Paper 23

Recommendation ☑ **DECISION** ☑ **NOTE**	**The Quality and Safety Committee is asked to:** **Receive** and **discuss** this report **Approve** the report to go to Trust Board
Reporting to:	**Trust Board**
Date	28th September 2017
Paper Title	Safeguarding Children and Adults at Risk Report 2016-2017
Brief Description	This report describes the work and developments in the last year provided by the Trust's Safeguarding Team for adults, children and maternity care. The report highlights the achievements over the period and gives assurances to the Committee of how we, as an organisation, are discharging our statutory duties in relation to safeguarding children under Section 11 of the Children Act (2004) and work within the guidance for Adult Safeguarding and the Care Act. In addition, it outlines how the Trust has responded to local and national developments, both internally and as a member agency of the Local Safeguarding Children Boards (LSCB) and the Local Adult Safeguarding Boards. The report provides detail in relation to training compliance and the governance processes around safeguarding
Sponsoring Director	Deirdre Fowler, Director of Nursing and Quality
Author(s)	Teresa Tanner – Named Nurse Safeguarding Children Helen Hampson Lead Nurse Safeguarding Adults Sharon Magrath Named Midwife for Safeguarding
Recommended / escalated by	None
Previously considered by	Quality & Safety Committee
Link to strategic objectives	SAFEST AND KINDEST - Deliver the kindest care in the NHS with an embedded patient partnership approach
Link to Board Assurance Framework	If we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning then we will fail the national quality and performance standards (RR 561)
Equality Impact Assessment	● **Stage 1 only (no negative impacts identified)** ● **Stage 2 recommended (negative impacts identified)** ● negative impacts have been mitigated ● negative impacts balanced against overall positive impacts

The Shrewsbury and Telford Hospital NHS Trust

Freedom of Information Act (2000) status	● **This document is for full publication** ● **This document includes FOIA exempt information** ● **This whole document is exempt under the FOIA**

Safeguarding Children and Adults at Risk Annual Report 2016/2017

Introduction

This report describes the activities during 2016-2017 of the Trust's Safeguarding Team for adults, children and maternity. The report highlights the outcomes over that twelve months and gives assurances to the Trust Board of how we as an organisation are discharging our statutory duties in relation to safeguarding children under Section 11 of the Children Act (2004) and work within the guidance for Adult Safeguarding.

In addition, it describes how the Trust has responded to local and national developments, both internally, and as a member agency of the Local Safeguarding Children Boards (LSCB) and the Adult Safeguarding Boards (SAB) including work undertaken within the Trust in relation to the national PREVENT agenda which is part of the Home Office CONTEST counter terrorism strategy.

The Trust is committed to recognising that all children and adults at risk have a right to be protected for their safety and well being and that all have a right to be protected from harm when in our care. Safeguarding encompasses:

- Effective responses to allegations of harm and abuse that are in line with local multiagency procedures
- Maintaining integrated governance systems and processes in reporting concerns or issues relating to Safeguarding
- Partnership working with Local Safeguarding Boards (Child and Adult), patients, families and community partners to create safeguards for children and vulnerable adults.
- Prevention of harm and abuse through the provision and delivery of high quality care.

National Safeguarding Arrangements

The requirement for organisations to have robust processes relating to safeguarding were outlined by Lord Laming's review into Child Protection Procedures (2009), the Care Quality Commission (CQC) report reviewing Safeguarding Children within the NHS (2009) and for adults, the Care Act (2014).

The CQC also requires health organisations to take reasonable steps to ensure that commissioned services are compliant with healthcare standards relating to arrangements to safeguard and promote the welfare of children across the following areas:

- Arrangements have been made to safeguard children under Section 11 of the Children Act (2004).

- Work with partners to protect children and participate in reviews as set out in Working Together to Safeguard Children (2015), bringing together all the statutory responsibilities of organisations and individuals to safeguard children.

- Making it explicit that safeguarding is the responsibility of all professionals who work with children.

- Agreed systems, standards and protocols are in place relating to information sharing about a child and their family both within the organisation and with outside agencies, having regard to statutory guidance on making arrangements to safeguard children under section 11 of the Children Act (2004).

- A child centred coordinated approach to safeguarding

- Assessing the needs of children / unborn and providing early help.

Section 11 of the Children Act (2004) places a statutory duty on key people and bodies to safeguard children. All NHS Trusts are expected to identify Named Professionals who have a key role in promoting good professional practice within the Trust. We are compliant with this requirement.

A report from the NSPCC (2014) suggests that although our children are safer than a decade ago, our society still falls short of protecting children from harm. One child per week dies as a result of abuse, the levels of neglect remains the same and one in six children are exposed to domestic violence. The latest triennial review (Brandon et al 2016) found the largest proportion of Serious Case Reviews (SCRs) related to the youngest children, who were aged less than one year. A total of 120 of the 293 children (41%) were aged less than one year at the time of their death or incident of serious harm and nearly half of these babies (43%) were under three months old.

CONTEST, the Government's national counter terrorism strategy, aims to reduce the risk to the United Kingdom and its interests overseas from international terrorism, so that people can go about their lives freely and with confidence. Preventing someone from becoming a terrorist or supporting terrorism is no different from safeguarding vulnerable individuals from other forms of exploitation. Therefore, the Trust's PREVENT Policy sits alongside the organisation's Safeguarding Vulnerable Adults Policy and the Safeguarding Children's Policy.

The Shrewsbury and Telford Hospital (SaTH) NHS Trust's Safeguarding Team advise and train staff regarding the management of child, adult protection, welfare cases and PREVENT, reminding all staff that safeguarding is the responsibility of everyone.

In 2016-2017 the Safeguarding team consisted of:

Executive Lead for Safeguarding	Mrs Sarah Bloomfield until 05 March Mr Colin Ovington from 06 March 2017
Associate Director for Patient Safety	Mrs Jo Banks, until 01 Jan 2017 Mrs Dee Radford since 02 Jan 2017
Named Doctor for Child Protection:	Dr Frank Hinde
Named Nurse for Safeguarding Children:	Mrs Teresa Tanner
Adult Safeguarding Lead:	Mrs Helen Hampson
Named Midwife for Safeguarding and Domestic Abuse:	Mrs Sharon Magrath
Safeguarding Specialist Nurse:	Mrs Sharon Woodland

Key Activities in 2016/2017

During 2016/2017 the following key activities relating to Safeguarding took place within SaTH:

Children and Young People

A key focus for the children's Safeguarding Team during 2016/2017 has been to continue to ensure all staff receives appropriate training. The Safeguarding Team provide training on induction (Level One awareness) following which appropriate staff should attend a Level Two course every three years. Additionally the Named Nurse provides training to specific staff groups who require Level three training such as Paediatric and Emergency Department clinical staff. At the end of 2016-2017 we reported the following levels of Safeguarding Children Training:

Table one: Safeguarding Children and Young People Training

Level	Rationale	Target	Compliance
1	Safeguarding children training allows staff to be able to identify early any safeguarding risks and to know what actions to take. Level 1training is the introductory level training that is necessary for workers (Intercollegiate Document 2014).	100%	100%
2	Safeguarding Children training allows staff to be able to identify early any safeguarding risks and to know what actions to take. Level 2 training for all staff who see children in there working day (Intercollegiate Document 2014).	85%	74%
3	Eligible staff who have received Safeguarding Children training (as per the intercollegiate document 2014) in the last 12 months.	98%	98%

With the exception of level two training we achieved the targets set by the Clinical Commissioning Groups (CCG). Since the end of 2016-2017 we have clarified our position in relation to level two training which has shown that our compliance is lower than reported. This has been clarified to commissioners and to the Quality and Safety Committee and assurance given that a recovery plan is in place to improve the position. Regular updates relating to our performance against the plan will be provided.

A requirement of the Serious Case Review (SCR) for Child B Peer Review was an action for the Trust to continue to enable learning, improvement and training for our staff. Regular meetings commenced in September 2015. It is an opportunity for medical staff to learn from cases where Child Protection or Safeguarding has been an issue with the Named Doctor and Named Nurse for Safeguarding and to raise concerns to social care if required.

During 2016-2017 the Trust was not involved in any published Serious Case Review (SCR) or Individual Management Report (IMR), however the SCR into H&I in Telford did take place during the year and will be published shortly.

The Trust has been promoting and being involved with multi-agency working in line with revised guidance, which has included ensuring the Trust is compliant as per the recommendations of the Goddard Enquiry (relating to pre volunteering checks) and also the report into the case of Dr Bradbury which has resulted in our Chaperone Policy being reviewed and amended specifically relating to children and young people.

Both Shropshire and Telford and Wrekin local authorities hold monthly Multiagency Risk Assessment Conferences (MARAC) meetings. The Named Nurse, the Named Midwife, the Safeguarding Support Nurse and a member from the Emergency Departments attend the meeting. An agenda is circulated prior to the meeting date which gives time for the health representatives to explore any relevant information to share at the meeting. The meetings discuss the most high risk cases, many of which will have been seen with our Emergency Departments (ED). Staff in the ED are encouraged to make referrals in line with the MARAC process and victims of domestic abuse are alerted on the SEMA system. This ensures that any alerted victim who re-attends the ED is automatically referred back to MARAC.

The Children Act (2004) places a statutory obligation on a number of agencies to safeguard and promote the welfare of children and young people whilst carrying out their normal functions. The

Executive Lead is represented on both the Shropshire and the Telford and Wrekin Safeguarding Children's Boards (LSCB) by the Associate Director for Patient Safety.

The Named Nurse and Midwife are members of the various subgroups of both the Telford and Shropshire Boards including Domestic Abuse, Child Exploitation, Training and Review and Learning.

The Trust was involved in a Domestic Homicide Review in 2016 - the report has not yet been published as we are awaiting confirmation from the Home Office. There is a comprehensive action plan, of which SaTH is part. One of the recommendations is around alerting the perpetrators of abuse as well as the victims, which we have now done since November 2016. GPs are also notified of attendance at the Emergency Department by a separate letter from the Consultant.

The Named Nurse for Children and Young People has, with a colleague, set up a Named Professional Network for the region which meets twice a year in Telford. There has been good attendance at the network meetings which provide a valuable support network for these staff.

Maternity

SaTH are compliant with the majority of Section 11 requirements in relation to maternity, however there is a need for effective safeguarding supervision and monitoring of practice in regards to safeguarding the unborn child to be available to all midwives, in particular the community midwifery teams. The opportunity for all maternity staff to reflect on their practice in relation to specific cases has been limited.

The midwife is often the first professional to work with new parents and need to be able to recognise early signs of neglect and abuse. Safeguarding supervision has been identified as an essential protective factor in child protection work (Laming 2003, 2009) and focuses on the safeguarding supervisor providing support allowing practitioners to clarify situations which have legal, professional and ethical components.

In November 2016, ten midwives completed the National Society for the Prevention of Cruelty to Children (NSPCC) training to be able to offer safeguarding supervision to their colleagues. A Safeguarding supervision policy has also been developed and plans for supervision are in progress however, this is subject to Midwifery capacity within the new models of care which is currently being reviewed.

Capacity for offering safeguarding supervision continues to be limited due to the numbers of Midwifery staff and the geography of Shropshire. The lack of supervision poses a risk to safeguarding within maternity and has therefore been added to the risk register.

The table below shows the number of supervision sessions (both individual and group) that were offered during 2016/17:

Table two: Midwifery supervision sessions during 2016-2017

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
One to One	1	3	5	2	1	0	0	1	0	2	0	1
Group	2	2	0	2	0	1	0	0	0	2	0	0

Safeguarding and Supporting Women with Additional needs (SSWwAN) meeting
The monthly SSWwAN meeting not only provides the opportunity for management oversight of all the complex social cases in Maternity but is an opportunity for information sharing from the multi-agency team to promote the safety and welfare of the unborn and other siblings within the family.

All pregnant women who engage with antenatal care are assessed at their booking appointment. A number of medical and social questions are asked to be able to assess both obstetric risk and other social risks. Any woman who is identified as having social complex needs that may require additional antenatal support and / or early help are referred through the Safeguarding and supporting Women with additional needs (SSWwAN) pathway.

Community Midwives offer early help assessments and all cases are discussed at the monthly multi-agency SSWwAN meeting. The meeting is chaired primarily by the Named Midwife with support from the Named Nurse and a safeguarding support Midwife (who works as a bank Midwife). The meeting is attended by Health Visitors, Community Midwives, and the Midwife for Improving women's health, an early help representative and a social worker.

The minutes of the meeting are shared with all agencies that attend the meeting and a summary of the information is added to each patient electronic record

The following table shows the number of bookings each month where a woman presented with at least one complex social factor (NICE 2010) and a current or past history of mental health issues that may require additional support during pregnancy to promote the safety and welfare of herself and her unborn.

Table three: Bookings with at least one complex social factor 2016-2017

Month	Shropshire	Telford and Wrekin	Powys
April	43	38	1
May	52	47	1
June	54	58	0
July	39	35	1
August	40	41	3
September	39	49	1
October	42	40	1
November	30	39	1
December	30	39	1
January	34	47	1
February	36	29	0
March	61	47	0
Total	**500**	**509**	**11**

The table below shows the number of women with additional needs that were discussed at each monthly SSWwAN meeting. It also includes the number of safeguarding referrals made each month, the number of safeguarding meetings attended by Midwives and the number of babies subject to a Child Protection Plan (CPP) or a Child in Need Plan (CIN).

NB: This table does not show the number of early help assessments offered by the community Midwifery teams.

Table four: Women discussed at each SSWwAN meeting 2016-2017

Month	Shrop	T&W	Referrals to Social care	Number of Strategy meetings, case conferences / core groups attended by Midwives	Unborn babies subject to a CPP / CIN
April	25	39	14	6	4
May	61	46	0	8	9
June	61	46	0	8	5
July	58	78	4	8	9/2
August	58	78	2	11	7/2
September	71	84	1	4	7/1
October	No data				
November	50	54	3	8	6/1
December	32	52	4	15	7/1
January	44	61	10	10	14/2
February	35	53	7	14	5/3
March	54	62	7	17	7/1
Total	549	653	52	109	93

In addition to the MARAC, the Named Midwife represents Midwifery services at the following multi-agency meetings:

Healthcare Governance Safeguarding Children Committee (also attended by the Named Nurse)
SaTH Safeguarding Operational Group

Shropshire Council

- Children's Centre advisory board
- Early Help Partnership / strengthening families through early help meeting
- Early Help stakeholder group
- Safeguarding Training Pool meetings

Telford and Wrekin

- Sexual Exploitation LSCB Sub-group
- Neglect LSCB sub group
- Training sub group

Domestic Incidents received from the Harm Assessment Unit (HAU)
The Named Midwife for Safeguarding and Domestic abuse receives Domestic incidents from the HAU where a pregnant woman has been identified within the household. This information is logged on Maternity electronic records and information with an action plan is shared with the community Midwife / teams. The following table shows the number of incidents in 2016/17 that were received each month where early help by was offered to the families.

Table five: Number of incidents leading to offers of Early Help 2016-2017

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March
	18	17	21	14	30	22		26	43	23	12	11

Safeguarding Vulnerable Adults

The Care Act 2014 - Embedding Making Safeguarding Personal (MSP) within SaTH
Making Safeguarding Personal (MSP) is a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. It is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is a shift from a process supported by conversations to a series of conversations supported by a process. Making Safeguarding Personal is reinforced throughout the Adult Safeguarding Awareness training at Level two and we have provided evidence of how we are embedding this culture to the Safeguarding Adult Boards which is then included in their Annual Reports.

Subgroups of the Safeguarding Adult Boards attended by SaTH
The subgroups play a central role in providing the SAB with evidenced assurance that safeguarding systems across the partnerships are sound and effective and also to highlight areas which require improvement. Subgroups are a vital part of the Safeguarding Adult Boards and attendance is also a requirement of the Care Act 2014. The sub groups that are attended by the Trust are:

- Quality, Performance and Operations Sub Group (Telford and Wrekin)
- Audit and Performance Sub-Group (Shropshire)
- MCA and DoLS (Telford and Wrekin and Shropshire combined subgroup)
- Partnership Training, Learning and Development (Telford and Wrekin)
- Learning and Development Sub Group (Shropshire)

The Quality and Operations Subgroup and the Audit and Performance subgroup are responsible for understanding the effectiveness and quality of the activities performed by all board partners, both individually and collectively in relation to safeguarding adults. An ongoing objective of the groups is developing and embedding assurances processes which include self-assessments and multi-agency case file audits.

The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) Subgroups meet quarterly and each member of the group is responsible on behalf of the agency they represent for bringing issues and developments in the area of Mental Capacity /DoLS which benefit from an inter-agency perspective. The group maintains a collective and developing awareness of best practice within the area of capacity and DoLS nationally, and as case law develops addresses issues arising as a consequence.

Learning and Development Subgroups aim to help promote, develop and signpost a range of training opportunities that provide high quality training that is up to date and contributes to preventing harm and abuse by equipping practitioners and others with the skill to detect potentially abusive situations and have the confidence to act earlier to promote the best outcomes for the individuals. The groups also provide assurance to the Safeguarding Adult Boards that all stakeholders and those who provide care have access to learning and development opportunities. The groups identify any gaps in knowledge and practice to be addressed. It enables organisations to demonstrate good reflective and auditing practice.

Table six: Adult safeguarding concern referrals April 2016 – March 2017

Month	Total	Instigated by the Trust	Towards the Trust
April	11	5	6
May	10	7	3
June	9	6	3
July	10	9	1
August	9	8	1
September	15	12	3
October	12	7	5
November	12	9	3
December	9	8	1
January	15	8	7
February	6	4	2
March	10	7	3
Total	**128**	**90**	**38**

Table six shows that there have been a total of 128 concerns raised in the Trust between April 2016 and March 2017. Thirty eight of these concerns were raised towards the Trust regarding issues of care and discharges. The outcomes of these enquiries were shared with all relevant agencies including the CQC, the Clinical Commissioning Groups (CCG), the Local Authorities and the referrer.

Section 42 of the Care Act places a duty on local authorities to make enquiries, or ask other agencies to make the enquiry and establish whether action is needed. Any actions would be to prevent abuse, harm, neglect, or self-neglect to an adult at risk. There were no Section 42 inquiries into the Trust during 2016-2017.

Table seven: Deprivation of Liberty Safeguards referrals April 2016 – March 2017

Month	Total	Approved	Not Approved
April	4	Nil	4
May	4	Nil	4
June	8	2	6
July	5	3	2
August	3	1	2
September	4	Nil	4
October	4	Nil	4
November	3	Nil	3
December	Nil		
January	7	1	6
February	2	Nil	2
March	5	1	4
Total	**49**	**8**	**41**

There have been 49 Deprivation of Liberty Safeguards referrals made to the appropriate Local Authority for approval during this period. Forty one of these were not approved. The reasons for not being approved include patients no longer meeting the criteria due to either capacity returning or being sectioned under the Mental Health Act.

However the majority of referrals were not approved due to the patients being discharged from hospital without being assessed by the Supervisory Bodies due to their lack of capacity within the

Local Authorities. This is a result of the Supreme Court ruling in 2014 following the Cheshire West case which saw a significant increase in referrals and resulted in a backlog of cases and referrals for authorisation being left unassessed. A three year review by the Law Commission has made recommendations of the current DoLS to be replaced with a new scheme called the Liberty Protection Safeguards. Further detail about this scheme is awaited.

Governance within the Trust

Overall governance in relation to safeguarding within the Trust is overseen externally via the Safeguarding children and adult boards of the Local Authorities and through the CCGs. Internally, the Trust has a Safeguarding Operational Group that reports to the Quality and Safety Committee through to the Trust Board.

The Trust Safeguarding Operational Group meets on a quarterly basis and is chaired by the Associate Director of Patient Safety. The group aims to ensure that whilst inpatients within the Trust, adults with care and support needs and children and young people are kept free from harm by enabling staff to:

- Work in a culture that does not tolerate abuse
- Work together with partners to prevent abuse
- Know what to do when abuse happens
- Share information about safeguarding with frontline staff via their managers.

In addition to our staff, the group is regularly attended by the Safeguarding Leads of the CCGs.

We complete and submit quarterly reporting templates in relation to safeguarding to the CCGs which are reviewed and discussed at the Clinical Quality Review meetings. In addition we now provide quarterly dashboards to the CCG and NHS England PREVENT leads to demonstrate our compliance against the requirements of staff training and support.

The Trust fully participates in both internal and external monitoring processes such as self assessments, clinical audits and statutory reviews to ensure systems are in place and functioning effectively. These include:

- Serious Case Review and Internal Management Review

- The Trust has been involved with a Domestic Homicide Review for Shropshire, the publications of which is awaited.

An informal audit was undertaken by Shropshire CCG Safeguarding Lead and Shropshire MCA/DoLS Manager on how the Mental Capacity Act is embedded into our practice. Three wards were visited at the Royal Shrewsbury Hospital (RSH). The opinion was very positive in that they felt staff had a good understanding of the five key principles of the mental capacity act and that staff were asked on each particular ward how many patients on that day lacked capacity and what support was available. The report also outlines that staff on the wards had a tendency to underestimate the level of interventions in support of the principles of the MCA when staff are working with patients who lack capacity but may not use the correct terminology. Comment also from the informal audit was that all staff were very receptive to the visit and fully engaged with the visit.

A similar informal audit was held at the Princess Royal Hospital (PRH), this was undertaken by the Telford and Wrekin CCG Safeguarding Lead and the MCA/DoLS Advisor for Telford and Wrekin. A simple tool was used for the process of the discussions which was consistent with the visit made by Shropshire to RSH. In the three wards visited there was evidence of the five key principles of

the Mental Capacity Act in practice. There was clear evidence of the documentation of the mental capacity act assessment forms including best interest forms which were maintained in the medical notes. Staff also demonstrated that they understood the importance of including all relevant parties i.e. the family, any carers involved in care, and any other medical professionals. It was reported that there was good multi-disciplinary team work. It was noted that staff attendance at MCA training was low and this was felt to be due to winter pressures and escalation levels. The visiting team also thanked the staff for their warm welcome and co-operation and openness in sharing their views.

The Trust was inspected as part of the review of health services and safeguarding for Looked after Children (LAC) in Telford and Wrekin. This was a joint Ofsted and CQC inspection. The CQC spent a couple of days with the Named Nurse and Midwife and looked at areas such as the Emergency Department in PRH and maternity services. There is a full multiagency action plan with numerous recommendations for the Trust which is monitored internally through the Safeguarding Operational Group and externally by the CCG on a regular basis. At the last review the Trust is progressing with actions against timescales although there has been some delay in others which are in the process of being addressed.

A review of the Trust's compliance with Section 11 of the Children Act is completed and submitted to both Local Safeguarding Children Boards by the Named Nurse every six months. During 2016/17, the self-assessment of the Trust was peer reviewed by the LSCB. This provided assurance to the LSCB that the standards of safeguarding processes and practice within the Trust are robust. One area that the Trust is not compliant relates to Safer Recruitment training.

Finally, the provision of safeguarding support and training was considered by the CQC when they visited the Trust in December 2016. The findings of the inspection in relation to safeguarding were generally positive with some actions to be taken to improve the update of Mental Capacity Act training.

Training provision in the Trust

Child and Adult Safeguarding training is provided by the Safeguarding Team. The training for both child and adult safeguarding comprises of:

- recognising abuse and the different forms of abuse
- criteria for a vulnerable adult referral
- how to make a referral child or adult alert
- indicators of abuse
- PREVENT
- the investigation/process once a referral has been made
- multi agency working
- legislation

The new Safeguarding People at Risk course continues to be successful and receiving positive feedback. From April 2017 it will be incorporated into the three yearly Statutory Safety Update for staff, the aim of this is try and increase the numbers being trained,

MCA and DoLS training

The Mental Capacity Act and Deprivation of Liberty Safeguards training continues to be provided by Shropshire Local Authority. These sessions have now been revised and there is now a two hour session which covers the basic principles of the MCA for all levels of staff. This session includes the five guiding principles of the Mental Capacity Act and assessing for capacity when a specific decision needs to be made. It also includes information regarding Best Interests decision making

and points to consider e.g. Lasting Power of Attorney, Advanced Decision, and Independent Mental Capacity Advocate (IMCA) There is also an opportunity to evaluate and reflect on the principles of the MCA in the members of staff working practice. The MCA advanced level two session has now been removed due to low attendance.

Deprivation of Liberty training is unchanged from the previous year and remains an hour and a half session again provided by the local authority. The session includes recognising and understanding the criteria for a DoLS referral.

Unfortunately both the MCA and DoLS training have not been particularly well attended. This is thought to be due to winter pressures and escalation issues. It is hoped that there will be an improved attendance as the training has now been revised.

Learning Disability Training

Four formal sessions have been delivered by the Shropshire Local authority. Each session was for two hours and included:

- Being able to differentiate between a learning difficulty and disability
- Definition of autism
- Access to learning disability services in hospital
- Assessing capacity, consent and best interest decisions
- Methods of communication

Child Protection Training

CQC compliance is for 80% of staff to have completed the relevant Child Protection Training. All new starters now receive a combined Safeguarding Children & Adults session as part of Corporate Induction session as part of Corporate Induction.

Level three staff (now known as targeted staff are staff who work with children all the time), receive a day long course and comprises Child Protection Awareness, Domestic Abuse Awareness and female genital mutilation (FGM) training. This has ensured that the staff in these frontline areas has completed their 3-6 hour training in one session and any further training that is needed can be on an ad hoc basis as part of their annual update.

This training continues to be well received and to date the Trust has over 90% compliance.

PREVENT

This is an area for focus for 2017 onwards but during 2016-2017 we provided basic PREVENT awareness training on all Corporate Induction sessions.

Safeguarding training in Maternity

All Midwives and Women Service Assistants are required to meet level three of the recommendations within the Intercollegiate Document (2014). This equates to a minimum of six hours safeguarding training over a three year period. The CQC Looked after Children review in October 2016 highlighted the need for Midwives to complete a minimum of between 12-18 hours safeguarding training over a three year period.

In 2016-2017 a safeguarding update was delivered on the Annual Maternity Mandatory training day One which included information regarding Child Sexual Exploitation (CSE), Female Genital

Mutilation (RCOG 2014) and amendments made to the Maternity safeguarding guideline now called Safeguarding and Supporting Women with Additional Needs (SSWwAN 2016).

All Maternity Staff (excluding admin staff) were also advised to complete the PREVENT and FGM e learning (four hours total) by the end of March 2017. A safeguarding training passport was issued to all staff in 2016/17 to highlight the number of safeguarding training hours and how these can be achieved. Plans are in place for the corporate training team to manage all the maternity safeguarding training data to be able to monitor compliance with the recommendations following the CQC visit.

Community midwives working with women with complex social issues are encouraged to attend multi-agency training to meet their individual training needs.

The Named Midwife for Safeguarding and Domestic Abuse offered additional training sessions to Community Midwifery teams regarding early help and the safeguarding process.

Compliance with Safeguarding Training within Maternity was 96% at the end of March 2017.

Looking forward 2017/2018

The Trust is committed to improving child and adult safeguarding processes across the organisation and aims to safeguard all children and vulnerable adults who may be at risk of harm.

Processes will be developed to empower, be person centred, preventative and holistic and we will continue to deliver the safeguarding agenda encompassing a multi agency and partnership approach. The governance arrangements for child and adult safeguarding will continue and systems will be put into place to allow for effective monitoring and assessment of compliance against locally agreed policies and guidelines. The Trust will work on findings of the CQC inspection in respect of safeguarding.

The known influences and policy drivers that are likely to be the focus of the safeguarding team for the forthcoming year are:

- To continue to provide attendance at LSCB/LSAB sub-groups and the Health Governance Safeguarding Group, to develop practices and contribute to the development of multi agency training strategy and procedures.

- To continue to provide in-house local guidance to complement LSCB/ LSAB procedures, protocols and practice guidelines.

- To ensure that SaTH adheres to the recommendations for staff training in child protection/adult safeguarding procedures

- Continue to work in partnership with local health and social care colleagues to keep children, young people and adults with a care and support need safe.

- To participate in Child Death Overview Panels, Safeguarding Adult Reviews and Domestic Homicide Reviews if required.

- To maintain the effectiveness of the Safeguarding Operational Group

- To continue to work with Human Resource department in ensuring DBS checks and “Managing Allegations against Staff” policy and process are adhered to

- To continue to ensure that staff adheres to the training programmes and training figures continue to increase.

- Continue to engage with people at risk of abuse, their family, carers, relatives and external agencies.

- To continue to work with local partners with the National Child Protection Information System.

- To become an active member of the newly formed West Midlands Regional Named Nurse for Safeguarding (Children) network.

- To meet the CQC recommendations following the CQC/Ofsted LAC review and the CQC comprehensive inspection of the Trust in 2016

- To ensure Midwifery staff are supported to meet the recommended number of safeguarding training hours.

- To ensure community midwives have capacity to meet their safeguarding responsibilities and are able to meet the requirements of Working Together (2015) - this continues to remain on the Maternity risk register.

- To ensure the new models of Maternity care support safeguarding supervision – this continues to remain on the Maternity risk register.

- A review of Maternity services in Shropshire is in progress and models of care will continue to be considered in 2017/18. Consideration will be given in how Maternity services can best promote the safety and welfare of our more vulnerable babies, offering early help in pregnancy and working with the multi-agency teams to prevent escalation and child protection issues.

- To significantly improve PREVENT awareness and training across the Trust

Recommendations

The Quality and Safety Committee is asked to:

- **Review, discuss** and **question** this report
- **Approve** the report for submission to Trust Board.