

MK Together

Annual Safeguarding Report 2023-24

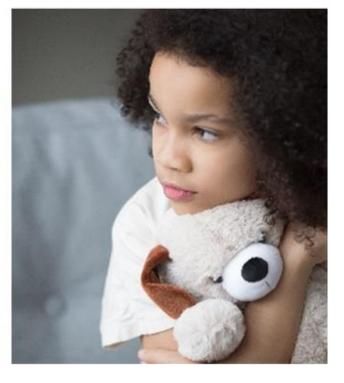












Contents	
Contacts	3
Introduction	4
Independent Scrutineer's Assessment	5
What is safeguarding?	7
MK Together Safeguarding Partnership	8
Children's Priorities	
Neglect	13
Missing	15
Local Authority Designated Officer (LADO)	16
Think Family	17
Adults Priorities	
Exploitation	18
Transition	19
Mental Capacity Assessments	20
Person in a Position of Trust (PiPoT) Referrals	21
Think Family	22
Self-Neglect	23
Hoarding	24
Summary	25
Appendix A – Partnership representation at MKTSP meetings 2023-24	26
Appendix B – Contributions and summary of 2023-24 budget	27
Glossary of terms	28

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

Multi-Agency Safeguarding Hub (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 MK Together Safeguarding Partnership in Milton Keynes:

MK Together, Civic, 1 Saxon Gate East, Central Milton Keynes MK9 3EJ mktogether@milton-keynes.gov.uk

Introduction

We are pleased to introduce the annual safeguarding report of the MK Together Safeguarding Partnership for 2023-24. 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, and Bedfordshire, Luton and Milton Keynes Integrated Care Board - work together with other key agencies as the MK Together Safeguarding Partnership.

This MK Together Safeguarding Partnership annual report covers the period from 1 April 2023 to 31 March 2024. The annual report outlines the key activities and achievements of the Partnership over the last year in relation to our recently agreed priorities.

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

MK Together Safeguarding Partnership

Independent Scrutineer's Assessment

2023/2024 has been a year of consolidation and change for the MK Together Safeguarding Partnership and it is again a pleasure to provide my assessment of what has, overall, been another satisfactory year for the partners. Unsurprisingly all partners have felt the combined challenges of increasing demand, tighter finances, a growth in overall need and increasing risk within Milton Keynes communities.

Like all partnerships, austerity, resource pressures and demands, and recruitment difficulties have continued to affect progress, and for NHS partners the challenges are significant, but my assessment is that the partnership remains both mature and resilient. One of the strengths of Milton Keynes as a place is the maturity of the partnerships, and a can-do approach to finding joint solutions to issues. In addition, relationships are strong enough to be transparent about these challenges and their impact on partners. This also means that in the main the focus on the effectiveness and safe practice of frontline services is not lost, and the majority of individuals are appropriately supported.

Looking back at the issues we needed to address over the year, much has been achieved. The restructured partnership arrangements have bedded in well and the Milton Keynes Health and Care Partnership Board is running well, supported by the work of the Integrated Care Board and the MK Deal delivery programmes. Our links with Safer MK and the Domestic Abuse Strategic Partnership are good and the partnership framework and structure has been able to focus on consolidating programmes and projects and progressing work plans.

The pressures on Milton Keynes University Hospital continue but the safeguarding team has been properly staffed and is providing a good service. Relationships at middle manager and service provision levels remain robust and creative practice in relation to key pressures has meant hospital discharge and emergency mental health responses have been well managed. The hospital continued to see significant pressures on paediatrics in relation to young people acutely unwell with mental health conditions, reflecting some of the wider system pressure, regionally and nationally for that group of individuals. Similarly, relationships with schools have significantly improved and the local authority has been building more effective ways to engage collaboratively with schools on safeguarding practice, concerns and effectiveness.

The partnership approach to developing, signing off and disseminating multi-agency protocols, policies, practice guidance and tools has improved, and the Section 11 (S.11) Review (which this year included adult services) demonstrated a high degree of confidence amongst multi-agency frontline practitioners and managers that they know what to do and where to get guidance. In addition, there was a lot of confidence in the MASH arrangements expressed at that review.

The partnership is adapting to include much of the work on serious violence required by the Home Office within its oversight as well as the rapidly changing approach to homelessness, the street homeless, and services for migrants and refugees.

The partnership continues to ensure adherence to the principle that safeguarding is a golden thread that is front and centre of all we do. The safeguarding handbook 2023 restated 5 key principles and a series of objectives which are overall being met. An independent review of the Safeguarding Adults Board (SAB) arrangements within our partnership was complimentary about the MK Together Safeguarding Partnership model, which provides a more holistic approach to safeguarding across all ages, all needs, all agencies, and a shared approach to improvement. The review made some helpful suggestions for further development.

I remain fully assured and convinced that the benefits of the MK Together Safeguarding Partnership arrangements outweigh the challenges of implementing national requirements that do not fully reflect the

way that joint partnerships work. I remain satisfied that challenge and scrutiny is welcomed and culturally established and continue to see good progress in addressing and implementing learning from reviews, audits and specific task and finish groups. All the partners work hard to improve safeguarding practice from learning gathered in many ways. 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 and are open and transparent in their interactions with the scrutineer.

Statutory requirements for key activities (S11 and the Review of Restraint) have been met. The S11 process provided rich information about practice across children and adults and identifying the need for further work on "Think Family" and on addressing neglect earlier and more robustly. The Review of Restraint at Oakhill STC was delayed but was completed at the start of the 2024/25 year.

Our review processes and approach are robust, and learning is welcome and applied. Towards the latter part of the year a reduction in referrals for Child Safeguarding Practice Reviews and Safeguarding Adult Reviews was identified which has led to a planned audit of referrals and interrogation as to why more are not being referred.

The publication of a revised Working Together to Safeguarding Children and the need to critically review local arrangements against new requirements, coupled with the steady consolidation of and improvement in our Adult Safeguarding arrangements and the evolution of the Health and Care Partnership led us to a point where we have agreed to review the Partnership Framework again, and identified four key areas for improvement.

The most pressing of those was the absence of a specific Strategic Plan for the Safeguarding Partnership, as opposed to the overarching Health and Care Partnership Plan. This has been initially rectified by the development of plans on a page, building on the various priorities in each of the five working groups, and is a priority for greater development in 2024/25, which will allow for a stronger, more coherent and less reactive focus on key areas of work. It remains a slight concern for me as Scrutineer that this plan may not sufficiently "lock into" the strategic plans of the Community Safety, Health and Care and Domestic Abuse partnership boards and vice versa, which will need to be monitored.

Secondly the Partnership needs to develop a more coherent assurance and performance system underpinned by a strong learning and improvement framework. A new approach to understanding our collective performance will be developed over 2024/25, starting with the creation of a partnership data set, and some agreed strategic performance measures. I am satisfied that whilst this will take time, the importance of this is well understood.

Thirdly, and related to the learning framework, at some point in the near future the question of appropriately provided and properly funded targeted multi-agency training will need to be explored. The partnership currently ensures all partners have safeguarding training in place, but a small programme of joint training is something that needs actively exploring.

All these are, however, strategic rather than practice issues. As far as practice is concerned, whilst improvement is always possible and necessary, I am satisfied that the Partnership's work continues to safeguard the citizens of Milton Keynes and continues to have the impact needed to maintain standards, maintain progress, and protect 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.

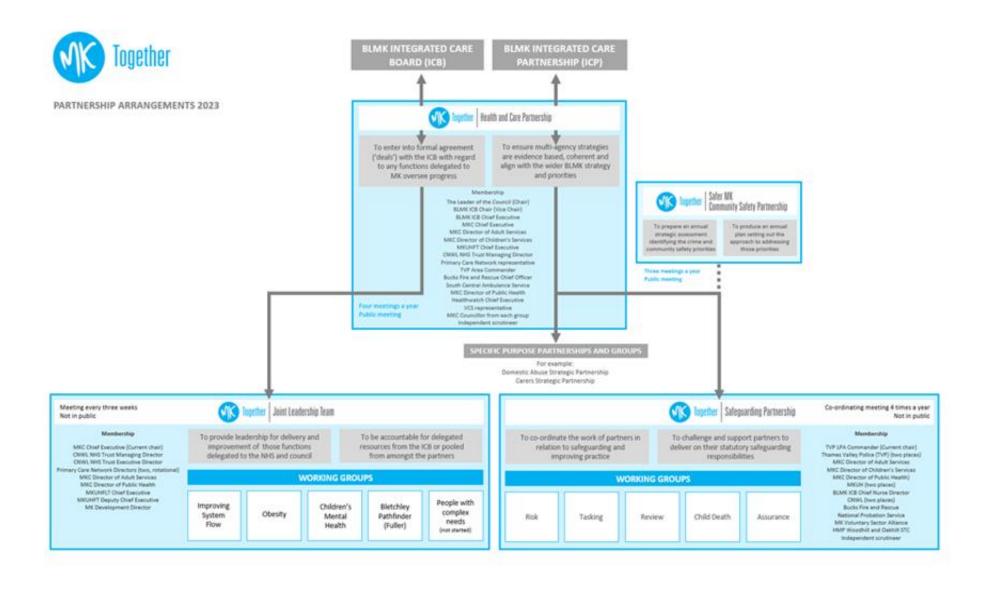
Safeguarding adults – Safeguarding duties apply to an adult who:

- 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.

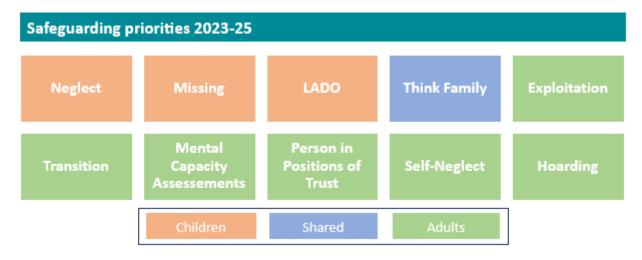
The MK Together Partnership



Safeguarding Partnership

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.



The work of the Partnership is delivered by five working groups. The working groups have been working on the agreed priorities whilst keeping a flexible forward plan to allow space for new and emerging risks and vulnerabilities requiring Partnership action.

The Safeguarding Partnership used the publication of Working Together to Safeguarding Children as an opportunity to review and refine the current governance arrangements. Consultation on changes needed to implement Working Together 2023 started in January 2024 and is ongoing with an anticipated publication of updated arrangements in Autumn 2024. This work ran parallel to a benchmarking exercise for compliance with the Care Act 2014. We are now implementing a slightly revised governance structure to ensure our arrangements remain compliant with both Working Together and the Care Act. A dataset is under development to ensure there is continued robust assessment of need and safe practice.

The Safeguarding Partnership has considered and discussed recommendations from a variety of inspections including Care Quality Commission (CQC) inspection of Milton Keynes University Hospital Trust, Central and North West London NHS Trust, Ofsted and HM Inspectorate of Prisons (HMIP). Assurance oversees actions relating to recommendations in order to assure the partnership that areas identified as needing improvement are proactively resolved. The implementation of new national initiatives have also been overseen by Safeguarding Partners including "Right Care, Right Time". Local

discussions took place within the Working Groups to ensure a partnership focus on this guidance and early indications are that it is working well in Milton Keynes.

The Safeguarding Partnership continues to discharge the duty of the Combating Drugs Partnership and commissioned a Task and Finish Group to identify and address any gaps in preventative provision for children and young people. This work is expected to be completed in 2024.

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

In this reporting period Assurance oversaw the review of the Early Help model led by Children's Social Care. This resulted in discussions around the need to review the current children's threshold document to enable timely and effective child protection actions when it comes to neglect. However, the S11 audit did provide evidence that there is a strong level of confidence amongst practitioners in using the current threshold document and referring to MASH. Assurance has also monitored the increase in the numbers of children who go missing, particularly those placed in Milton Keynes from another area, and worked with Risk and Tasking to actively adapt practice to meet the changing needs of these children. This is a particular focus in the Serious Youth Violence audit that was planned for the 2024/25 reporting period and scheduled for completion during the summer of 2024.

Assurance maintains oversight of the completion of recommendations from statutory reviews, sharing responsibility for putting plans into action with Review.

Following the publication of Working Together to Safeguard Children 2023 and the completion of the Safeguarding Adults Benchmarking exercise, Assurance will be revisiting how data is used to assure the Partnership that agencies are appropriately safeguarding children and vulnerable adults and quickly identifying risks to systematic safeguarding practice. Assurance will work closely with the other Working Groups to ensure a robust learning and improvement framework is embedded within the Safeguarding Partnership.

Assurance oversaw and agreed a revised communication protocol which was introduced with clear guidelines to agencies as to the expectations of them in terms of adoption, dissemination, and implementation of new and updated protocols and processes by their staff. Plans are in place to audit the success of this and identify the outcome of the implementation requirements.

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

Between April 2023 and March 2024, the Local Case Review Panel carried out three adult rapid reviews. One did not meet the threshold for a Safeguarding Adults Review (SAR), one was paused awaiting the outcome of a related audit, and one was progressed to a full SAR. One SAR report was published, and one Local Learning Review was completed, and the report published.

Review completed two Child Safeguarding Practice Reviews (CSPR), publishing the report for one and producing a Learning Bulletin for publication for the other. Two children's rapid reviews were carried out, one of which did not meet the threshold for a CSPR. The other did meet the threshold and a CSPR was commissioned. One Serious Incident notification was received that did not meet the criteria for a rapid review.

Review oversaw the commissioning of one Domestic Homicide Review (DHR), the completion of one DHR, the publication of one previously completed DHR report, and received approval from the Home Office to publish another report.

Key learning themes from these reviews included the need to understand and collectively meet the needs of the whole family, and to ensure all multi-agency pathways and procedures are socialised within agencies and used effectively. Review worked with Assurance and Tasking to recommend work to further improve the Think Family approach and review and relaunch the Interagency Adult at Risk Management Protocol (IARM).

Information sharing elements of multi-agency safeguarding policies were enhanced, particularly in relation to the interface between services for children and services for adults; the need for practitioners to be aware of all agencies involved with a family was highlighted and reinforced to services. Policies and training programmes have been updated to include how to employ professional curiosity and improve information gathering.

Learning continues to be identified at earlier stages through the embedded rapid review process for both adults and children's reviews. The voice of the individual or families where the individual is deceased is sought in all reviews. Review works with the organisation Advocacy After Fatal Domestic Abuse (AAFDA) to ensure the experience of the victims and their families is captured. Subject experts are commissioned where appropriate to ensure all protected characteristics are appropriately considered.

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

Risk identifies new and emerging areas of risk and exploitation. This Working Group maintains oversight of case-based panels including Channel and the Multi-Agency Risk Management Group.

Risk completed a scoping exercise to assess the extent of peer-on-peer sexual harassment in schools. We are reassured that incidents are managed and reported appropriately by staff, and that each school's safeguarding policy is accessible on their website. A straightforward reporting process flowchart has been developed and distributed to school Designated Safeguarding Leads. Working closely with Tasking, Risk has monitored the impact of multi-agency activity to address concerns around street drinking, rough sleeping and aggressive begging in the city centre. This work continues although we have seen a reduction in this behaviour by using a combination of increased visits and support by the council's Rough Sleeper Team and CNWL's drug and alcohol and mental health outreach, as well as enforcement tactics such as Community Protection Warnings. Work is ongoing to promote an alternative donation pathway and encouraging the public to report anti-social behaviour.

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

Tasking has been developing a trauma informed toolkit for use in universal children's settings following consultation with practitioners about trauma informed practice. This will be ready for distribution in the 24/25 academic year. This accessible two-page document provides easy hints and tips to embed trauma informed practice into everyday engagement and provides links to established reports for further reading if required.

Tasking will take the same approach to develop a Think Family toolkit, again ensuring it is an easy-to-read guide to ensure practitioners take a holistic approach to assessment and engaging, ensuring the needs and the views of family members are noted and listened to.

Tasking has also overseen the embedding of the Serious Violence Duty as business as usual and has agreed the funding of several preventative interventions for young people at risk of criminal and sexual exploitation.

In relation to modern day slavery Tasking has engaged in initiatives to support TVP's Operation Aidant, facilitated the embedding of housing protocols, provided training for taxi licensing, raised awareness of the National Referral Mechanism through training sessions, and supported a collaborative approach during County Drug Line Week with targeted interventions.

A multi-agency discussion about hoarding was held at the June 2023 Tasking meeting. This raised awareness of support available, including a hoarders' group, and an overview of a new multi-agency process for enforcement, led by Environmental Health.

Child Death reviews deaths of children normally residing in Milton Keynes in order to consider potential themes, identify modifiable factors and make any recommendations for preventative action. Child Death produces a standalone annual report reporting on its activity.

Child Death fulfils the statutory obligations for multi-agency child death reviews, addressing all deaths of children normally residing in Milton Keynes, and, where applicable, reviewing cases of non-resident children who have died in Milton Keynes. This process aims to identify and report contributory or modifiable factors, including neglect, share lessons learned and make recommendations for preventing future child deaths and promoting the health, safety, and well-being of children.

Child Death uses standard national reporting templates to gather information from all agencies involved with a child and their family prior to the child's death or in connection with the investigative process thereafter. Utilising standardised forms enables the identification of national issues, as all partnerships use the same reporting format. The information gathered includes family demographics, such as living conditions, specifically looking at areas of deprivation, and whether there were concerns pertaining to child abuse or neglect contributing to the child's death. Notably, neglect was not specifically identified as a modifiable factor in any child deaths reviewed in Milton Keynes during 2023-24. The identified modifiable factors included associations with gangs, lack of engagement with education and support services, and the need for improved cross-agency communication.

Child Death adopts a family-centered approach, using standard national templates to gather comprehensive family history, including details from pregnancy through to school years. This information encompasses intrinsic factors related to the child, such as prenatal influences, known health conditions, and social relationships, gathers information about physical or mental health issues affecting parents or carers and considers service provision.

Work also commenced to introduce a revised Unexpected Child Death Pathway process, overseen by the Safeguarding Partnership to incorporate support for education providers and other children who may be at risk in cases of suspected suicide and weapon enabled homicide.

Single and Joint Agency Activity in Priority Areas

Children's Priority: Neglect

MKCC MASH saw a 14% increase in contacts in the year 23/24. Child in Need cases reduced by 4% however the number of children subject to Child Protection Plans rose by 41%. Cases citing neglect as a risk indicator increased by 26%. Work to understand the reason for this increase has been ongoing. Discussions are ongoing regarding the implementation of the Graded Care Profile 2 which is supported by BLMK ICB, who are collaborating with partners to achieve best practice in identifying the effects of neglect on children and young people as well as parental capacity, which will lead to positive care and intervention plans.

Health partners have been making progress with the development of the neglect pathway and system. The Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB) plans to conduct a workshop for all stakeholders to assess the requirements for a comprehensive Child Protection Medical Assessment (CPMA) process, aimed at ensuring a robust and effective response for children in Milton Keynes.

Central and North West London NHS Foundation Trust (CNWL) employs a thorough approach to assessing neglect, incorporating this topic into mandatory safeguarding training and providing safeguarding supervision, particularly for teams that have direct contact with children. Additionally, CNWL offers enhanced safeguarding supervision for staff in adult mental health services to maintain a focus on the needs of children within families.

In response to early findings from a local Domestic Homicide Review, extra safeguarding supervision has been instituted for staff in adult mental health services to reinforce the importance of considering children's welfare within the family context.

For 0-19 health services, safeguarding competency booklets have been developed for newly hired nurses, which include guidance on identifying vulnerabilities within the community. Staff receive information on the risk assessment triangle and the MK Together 'Levels of Need' document to help in recognising and addressing needs, including neglect.

During 2023/24, CNWL introduced the Children and Young People who are Not Brought to Health Care Appointments Policy to assist staff in understanding the procedures and factors that increase the risk when children miss appointments.

As part of the new induction process for CNWL staff working in MK, a safeguarding induction pack is currently being developed, which includes an introduction from the safeguarding team. Current mandatory training data for safeguarding children indicates consistent embedding of this training within the workforce, with 97% for level 1 and 96.8% for level 3. Over the past quarter (Q4 2023/24), a number of individual safeguarding supervision sessions were facilitated, as well as group supervision sessions across community children's services, Child and Adolescent Mental Health Services (CAMHS), and adult mental health services.

Looking ahead, a trust-wide audit during 2024/25 to evaluate the supervision provided for staff in adult services is being planned. It is noteworthy that neglect is the highest risk indicator for children subject to a child protection plan, affecting 75% of this cohort.

The new Independent Learning Review process has highlighted issues of neglect, reviewing six cases over a nine-month period. This process will inform tailored training and advice for staff to enhance their approach to addressing neglect.

Both CNWL and Milton Keynes University Hospital Foundation Trust (MKUHFT) have been planning the implementation of the new Patient Safety Incident Response Framework (PSIRF) and learning responses have been initiated, such as After-Action Reviews, to glean insights from safeguarding cases, including those related to chronic neglect. CNWL is also collaborating with partners to enhance mechanisms for sharing learning outcomes from these responses.

The Safeguarding Team at MKUHFT plays a vital role in assisting Trust staff in recognising and understanding the signs of neglect, thereby advocating for children and highlighting that any child can be subjected to neglect. Through safeguarding supervision, support, advice, and training, the Trust empowers all staff to recognise cumulative signs of neglect, report appropriately, and take proactive measures to prevent ongoing neglect.

Thames Valley Police (TVP) is currently reviewing internal processes to ensure the timely and suitable referral of cases concerning neglect. They are also assessing investigation processes to address instances of the criminal offence of wilful neglect effectively.

Children's Priority: Missing

Addressing the issue of missing children is a major priority. A current improvement plan has been initiated to tackle the challenges faced by Milton Keynes City Council's Children's Social Care (MKCC CSC), including a significant increase in both the number and complexity of cases. Collaborative work is being conducted at both operational and strategic levels with Thames Valley Police (TVP) to launch new co-owned processes that will facilitate the integration of the Philomena protocol, as well as new methods for submitting intelligence and ensuring that missing cases are centrally considered in relevant plans for young people. These efforts align with recent His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and Ofsted reports.

An updated form for 'Return from Missing Conversations' has been drafted, which will allow for enhanced analysis and oversight. Data is being monitored and shared with senior leadership, and a new joint process between TVP and Children's Social Care is being introduced to support audits and monitoring. Recently, TVP completed a comprehensive review of the missing persons process, resulting in enhancements aimed at early risk identification and establishing the appropriate level of response. Notably, the average time to assign a risk grade has been reduced from eight hours to forty minutes. Improvements have also been made in governance and oversight of missing cases.

BLMK ICB facilitates multi-agency forums to discuss children and young people who are at risk of going missing or experiencing exploitation. Service providers are supported in identifying systems and processes that enable the recognition of these risks for young people accessing healthcare services. Collaboration with the Contextual Safeguarding team to develop systematic pathways aimed at improving outcomes for children and young people is ongoing.

A primary focus for CNWL is the timely sharing of information regarding children identified as missing. This involves implementing a notification system to communicate information from the local authority to the 0-19 Hub, School Nursing Service, and CAMHS. School Nurses and CAMHS also have the opportunity to share intelligence within the Contextual Children's Safeguarding Board, and the insights gained from this group are disseminated to all Safeguarding Leads within CNWL. Furthermore, School Nurses and CAMHS workers are encouraged to utilise the exploitation tool as necessary.

The Safeguarding Team at MKUHFT works collaboratively with staff to raise awareness of contextual safeguarding and issues related to missing children. This collaboration ensures that staff are equipped to recognise risks that extend beyond the family home. A multi-agency Contextual Safeguarding Panel reviews themes and emerging risks. An alert system is in place for missing children, notifying relevant professionals upon their attendance at MKUHFT.

Children's Priority: LADO

The Local Authority Designated Officer (LADO) landscape is extensive and the overall workload related to LADO has significantly increased, with a reported 24% rise in activities across the board. In certain areas, such as information requests and referrals, this increase has exceeded 100%. While the increase in LADO referrals was not specifically addressed by Assurance over the past year, it was raised during the S11 audit, prompting agencies to reassess their protocols concerning this matter. Currently, the LADO service is staffed by two officers. A review is underway to assess the sustainability of this staffing arrangement in light of the growing demands across all areas of work.

To enhance engagement and understanding of safeguarding complaints, it is necessary to provide additional training for schools. BLMK Integrated Care Board (ICB) has established a clear pathway for the referral and oversight of LADO cases.

CNWL has in place a policy regarding allegations against staff who work with children, supported by practical assistance from the Safeguarding Team to aid colleagues in reporting and collaborating with the LADO. Systems are established within the Trust's Datix system and governance framework to ensure that any allegations made against staff are appropriately reported, risk-assessed, and acted upon during investigations.

Safeguarding training at MKUHFT includes discussions on allegations against staff and the necessary responses. The MKUHFT Safeguarding Team collaborates closely with Human Resources, as well as with law enforcement agencies, to address any criminal investigations involving Trust staff. There are established communication channels between the Security Manager and the Safeguarding Team to ensure that any reported incidents regarding staff are shared and addressed appropriately.

Within Thames Valley Police (TVP) collaborative practices are in place where specialised detectives assist the LADO to facilitate thorough investigations and safeguarding measures. An anecdotal increase in LADO referrals has been noted since the beginning of the financial year.

Children's Priority: Think Family

The increase in the number of children under care plans and those entering the looked-after system has necessitated a revision of MK's practice model. There has been a 35% increase in children entering care and a 40% rise in children subject to child protection plans. Additionally, the number of Independent Learning Reviews in Social Care has risen, aiding in the identification of practice gaps and areas for improvement.

To address these challenges, the new Child First Practice model will be implemented in May 2024. This model is aligned with the <u>Children's Social Care National Framework</u> and the <u>McAllister Review</u>. Its core principles will focus on promoting appropriate interventions, valuing lived experiences, and prioritising the needs of children in decision-making.

The Think Family approach is recognised across health services as essential to effective safeguarding practices. CNWL's safeguarding training and supervision integrate this model, ensuring all staff in Children's Services are provided with support and additional training opportunities through webinars available throughout the year.

In CNWL safeguarding supervision sessions, the significance of understanding family dynamics is emphasised with clinical records being regularly reviewed for relevant information. The Children's Safeguarding Team offers specialised supervision sessions and organises 'Think Family' lunchtime webinars, which underscore the importance of documenting family dynamics and relationships within patient records. Unplanned supervision sessions are also available for staff as specific cases arise.

Within MKUHFT, updates regarding the Think Family agenda will be communicated to Safeguarding Champions within the Joint Adult and Child Forum and to relevant managers for broader staff dissemination. The Safeguarding Team is committed to prioritising contextual safeguarding, which aligns with the Think Family ethos, and is actively working to ensure this approach is integrated across the organisation. The Think Family strategy advocates for coordinated approaches to safeguarding adults and children, recognising that they do not exist in isolation. By adopting this perspective, MKUHFT aims to enhance the existing safeguarding strategy and provide a comprehensive response to the needs of children, young people, and adults.

When interacting with families, all TVP officers are encouraged to consider the broader context and employ professional curiosity to assess complex issues that may inform police involvement. Child Protection referrals are mandated whenever concerns arise. Training on Voice of the Child (VOC) and lived experiences has been initiated, alongside enhanced secondary investigation efforts to deepen officers' understanding of familial risks.

Adult Priority: Exploitation

MKCC Adult services increased the use of the Inter-Agency Risk Management protocol (IARM) to facilitate collaboration among agencies in addressing individuals who are vulnerable to exploitation when the criteria for a statutory safeguarding inquiry under Section 42 of the Care Act 2014 are not met. For instance, all individuals known to adult services who are vulnerable due to rough sleeping now have an IARM in place. Work is ongoing to ensure this protocol is socialised within the partnership so that the most appropriate agency acts as lead professional based on who knows the individual best and what their predominant needs are.

In 2023, a PowerBI dashboard was introduced to aid discussions and decision-making during the monthly Operational Managers Performance Meeting. This dashboard tracks all referrals received by the safeguarding team, categorised by 'type of abuse' and aligned with statutory guidance from the Care Act. Alongside the ten statutory categories, 'sexual exploitation' has also been included. The dashboard facilitates the identification of themes and trends in abuse and exploitation types. If an increase is noted, the Operational Managers meeting determines the appropriate response, which may include a detailed audit conducted by the Quality and Performance Team to understand the reasons for increased referral rates in specific areas, allowing for proactive preventative measures.

BLMK ICB is enhancing awareness of exploitation through GP forums, which include discussions on referral routes and processes, with support from police colleagues. The ICB has a designated strategic Prevent Lead and a place-based Prevent Lead. Training levels have been reviewed and are now aligned with relevant guidance.

CNWL is drawing on best practices from inner London. The strategy leverages existing strengths in promoting a holistic approach, including Think Family, Transitions work, and adherence to the Mental Capacity Act. Any insights gained from this process are communicated to all pertinent staff and clinical groups across the Trust.

MKUHFT's Level 3 face-to-face training package addresses extra-familial harm, encompassing risk indicators, vulnerabilities, and effective communication strategies with potential victims of exploitation. The Safeguarding Team is committed to enhancing awareness of adult safeguarding and utilised resources from the Ann Craft Trust during November 2023.

Thames Valley Police (TVP) has been developing Harm Reduction Units (HRUs), which have been launched in Buckinghamshire and will soon be implemented in Milton Keynes. These units aim to address chronic and long-term harm, assisting in the identification of adult exploitation. Currently, through the National Referral Mechanism and Modern Day Slavery protocols, there are active measures targeting criminal gangs who exploit adults.

Presently, the HRU has a primary focus on young people, providing opportunities for early intervention. While adults remain a consideration, many identified cases so far have a history of significant criminal involvement.

Identified cases of adult exploitation, such as cuckooing, have been addressed by Neighbourhood Police Teams (NHPT). As the HRU becomes more established, this approach will adapt to prioritise earlier identification of potential victims.

Adult Priority: Transition

MKCC Adult Services has established a Preparing for Adulthood Team within the Working Age Adults Service. This team has fostered strong partnerships with colleagues in Children's Services, working with young people aged 14-25 who have Special Educational Needs and Disabilities as they transition to adulthood. The team was instrumental in creating a Preparing for Adulthood Strategy, which was coproduced with children in transition to Adult Services, their parents and carers, service providers, and staff from both Children's and Adult Services.

The Preparing for Adulthood Team works collaboratively with Children's Services to identify young people approaching adulthood, enabling proactive care planning to facilitate their transition into adult services. The team adheres to principles established in the strategy that reflect the priorities emphasised by young people, including personalisation, preparation, transparency, independence, and partnership.

The ICB collaborates with the Transition workstream within the Special Educational Needs and Disabilities (SEND) Strategic Partnership. The ICB is in the process of establishing shared principles for local implementation. Efforts are underway to integrate Transitional Safeguarding as a fundamental aspect of the local approach. The ICB has also responded to findings from Safeguarding Adult Reviews (SARs) that identified transition as an area of concern.

CNWL is working to learn best practice in transitional safeguarding from successful practices from inner London where targeted services have been developed to support young people aged 16-25 who require significant assistance but may experience reduced services upon turning 18. This knowledge will guide practice development in Milton Keynes moving forward.

For the 2024/2025 period, there will be an emphasis on supporting transitions across all services in alignment with the 'Think Local, Act Personal' guidance, thereby extending the focus beyond those transitioning from Children's to Adults Services.

MKUHFT staff frequently consult the Safeguarding Team during professional and multidisciplinary meetings, particularly when addressing the healthcare needs of children transitioning into adulthood. Within the Safeguarding Team, a Learning Disability Liaison Nurse attends pre-operative assessment appointments and provides support to children, adolescents and their parents and carers throughout their hospital experience in adult services.

TVP offers various initiatives and programmes, some of which are newly established while others have been long-standing. These include:

- Multi-Agency Homelessness Response, in which MKCC Community Safety is actively involved.
- Multi-Agency Tasking And Co-ordination (MATAC), a project aimed at preventing and disrupting domestic abuse offences.
- DRIVE, a domestic abuse perpetrator program designed to work with high-risk offenders to break the cycle of offending.
- KOBI, a collaborative initiative between the Police and the National Probation Service that engages with stalking perpetrators on an individual basis to address their offending behaviour.

Adult Priority: Mental Capacity Assessments

Adult Services have spearheaded the creation of Mental Capacity Act Standards, which have been adopted across the partnership. This initiative addresses discrepancies in policy and procedure among local agencies and recognises that the current Code of Practice requires updates due to recent changes in case law.

To enhance both the quality and quantity of Mental Capacity Assessments, collaborative learning from Safeguarding Adult Reviews (SARs) has been utilised to design an in-house mental capacity workshop. Since its introduction in August 2023, training has been provided to nearly 75% of the necessary staff, resulting in an increase in completed mental capacity assessments. The focus will now shift toward consistency and quality assurance.

Mental Capacity Act Bitesize training sessions have been conducted across the ICB and partner organisations, covering the following topics:

- Overview and induction into the Mental Capacity Act (MCA)
- Application of the Mental Capacity Act for individuals aged 16-17 and older
- Guidance on the Mental Capacity Assessment Form
- Relevant information necessary for assessing capacity pertaining to various decisions

These training sessions are offered on a quarterly basis throughout the year.

Additionally, Mental Capacity Act Lead meetings are scheduled with the Local Authority MCA Leads within the Bedfordshire, Luton, and Milton Keynes area to collaboratively update and enhance a local MCA Competencies working document. This document will serve as a valuable resource for all staff and practitioners during supervision and other relevant contexts.

Proactive project initiatives are underway focusing on children in foster care with complex needs as they transition into adulthood, which includes considerations regarding Deprivation of Liberty for these individuals.

CNWL has developed an MCA template available in the clinical records system (SystmOne) to aid staff in recording MCA assessments and ensuring they complete necessary assessments. This template has been widely communicated across the Trust and is integrated into staff training programs.

An auditing system is being developed to identify areas of best practice, as well as those that may require additional support.

The Safeguarding Team at MKUHFT has made significant efforts to assist staff in conducting Mental Capacity Assessments. Targeted bite-sized training is provided to staff as required. In addition, staff are encouraged to refer individuals to the Advocacy Service, which supports patients in decision-making processes and helps them understand their care and treatment options. When a patient lacks capacity, the advocate ensures that the patient's perspective is considered.

Thames Valley Police (TVP) adheres to the principles of "right care, right person" and will continue to address concerns related to adults who may lack capacity and/or are at risk of immediate harm.

Adult Priority: PiPot Referrals (Persons in a Position of Trust)

The PiPoT process is being effectively integrated across all safeguarding partners, with the referral procedure being adhered to in accordance with established policy. There has been a noticeable enhancement in understanding the PiPoT process, as evidenced by an increase in referrals made throughout the year. In the 2023/24 period, a total of 49 PiPoT referrals were received and addressed by MKCC Adult Services.

Human Resources and the Safeguarding Team within MKUHFT work collaboratively to provide essential support while prioritising public safety.

A new policy for PiPoT will be implemented at MKUHFT to offer guidance when allegations against staff arise. This policy will outline the Trust's procedures to ensure allegations are properly investigated and that all relevant agencies are involved in safeguarding patients and staff.

The ICB safeguarding policy aligns with inter-agency procedures concerning PiPoT. The safeguarding team plays a vital role in supporting the organisation with PiPoT referrals.

Currently, CNWL is developing a Trust-wide PiPoT policy, which has been adopted by the policies group following a review of the initial draft. Local PiPoT procedures and the Allegation Against Staff Working with Children Policy are utilised to guide personnel in managing allegations against staff. This typically involves a mandatory report in the Trust's Datix system and oversight of risk assessment and action processes during investigations.

TVP will continue to record and investigate offences and will note when it pertains to PiPoT.

Adult Priority: Think Family

Adult Services within Milton Keynes City Council have incorporated insights from MK's Board of People with Lived Experience, known as 'Stronger Together', emphasising the importance of involving relevant people from a person's support network in their care, in line with the Think Family approach. A follow-up system has been implemented to contact young people after they have transitioned from services to gather feedback on their experiences. One of the key inquiries addresses whether family members and caregivers were adequately included in the care process. The feedback received from Stronger Together, together with principles of 'Think Local, Act Personal', has contributed to the development of MK's framework for measuring outcomes for people. The 'Think Local, Act Personal' initiative prioritises the inclusion of significant people in care and support planning.

The Preparing for Adulthood Team adopts an enhanced Think Family approach, collaborating with parent/carers of young people from the age of 14 years. The next objective is to engage with colleagues in Children's Services to explore how this methodology can be expanded across all our services, extending beyond just the transition phase from Children's to Adult Services.

Safeguarding training and supervision within the ICB are aligned with the Think Family model, which is actively applied through case reviews that facilitate exploration and discussion of this approach.

As part of Central and North West London NHS Foundation Trust, the Think Family philosophy is promoted in all clinical engagements. This commitment is supported by the child and adult safeguarding teams. Extensive communication efforts are made to inform clinical staff about this model, including two annual conferences aimed at raising awareness about the initiatives. CNWL's internal safeguarding training program is consistently maintained with high participation rates.

The Level 3 training package for Milton Keynes University Hospital NHS Foundation Trust is undergoing a revision. This face-to-face four-hour programme is suitable for both adult and child safeguarding training. Compliance with Level 3 training emphasises the Think Family approach while adhering to the statutory requirements outlined in both Intercollegiate Documents. The Trust's safeguarding training portfolio will continue to expand appropriately, incorporating ongoing tailored training to address the diverse needs of the Trust.

All interactions with families require Thames Valley Police (TVP) officers to adopt a holistic perspective and employ professional curiosity to address complex issues that may influence police attendance. Adult Protection referrals are mandatory whenever concerns arise. There is an emphasis on enhanced secondary investigations to better equip officers with an understanding of risks present within the family environment.

Adult Priority: Self-Neglect

As highlighted by the preliminary insights from the most recent national SAR analysis, self-neglect remains one of the most prevalent forms of abuse resulting in safeguarding referrals.

Over the past year, MKCC learning offerings for staff have been enhanced to include dedicated sessions on self-neglect. This includes inviting Professor David Orr to present a seminar to Adult Social Care (ASC) colleagues on effective strategies for working with people who self-neglect. Furthermore, a concise training series titled "Safeguarding Unlocked" has been developed. This series complements MKCC's mandatory training requirements and provides staff with opportunities for focused learning relevant to their specific practices, particularly in relation to self-neglect.

The implementation of the Inter-Agency Risk Management protocol (IARM) for individuals at risk of self-neglect, such as those experiencing homelessness, has been prioritised. This initiative is informed by learnings from SARs, highlighting the necessity of multi-agency risk management and improved communication to proactively support those at risk of self-neglect, aiming to reduce the potential for serious harm or fatality.

The ICB actively supports and collaborates on broader initiatives addressing safeguarding concerns associated with self-neglect.

With its extensive focus on mental health, CNWL has developed considerable expertise in managing self-neglect, which is evident in both policy and practice. Additionally, District Nursing and Rehabilitation services have a substantial number of staff who routinely address issues of self-neglect. This matter is also a fundamental component of training programs, as shown by the volume of self-neglect referrals made to and from the clinical teams.

Self-neglect will be incorporated into the latest Level 3 training package offered by MKUHFT. This training will cover recognition of indicators of self-neglect, response strategies, and relevant legal considerations. The referral pathway to drug and alcohol services is currently undergoing review.

TVP encourages officers to refer cases where self-neglect poses a risk to adults. Individuals will be directed to appropriate support resources that are supported by multi-agency strategies.

Adult Priority: Hoarding

Hoarding was identified at Assurance as an issue in the light of some SAR findings and an audit of the multiagency risk assessment protocol introduced at the beginning of the year. It was identified that this tool had not been disseminated and adopted by partners.

MKCC Adult Services has continued to develop the hoarding peer support group, which is facilitated by a colleague from adult services and a person using services with lived experience of hoarding. The group is now hosted at the recovery college, which people attending advised was accessible to them.

There are case study examples from the past year which illustrate the benefits of multi-agency working to address hoarding, which has the potential to cause the person with care and support needs, and the public, harm. The mental health and complex needs team used the IARM to bring together services including environmental health, the police, the community safety team and health colleagues to assess risk and action plan and achieve good outcomes for the people they are working with, in reducing the risk to themselves and others.

Effecting change with people who hoard can take time. In order to ensure focus is maintained, where people are the subject of a section 42 enquiry and the work has been ongoing for over 28 days, in accordance with the multi-agency safeguarding policy, the enquiry is reviewed by MKCC's head of service for safeguarding and Principal Social Worker. The safeguarding investigator is invited to a forum, to receive additional oversight, advice and guidance and where appropriate, support in escalation. This forum provides the platform to be able to have oversight and respond to the most high-risk cases across the services.

As with self-neglect, CNWL has extensive experience of working with hoarding across the Trust, and those lessons are communicated to all relevant staff and clinical groups and services. A member of the safeguarding team also has extensive clinical experience in homelessness, self-neglect and hoarding and has worked with partner agencies on the development of hoarding and clutter documents.

The Safeguarding Team within MKUHFT signpost staff to the Fire and Rescue Service, for fire safety checks. This allows (with consent) the Fire Service to go out to conduct home safety visits. They can provide safety planning for adults who may be at increased risk such as adults with care and support needs, mental health issues, disability, limited mobility, and hoarders. This service will be promoted on the Safeguarding Internet page, ensuring staff have increased awareness of this ability to safeguard in the community.

The ICB positively supports and engages with wider working around safeguarding concerns related to hoarding.

TVP officers are encouraged to make referrals when the level of self-neglect may put adults at risk. Individuals are sign-posted to sources of support underpinned by multi-agency strategies.

In conclusion

The Milton Keynes MK Together Safeguarding Partnership has maintained strategic oversight of safeguarding activity whilst consulting on revised arrangements as set out in Working Together 2023.

Priorities for 24/25 were agreed and will be consulted on in early 2025 to set the scene for a new three-year strategy. The benefits of a single team supporting both the Community Safety and Safeguarding Partnerships, and the clear links with the re-structured Health and Care Partnerships, continue to outweigh the benefits of separate approaches as Safeguarding remains the golden thread in all partnership activity. In addition to these priorities the Partnership will also be focusing on ensuring the voice of the child and people with lived experience is captured within the work of the Partnership, ensuring its dataset captures responses to people with protected characteristics and embedding the new arrangements.

In addition to the safeguarding priorities, the Safeguarding Partnership will be working on the following areas of development over the coming year: Voice of the Child/People with lived experience; data regarding protected characteristics; multi-agency training; embedding new arrangements. A new strategic plan is also currently being developed.

The partnership is open about the challenges it faces with the changing needs of an ever-growing local population and national restructures in partner organisations and therefore keeps the arrangements flexible enough to adapt and respond. Refreshed Multi-Agency Safeguarding Arrangements (MASA) were published in 2023 to incorporate the move from Health and Wellbeing Boards to the Health and Care Partnerships, and in December 2024 the MK Together Safeguarding Partnership will publish a refreshed handbook ensuring compliance with children's and adults' legislative guidance.

The MK Together Safeguarding Partnership remains proud of its innovative approach to ensuring the most vulnerable residents are protected and safeguarded, and that we collectively learn from each other and are committed to the residents of Milton Keynes.

Appendix A Partner Agency Representation at MKTSP Meetings 2023/24

Agency attendance – MK Together Safeguarding Partnership meetings 2023 - 2024

Agency	April '23	July '23	Oct '23	Jan '24
Milton Keynes City Council	•	•	•	•
Thames Valley Police	•	•	•	•
Bedfordshire, Luton and Milton Keynes Integrated Care Board	•	•	•	•
Independent Scrutineer	•	•	•	
Bucks Fire and Rescue Service	•	•	•	•
Central and North West London NHS Foundation Trust	•	•	•	•
HMP Woodhill		•		•
Milton Keynes University Hospital Foundation Trust	•	•	•	•
National Probation Service	•	•	•	•
Oakhill Secure Training Centre	•	•	•	•
Public Health, Bedford and Milton Keynes	•			•
Community Action MK		•		•

Appendix B Contributions and Summary of 2023/24 Budget

Agency Contributions for 2023-24

	Children's	Adults	Total
BLMK ICB	-51,482	-14,300	-65,782
Thames Valley Police	-18,595		-18,595
National Probation Service		-4,539	-4,539
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 Fire & Rescue Service		-650	-650
MK City Council incl. public health	-107,504	-41,500	-149,004

Summary of 2023/24 End of Year Budget Position

2023/2024 Actuals				
Income	Brought forward from 2022/2023	-157,812.61		
	Contributions	-262,632.00		
	WT Implementation funding (one off funding)	-47,300.00		
Expenditure	Employee costs	211,490.92		
	Independent Chair/Scrutineer	13,219.87		
	Review activity costs	19,320.71		
	Website, policies and procedures	11,655.90		
	Boxing fund (one off funding)	10,000.00		
	Misc	1,902.30		
	Total carried forward to 2024/25	-200,154.91		

Glossary

ASC	Adult Social Care	MCA	Mental Capacity Act
BLMK	Bedford, Luton and Milton Keynes	МК	Milton Keynes
CAMHS	Child and Adolescent Mental Health Service	MKCC ASC	Milton Keynes City Council, Adult Social Care
CNWL MK	Central and North West London NHS Foundation Trust Milton Keynes	MKCC CSC	Milton Keynes City Council, Children's Social Care
CSC	Children's Social Care	MKTSP	MK Together Safeguarding Partnership
CSPR	Child Safeguarding Practice Review	MKUHFT	Milton Keynes University Hospital NHS Foundation Trust
DHR	Domestic Homicide Review	NHPT	Neighbourhood Police Teams
GP	General Practitioner	NHS	National Health Service
HMICFRS	His Majesty's Inspectorate of Constabularies and Fire & Rescue Services	NRM	National Referral Mechanism
HRU	Harm Reduction Unit	Ofsted	Office For Standards in Education
IARM	Interagency Adults at Risk Management Protocol	PiPoT	Persons in a Position of Trust
ICB	Integrated Care Board	SAB	Safeguarding Adults Board
LADO	Local Authority Designated Officer	SAR	Safeguarding Adults Review
LCU	Local Command Unit (Police)	SEND	Special Educational Needs and Disabilities
MASH	Multi-Agency Safeguarding Hub	SMART	Specific, Measurable, Attainable, Realistic and Timely
МАТАС	Multi-Agency Tasking And Co- ordination	TVP	Thames Valley Police