MK Together Safeguarding Partnership

Annual Safeguarding Report 2022-23

Contents

Contacts 3

Introduction 4

Independent Scrutineer's Assessment 5

What is safeguarding? 7

MK Together Safeguarding Partnership 8

Sponsors' highlight reports:

- Assurance Board 9
- Review Board 11
- Risk Board 13
- Tasking Board 15
- Child Death Board 17

Agency highlight reports:

- Bedfordshire, Luton and Milton Keynes Integrated Care Board 19
- MKCC Children's Social Care 21
- MKCC YJSS 23
- MKCC Adult Social Care 25
- Central & North West London NHS Trust 28
- Milton Keynes University Hospital NHS Trust 31
- National Probation Service 34
- Oakhill Secure Training Centre 36
- Thames Valley Police 39

Appendix A – Partnership representation at MKTSP meetings 2022-23 40

Appendix B – Contributions and summary of 2022-23 budget 41

Glossary of terms 42

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 City 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
01908 253169/70

Emergency Social Work Team (out of office hours)
01908 265545

children@milton-keynes.gov.uk

Contact details for the MK Together team to find out more about the Safeguarding Partnership in Milton Keynes:

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Introduction

We are pleased to present the annual safeguarding report of the MK Together Partnership for 2022-23. 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 City Council; Thames Valley Police; Bedfordshire, Luton and Milton Keynes Integrated Care Board - work together with other key agencies as the MK Together Safeguarding Partnership.

This MK Together Partnership annual report covers the period from 1st April 2022 to 31st March 2023. 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.

Strong partnerships are at the heart of the way we do things in Milton Keynes. We have long since realised that we will have greater impact on the lives of local people if we work closely together.

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

The MK Together Safeguarding 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
Sarah Stanley – Chief Nurse, BLMK ICB
Supt. Emma Baillie – TVP LPA Commander, Milton Keynes

Independent Scrutineer's Assessment

I am glad to be able to provide my assessment of what has, overall, been a satisfactory year for the MK Together Safeguarding Partnership. The year has been busy and has begun to address some of the challenges that could not be addressed during the Covid and post Covid years. Like all partnerships, austerity, resource pressures and demands, and recruitment difficulties have affected progress to a minor degree, but my assessment is that the partnership is both mature and resilient, and relationships are strong enough to be transparent about these challenges and their impact on partners.

The year has also dealt with significant pressures across our NHS system and the embedding of the major structural changes leading to the establishment of the Integrated Care Board (ICB). These have not destabilised the partnership but have required the development of new relationships and a restructuring of partnership arrangements to facilitate the MK Deal and delivery of the Health and Care strategy and plan within Milton Keynes. This has had the unforeseen impact of strengthening the Partnership's relationships with the Criminal Justice system and embedding safeguarding more visibly within the Safer MK and Domestic Abuse partnership arrangements, without significantly affecting engagement with our varied NHS partners.

It has brought challenges for the ICB as the safeguarding arrangements are different from those in the rest of the ICB footprint, which means slightly more adjustment at place level for them with regard to safeguarding activity and safeguarding assurance.

The pressures on MKUHFT have been significant and there has been significant turnover in their safeguarding staff team, as well as at senior manager level. Whilst engagement at the partnership has been more challenging for them, the relationships at middle manager and service provision levels remain robust and creative practice in relationship to key pressures has meant hospital discharge and emergency mental health responses have been well managed. The year did bring significant pressures on paediatrics in relation to young people with acutely unwell mental health conditions, reflecting some of the wider system pressure, regionally and nationally for that group of individuals.

Positive engagement with the designated safeguarding forums across our school system has built over the year, and schools have been supported as the safeguarding demands and impact of high levels of public concern arising from the OFSTED inspection framework have brought safeguarding into very significant focus for schools. It remains a challenge to gain a common voice or 'identity' across the school sector, and the reduced responsibilities for local authorities as Education Authorities have created a disconnect between the general application of the term 'education' to indicate a coherent organisational identity for schools and the reality that every school is independent of others. This structural issue is national, and Milton Keynes has worked hard to address it. It remains a concern going forward, however.

The Partnership has overall demonstrated adherence to the principle that safeguarding is a golden thread that is front and centre of all we do. It is occasionally challenging to ensure the effective high level strategic engagement in Milton Keynes demonstrably translates through and is understood by the frontline and vice versa.

One area of focus over the year has been to improve the way in which partnership agreed multi-agency protocols, policies, practice guidance and tools are disseminated, and properly embedded into practice, becoming socialised and having the required impact. Seeking assurance on that must continue to be a focus in 2023/2024, as must a strong degree of clarity about how statutory duties for adult and children's safeguarding are fully addressed and delegated within the Partnership structures in place.

I am fully assured and convinced that the benefits of the MK partnership arrangements outweigh the challenges of implementing national requirements that do not fully reflect the way the partnership works. This is largely a reflection of the MK footprint and identity creating a very strong interagency approach at the frontline and long-established trust between partners. I remain satisfied that challenge and scrutiny is welcomed and culturally established and have seen good progress in addressing and implementing learning from reviews, audits and specific task and finish groups. Agencies willingly share and learn from external regulatory and statutory reviews, inspections and service audits and are very cooperative in relation to contributing to improvements. Our review processes and approach are robust, and learning is welcome and applied.

I am clear that in the year ahead, whilst maintaining momentum on our shared priorities, we will need to fully scrutinise how well we deliver what is required of us as a partnership and ensure that our understanding of practice collectively and individually is robust enough to identify individual agency and multi-agency safeguarding concerns and address them at operational, managerial and strategic levels. This needs to sit alongside the work underway to address key areas for development already underway with Mental Health Services, effective services for young people, transitions between children and adults, and the safety and quality of services for children and young people with disabilities and neuro-diverse conditions. In addition, the partnership will need to address pending changes in arrangements for safeguarding children and the impact those may have on our current MK Together approach.

We may also need to review and refresh a number of joint policies, long established but not updated, including our collective Think Family approach and arrangements, and assess the effectiveness and impact of the changes in services to vulnerable adults, and the creation of a joint vulnerable adults service, and the new Contextual Safeguarding Service. A weather eye also needs to be kept on the quality and appropriateness of providers of service in the community as services become more and more focused on maintaining care in our communities.

All in all, however, these issues are all within the bounds of normal strategic, scrutiny and development processes, and I am assured that Milton Keynes is a robust and effective partnership which is well informed, and produces good outcomes for the people of Milton Keynes, especially those who are the most vulnerable.

Jane Held
Independent Scrutineer

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 is 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.

Our Priorities 2022/23

- Domestic Abuse
- Violent Crime
- Hate 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

Independently chaired by Safeguarding Scrutineer

The 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. It is chaired by the Independent Scrutineer.

What has the board done to fulfil last year's next steps, and to safeguard and promote the welfare of children and vulnerable adults?

Our primary function is to consistently seek assurance on improvement and to drill down into areas of limited progress. We meet monthly to do this, and our agendas are planned ahead to ensure we not only monitor action plans but seek to follow up on those plans implemented in terms of review reports and audits to test application and impact. This has shown us that whilst some improvements have embedded well and had an impact others have required revisiting. This programme is complemented by Case and Learning Review findings and action plans and learning from inspections. Our action plan is reviewed monthly, and much on the plan has been successfully completed over the year. The action plan is now looking reasonably up to date, and the actions are pragmatic, achievable and designed to achieve the best possible improvement in the simplest way. This is helped by the Review Board's focus on deliverable recommendations resulting from Reviews.

Over the year we have focused on regular monitoring of the Improvement Programme at Oakhill Secure Training Centre. We are pleased to see greater investment, and significantly greater oversight by the Youth Justice Board of day-to-day care at Oakhill, and a reasonably smooth introduction of girls to the unit. There is much still to do but the trajectory is encouraging. We have also identified, as the consequence of the findings from a review as well as audit outcomes, that two protocols agreed over the past three years in relation to adults with care and support needs have not had the required impact. New projects have been established to address this and their work is near completion.

We now have a good audit programme, and partners are increasingly confident about bringing particular agency audit reports to the Board to demonstrate their own improvements in practice or otherwise. Similarly, we are getting inspection reports more regularly and are able to both monitor their action plans and identify and address common multi-agency themes. Our project groups have decreased in number over the year and are better focused and delivering outcomes within a reasonable timescale. We have agreed that all new multi-agency protocols, practice guides and policies brought to the Board for sign off and implementation are only signed off when accompanied by a credible dissemination, communication and socialisation plan, and review and audit plan.

Of the three areas identified for scrutiny only one has been progressed. The project to examine services for vulnerable, criminal and sexually exploited and missing young people has been deferred because of significant and promising changes to those services. The second has been deferred to next year but encouragingly, the focus on this area has already changed and work is being led by Adult Social Care working with partners to examine how to improve this. The scrutiny of CAMHS services is progressing slowly. It was delayed due to the scrutineer's personal circumstances and for discussions related to the MK Deal but is now well on the way to completion by the end of 2023.

We have introduced an annual cycle of agency reporting on safeguarding data. This is proving to be helpful and informative. It is seen at present as more effective than trying to agree a single Board Data set.

How has your Board incorporated feedback from service users of agencies to make decisions and shape the delivery of services?

For most of our work, not directly, although we frequently review Agency reports that include service user feedback and are continuously informed by the contribution made by HealthWatch in particular.

For specific projects we include user contributions where appropriate. In the past year this has included some of the reports produced by CNWL.

We always include the views of young people as part of the Annual Restraint Review.

What difference has what you have done made and how do you know?

The Board's purpose is to continually and consistently monitor the impact of improvement activity across the partnership, to test effectiveness, and to identify risk and emerging areas of concern. We know we have made a difference by:

- Re-auditing activity resulting from the Board's work and exploring effectiveness as part of that audit, as well as impact and outcomes.
- The number of successful project group programmes of activity implemented over the year – particularly in relation to vulnerable adults.
- The identification of multi-agency themes that emerge out of and benefit from the Board's work, as well as the professional links and connections made to address shared or common problems that emerge.
- The healthy level of challenge and interrogation of agency reports, presentations and discussions.
- The fact that despite delays in official scrutiny exercises two of the three areas selected for scrutiny have developed their own programme of work to address on a partnership basis the concerns that led to the specific priorities being selected.
- The outcomes of the statutory assurance activity we undertake through our Section 11 audit programme and the annual statutory restraint review at Oakhill.

For those areas with little or no evidence of progress, what will you do to support improvement?

In 2023/24, we will complete the work on the CAMHS Scrutiny and begin work on the Transitions Scrutiny Exercise, and the progress made to address it.

We will seek to implement, embed and socialise the new protocols being developed for early identification and multi-agency approaches for Adults with Care and Support Needs and audit the implementation at the end of the year.

We will continue to monitor the action plan, introducing new projects as necessary over the year as identified by CPSRs, SARs, DHRs, and Inspections of Services.

We will review the impact of the data reporting cycle on our understanding of the effectiveness of our services in terms of safeguarding practice and identify whether it is possible to create a simple, appropriately informative and challenging data set or not.

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 to fulfil last year's next steps, and to safeguard and promote the welfare of children and vulnerable adults?

Between April 2022 and March 2023:

- Five adult rapid reviews were carried out by the Local Case Review Panel. Two were progressed and included in a joint thematic systems based Safeguarding Adults Review (SAR).
- Two rapid reviews were carried out relating to children. Neither met the threshold for a Child Safeguarding Practice Review (CSPR).
- We published two SAR reports, one of which was a mental health thematic review.
- One adult local learning review has been commissioned.
- A Learning Bulletin focusing on knife crime has been published.

Learning continues to be identified at earlier stages through the embedded rapid review process for both adults and children's reviews.

The Board continues to follow vigorous processes to develop action plans, reflecting recommendations from reviews to ensure timely implementation and monitoring through Assurance Board. We continue to identify themes for improvement and ensure these are reflected within action plans in order to promote system-wide learning.

How has your Board incorporated feedback from service users of agencies to make decisions and shape the delivery of services?

Learning Bulletins are produced from each review and circulated to all partners and agencies.

The voice of the individual or families where the individual is deceased is sought in all reviews.

Recommendations from these reviews are turned into actions which are then implemented by the relevant services. We also work with AAFDA to ensure we capture the experience of the victims and their families.

We commission experts where appropriate for DHRs, including people of BAME backgrounds.

What difference has what you have done made and how do you know?

A 'Think Family' appreciative inquiry workshop was held, and recommendations progressed. As a result, a pathway for Looked After Children going into hospital has been considered. A need to consider how partners have a 'trauma informed approach' to children was also emphasised.

The professionals' meeting audit was revisited, to assess how well the recommendations had been implemented. A report was submitted to Assurance Board with further recommendations for progressing.

The recent thematic systems-based review highlighted that frontline staff demonstrate persistence, ingenuity and compassion, and make reasonable adjustments in their service delivery where appropriate.

Our Local and National CSPR learnings have been incorporated into our Serious Violence Strategy, which includes a multi-agency project to ensure agencies are trauma-aware when working with children.

For those areas with little or no evidence of progress, what will you do to support improvement?

Review Board 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 continue to focus on embedding a robust process where cases do not meet safeguarding threshold but where learning is evident.

Sponsor's Annual Highlight Report – Risk Board

Sponsor – Thames Valley Police

The Risk Board has strategic oversight of case-based panels and ongoing and emerging risks and vulnerabilities, providing escalation routes for concerning issues and developing strategic response and action.

What has your Board done to fulfil last year's planned next steps? What else has your Board done to safeguard and promote the welfare of children and vulnerable adults over the past year?

Risk Board have liaised with the Contextual Safeguarding Board on unregulated care homes, which has resulted in a monthly update of all known care homes, both unregulated and regulated, in Milton Keynes being circulated.

The Independent Scrutineer is conducting a scrutiny review into the mental health of children before they reach the CAMHS threshold. This will link into current missing children/contextual safeguarding processes. We will then link in with the Assurance Board on outcomes and any emerging vulnerabilities identified.

A scoping exercise is in progress to ascertain what support is available for children who are exposed to domestic abuse. Once this has been completed, we will analyse the results and discuss what is needed to provide further support or improve awareness of what is currently available.

We carried out a desktop exercise to assess Community Trigger trends. Themes were identified and the agreed recommendations were actioned and shared with our partners and Registered Social Landlords.
We reviewed the issue of aggressive begging and anti-social behaviour in the City Centre. Work is being carried out through Tasking Board and we will continue to receive updates from them.

How has your Board incorporated feedback from service users of agencies to make decisions and shape the delivery of services?

Feedback from residents and councillors through ASB Case Reviews (formerly known as Community Trigger) highlighted the need for further awareness raising around unregulated care homes. This has been incorporated into MK City Council safeguarding training.

Feedback from schools following an incident of serious violence led to the Child Death Pathway for suicide being updated to include any traumatic death. Schools now receive contact and support from Public Health where a pupil passes away traumatically, or an incident occurs on or near the premises.

Following feedback from school colleagues regarding concerns around school lockdown procedures, a counter-terrorism specialist security advisor has attended both a primary and a secondary school DSL meeting to provide reassurance and direct DSLs to government guidance.

What difference has what you have done made and how do you know?

Whilst the number of ASB Case Review requests has increased, we have been able to direct a lot of the complaints about ASB to the Vulnerable Adults Pathway. This has led to improved communication between Housing Associations and TVP, and ensured Adult Social Care are able to lead on safeguarding for alleged perpetrators with care and support needs.

The questions asked as part of the scoping exercise around children who are exposed to domestic abuse have helped make agencies aware of what support is available and think about what they could implement themselves.

Concerns raised around drug related deaths led to a scoping review of recent local drug related deaths. Public Health have led on taking forward the recommendations.

For those areas with little or no evidence of progress, what will you do to support improvement?

We acknowledge that we weren't getting reports regarding vulnerabilities relating to asylum seekers and refugees and will add this to our forward plan.

We will facilitate a conversation with the Violence Reduction Unit (VRU) to ensure projects are implemented and the impact is evaluated.

Sponsor's Annual Highlight Report – Tasking Board

Sponsor – Milton Keynes City 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 your Board done to fulfil last year's planned next steps? What else has your Board done to safeguard and promote the welfare of children and vulnerable adults over the past year?

Tasking Board have overseen the successful implementation of the Safer Streets initiative aimed at addressing and mitigating Violence Against Women and Girls (VAWG). This has included – but is not limited to - putting up additional CCTV cameras in Central Milton Keynes, cleaning up and treating overbridges into connecting estates with anti-graffiti paint, increased pest control, and more resources to create a safer environment within the night time economy.

We have managed the development and agreement of the Serious Violence Strategy and multiple strategic needs assessments. We were pleased to note that when the Serious Violence Duty went live, we were well ahead with our strategy.

A scoping exercise was carried out on modern day slavery to highlight the most common risk factors in MK. A number of recommendations for improvement came from this, which the Board will monitor.

The Board has monitored a number of projects focused on reducing Anti-Social Behaviour and car cruising in CMK (North Ninth, Station Square, Network Rail). Phone boxes have been removed, PSPO signs (alcohol and car cruising) have been put up for visible enforcement, landscaping work has been carried out, alternatives to fines for perpetrators of ASB have been offered, Op Chromium has been put into place.

We organised and facilitated a professional webinar to launch the contextual safeguarding team and start the discussion around trauma informed care. The trauma informed care task and finish group have since met to start work on establishing a baseline, develop a toolkit and deliver training.

Recommendations from CSPRs, SARs and DHRs have been taken forward as appropriate, such as disseminating information for professionals around inter-familial sexual abuse. We also held an in-person learning event to look at areas of concern which are regularly highlighted in reviews and reviewed safeguarding adult procedures across the system.

Multi-agency working on support for hoarders and enforcement, where appropriate, was reviewed.

A task and finish group was set up to roll out the concealed pregnancy guidance, to ensure it gets embedded within agencies.

The Board has worked closely with the Violence Reduction Unit to support mentoring schemes and street games as well as School, Hospital, and Custody Navigators. These programmes help to reduce the cycle of violence and support people who present with vulnerabilities.

How has your Board incorporated feedback from service users of agencies to make decisions and shape the delivery of services?

The serious violence strategic needs assessment is used to inform the Serious Violence Strategy.

We carry out an annual public crime and community safety survey to help Safer MK and its partners understand what's important to local people about tackling crime. This feedback is used to inform future work to make MK safer. This year we added questions on safeguarding, as part of the annual listening exercise.

Tasking Board has implemented an annual listening exercise to gain the views of the public on key issues around safeguarding and community safety. Events included:

- ASB Awareness Week
- Help for Households
- Hate Crime Awareness Week
- White Ribbon/Domestic Abuse awareness 16 days of action
- Knife Angel – Monument Against Violence and Aggression

What difference has what you have done made and how do you know?

We regularly evaluate the impact of funded interventions.

Surveys, strategic needs assessments and community engagement exercises help us to ascertain what has improved over the preceding twelve months.

For those areas with little or no evidence of progress, what will you do to support improvement?

Multi-agency working – how to improve aspects of this, especially information sharing, in response to recommendations from reviews.

Specific projects to tackle intractable issues (*eg* ASB at North Ninth Street); although improvements have been made, sustaining these will be difficult and resource intensive. We will need to look at begging in the coming year as a next step.

Work with the PCC to evaluate the implementation of the Serious Violence Duty.

Evaluate the impact made by the Safer Streets Project which included structural (Safer Route), diversion (Project Vigilant) and behaviour change (Bystander training and campaign) has had on feelings of safety in the night-time economy.

Sponsor's Annual Highlight Report – Child Death Board

Sponsor – Milton Keynes City 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 your Board done to fulfil last year's planned next steps? What else has your Board done to safeguard and promote the welfare of children and vulnerable adults over the past year?

The Child Death Board was notified of 25 child deaths during this period.

All child death review information has been recorded on the National Child Mortality Database (NCMD) and the deaths of children who had a learning disability have been reported to LeDeR (a service improvement programme for people with a learning disability and autistic people).

The Child Death Board met four times during the year and completed the final review of 28 child deaths. The Board was well represented at meetings and all agencies contributed to discussion and decision-making.

None of the child deaths reviewed had been the subject of a Health Serious Incident process.

The learning from local Child Safeguarding Practice Reviews (CSPRs) and Rapid Reviews feeds into the final CDB review of the child's death. Of the 28 deaths reviewed three had been the subject of a CSPR. A further three deaths were subject to a Rapid Review but did not result in a CSPR.

Of the 28 deaths reviewed, smoking by family members was noted in ten cases.

How has your Board incorporated feedback from service users of agencies to make decisions and shape the delivery of services?

The MKUHFT Bereavement Midwife and Coroners Officer are able to share family views during meetings. The final review considers any feedback from families and reviews are only completed once all other processes or investigations have been completed.

The standard national reporting forms include questions about views of parents. Of the 28 deaths reviewed there had been no complaints by parents or carers reported to any agency.

What difference has what you have done made and how do you know?

The Board has met the statutory requirement of reviewing child deaths and considering whether there were any modifiable factors – factors that by local or national intervention may reduce future deaths.

Modifiable factors were identified in nine of the child deaths reviewed. Some of the modifiable factors identified were already being addressed via other forums, partnerships or processes. Agencies continue to provide consistent safe-sleeping and stop-smoking advice and signpost families to support services.

Prevention, diversion, information sharing, and enforcement work was noted to be taking place as part the Community Safety Partnership Serious Violence Strategy; a Violence Reduction Co-ordinator is supporting the implementation of the new strategy.

As high maternal BMI has been identified a risk factor for premature delivery**,** agencies signpost to support services, though there is potential for greater awareness of services. BLMK ICB ran a webinar to raise awareness among professionals. During the year the standard reporting form was amended by NCMD to incorporate a specific field to capture this data, which should allow for better local and national analysis in the future.

The Board has contributed to the review and revision of the local joint agency response process.

For those areas with little or no evidence of progress, what will you do to support improvement?

There is more work to do to ensure support to stop smoking reaches those who need it most. Signposting by all clinicians remains an important area for development, alongside wider work across partners to promote services in deprived areas and appropriately control access to tobacco.

The Board is liaising with MKUHFT to identify Consultant Paediatricians who could attend meetings in the absence of a Designated Doctor for Child Deaths.

Work is taking place to introduce a dedicated key worker role or team to cover the BLMK area, so bereaved families have a single, named point of contact, who can signpost them to sources of support and can provide information on the child death review process.

Agency Annual Highlight Report
Bedfordshire, Luton and Milton Keynes Integrated Care Board

What has your agency done to fulfil last year's planned next steps? What else has your agency done to safeguard and promote the welfare of children and vulnerable adults over the past year?

The ICB have significant involvement within the partnership regarding work around Domestic Abuse (DA). The Designated Adult Safeguarding Nurse chairs the Domestic Abuse Strategic Partnership board, attends the DA operations group and provides support through panel membership within Domestic Homicide Reviews. This enables the ICB to be at the centre of developments, planning and implementation of the DA provision within MK. The ICB continue to have DA champions within primary care; it is anticipated they will merge with the wider MK DA champions network when developed.

The ICB have developed a level 3 safeguarding training package for Primary Care, which utilises reviews and their findings as the basis for practitioner learning and development.

The ICB have engaged with action planning following recommendations outlined in statutory reviews.

Internally, opportunities are maximised to share learning from reviews and promote collaborative discussion, this is highlighted, for example, through the mental health collaborative in relation to the mental health thematic review findings, which help influence the future direction of mental health services.

The implementation of Liberty Protection Safeguards (LPS) is now on hold by government for the life of the current parliament, there is no date for implementation. The Health and Care Partnership had ongoing targets to meet and was prepared for the responsibility of implementing LPS as was originally intended. However, it has been decided to refocus our attention on building knowledge and application of The Mental Capacity Act (2005) for the wider workforce and share best practice going forward. The intention is to rename and re-purpose the BLMK ICB - LPS Health Steering Group and consider implementing a Mental Capacity Act Community of Practice Group.

A deep dive audit was carried out for children in care, the objectives of the audit were to seek assurance around agency processes and identified areas for development. Positive practice included MK agencies know their LAC well. Challenges included transition pathways for complex children and access to mental health services. Work continues via the Health and Social Care Forum which is co-chaired by the ICB Designate Nurse Safeguarding CYP and Children in Care. Achievements to date include revision of pathways to screen and review children and young people to ensure access to the appropriate services at an early stage.

How has your agency utilised feedback from people who use your services to inform their work and influence service provision?

BLMK ICB has a culture of listening to and engaging with service users, Children/young people, seeking their views in decision making and development of service and policies. Examples of these are:

- Participating in listening events with Children in Care Council.
- Co-production with service users around LGBTQ issues.
- Local Maternity voices.
- Patient participation groups at GP surgeries.
- Parent and Carer Forums.
- Supporting the Introduction of the ICON programme.
- Continued development of policies and procedures, which support the voice of the individual.
- Gathering lived experiences from people who have used or are using services.

What difference has what you have done made and how do you know?

Our GP audit tool kit supports Primary Care to evaluate their Safeguarding response and helps identify areas for development to enhance safeguarding practice.

Revision of pathways to support children and young people to access appropriate neurodevelopmental and mental health services.

Designated professionals link in with commissioning and Heads of Quality where there are identified gaps in service provision to address local need. This will be measured through future audits, surveys and patient engagement.

For those areas with little or no evidence of progress, what will you do to support improvement?

We will:

- Strengthen the contribution to the safeguarding partnership from ICB
- Continue to improve pathways for LAC
- To strengthen the knowledge and application of the MCA within the wider workforce.
- To continue to share good practice and developments
- Support the partnership in the implementation of the Graded Care Profile 2 assessment tool
- Utilise the self-assessment framework to support the ICB Safeguarding Strategy which will set out our ambition and values for safeguarding across the partnership

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

What has your agency done to fulfil last year's planned next steps? What else has your agency done to safeguard and promote the welfare of children and vulnerable adults over the past year?

There are currently 2 community larders, 1 at Moorlands Family centre and Saplings Childrens centre. At present there are more than 50 people accessing both sites. Payments for access are £3.50 for a single person and £5 for a family. A third is planned for launch in September at the Rainbow Children's Centre. The feedback has been positive from families and the larders offer ambient items as well as fresh fruit and vegetables. The food mainly comes from SOFEA, (South Oxfordshire Food and Education Alliance) which in turn is supported by the Local Authority. The Performance Team are currently working with the CFP team to develop a more robust data set so that centre staff can more track trends, themes and outcomes. However, there are currently 300 cases that are linked to Children's Centres that are open as Family Support and of this number 70.2% were target families. With regards to the childcare deposit scheme only 10 people have accessed thus far, and they have all been able to gain sustained employment. This model is something that the service wants to continue to use as it is a tool that helps break intergenerational worklessness and has supported increased self-esteem amongst parents.

In 2021-22 as part of a Healthy Relationships Schools Project, Social Care were given £55k to deliver the Escape the Trap program (ETT) in schools and successfully commenced with a sustainable project. This funding was accessed via the Domestic Abuse – New Burdens Funding from Central Governments. Escape the Trap is a programme specifically designed to help all young people to recognise abusive behaviours and identify the impact of such behaviours on their mental health and emotional well-being. The programme supports them to consider their expectations of relationships and what kind of partner they would like, as well as the kind of partner they would like to be. In 2022-23 a further £100k funding was applied for, to build on delivering ETT in schools but also to recruit a second worker to deliver a suitable boys' program.

A significant amount of time was spent trying to source an established program to support young males in schools that could deliver what was required, unfortunately nothing suitable was located. Therefore, using our own expert knowledge, the team devised their own informative program to pilot and review in schools. Despite its initial challenges this is now proving successful and has had good feedback from the Young People who have been in attendance. The plan is for these projects to run until March 2024 as this is when the current funding comes to an end. If there is no more funding for this intervention, then this valuable work will unfortunately cease.

HRP Staff delivered Domestic Abuse awareness training to 60+ staff from across the various children and Family Centre's on 9th May 2022 and the feedback from staff was positive. The training was able to help new staff particularly to identify the signs and symptoms of Domestic Abuse, therefore enabling victims to be supported early.

The service has formed a link with the new Suicide Prevention Coordinator for BLMK and intend to meet to see what specific support he can offer in the upcoming months.

In 2021-22 approximately £50k was sourced from the Knife Prevention fund via YOT and with this money we added additional staffing resources to the Specialist Assessment and Intervention Team (SAIT). This included:

- Primary Mental Health Worker – 15 hrs per week
- Family Support Worker – 15 hrs per week
- Additional worker 6 hrs per week to support above
- The aim of these workers was to support specific CMET (as previously known) cases with direct 121 support and worked with both children and parents.
- This funding was made permanent in 2022-23 but will now be transferring to the new CST for them to potentially manage directly. The PMHW post has already moved across and we are in the early stages of deciding what would suit best regarding the FSW role.

How has your agency utilised feedback from people who use your services to inform their work and influence service provision?

The teams at the centres regularly request the views of residents who use the centres to improve the offer. This year the service have been able to speak to clients who use the child deposit scheme, the community larder and the parenting support offer. Feedback from the child deposit scheme has been positive and the team will be actively promoting this initiative in the upcoming months to support parents back to work.

What difference has what you have done made and how do you know?

The core difference has been the following:

- Increased awareness of DA, signs and symptoms, particularly for new staff.
- Reduction in holiday hunger.
- Increased self-esteem and attempting to breaking the cycle of intergenerational worklessness.

We know this through feedback and consultation sessions taking place with parents. Feedback is being used to shape practice and parents are more becoming more aware of the benefits of co-production. Feedback tools are – Annual satisfaction survey, quality assurance observation, daily session evaluations, social media feedback and open-door access to share anytime. Also observing children under 5 for their view.

There has also been positive feedback from the Young People who attended the REACH program, which is part of the Healthy Relationships Project, aimed at 12–17-year-old boys. The sessions enabled the Young People to think about their feelings, consent and what a healthy relationship looks like.

For those areas with little or no evidence of progress, what will you do to support improvement?

More progress is required to get more parents to use the deposit scheme so that they can find and stay in work. This will support children to remain in education and enable parents to feel more connected with themselves and their children as their self-esteem will be lifted due to increased financial independence. To increase the numbers of parents using this scheme there will be a relaunch of the scheme via a seminar and increased marketing of the benefits of the model across all children's centres. This will also include an update on the benefits calculation tool as well, which was also very helpful in supporting parents back to work. More information will also be gathered on the impact of the suicide prevention work in the coming year. Focusing on support with mental health, recognising signs, symptoms and supports available.

Agency Annual Highlight Report
Milton Keynes City Council (YJSS)

What has your agency done to fulfil last year's planned next steps? What else has your agency done to safeguard and promote the welfare of children and vulnerable adults over the past year?

The multi-agency/multi-disciplinary Contextual Safeguarding Team (CS Team) was launched in February 2023 as a new element of the Youth Justice and Support Service (YJSS) to focus on extra familial harm in relation to the criminal exploitation of children, and the overlap with serious youth violence. The specialist team has improved partnership working, information sharing, and forward planning to address various issues including child exploitation, knife crime, serious youth violence, county lines, gangs, trafficking, and modern-day slavery. They have successfully established positive information sharing and multi-agency working with Thames Valley Police, who have specialist police officers based within the CS Team. This enables a proactive approach to managing contextual risks of children and young people open to both the CS Team and YJSS and results in more robust co-ordinated partnership response to safeguarding concerns and targeting adult perpetrators who are exploiting children or engaging them in acts of serious youth violence.

The youth work provision in the YJSS has been located within the new CS Team so that we can maximise the specific skills and approach of Youth Workers and Youth Support Workers to increase the level of young people's engagement and with a view to engaging them with community provision as part of a planned exit strategy. The Youth Workers continue to deliver community enrichment programmes for young people on statutory interventions with the Youth Justice Service (YJS) including those accessing the Early Support Project (ESP).

The ESP has been further expanded with the introduction of the Achieving Change Together – NOW (ACT-NOW) programme which is an exciting new initiative where Youth Justice and Police have joined up in order to address knife-related offending in Milton Keynes. We have developed a creative and imaginative way to offer voluntary support to young people when a 'reachable and teachable moment' presents itself, such as being arrested for a knife offence. We respond to young people within 90 minutes of notification from the Police and complete a home visit within 48 hours to encourage young people to work voluntarily with the ESP pending Police outcome.

How has your agency utilised feedback from people who use your services to inform their work and influence service provision?

In 2021 we introduced independent evaluation using the Participation and Engagement Team of Youth Workers. At the end of every intervention, young people are given the opportunity to meet with a participation worker who is independent from the Youth Justice and Support Service and complete a questionnaire on their experience during their time with YJSS and also their experience of partner agencies. This service has been expanded to meet with all young people who engage with our Early Support Project, alongside using volunteers from the Youth Resilience Project to complete independent evaluations with young people. Latest data shows that the overall feedback from those working with YJSS is positive, with 85% of respondents reflecting that their experience was okay, good or excellent. This was an increase from last year which showed 82%.

Young people also have the opportunity to engage in research being conducted by the Institute of Criminology at Cambridge University. The research is focusing on the impact of the relationship between young people and key professionals working with them. Those young people who engage with the research have their hours counted towards Community Enrichment (Reparation).

As well as the voice of young people, parents/carers views are sought through the use of the self-assessments. Parents who attend group work interventions are also provided opportunities to complete an evaluation questionnaire. Further work is being explored on how to collate this feedback to ensure it informs practice development going forward. The views obtained continue to inform policy developments and the overall strategy which is reflected in the annual Youth Justice Plan.

We have continued the development work around capturing the voice of children who have offended, and their lived experiences of involvement in the YJS, and working with the YJSS and its partners. This continuing development which expanded to include trained community volunteers continues to help us to enable the voice of children and families involved in the YJS, alongside that of staff, volunteers and victims, to more meaningfully contribute to the service and the way, how and where it is delivered.

What difference has what you have done made and how do you know?

The Early Support Project (ESP) that offers children and young people early support and intervention including prevention work to reduce the likelihood of the child becoming known to the formal Youth Justice System, targeted prevention for children that have accessed the formal Youth Justice System previously, yet require further support, and diversionary work for young people who had some low-level and informal Police contact. The ESP service offer includes the Promoting Reintegration and Reducing Exclusions (PRRE) Speech and Language Therapy (SLT) project in primary and secondary schools. Our latest offending rate is 2.66% (rolling period over 2 years) this compares to a national rate for reoffending for statutory cases of 31%.

The Speech, Language and Communication Needs (SLCN) Assessments conducted between 2022/2023 identified that 98% of children assessed under our PRRE SLT project in primary and secondary schools, had an identified SLCN following assessment. This is a 2% increase from 2021/2022 data. Children can be referred to PRRE if they are assessed by their education provision as being at the greatest risk of school suspensions or a move to alternative education.

Since ACT-NOW commenced, we have responded to 38 arrest incidents, some of which are on more than one occasion for the same child. There have also been a further 10 young people referred in after being in Police Custody. We have 4 young people who were visited in custody under ACT-NOW who were resident outside of Milton Keynes and so were not offered ACT-NOW longer-term intervention, but relevant information was shared with the home local authority for all these children to make them aware of the arrest and circumstances. It is too early to provide detailed reoffending data for this cohort.

For those areas with little or no evidence of progress, what will you do to support improvement?

The CS Team and ACT-NOW are in early stages of development and therefore there has been no detailed in-depth analysis of outcomes and impact. We have an external Health Check of the CS Team that has been arranged to be completed with the National Working Group in September 2023. The Office for the Police and Crime Commissioner is organising an external evaluation for all elements of the Op Deter Project (of which ACT-NOW is the youth element developed in Milton Keynes).

Agency Annual Highlight Report
Milton Keynes City Council (Adult Services)

What has your agency done to fulfil last year's planned next steps? What else has your agency done to safeguard and promote the welfare of children and vulnerable adults over the past year?

We have had a review of our safeguarding service from partners in Health and Care. Sian Walker McAlister was our consultant for this piece of work. She commented that we were self-aware as a leadership team as a result of the internal assurance processes we have in place, including the application of our Quality Assurance Framework and associated audits. Sian left us with some recommendations for continuous improvement which will be discussed in further detail later.

The Community Support Team has been consolidated with the mental health social care team and rough sleepers team to form the Mental Health and Complex Needs Team. The new team has wider knowledge and skill base, working with people with complex needs including mental health, substance misuse, hoarding, cuckooing, and prevention of eviction which is supported through tenancy sustainment. Bringing the three services together has strengthened the links across CNWL mental health services, ARC, Thames Valley Police, Probation / Offender Management, Housing and third sector organisations to support people who present as complex and / or vulnerable for example, Operation Intercept - the team worked successfully with ASB team, legal team and TVP to support vulnerable people experiencing financial abuse and obtained injunctions against three perpetrators.

The performance activity across the Mental Health and Complex Needs team is monitored through Assurance Adult's Leadership Team (ALT) which is chaired by Victoria Collins (DASS) and attended by Heads of Service, Service Managers and Team Managers across Adult Social Care.

The domestic abuse coordinator continues to deliver the action plan agreed by the DA board.

We have continued to ensure the learning from SARs and learning events is fed into our operational procedures. For example, a learning event held at the end of 2022 regarding the death of SS has led to the review of our multi agency safeguarding policy, and interagency risk management protocol. It was noted from the tabletop review that the interagency risk management protocol was not utilised by workers when the criteria for section 42 enquiry was not met, and workers across the partnership did not see the correlation between the two policies. We have brought the policies together and added flow charts to support worker accessibility. Changes have been agreed by the Assurance Board.

Due to repeated concerns within SARs re: the application of the Mental Capacity Act 2005, we have developed some standards to support agencies with guidance of updates in case law critical to the application of the Act, whilst an updated Code of Practice is awaited. The standards have been agreed across the partnership.

We are now working on how we can embed the learning from a recent SAR re: disengagement from services, support for carers, psychological therapies and management of pressure ulcers.

How has your agency utilised feedback from people who use your services to inform their work and influence service provision?

We have built the LGA's Making Safeguarding Personal Outcomes Framework into our section 42 form to allow us to gather and monitor peoples experience of our section 42 enquiry work. As well as our QAF audits of feedback from people using services, we are about to launch a longitudinal audit trail to capture a person's journey through the ASC system, including safeguarding services. Based around the 6 principles of the 'Think Local, Act Personal' report, the Principal Social Worker (PSW) and Principal Occupational Therapist (POT) will periodically check in with the person as they journey through the system, to develop our understanding of the experiences of people using services to this can influence process and decision making where required.

What difference has what you have done made and how do you know?

Evidencing the outcomes for people using services and the 'voice of the person' in our work was feedback from our recent mock inspection and safeguarding consultancy. The previous box details the investments that we have made into our continuous improvement in this area, including continued application of our QAF, application of the Making Safeguarding Personal Outcomes Framework, longitudinal audit trails of the person's journey.

Team Managers and Deputy Managers make direct contact via telephone call or home visit with people who have used service to gather their feedback about their experience of using the service and what difference it made to them. We can then discuss arising themes to understand what we may need to do differently or learn from what we did well.

A quality and performance officer is also working with our front-line workers to write up some case studies of our intervention so that we can share our learning across our whole service, and part of this process will include making contact with the person to ascertain their experience of the work we have completed with them.

For those areas with little or no evidence of progress, what will you do to support improvement?

Recruit Service Manager for Safeguarding Team - we have reviewed and amended the safeguarding management role, developing a new service manager position which will now focus solely on safeguarding, we are currently recruiting to this new role. The service manager will support the following implementations below:

Additional oversight - Review our triage process, in response to the learning event 'SS' we aim to increase the oversight and improve the management processes for repeat referrals.

Implement recommendations from safeguarding consultancy - Including embedding strengths-based practice specifically in relation to safeguarding, adapting our section 42 enquiry paperwork to make it more robust and user friendly and support 'legal literacy' of staff.

Review of Safeguarding Investigators training and further development of competency model - We are currently reviewing our training offer for safeguarding and plan to refresh our model including the use of blended learning, competency-based assessment based on job role, and exploring the possibility of joint training with partner agencies.

Launch new reviewed multi agency safeguarding and risk management policy - Internally and across the partnership, to encourage that section 42 legal framework and risk management protocol are applied appropriately with the main aim of consistent risk management and communication between the MDT working with the person. MKCC will lead a review of effectiveness across partnership towards the end of 2023.

Learning from our data - We are exploring the trends and themes from our safeguarding data and undertaking targeted audit work if an increase or decrease is noted in type and location of abuse to feed back to MK Together Assurance Board where appropriate and contribute to service development and delivery.

Agency Annual Highlight Report
Central & North West London NHS Trust

What has your agency done to fulfil last year's planned next steps? What else has your agency done to safeguard and promote the welfare of children and vulnerable adults over the past year?

CNWL held its annual Domestic Violence conference, which asked 'what difference had the Domestic Abuse Act 21 made?'. Topics included learning from domestic homicide reviews, the importance of a health response to domestic violence and the policing perspective. CNWL continue to keep domestic violence high on the agenda, with over 100 'Domestic Abuse Champions' and the introduction of the Domestic Violence Routine Enquiry Form which is now part of the Clinical System.

CNWL also hosted the annual Safeguarding conference to focus on the 'voice of the child and adult'. The event welcomed guest speakers and topics to include extra familial harm and contextual safeguarding, self-neglect, female genital mutilation (FGM) and harmful practices, think family, professional curiosity and identifying sexual abuse. The FGM assessment tool kit has also been embedded in our Clinical System and is accessible to all practitioners.

Following the National Confidential Enquiry into Suicides; CNWL launched an initiative to improve the quality and compliance with the Trust Risk Assessment Policy. This work has included both a Trust wide and local MK Steering Group to engage Clinical Leaders, with focused work on Clinical Education, the launch of the Trust Risk Assessment Dashboard and performance reporting to provide improved oversight. Year two of the project will focus on the benefits to the patient in using the new approach and an enhanced auditing tool which focuses on the quality of the risk assessment and safety plan.

The Trust has also launched Dialog + in MK Mental Health Community services. Dialog + is a scale of 11 questions, where patients rate their satisfaction with eight life domains and three aspects of their treatment. Dialog provides a subjective score for quality of life and satisfaction with treatment and is utilised for care planning with the person to help them achieve an improved quality of life and care provided.

At the Campbell Centre, a focused action plan has been implemented, following feedback from a CQC visit. This work includes improving the care for patients with complex emotional needs, both within the community, in hospital and with partners across MK Together. A Quality Improvement Project has also been launched to improve patient experience, by reducing self-harming behaviours by 15% by the end of December 2023. Several 'change ideas' have already been trialled such as protective time for staff and patients to care plan, improving multi-disciplinary care planning, strengthening the 'safety huddle' and improving therapeutic clinical observations.

Healthwatch will also start working with CNWL at the Campbell centre, as an independent 'listening ear' to hear patient views and work with us to improve our services. The service will also continue to build on the work implemented this year with weekly focus groups for patients, Directors Surgeries for Staff and Carers and Family Surgeries chaired by the Matrons for Willow and Hazel wards.

The Health Visiting service has been supporting an increase in demand from families requiring additional support and increase in the number of children on child protection plans. This additional demand for safeguarding expertise has impacted some general performance indicators and the service has worked in partnership with Public Health to monitor and review performance targets.

The Health Visiting service also offered a bespoke service to Asylum seekers who were residing in the holding hotels in MK. The team have also supported an increase in families requiring additional support with the cost-of-living crisis, with a signposting service to both the food banks and 'baby basics' which is a charity offering supplies when preparing for a new baby.

The Community Mental Health Services have, over the last 3 years, undertaken transformation work which includes improving access to services, improving treatment and access to psychological interventions and strengthening access to emergency support within the crisis and hospital liaison pathway.

The Mental Health Services also hosted the first 'Think Physical' conference, which promoted the importance of good physical health for patients with mental health needs. Access to physical health checks for patients with a mental health need is monitored via performance data every month and reported at a variety of levels in the organisation.

How has your agency utilised feedback from people who use your services to inform their work and influence service provision?

All services across CNWL utilise the Friends and Family Test (FFT), which enables patients to feedback in real time and score their satisfaction with the service. Patient satisfaction by way of the FFT is monitored at every month and quarter end and is reviewed at a variety of levels in the organisation. When required, improvement plans are implemented and reviewed via our system of forums for effectiveness.

The National Initiative 'Triangle of Care', which promotes a three-way partnership between patients, carers and clinicians, is now embedded in MK Mental Health with carers champions at each site, which means we are working towards strength-based work in all our services in partnership with families.

The Mental Health Team have hosted another successful 'Think Family Conference' for staff, to hear experiences from families and patients to highlight and promote good practice.

All Mental Health inpatient services hold weekly community meetings to listen to patients views and at the Campbell centre further patient focus groups and carers groups are held to talk about the quality of the service and to focus on specific topics.

We have recently completed renovations at the Campbell Centre, following patient feedback about the removal of shared accommodation.

What difference has what you have done made and how do you know?

CNWL has a range of performance indicators in place to monitor all aspects of service provision, this includes monitoring waiting times for treatment and monitoring service key performance indicators. There are governance processes in place, to ensure all indicators and wait times are reviewed at an appropriate level and in partnership with commissioners.

This year, there has been focus on improving the diagnostic pathway for ADHD via CAMHS service. A new MK ADHD screening process has been introduced, which speeds up the time to screen children who do not require a more detailed assessment. In addition, CNWL have commissioned 'Healios', an online provider for clinical diagnosis to work in partnership within the ADHD pathway. The service has noted a

14% reduction in the number of children waiting for treatment since April 2022. The service continues the Quality Improvement Initiative into 2023/24.

The findings from this year's MKTSP 'Voice of the Child' audit showed that Health Visiting Team have made good progress in considering other siblings in the home and that any concerns are reported and recorded appropriately on the clinical system. This demonstrated that staff were capturing the voice of the child and remain professionally curious, especially when other siblings were in the home during school time.

CNWL also has a rolling programme of audits in place, and this includes auditing risk assessments and care plans and reviewing safeguarding practice and recording of information on the Safeguarding Information Node. The results from audits showed that many of our services have excellent recording practice; however, as some inconsistencies are noted in regard to risk assessment, care planning and using the safeguarding information node, work will continue to improve this during 2023/24.

For those areas with little or no evidence of progress, what will you do to support improvement?

At the Campbell Centre, a focused action plan has been implemented, following feedback from a CQC visit. The work to improve the safety culture will continue during 2023/24 and a range of outcome measures will be utilised to support the improvement journey.

An additional package has been commissioned from the Healios provider over 2023/24 to provide additional capacity for CAMHs teams in providing children with ADHD assessments.

CNWL will continue work to improve the quality of risk assessments and care plans across services. This will include clinical education to support practitioners and implementing case load management tools to show where patients need clinical records updating.

The safeguarding children's team will continue to strengthen access to safeguarding supervision, particularly in areas of risk.

Agency Annual Highlight Report
Milton Keynes University Hospital Foundation Trust

What has your agency done to fulfil last year's planned next steps? What else has your agency done to safeguard and promote the welfare of children and vulnerable adults over the past year?

Cessation Liberty Protection Safeguards implementation – Mental Health Practice Educator appointed and now wider Trust review of staff training and the further embedding of MCA/DoLS and focus on Mental Health bitesize training and partnership working.

Work continues to ensure all learning from statutory adult and children reviews is shared across the Trust, is incorporated into key committees/forums/training, and helps to inform our future audit programme.

Ongoing review of safeguarding training provision in relation to Intercollegiate Document to enhance multi-agency approach and ensure learning from investigations/reviews are incorporated.

Focus remains on Hospital Navigator scheme contributing to regional and national data profiling for violence reduction. Building on raising the profile of service and referral processes.

Continued partnership working with Mental Health services to improve pathways, processes across the Trust for adults, Children and young people including escalation and review of complex cases.

Dedicated space to support the continued work of the Hospital Independent Domestic Violence Advisor and improved referral mechanisms, building internal relationships and increasing referral numbers.

Membership in key Partnership Meetings.

Safeguarding now sits in portfolio of the Associate Chief Nurse for Operations & Safeguarding.

Increased focus on Section 42 reviews.

Safeguarding voice and representation on key internal/external reviews serious incident/ patient safety board/harm prevention group.

Improved data collection to ensure greater understanding of safeguarding activity, identify key themes and using analysis of the data to support key areas of workplan focus for the coming year.

Safeguarding committee feeds into Quality Risk Committee & Trust Board ensuring safeguarding is everyone's business.

How has your agency utilised feedback from people who use your services to inform their work and influence service provision?

The Friends and Family test is in place in all clinical areas - gathering feedback from those who have experienced services allows for a more holistic understanding of their effectiveness. The Patient Experience platform captures feedback from various methods -SMS text, FFT, social media - which is used to provide

valuable insights, promote learning, influence practice and drive standards. This helps to inform areas of good practice and areas for development, including policy/process and service change redesign.

Feedback & learning from Section 42 Enquiries and incidents has been used to support review of practice. Focused work looking at pressure ulcers is managed via the care review panel and harm prevention group which now includes safeguarding membership for oversight/advisory capacity.

Learning from complaints and incidents to inform training, development of staff/change in processes and development and review of policies.

Matron for Patient Experience and Learning Disability has undertaken training within appreciative inquiry and implemented this methodology when scoping experiences from service users. This has also informed the development of the Learning Disability Strategy.

Feedback from children and families is an essential source of evidence when measuring impact.

Debriefing and table-top learning events to promote reflective practice and open facilitated discussions post-incidents, including collaborative approach across teams/services.

Introduction of Patient Safety Incident Response Framework focus of safety & closely linked with safeguarding.

What difference has what you have done made and how do you know?

The Trust is represented on key partnership boards/committees to raise profile and ensure system wide partnership work focused on improving outcomes.

Improved escalation processes for children presentation with CAMHs related issues with agreed format for escalation, now well established.

Safeguarding Data collection and review of key themes formally reviewed at safeguarding committee which has moved from quarterly to monthly.

Involvement in CSPRs/DHRs/SARs/complex case reviews, and recommendations and learning starting to be more widely shared and key part of Safeguarding Committee.

Learning from incidents/serious incidents and Section 42 has led to implementation of Harm Prevention Group/Care Review Panel where the Safeguarding team are key members.

Annual SAAF and Section 11 frameworks provide assurance and highlight gap analysis to inform MKUHFT's future work plan.

Review of safeguarding aspects of recent CQC reports - benchmark/gap analysis at MKUHFT.

For those areas with little or no evidence of progress, what will you do to support improvement?

Appoint Head of Safeguarding – continued review and development of the Safeguarding and Vulnerable Persons Hub, processes and policies.

Review of Section 42 Provider Enquiry Process to ensure focus on learning and themes and continued focus on improving outcomes for adults. Work to ensure triangulation of themes with other methods such as incidents/complaints.

Review with MKCC of safeguarding referral process and feedback/outcomes.

Wider review of Safeguarding training including a gap analysis.

Development of robust Safeguarding Supervision programme, policy update in line with BLMK Safeguarding Supervision publication.

Child Protection Medical/Neglect process - system review.

Child Death Process – review themes and using analysis of the data to support key areas of workplan focus for coming year.

Safeguarding committee feeds into Quality Risk Committee & Trust Board ensuring safeguarding is everyone's business.

Agency Annual Highlight Report
National Probation Service

What has your agency done to fulfil last year's planned next steps? What else has your agency done to safeguard and promote the welfare of children and vulnerable adults over the past year?

We have maintained and strengthened membership of partnership forums, reviewing which forums we can make a difference in and which forums what is the correct level of attendance. We now have a Deputy Head of PDU in post which helps to increase our visibility and engagement at senior level, including DHR panels.

In relation to joint training, our strengthened links to local MASH and other partners has increased our knowledge to additional training which may benefit staff. This is circulated to relevant staff, although we acknowledge that priority is given to our own safeguarding training and resource capacity can impact on staff therefore having opportunity to take up additional training offers.

Work has been completed to ensure we have a quality assurance model for referrals and enquires sent to the MASH. This is monitored locally but meets requirements laid out in the Child First Probation Policy. Recruitment and retention work is ongoing and remains a priority.

We continue to focus on quality of risk assessment and sentence planning continues, with audits focusing on whether there is person in probation involvement. This forms part of our regional case audits each month.

How has your agency utilised feedback from people who use your services to inform their work and influence service provision?

Our EPOP (Engaging with People on Probation) team in the region has established itself now. The EPOP team holds regular forums with Senior Leaders and people on probation to learn what has worked well and what could have been more successful if delivered differently. These are held locally across the region as some issues may be specific to certain locations.

Actions and commitments are taken from these meetings and shared as suggestions with local offices, practice changes are then considered and introduced, for example, swift enforcement action was something requested, being clearer about next appointments and frequency of contact.

The EPOP forums and the yearly questionnaire to people on probation, help us to identify which services should be sought under the commissioned rehabilitative services contracts. This year we have continued with two specific women's services, and housing and Education, Training and Employment (ETE) services. But we have built on this with personal wellbeing contract and a finance benefit and debt service for example.

What difference has what you have done made and how do you know?

Introducing quality assurance measures to MASH enquires and referrals – success measured by fewer referrals and enquires being unanswered.

Implementation of yearly staff Competency Based (CBF) every three years. Monitored through staff CBF records, staff cannot progress through the organisation and PayScale's if training is not up to date and embedded in practice.

Monthly Case Audits take place by the quality and performance team, this looks at assessment and planning, risk management, enforcement and sentence delivery. The audit shows us actions for specific cases, but its frequency also quickly alerts us to themes for development. Local Learning, Engagement and Accountability Panels monitor quality actions and track that these are met.

The Probation services works with those over the age of 18 so staff have limited contact with children. However recent changes to our OASys assessment provides greater capacity to prompt for a consideration on all aspects of the welfare of a child, moving the focus on whether that person on probation may pose a threat to a specific child. This has increased the number of enquires we make each year and give greater reassurance that potential risks are identified.

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. 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.

For those areas with little or no evidence of progress, what will you do to support improvement?

To increase the speed of enquires to DAU and MASH, we are appointing case administrative staff to work in each of these organisations. Staff have been appointed, but full vetting and training remains outstanding.

Key priorities to develop are improving timeliness of something the initial sentence plan (should reach a 15 day target, but currently sitting outside this) and to increase timely updating of records where a person has been seen. Both these priorities help to improve safeguarding as it gives quicker access to partners already working with that case or highlights where referrals are made, up to date records also helps with next steps where a review of risk and compliance is needed.

Partnership training needs to be explored further. How can we increase our staff being able to take advantage of opportunities and how can we contribute to joint training events. Having Probation staff working in MASH will help this as staff will be more integrated, but additionally, this can be built into our staff retention policy.

Agency Annual Highlight Report
Oakhill Secure Training Centre

What has your agency done to fulfil last year's planned next steps? What else has your agency done to safeguard and promote the welfare of children and vulnerable adults over the past year?

The Behaviour Management Strategy was launched in February 2022, and rolled out through a series of workshops to existing staff. Refresher training was delivered in May & October 2022. The workshops also feature as part of the initial training course to ensure that new staff can understand and implement it practically. The BMS is based on the Building Bridges framework and has helped us to improve behaviour management through relationship-based practice and creating a rewards-based culture. Between April 22 and March 23 there was 50.3% decrease of overall incidents compared to the 12 months previous and a 40% decrease in the rates of use of force for the same period. Other tangible evidence is the rate at which we complete a standing relocation versus a prone relocation. With emphasis being on de-escalating children, and this continuing even once holds are placed, we are able to reduce the number of high-end relocations and thus reduce the risk of potential injury to a child as a result of this.

A review of the Centre's Safeguarding Children Policy has been completed. This has elaborated further on the processes in place for safeguarding and child protection concerns. This updated Safeguarding Children Policy is robust in ensuring the clear procedures and processes for ensuring the safety and wellbeing of the children at Oakhill STC. Duty Directors have been provided with additional training around completing MASH and LADO referrals, thus reducing any delay in information sharing.

Child Protection thresholds and LADO thresholds are clearly set out and in line with those of MK City Council's policies and threshold document and the processes for making a LADO referral and MASH referral to both the host Local Authority and the child's home Local Authority are now in place.

The role of the Youth Custody Service (YCS) is clearly detailed, and it is highlighted that the onsite monitors should be informed of any child protection concerns or concerns around staff conduct. The Youth Custody Service complete regular checks of the safeguarding referrals received in the Centre and the actions completed. There is an honest, open and professionally constructive working relationship between the Safeguarding Team and the LADO service which further ensures the safeguarding of the children in Oakhill's care.

The child debrief process has evolved over the past year, with us identifying that some children will not engage with the Minimising and Managing Physical Restraint (MMPR) team. We identified the need to advise 'the best person possible' to complete the debrief. This means that debriefs will be completed to a better standard and the team track this via a tracker. The monthly Risk Management Meeting (RMM) includes a section around the child's voice, and we look to view the debrief of the child involved in the incident that was viewed at RMM. The process has recently been supported by national guidance from the YCS central team to support the collation of the debriefs in a view to driving up the standards up. We have also allocated the coordinators to CSTs (Core Support Teams) which forms part of our enhanced support services model. This multi-disciplinary meeting allows the MMPR coordinator to provide direct staff to the SRMs and the staff working frontline with the child.

Staff continue to be referred to the Traumatic Risk Management team regularly post incident and we have seen a recent increase in the number of referrals associated with the levels of self-harm on Oak block. The list of staff involved in incidents and that have been assaulted are reviewed at the monthly RMM where their support mechanisms are discussed, and we ensure that the suitable referrals are being completed. All new staff to the centre are now appointed a mentor from the senior leadership team, who will check in with them when they have experienced a challenging incident or shift. Oakhill STC, alongside the YCS, held a Safety Summit in April 2023; an action plan has been developed with key areas identified to improve staff well-being and support.

There has been some good quality work completed by the Resettlement Team in regard to Release On Temporary Licence (ROTL). There is a new ROTL policy in place and successful visits have taken place with other organisations in the local area, such as the Food Bank. Upskill U, mentoring service, will continue work with the children upon their release if the child and their professional network are in agreement with this and is a positive continuation of a working relationship. The children's case workers will also attend post release meetings for the children to check in with their progress and show continued support for them.

Staff from both the Resettlement and Safeguarding teams met with HMIP inspectors who are undertaking a Remand Thematic Review to look at the outcomes for children who are held on Remand. Oakhill were able to contribute to this with the experiences of children from within the Secure Training Centre and provide insight into the differences to their peers within the Youth Offending estate.

How has your agency utilised feedback from people who use your services to inform their work and influence service provision?

The children in our care have the opportunity to attend a Youth Council meeting once per month. Through this meeting the children have been able to negotiate changes within the centre such as:

- Extended times for their phone lines to be active.
- A higher level of pocket money to utilise on their phone credit and tuck options.
- Menu options available to them for mealtimes within the centre.
- Changes to Policy and Operating Procedures.

The children also have access to a complaints and grievance process. This has improved recently with more guidance and regulation being in place regarding length of time for complaints to be processed and responded to. Oakhill STC worked with the Prison and Probation Ombudsman (PPO) to review complaints practices and ensure children's voices are heard.

Oakhill STC continues to work jointly with Barnardo's Advocacy Service - 'Your Rights Your Voice' (YRYV). Quarterly Review Meetings are held with the on-site Barnardo's team to ensure children have access to staff who can advocate on their behalf.

Within the last year the Children's Commissioner have visited Oakhill to assess the access for children to their families and significant others. Feedback from this visit has been used as part of wider policy changes in the Juvenile Criminal Justice System.

What difference has what you have done made and how do you know?

As detailed above the implementation of the new behaviour management strategy within the Centre has seen a 50% decrease in the use of force within the past 12 months directly impacting on the safety and wellbeing of the children.

A Quality Assurance Visit was conducted by the Youth Custody Service in November 2022 which reviewed the education received by children and the Resettlement provision. It was reported that the Resettlement Team actively challenges the responsible authorities when staff have concerns and that children speak positively about their resettlement practitioners who are in regular contact with them and keep them informed of relevant issues. The managers at Oakhill are able to provide in depth knowledge of all children in the Centre.

Some points for progress were noted to be children's access to ROTL due to eligibility and risk and a lack of information post-release due to external agencies not providing this.

Further feedback from children and parents speaks of positive relationships formed with staff members and the continued support offered to children at Oakhill STC. This is also echoed by numerous Local Authorities.

Oakhill Continues to provide 25 hours of education to children per week and empowers them to achieve both in terms of academic achievement and in regard to softer skills relevant for their social development and re-integration into the community.

For those areas with little or no evidence of progress, what will you do to support improvement?

Mobility/ROTL for children remains an area of improvement. The criteria in the new ROTL guidelines limits the number of children at Oakhill STC who are eligible for this however, internal processes need to be commenced in a timelier manner in order to ensure that those who are eligible are afforded this opportunity.

Following feedback from the Safety Summit held in April 2023, an action plan will be completed to ensure staff are supported and children feel safe within our community.

Agency Annual Highlight Report
Thames Valley Police

What has your agency done to fulfil last year's planned next steps? What else has your agency done to safeguard and promote the welfare of children and vulnerable adults over the past year?

Worked together with Milton Keynes children's social care in setting up and working with the contextual safeguarding team to safeguard children who are groomed, targeted or exploited.

TVP has introduced a new MASH exploitation process where a dedicated team reviews referrals where exploitation is a factor either in children or adults. These referrals are sent through to the problem-solving team for review and allocation to an officer is the necessary threshold for Police intervention is met.

TVP is rolling out trauma informed awareness training to all custody sergeants and staff.

TVP and Milton Keynes Childrens social care have set up a focused deterrence project which has been funded by the VRU. This project offers enhanced support, diversion and enforcement to children and adults who are habitual weapon carriers and present a risk to the community.

How has your agency utilised feedback from people who use your services to inform their work and influence service provision?

TVP do not routinely seek feedback from the subjects of this work locally as onward referrals are made into other agencies. The wider work around service improvement and the voice of the child is centrally owned in TVP strategy and covers differing aspects of safeguarding which is usually thematic e.g. domestic abuse, child abuse, child criminal exploitation etc.

What difference has what you have done made and how do you know?

The focused deterrence project has not yet reached its first evaluation stage. When the results are known, this will be shared with the wider partnership.

The new MASH exploitation process creates a single 'front door' for exploitation referrals, this is a new process and not yet subject of evaluation.

For those areas with little or no evidence of progress, what will you do to support improvement?

Evaluation of the focused deterrence project. This will be completed by the VRU head of research.

Evaluation of the new MASH exploitation process.

The problem-solving team will be subject to a force restructure in early 2024 with new teams being implemented to manage safeguarding and exploitation. This will also incorporate new structure on the reach and scope of this department but also how it will work with partner agencies.

Appendix A
Partnership Representation at MKTSP Meetings 2022/23

Agency attendance – MK Together Safeguarding Partnership meetings 2022 – 2023

Agency	April 22	July 22	Oct 22	Jan 23
Chief Executive, MK City Council	✓	✓	✓	✓
Bedfordshire, Luton and Milton Keynes Integrated Care Board	✓	✓	✓	✓
Bucks Fire and Rescue Service	✓	✓	✓	X
Central and North West London NHS Foundation Trust	✓	✓	✓	✓
Governor, HMP Woodhill	✓	✓	X	✓
Independent Scrutineer	✓	✓	X	✓
Director of Adult Services, MK City Council	✓	X	✓	✓
Director of Children's Services, MK City Council	X	✓	✓	✓
Director of Customer and Community Services, MK City Council	✓	✓	✓	✓
Milton Keynes University Hospital Foundation Trust	✓	✓	✓	X
Head of Delivery, National Probation Service	X	✓	X	✓
Director, Oakhill Secure Training Centre	X	X	✓	✓
Director, Public Health, Bedford and Milton Keynes	✓	✓	✓	✓
LPA Commander, Thames Valley Police	✓	X	✓	✓
Chief Executive, Community Action MK	X	✓	✓	✓

Appendix B
Contributions and Summary of 2022/23 Budget

Agency Contributions for 2022-23

	Children's	Adults	Total
BLMK ICB	-51,482	-14,300	-65,782
Thames Valley Police	-18,595		-18,595
National Probation Service		-4539	-4539
MK University Hospital Foundation Trust	-1,974	-3,250	-5,224
G4S Care & Justice Service (UK)	-1,974		-1,974
CNWL MK	-1,974	-3,250	-5,224
Police & Crime Commissioner (via TVP)		-7,800	-7,800
Bucks & MK Fire & Rescue Service		-650	-650
MK City Council incl. public health	-107,504	-41,500	-149,004

Summary of 2022/23 End of Year Budget Position

2022/2023 Actuals		
Income	Brought forward from 2021/2022	-133,944.36
	Contributions	-271,818.00
Expenditure	Employee costs	215,014.98
	Independent Chair/Scrutineer	8,589.24
	Review activity costs (excluding DHRs)	10,800.00
	PHEW & TriX Support (website, policies and procedures	10,000.00
	Misc	3,545.53
	Total (c/f to 2023/24)	-157,812.61

Glossary

AAFDA	Advocacy After Fatal Domestic Abuse
ASC	Adult Social Care
BAMER	Black Asian, Minority Ethnic and Refugee communities
BLMK	Bedford, Luton and Milton Keynes Clinical Commissioning Group
CAMHS	Child and Adolescent Mental Health Service
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
CSPR	Child Safeguarding Practice Review
CST	Community Support Team
DA	Domestic Abuse
DHR	Domestic Homicide Review
EPOP	Engaging with People on Probation
EDI	Equality, Diversity and Inclusion Advisory Group
ESP	Early Support Projects
FSW	Family Support Worker
FGM	Female Genital Mutilation
GP	General Practice
HMIP	HM Inspectorate of Probation
HRP	Healthy Relationships Project
ICB	Integrated Care Board
LAC	Looked After Child
LPA	Local Policing Area
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
MCA	Mental Capacity Act
MK	Milton Keynes
MK ACT	Domestic Abuse Charity
MKCC ASC	Milton Keynes City Council, Adult Social Care
MKCC CSC	Milton Keynes City Council, Children's Social Care
MKUHFT	Milton Keynes University Hospital NHS Foundation Trust
NHS	National Health Service
Ofsted	Office For Standards in Education
PDU	Probation Delivery Unit
PMHW	Primary Mental Health Worker
RSL	Registered Social Landlord
SAAF	Safeguarding Adults Assurance Framework
SAR	Safeguarding Adult Review
SFO	Serious Further Offences
SMART	Specific, Measurable, Attainable, Realistic and Timely
TRiM	Trauma Risk Management
TVP	Thames Valley Police
VAWG	Violence Against Women and Girls
VRU	Violence Reduction Unit
YCS	Youth Custody Service
YJSS	Youth Justice and Support Service