Paper 27i

Recommendation ☐ DECISION ☑ NOTE	**The Trust Board is asked to note the annual Safeguarding Report**
Reporting to:	**Trust Board**
Date	29 November 2018
Paper Title	Safeguarding Annual Report
Brief Description	This report (in Information Pack) 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 which at present is not meeting targets and the governance processes around safeguarding within the Trust.
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Recommended / escalated by	Infection Prevention and Control Committee
Previously considered by	Quality & Safety Committee
Link to CQC domain	◉ Safe ○ Effective ○ Caring ○ Responsive ○ Well-led
Link to strategic objectives	
Link to Board Assurance Framework	

Outline of public/patient involvement	
Equality Impact Assessment	○ **Stage 1 only (no negative impacts identified)** ◉ **Stage 2 recommended (negative impacts identified)** *** EIA must be attached for Board Approval** ○ negative impacts have been mitigated ○ negative impacts balanced against overall positive impacts
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 2017/2018

Introduction

This report describes the activities during 2017/2018 of the Trust's Safeguarding Team for adults, children and maternity. The report highlights the outcomes over the 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 significant 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 (2018), 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.

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 2017/2018 the Safeguarding team consisted of:

Executive Lead for Safeguarding	Mrs Deirdre Fowler
Associate Director for Patient Safety	Mrs Dee Radford
Named Doctor for Child Protection:	Dr Frank Hinde until Sept 2017 Dr Shashwat Saran from Sept 2017
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 2017-2018

During 2017/2018 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 2017/2018 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 2017/2018 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	85%	56%

	Document 2014).		
3	Eligible staff who have received Safeguarding Children training (as per the intercollegiate document 2014) in the last 12 months. Level 3	98%	93%

Within the last twelve months training has continued in its' present format of being on SSU 3 yearly day with additional bespoke sessions for wards, especially in Adult Safeguarding, however none of the required compliance has been achieved, this is in part due to staff cancelling or not turning up for their training due to ward staffing levels, sickness or capacity to be released from the ward during the September – March time. This has impacted enormously on the training figures. Staff have been encouraged to undertake the Safeguarding Children module on line. The figures for Safeguarding Children level 2 also include medical staff which, at the end of 2017/2018 was only 22% compliant. This has been clarified to commissioners 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. Level 3 decrease is due to sickness and maternity leave by staff. Training sessions continue to be well supported for level 3 staff.

During 2017/2018 the Trust has been involved in Serious Case Review (SCR) or Individual Management Report (IMR) for Child D (ongoing case not yet published) and Family Q5 which was published by Telford and Wrekin. Lessons from these Serious Case Reviews have been incorporated into training.

Both Shropshire and Telford and Wrekin local authorities hold monthly Multiagency Risk Assessment Conferences (MARAC) meetings. The Named Nurse, the Named Midwife and the Safeguarding Specialist Nurse for Adults attend these monthly meetings. 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. From November 2017 and in line with the recommendations of a Domestic Homicide Review, the perpetrators of Domestic Abuse are also alerted on the SEMA system, thus allowing cross reference of cases, particularly in the ED.

An example of how well this works was an incident whereby a female had attended the ED with an injury, the staff could see her MARAC alert, managed to find an occasion to speak to her alone, and ask if all was well at home. She disclosed the incident was different to that she had said on arrival, the partner (also the perpetrator) was asked to leave the department and was arrested by the police. The NICE guidance 2016 states that all front line staff should take every opportunity to ask all patients about Domestic Abuse.

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 as well as Early Help Partnerships Meetings and the Pan Shropshire Health Governance Safeguarding Group.

The Trust was involved in a Domestic Homicide Review in 2016 –this has now been published and all recommendations have been put in place.

The Regional Named Professionals Network which was set up in 2016 by the Named Nurse together with the Head of Safeguarding at New Cross has continued to strengthen, with the six

monthly meetings taking place in Telford and guest speakers have included the Regional Paediatric Sexual Abuse Referral Centre and the NHSE Prevent coordinator.

Table two: Referrals to partner agencies in 2017/2018:

Month	Referrals to Social Care	Referrals to MARAC	LADO referrals
Q1	8	21	1
Q2	10	36	2
Q3	2	27	0
Q4	6	25	0

Referrals to Social Care are children that have been admitted with a suspicious injury or those whose parents are known to be 'Toxic Trio' (Domestic Abuse, Parental Mental Ill Health or Parental Substance Misuse) and have attended ED and children require protecting. Not all these referrals result in Child Protection Assessment by Social Care, most are Early Help.

It has been noted that apart from the Police, Acute Health are the next largest referrer of cases to the MARAC process, the figures above do not include Maternity cases.

LADO (Local Authority Designated Officer) allegations made against staff who work with children. These are cases where there has been incident at work or home and the member of staff works with children or young people within the hospital, as they work in a 'Position of Trust' they are referred to the LADO.

Maternity

Infancy remains the period of highest risk for serious and fatal child maltreatment. In the most recent triennial analysis of serious case reviews (Brandon et al 2016), 120 of the 293 children (41%) were under one year at the time of their death or serious harm and almost half these babies (43%) were under three months old.

Safeguarding Supervision:

The midwife is often the first professional to work with new parents and therefore needs to be able to recognise early signs of neglect and abuse to safeguard the unborn. 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. The current model of safeguarding supervision in Maternity is offered ad hoc and can be ineffective at supporting and empowering Midwives to safeguard their caseload.

In November 2016 ten staff completed the NSPCC safeguarding supervision training with a view to embedding safeguarding supervision into Maternity practice. In November 2017 the Maternity safeguarding supervision policy was implemented however, compliance with the policy has been met with different challenges. Community Midwives with complex caseloads value the opportunity to access safeguarding supervision but within the current model of Maternity care, there is little capacity to embed this in practice.

Maternity now have seven Midwives who have the skills to deliver safeguarding supervision across the service. Considering the evidence demonstrating the importance of safeguarding supervision, a business has been submitted to highlight the number of hours required to offer effective group supervision which will be more cost effective than the one to one models.

Lack of safeguarding supervision increases the risk of significant harm to the unborn and has therefore been added to the risk register.
The average number of safeguarding supervision sessions offered on a one to one basis was one
The average number of group supervision offered / month was one.

Capacity for Community Midwives to safeguard the unborn / be compliant with Working Together 2015:
The current model of Maternity care is not conducive to offering a flexible service to those women who are unable or choose not to attend their hospital appointments. The lack of continuity increases the risk of safeguarding issues being missed or drift occurring. Attendance at case conferences and other safeguarding meetings is improving compared to anecdotal evidence from 2016/17

This above risk is on the risk register and in some areas midwives are looking ways of improving the continuity of care during the antenatal and postnatal period to meet the requirements of Working together 2015.

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 few 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 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 2017-2018 NB: Some missing data.

Month	Shropshire	Telford and Wrekin	Powys
April	38	37	0
May	51	57	0
June	45	35	0
July	48	37	0
August	46	32	0
September	-		0
October	54	42	0
November	50	58	1
December	57	26	0
January	-	-	0
February	-	-	0

March	-	-	0
Average Total	**583**	**486**	

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 2017-2018

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	58	57	3	9	2
May	47	31	6	11	6
June	28	62	3	8	11
July	27	52	6	20	11
August	57	69	15	10	5
September	-	-	-	-	-
October	32	46	4	8	2
November	38	49	-	-	-
December	47	51	-	-	-
January	-	-	-	-	-
February	46	47			
March	-	-	-	-	-
Total average	**506**	**618**	**14**	**132**	**74**

Domestic Abuse:
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

All women are asked the marked question for DA at booking if it is appropriate. Where partners are present, the midwives are advised to repeat the marker questions later in pregnancy.

The Midwife is encouraged to use the MARAC form as a risk assessment tool following a disclosure of Domestic Abuse.
MARAC assessments completed and referred by Maternity during the time period was 14
The average number of HAU incidents received was 234

Training:
Level 3 training is offered monthly at the Maternity mandatory training days. The theme for 2017/18 was Domestic Abuse and “asking the question”.

The average percentage for maternity staff being compliant with attending an annual update is over 80%.

Safeguarding Adults with care and support needs

Changes to Legislation notified in 2017

Liberty Protection Safeguards Law Commission
On the 13 March, 2017 the Law Commission published its recommendations regarding MCA and DoLS. This followed the House of Lords post legislative scrutiny of the MCA and the Supreme Court decision in the Cheshire West case. The Law Commission concluded that the current system was in crisis and has suggested an entirely new scheme to replace DoLS to be called Liberty Protection Safeguards. This will require new legislation which they have also published.
This is a summary of the expected changes which will have a significant impact on the Trust.

- DOLS will be replaced by the Liberty Protection Safeguards
- The Proposed new Bill is to be called Mental Capacity (Amendment) Bill
- The new safeguards will apply in care homes, hospitals, supported living share housing (where the person lives with a paid carer), private housing
- Provision to allow people to move from one setting to another
- To cover all of those aged 16 and over
- Hospital mangers will oversee LPS for in-patients
- Hospital managers to be responsible for granting the deprivation of Liberty
- Assessments to include capacity, medical and care needs
- LPS to last for 12 months with a 12 month renewal and then 3 yearly
- Right to advocacy
- Improvements to process and record keeping around assessments and decisions
- Consideration regarding unifying the MCA and MHA in the future

Department of health guidance has not been published as yet. It is expected that this new legislation will come into force in 2019. This will have significant implications for all acute Trusts.

Court of Appeal decision January 2017. Patients in Intensive Care Units no longer requiring a Deprivation of Liberty Safeguards referral unless exceptional circumstances.

The Court of Appeal January 2017 handed down judgment in R (Ferreira) This judgment has important implications for all NHS Trusts. The Court of Appeal upheld the decisions of the Coroner and Divisional Court. The decision was that the majority of patients in ITU were free to leave and the true cause of their lack of freedom to leave was their underlying illness. This contrasts with the position of those in Cheshire West where steps to be taken to prevent a person leaving their placement are taken because of their mental disorder. Patients in ITU will not normally be deemed to be deprived of their liberty (unless there are exceptional circumstances). Their stay will therefore not require authorisation under the Mental Capacity Act.

Subgroups of the Safeguarding Adult Boards (SAB) 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)

- The Safeguarding Team at SaTH continues to attend the subgroups of the Safeguarding Adult Boards
- Mental Capacity Audit tool reviewed by MCA and DOLS subgroup

Shrewsbury and Telford Hospital Trust MCA Audit April 2018

Shrewsbury and Telford Hospitals Trust complete an Adult Safeguarding Dashboard on a quarterly basis to assure both Telford and Wrekin CCG and Shropshire CCG that they are meeting their responsibilities in respect of Adult Safeguarding. This dashboard is informed by the national guidance determining safeguarding requirements within the NHS.

The dashboard identifies that the provider will support a "best practice audit for both Safeguarding and MCA and respond to the recommendations…..embedding the principles of the MCA & Adult Safeguarding."

SATH undertook a MCA Audit in April of 2018 utilising an audit tool developed in conjunction with both CCGs' Adult Safeguarding Leads and reviewed by the MCA Operational Group. The evidence base for the issues under enquiry was influenced by the London Safeguarding Adult Reviews Report. This publication was commissioned by the London area Association of Adult Directors of Social Services and examined 27 Safeguarding Adult Reviews in London over 2 years. It noted some practice issues regarding the use of the MCA, these included: missing or poor capacity assessments especially about admissions to hospital or a care home; absence of explicit best interest decision making; lack of risk assessments and poor responses to escalating risks; lack of reviews of capacity decisions despite increasing risks; misunderstanding of MCA legal powers; insufficient challenge of capacity decisions by others; presumptions of capacity not tested; misunderstandings about self-determination and capacity; absence of BI decisions framework; absence of any assessment of Capacity documentation.

The audit was completed for service users whom the clinical team had predetermined lacked capacity in respect of a specific decision e.g. consent to receive hospital based care and treatment, surgery, etc. A cohort of 31 service users was identified from a mix of wards and across both hospital sites.

Overall the SATH specialist clinicians who undertook all of the audit returns found no major issue pertaining to "legal literacy about the MCA" regarding significant gaps in knowledge or practice as was the case with the London SARS. This was reaffirmed by the review of the completed audits undertaken by the two CCG safeguarding leads.

Overall the audit demonstrated high levels of adherence to the 5 principles of the MCA as evidenced by the use of the MCA Forms 1 and 2 augmented by Form 4.

There was evidence of how clinicians recognised the importance of consultation with families and how this is used to inform clinical decision making. Meaningful consultation is important so that relatives "can give information on the person's wishes and feelings, beliefs and values,"[1] in order to inform the decision making process. This also included knowledge about LPA and the need to ensure documentary evidence is properly stored.

The main learning is the need to provide more specific detail with regard to the rationale behind the findings of the capacity assessment using MCA Form 1. There was one MCA Form 1 which was of a poor standard and this is again being addressed in the actions it is also anticipated that the positive practice will be shared with clinical teams by the main auditor.

SATH have already posted upon the intranet further briefings from NHSE about the 5 principles of the MCA, how to compete a capacity assessment and guidance on consent and best interest, which is also being used as aids when providing assistance to new staff.

ACTIONS/RECOMMENDATIONS	LEAD	TARGET DATE
To insert into MCA form 1 after the Y/N questions regarding the capacity assessment the following prompt: "Brief details of your decision must be given"	Helen Hampson	September 2018. Completed
Provide on the SATH intranet additional guidance on the 5 principles of the MCA, Consent, Capacity and BI	Helen Hampson	May 2018. Completed
Utilise the findings of the audit in future training sessions on the MCA planned	Helen Hampson	October 2018. On-going

Training

Mental Capacity Act/ Deprivation of Liberty Safeguards training had been provided by the Shropshire Local Authority but this was not recurrent funding which had been provided by the Shropshire CCG. The Trust has not had MCA/DoLS training for a year and for this reason was put on the risk register. Funding was then agreed by the Trust and Shropshire local authority are now delivering twelve sessions which commences in August 2018. Telford and Wrekin CCG are providing four free sessions.

Adult Safeguarding Training is delivered by the Safeguarding Team and this training is for all patient handlers once every three years. Currently this training is achieving 56%. The NHS guidelines and recommendations is at 85%.

Table six: Adult safeguarding concern referrals April 2017 – March 2018

Month	Total	Instigated by the Trust	Towards the Trust
April	9	8	1
May	11	9	2
June	9	7	2
July	13	11	2
August	9	6	3
September	14	10	4
October	15	11	4
November	11	7	4
December	10	10	0
January	13	10	3
February	7	5	2
March	13	8	5
Total	**134**	**102**	**32**

Table six shows that there have been a total of 134 concerns raised in the Trust between April 2017 and March 2018. Thirty two 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 three Section 42 inquiries into the Trust during 2017-2018 which have resulted in actions that have been completed regarding patient care and communication. The Trust has seen an increase in the amount of safeguarding concerns regarding self-neglect. Self-neglect was introduced as a category of abuse with the introduction of the Care Act 2014.Staff are reminded throughout training that significant self-neglect is now a category of abuse.

Characteristics of self-neglect include:

- Living in very unclean circumstances
- Neglecting household maintenance creating hazards
- Obsessive hoarding
- Animal collecting
- Failing to provide care for him/herself that health or wellbeing may decline
- Poor diet and nutrition
- Failure to maintain social contact
- Failure to manage finances
- Declining prescribed medication
- Unwilling to attend appointments including healthcare

Table seven: Deprivation of Liberty Safeguards referrals April 2017 – March 2018

Month	Total	Approved	Not Approved
April	5	1	4
May	4	0	4
June	10	0	10
July	6	1	5
August	7	1	6
September	9	0	9
October	8	1	7
November	1	0	1
December	3	1	2
January	10	3	7
February	5	1	4
March	7	1	6
Total	**75**	**10**	**65**

There have been 75 Deprivation of Liberty Safeguards referrals made to the appropriate Local Authority for approval during this period. Sixty five of these were not approved. The reasons for not being approved include six patients were sectioned under the Mental Health Act, eight patients their capacity returned. The remaining fifty one patients were discharged from hospital prior to the DoLS assessments taking place.

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 un-assessed. 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, Internal Management Review and Domestic Homicide Review

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 2017/18, 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.

Training provision within 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

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 and 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. The training for 2017 has included external speakers from the Shropshire Parent and Carer Council following some negative feedback about how a young person with additional needs had been treated by staff in the ED.

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

PREVENT

Prevent training continues to be a statutory requirement for NHS staff, with an 85% compliance rate being set. Corporate Induction continues to deliver basic Prevent awareness training. In July 2017 an intensive programme of face to face WRAP (1 Hour) training commenced and achieved an increase in compliance from 0% to 42.2% by the end of 2017-2018.

Looking forward 2018/2019

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 continue to be an active member of the 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.

- The intensive programme of face to face WRAP 3 (Prevent) training finished in June 2018. The Prevent training delivery method is scheduled to change from face to face to an e-learning package. This mode of delivery has only recently been approved by the national Prevent trainers. The e-learning package will be the predominant means of training moving forward with limited Ad hoc sessions remaining available. It is anticipated that the Trust will not meet the set target of 85% by March 2019. Currently staff safeguarding adults training is under review to address low compliance, this includes Prevent.

Recommendations

The Quality and Safety Committee is asked to:

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