through investigation and proactive work.
- Recent Knife Amnesty collected 55 knives.
- Support Junior Film makers for school education programme.
- Serious Violence Cohort managed by Problem Solving Team.
- Police Co-Chair (Deputy LPA Commander) Serious Violence Delivery Group.
- Violence Interrupter Programme.
- Sharing of hate crime case studies at the Independent Advisory Group (IAG) for discussion for discussion and feedback.
- Consultation with IAG regarding stop and search proportionality.
- Joint Agency mental health training to be implemented following Coroner Reg 28 Review led by Police.

What assurance do you have that learning from reviews has been embedded into practice?

Thames Valley Police receive recommendations and actions from SARs, LSCPRs & DHRs from all 9 Local authorities within the force area. The centralised model of collating and considering is overseen by a recommendations panel under the Governance and service improvement department, leading to Force change and learning. The model includes a review and assurance mechanism to drive compliance and assess effectiveness of change.

This has been used to provide reassurance over current practices, as well as inform appropriate amendments to Operational Guidance and training for our staff when dealing with safeguarding and vulnerability.

Areas for Milton Keynes have included the considerations given to mental health when receiving reports of domestic abuse.

It has also brought about greater emphasis on ensuring that all disclosures are considered by parties involved. The latter, not only to ensure appropriate recording but to reduce any suggestion of gender bias and to ensure the voice of the child / person is considered.

What will you do next?

Through the Risk Board have asked the independent scrutineer to review existing structures for missing and exploited children to see whether improvements can be made to improve joined up operating practices.

Appendix A – Partnership representation at MKTMB meeting 2021/22

Agency attendance – MKTMB meetings 2021 - 2022

	April 21	July 21	Nov 21	Feb 22
Chief Executive, MK Council	✓	✓	x	✓
Director of Adult Services, MK Council	✓	✓	✓	✓
Director of Policy, Insight and Communications, MKC	✓	✓	✓	✓
Managing Director, Diggory Division, CNWL	✓	✓	✓	✓
Director of Children's Services, MK Council	✓	✓	✓	✓
Independent Scrutineer	✓	✓	✓	✓
Head of Quality and Safeguarding, MKUHFT	✓	✓	✓	x
Nursing Director, Diggory Division, CNWL	✓	✓	✓	✓
Chief Nurse, BLMK Commissioning Collaborative	✓	✓	✓	✓
Director of Public Health, Bedford and Milton Keynes	✓	✓	✓	✓
Healthwatch MK	✓	NA	NA	NA
Bucks Fire and Rescue Service	✓	✓	✓	✓
Chief Operating Officer, MK CCG	x	x	x	x
Director Of Patient Care/Chief Nurse, MK UHFT	✓	x	x	✓
Senior Operational Support Manager, Probation Service	x	x	✓	x
Governor, HMP Woodhill	✓	✓	✓	x
Supt, Thames Valley Police	✓	✓	✓	✓
DCI, TVP	x	x	✓	x
Chair of VSA/Community Action MK	NA	NA	NA	✓

Appendix B – Contributions and summary of 2021/22 budget

Agency contributions for 2021/22

	Children's	Adults	Total
MK CCG	-51,482	-14,300	-65,782
TV Police	-18,595		-18,595
National Probation Service	-891		-891
TV CRC Community Rehabilitation Company	-2,673	-975	-3,648
MK General Hospital	-1,974	-3,250	-5,224
G4S Care & Justice Service (UK)	-1,974		-1,974
MKCHS (CNWL)	-1,974	-3,250	-5,224
Police & Crime Commissioner (via TVP)		-7,800	-7,800
Bucks & MK Fire & Rescue		-650	-650
MK Council inc public health	-107,504	-41,500	-149,004

Summary of 21/22 end of year budget position

21/22 Actuals		
Income	Brought forward from 20/21	-110,138
	Contributions	-257,880
Expenditure	Employee costs	185,190
	Independent chair/scrutineer	7,537
	Review activity costs (excluding DHRs)	34,484
	PHEW Support (website, policies and procedures)	5,298
	Misc	1564
	Total (c/f to 22/23)	-133.944

Glossary

AAFDA Advocacy After Fatal Domestic Abuse
ACE Adverse Childhood Experiences
ASC Adult Social Care
BAMER Black Asian, minority ethnic and refugee communities
BLMK Bedford, Luton and Milton Keynes Clinical Commissioning Group
CADO Community and Diversity Officer
CAMHS Child and Adolescent Mental Health Service
CCG Clinical Commissioning Group
CDOP Child Death Overview Panel
CFA Child and Family Assessment
CFP Children and Families Practice
CMET Children Missing, Exploited and Trafficked
CNWL MK Central and North West London NHS Foundation Trust Milton Keynes
Covid-19 Coronavirus Disease 2019
CQC Care Quality Commission
CSE Child Sexual Exploitation
CSPR Child Safeguarding Practice Review
CSC Children's Social Care
CST Community Support Team
CWD Children with Disabilities

DA Domestic Abuse
DASM Designated Adult Safeguarding Manager
DASH Domestic Abuse, Stalking and Honour Based violence
DHR Domestic Homicide Review
DSM-5 Diagnostic and Statistical Manual of Mental Disorders
DNSA Designated Nurse for Safeguarding Adults
DNSCLAC Designated Nurse for Safeguarding Children and Looked After Children
DV Domestic Violence
DWP Department for Work and Pensions
eCDOP system to record and notify child deaths
ED Emergency Department
EDI Equality, Diversity and Inclusion Advisory Group
ESP Early Support Projects
FAST Family Assessment and Support Team
FGM Female Genital Mutilation
GP General Practice
HMIP HM Inspectorate of Probation
HRP Healthy Relationships Project
IAG Independent Advisory Group
IDVA Independent Domestic Violence Advisor

Glossary

IMR Individual Management Report
IOM Integrated Offender Management (scheme)
JTAI Joint Targeted Area Inspection
LAC Looked After Child
LPA Local Policing Area
MAPPA Multi-Agency Public Protection Arrangements
MARAC Multi-Agency Risk Assessment Conference
MASH Multi-Agency Safeguarding Hub
MATAC Multi-Agency Tasking and Coordination
MCA Mental Capacity Act
MK Milton Keynes
MK ACT Domestic Abuse Charity
MKC ASC Milton Keynes Council, Adult Social Care
MKC CSC Milton Keynes Council, Children's Social Care
MKUHFT Milton Keynes University Hospital NHS Foundation Trust
NHS National Health Service
NPS National Probation Service
Ofsted Office For Standards In Education
OPCC Office of the Police and Crime Commissioner
PDU Probation Delivery Unit

PIPOT People In Positions of Trust (policy)
PMHW Primary Mental Health Worker
RSL Registered Social Landlord
SAAF Safeguarding Adults Assurance Framework
SAR Safeguarding Adult Review
SECTION 11 Children Act 2004
SECTION 47 Children Act 2004
SFO Serious Further Offences
SLA Service Level Agreement
SMART Specific, Measurable, Attainable, Realistic and Timely
STRAT Strategy Meeting Processes
STEP Supporting Teenagers Empowering Parents
TRiM Trauma Risk Management
TVP Thames Valley Police
VARM Vulnerable Adult Risk Management
VAWG Violence Against Women and Girls
VRU Violence Reduction Unit
YCS Youth Custody Service