Safeguarding Team

Annual Report

2018/19

Contents

1. Forward

It is my pleasure to introduce the Safeguarding Annual Report for 2018/19. It summarises the work undertaken within the Trust in respect of safeguarding, planned developments and the strategies moving forward into 2019/20.

Sections 9, 10 and 11 also outline the work undertaken around mental health, learning disabilities and dementia, which are aligned to the safeguarding team and the Chief Nurse and Head of Safeguarding's portfolio. It is acknowledged that these areas are not just about safeguarding but they do recognise the links with the increased vulnerabilities of these client groups.

This report provides assurance to the Trust, its patients and their families and our partner agencies that we see safeguarding as a key priority and ensure that all our staff are aware that 'safeguarding is everyone's business' and we all have a role to pay in ensuring our patients and their families receive outstanding care.

Suzanne Banks
Chief Nurse

2. Introduction

Sherwood Forest Hospital NHS Foundation Trust (SFHFT) has a statutory responsibility for ensuring that the services provided by their organisation have safe and effective systems in place which safeguard adults, children and young people at risk of abuse, neglect and exploitation.

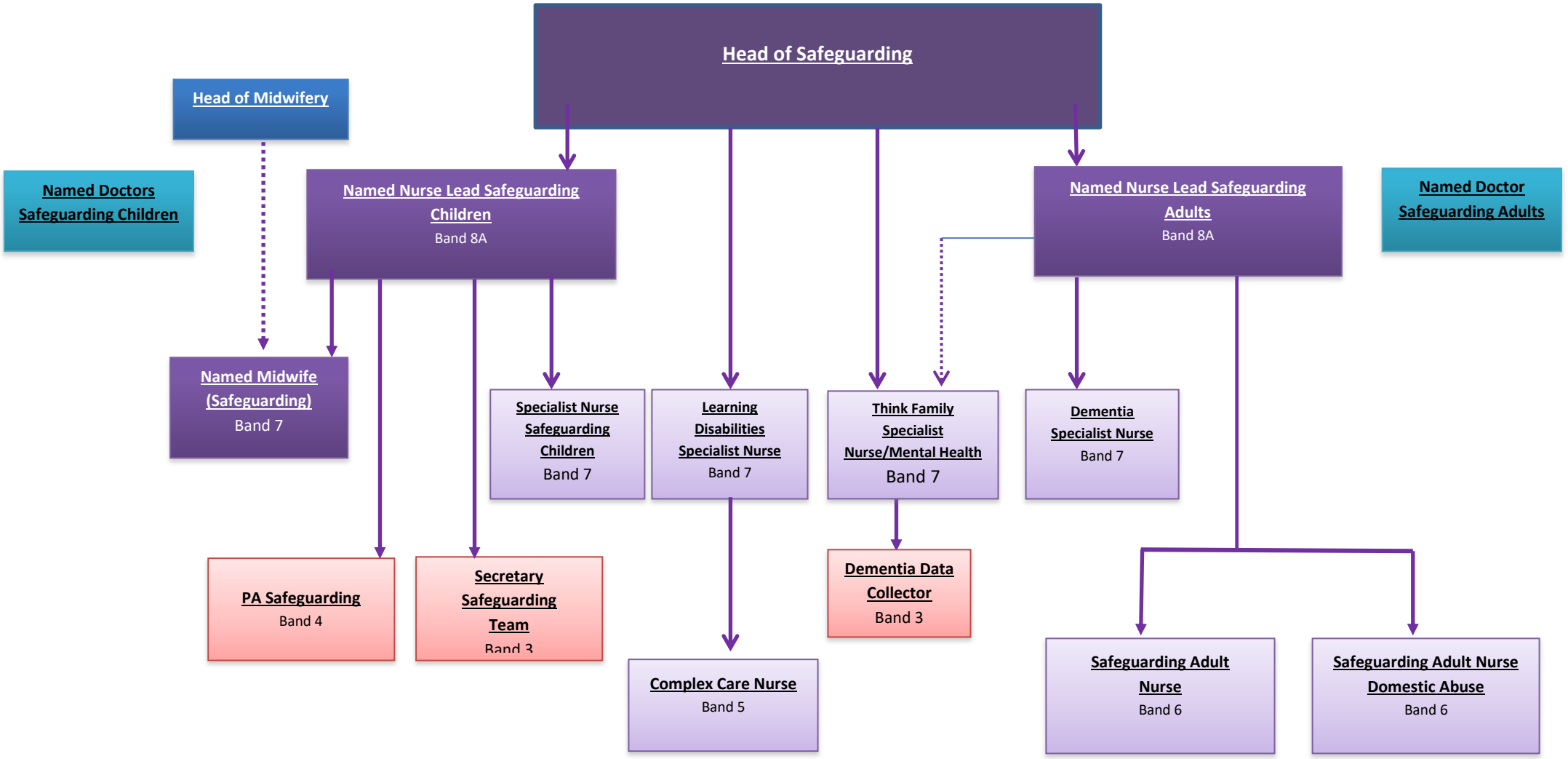
The aim of this report is to summarise the safeguarding activity within Sherwood Forest Hospital Foundation Trust (SFHFT) during the period 2018/19. This activity was analysed against set objectives which are in line with Nottinghamshire Safeguarding Adult Board (NSAB) and Nottinghamshire Safeguarding Children Board (NSCB) reporting requirements and National/Legal requirements e.g. Care Act 2014, Children Act 1989/2004 and set actions for the next year (2018-2019).

Furthermore, the report aims to:

- Provide assurance to the Trust board that the Trust is fulfilling its safeguarding obligations
- Assure service commissioners & regulators e.g. CQC and NHS Improvement that the Trust's activity over the year has developed in terms of preventing abuse and reducing harm; as well as embedding MCA/DOLs into clinical practice using the model of 'Making Safeguarding Personal' and ensuring that the 'Voice of the Child' is heard
- Appraise the Trust staff & managers regarding the activity and function of the safeguarding team and the support it provides to operational and clinical service delivery
- Ensure that patients, service users and carers know that safeguarding of children and adults is a Trust priority

The report will also provide an overview of developments within the safeguarding arena both locally and nationally over the last 12 months. Highlighting how these developments have impacted upon the service provided by the Trust and how we work as a partnership to ensure the patients and their families within accessing services within Nottinghamshire are protected.

3. Think Family Safeguarding Team Structure & Functions



4. Key National Themes

CSE (Child Sexual Exploitation)

Child sexual exploitation (**CSE**) is a form of sexual, emotional and physical abuse which involves the manipulation and/or coercion of a child/young person under the age of 18 into sexually activity. This may be through the use of technology.

CSE continues to be a priority for SFHFT. The safeguarding team undertook a lot of work around CSE during 2017-2018 and work has continued over the last 12 months. The team have raised further awareness of CSE across the organisation, strengthening the resources available and training across all areas. CSE training is now incorporated into the New Trust Induction training, which means staff new to the organisation will be equipped with the necessary skills required from the moment they start employment with Trust.

Since its launch in January 2018 the Emergency Department (ED) and Urgent Care Centre (UCC) CSE screening/risk assessment tool has been extremely successful. It is now fully embedded within the ED/UCC triage process and results show a significant increase in referrals to social care due to identified concerns around children at risk of exploitation. SFH are one of very few acute hospitals that undertake routine screening for CSE for all children presenting to ED/UCC over the age of 10. The tool will be part of the routine safeguarding documentation audit undertaken within ED/UCC and this will form part of the safeguarding children work plan for 2019-2020

As an organisation SFHFT continue to provide representation at the Multi Agency Sexual Exploitation (MASE) group and the Concerns Network. This ensures oversight of CSE at a local level, sharing information with other agencies to protect vulnerable children/young people. Children/young people identified at risk are flagged within the Trust Sexual Health Services and ED, enhancing information available to staff aiding effective and safe risk assessments.

Moving forward work will continue in 2019 -2020 around CSE, ensuring effective use of the ED/UCC CSE screening/risk assessment tool through audit.

FGM (Female Genital Mutilation)

As part of a world wide effort to eliminate FGM, the Department of Health's FGM Prevention Programme aims to improve the way in which the NHS responds to the health needs of girls and women who have had FGM, and to actively support prevention. It aims to support professionals to be confident when having discussions with women and girls, to record and share FGM information appropriately and to take the necessary action to safeguard girls against risk.

The Serious Crime Act 2015 introduced mandatory reporting by regulated professionals from October 2015. This means that whenever regulated professionals (health, social care and education) identify that a girl under 18 has had FGM, or if the girl discloses this herself, the professional must make a report to the police. FGM has been a key focus in all levels of training during 2018-2019 and has also forms part of the New Safeguarding Think Family Induction training. This has ensured all staff starting employment at the Trust have the knowledge and skills to recognise and report FGM as per process.

As part of the national FGM-IS project SFHFT will be starting to input any disclosed cases of FGM onto the Summary Care Record. When a woman who has survived FGM has a female baby an alert will be placed onto the child's SystmOne record until they reach they age of 18. Responsibility for inputting on to the FGM-IS will sit within the Safeguarding team, as well as the current inputting on to the HSCIC database for FGM. Work is currently underway around the implementation of this process and will be a key focus in 2019-2020 along with updating the FGM policy to reflect these changes.

The Named Midwife provides assurance for the Trust and leads upon any statutory responses to identified risks or cases from a safeguarding perspective.

Moving forward to 2019/2020 As part of the national FGM-IS project SFHFT will be starting to input any disclosed cases of FGM onto the Summary Care Record. Trust FGM policies to be reviewed to reflect FGM-IS. The safeguarding team will also be auditing staff knowledge around FGM through ward/department visits.

Modern Slavery

Modern Slavery was introduced as a separate category of abuse in the relation to adults at risk under the Care Act in 2014. It involves the recruitment, movement, harbouring or receiving of children, or adults through the use of force, coercion, and abuse of vulnerability, deception or other means for the purpose of exploitation. Individuals may be trafficked into, out of or within the United Kingdom. They may be trafficked for a number of reasons including sexual exploitation, forced labour, domestic servitude and organ harvesting.

The Modern Slavery Act 2015 identifies Modern Slavery as a national and local priority**.** Local safeguarding adult boards require assurance that staff are required to be able to identify and respond appropriately to potential modern slavery and know when and where to refer concerns. SFHFT staff will work with survivors of modern slavery. Think Family safeguarding training includes information on modern slavery.

During 2018/2019 we have developed our position statement in relation to Modern Slavery. There has been a focus on staff understanding and responding to any concerns or disclosures of Modern Slavery.

Moving forward further work will be undertaken with Human Resources and the Procurement Departments to ensure SFHFT has taken steps to ensure that slavery and human trafficking are not taking place in the business (or in any supply chain) or declare that no steps to confirm the existence of slavery or trafficking have been taken (Transparency in Supply Chain Provisions).

MCA/DOLs

The Mental Capacity Act 2005 provides a statutory framework for acting and making decisions on behalf of individuals who lack the mental capacity to do so for themselves. It introduced a number of laws to protect these individuals and ensure that they are given every chance to make decisions for themselves. The Government added new provisions to the Act: the Deprivation of Liberty Safeguards in 2008, which related only to those adults residing in care homes and hospitals who, in their own best interest, need to be accommodated under care and treatment arrangements that may have the effect of depriving them of their liberty - as defined in the 'Cheshire West' Supreme Court ruling - but who lack the capacity to consent to these arrangements. Local Authorities have a statutory obligation to assess all those people who fall within the remit of the safeguards to ensure that the arrangements made for them really are in their best interest and to take remedial steps if found otherwise. The people responsible for undertaking this work are specially trained social workers called 'Best Interest Assessors'.

A bench mark audit was undertaken in September 2017 to review the current baseline of MCA/DoLS across all divisions within the Trust. It highlighted MCA/DoLS and Mental Health required a focus into 2018/2019 to ensure it is integral to person centered care delivery within divisions and assures coordinated and seamless pathways/transitions of care of the patient journey, where a person lacks capacity within the decision making process and, which, evidences the best interest of the patient.

During 2018/2019 a development plan was implemented to support organisational change, which reflects the Trust's shared values and behaviors (CARE), and measures quality improvement. This was delivered as part of the Think Family Safeguarding priorities. Ward audits have been implemented on a monthly basis to provide assurance that quality improvement is embedded within the divisions and where there are identified needs through an action plan. 2 wards were identified during 2018-2019 to pilot MCA/DoLS supervision to support learning in practice

Moving forward in 2019-2020 the Trust will look to develop new ways of working to meet its responsibilities with the ascent of the MCA bill and the change to the Liberty Protection Safeguards (LPS) and how this may affect the work we do.
We will continue to progress the embedding and audit of MCA within delivery of person centred care

Making Safeguarding Personal (MSP)

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 about seeing people as experts in their own lives and working alongside them. It is about collecting information about the extent to which this shift has a positive impact on people's lives. It is a shift from a process supported by conversations to a series of conversations supported by a process.

MSP aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances. It is about engaging with people about the outcomes they want at the beginning and middle of working with them, and then ascertaining the extent to which those outcomes were realized at the end.

Moving forward in 2019/2020 MSP will continue to be of the part the 'Think Family' safeguarding priorities.

5. Safeguarding Activity and Key Achievements in 2018/2019

Our progress has included:

Domestic Abuse

Within the Safeguarding team there has been a dedicated post to domestic abuse. Following the successful secondment of the domestic abuse nurse to another position within the Trust, we have taken the opportunity to review the current service provision and ways we can improve the quality of care delivery we provide to survivors of domestic abuse. This is currently being developed as a pilot with Nottinghamshire Women's Aid. This work has focused on an Independent Domestic Violence Advocate (IDVA) being based within the Trust Safeguarding Team during core hours of service delivery. The pilot will look at developing:

- support for the recognition and response of staff where there are concerns/disclosures of domestic abuse,
- the transition of care to primary care and the engagement with wrap around services for survivors and /or families where there is an identified need/risk,
- Improvement in the health outcomes for survivors and/or families including the voice of survivors (adult/child).

There has been a focus on supporting staff that are affected by domestic abuse. The Trust Human Resource Department has attended domestic abuse training including risk assessment. We have seen an increase in confidence in staff seeking support for their health

and wellbeing and in support and safety planning for managers and staff .The workforce policy has been strengthened and supporting information has been developed for employees and managers.

Safeguarding SystmOne Unit

Since the integration of the safeguarding adult and children's teams the database systems were identified as out of date and problematic to use. The team were experiencing issues with inaccurate data being collation and difficulties accessing each other's systems. The existing databases were also no longer fit for purpose as they were developed some time ago and in an ever changing environment new data needs collecting and these systems do not allow for this. These issues created a significant risk to both patients and the Trust.

Data collated by the safeguarding team is used to provide assurances to the Trust and external Safeguarding Boards via quarterly and annual reports provided by the Safeguarding Named Nurses. The data is collated and produced by the safeguarding team themselves.

The safeguarding team approached NHIS to request support around developing a new or using an existing system to support with providing the team with a consistent approach to the collection of safeguarding information and data reporting. The system used by the safeguarding team needed to provide the necessary security for confidentiality due to the nature of the information we collate.

Following a review of a number of options it was decided a safeguarding unit within SystmOne would provide the necessary requirements. During 2018/2019 this system has been developed and the team are starting to input and collate information. Reporting processes have been established and moving forward these systems will be used to provide the data for the quarterly and annual reports.

Safeguarding Think Family Champions

Since the Safeguarding Adult and Children team's integration a number of joint developments have been undertaken to further embed the think family ethos and to provide consistency across the team moving. One of these developments has been the incorporate of both adult and children safeguarding champions into Think Family Champions. There is now a total of 92 champions across the organisation, all have received specific training to equip them with the additional skills and knowledge required to support the safeguarding agenda within their own areas. Their role is to provide general day to day advice around safeguarding and to support the safeguarding team in embedding and raising awareness of safeguarding across the Trust.

MCA/DoLS Audit

During 2018-2019 there has been a focused intervention through a development plan to embed three interlinked strands:

- Recognition of the Mental Capacity Act/ DoLS Framework as fundamental to care within the patient care pathway/ journey
- Process
- Ownership/ Sustainability

Ward based audits have been undertaken to provide assurance of progress following the MCA/DoLS bench mark audit in 2017-2018 which was undertaken across all divisions within the Trust.

The face to face audit allows any identified concerns in the MCA framework including gaps in the DOL process to be discussed with the Senior Nurse on duty. An action plan is formulated for the ward to complete by the end of that working day.

Safeguarding Children and Adults – (Quality Schedule)

The following targets for 2018/19 were achieved as specified below:

1) **To provide outstanding care to all patients**
   - **2018/2019 will see the development of Lessons Learnt through Mandatory Training.**
     Lessons Learnt training was developed and delivered through Mandatory Training. The training focused on 2 local reviews, one child and one adult view with similar themes of was no brought/Did not attend, transitions, neglect, lack of communication with professionals losing sight of the adult and child within the cases.

2) **To support each other to a great job**
   - **2018/2019 will see the development of the Think Family Champion role which will integrate both adult and children safeguarding champions.**
     The Think Family Champion role was developed integrating both adult and children safeguarding champions. There is now a total of 92 champions across the organisation all having received addition training and supervision to support them to undertaken their roles and embed safeguarding within their areas.
   - **Work will continue around safeguarding supervision.**
     The safeguarding children supervision programme continues to be successful with further development in providing supervision for paediatric ward staff routinely. There have also been developments around safeguarding supervision across adult areas within trust**.**

3) **To inspire excellence**
   - **In 2018/2019 a 12-18 month development plan will be implemented to support organisational change, which reflects the Trust's shared values and behaviours (CARE), and measures quality improvement.**
     The development plan has been implemented. Ward audits have been undertaken to provide assurance of progress following the MCA/DoLS bench mark audit. The safeguarding supervision pilot for MCA/DoLS of 2 wards has been extended to include an additional 2 wards.

4) **To get the most from our resources**
   - **The development of Think Family Safeguarding Induction training will ensure our staff entering the organisation will be able to demonstrate the necessary knowledge and skills to recognise, respond, refer and record any safeguarding concerns.**
     The Think Family Safeguarding Induction training has commenced and has received very positive feedback support compliance rates for level 3 safeguarding.
   - **The development of our training aims to create a positive learning environment for staff and actively seek the barriers and enablers when working with safeguarding concerns.** Work has begun looking at these barrier and enablers to see how the safeguarding team can support by streamlining systems and processes were possible. The development of electronic referrals has supported this.

5) **To play a leading role in transforming the health and care of our community**
   - **Safeguarding priorities during 2018/2019 will continue to ensure where there are safeguarding concerns adults, children and carers are recognised as partners in the outcomes they wish to happen. This will focus around Making Safeguarding Personal, Voice of the Child and views of fathers**. Documentation in some areas of the organisation has been reviewed to ensure they support in gaining the wishes and feelings of adults, children and their families. This work will be ongoing during 2019/2020

Safeguarding Adults Reviews (SARs) and Domestic Homicide Reviews (DHRs) and Children Serious Case Reviews (SCRs)

SFHT has a statutory requirement to engage in any multi-agency Serious Case Reviews (SCR's), Safeguarding Adult Reviews (SAR's) or Domestic Homicide Review's (DHR's) where we have had involvement in the care of the victim, perpetrator or their family, if relevant.

- **Domestic Homicide Review (DHR)**

There are 3 on going for year 2018/19 Nottinghamshire DHRs which Sherwood Forest Hospitals is a member of the review panel. 2 of the reviews are near completion and awaiting submission to the Home Office. 1 DHR is currently being established with SFHFT attending the panel meeting.

- **Safeguarding Adults Review (SAR)**

Sherwood Forest Hospitals have not been engaged in any on-going SARs during 2018/2019.

- **Serious Case Reviews (SCR)**

There has been no new SCR during 2018/2019.

KN15 – This was following the death of a 13 year old girl by way of hanging, the case drew a lot of media attention. SFH had not had contact with the child herself but had been involved with family

members. The SCR and coroner's inquest are now complete. There were no specific actions for SFH however the safeguarding team have reviewed and shared learning throughout the Trust.

ADS15 – this was an out of area SCR following the death of a baby. SFH were involved when the baby had an admission to the paediatric ward for faltering growth. A SCR was initially started, but this was subsequently downgraded to a Serious Incident following the outcome of coroner's inquest which ruled the death was accidental This has led to the revision to the overview report, SFH will continued to be part of this process the report has been completed and is awaiting sign off. All actions for SFH were completed at the initial stages of the review.

Learning Event – Injuries in Pre- Mobile Babies

A learning review was commissioned by the then Nottinghamshire Safeguarding Children Board (NSCB) following five Serious Incident Notifications (SINs) being submitted to Ofsted between 29th March 18 and 29th May 18 whereby non-mobile babies had received serious non-accidental injuries. A total of 6 cases were reviewed with purpose of the review being:

- Consider an overview of what is known about the circumstances of each event
- Identify any common features
- Identify any immediate and longer-term action required in order to prevent future injuries

The children within the review were aged between 6 and 11 weeks at the time of the incident leading to injury. Previous injuries or concerns had been raised in relation to the subject child in two cases and in four cases in relation to their older siblings. Two of the children were previously known to Nottinghamshire Children's Social Care and one of these was subject of a Child in Need Plan at the time of the incident. SFH were involved in 4 of the cases with the children being treated for their injuries at Kings Mill Hospital (KMH). 1 of the 4 the cases treated at KMH was also under internal investigation due to concerns around processes not being followed.

Conclusion and Findings

The review concluded the following: -

- None of the cases met the criteria for Serious Case Review (SCR).
- This review did not reveal any significant failures by agencies that could have prevented injuries to any of the children.
- No systemic issues were identified leading to pre-mobile babies being unsafe in Nottinghamshire
- Investigations ongoing in all of the cases but analysis of the cases to date has not indicated that events leading to injuries could have been predicted

Identified Practice Issues:

• Effectiveness of strategy discussions
• Repeat skeletal surveys
• Pathway for non-mobile baby with bruising or a suspicious mark
• Lack of clarity within MASH regarding responsibility for arranging child protection medical.
• Quality of decision making and requirement for pre-birth ICPC

• The challenge of dealing with “Hidden males”.
• “Routine enquiry” by midwifes in relation to domestic abuse.

SFH Actions to date:

- Child protection medical proforma has been reviewed and amended to ensure decisions around repeat skeletal surveys are clear and documented. Where decisions are made to cancel the repeat this is to be agreed with the Named Doctor/safeguarding or senior Paediatrician and paediatric radiologists.
- SFH contributed to the review of the Bruising in Babies pathway and have circulated this within the relevant areas of the organisation. This is being used within the Safeguarding Think Family training where there is a scenario around a bruise in a non-mobile baby.
- The safeguarding team are currently in the process of developing a SOP for the admission and discharge of children who require a child protection medical. The aim of this is to support staff in following the correct processes and to provide clarity around roles and responsibilities of all agencies involved including strategy discussions/meetings.
- Planned repeat routine enquiry audit within maternity services to take place in 2019/2020.
- Training is being developed around dealing with difficult and challenging parents in safeguarding cases. These will be delivered via workshops within the relevant areas.
- Debrief and supervision with the staff involved in this case has been undertaken.

6. Working with Partners

Nottinghamshire Safeguarding Children Board /Partnership

With the publication of the new Working Together to Safeguard Children statutory guidance in July 2018. The Nottinghamshire Safeguarding Children Board was tasked with reviewing its leadership arrangement. The new statutory guidance required only the 3 statutory partners to lead the Nottinghamshire Safeguarding Children arrangements. It was therefore decided that the new structure would include a senior leadership group which included –the CCG’s, police and the local authority. The final Safeguarding Children Board met in December 2018, the new Safeguarding Partnership met January 2019, there is a requirement that the new structures and processes come into force in April 2019.

Our new safeguarding arrangements were published on 27thDecember, we were the sixth area to do so, the DfE have confirmed that they are compliant with Working Together 2018.

The first meeting of the Strategic Leadership Group (SLG) has taken place. The SLG will be chaired on a 12-month rotational basis by the safeguarding partners and the first chair is the Corporate Director for Children, Young People and Schools. The SLG agreed that the cross-authority Child Death Overview Panel will report directly to the SLG. Assurance from Operation Equinox will be provided on a 6-monthly basis to the SLG. Arrangements for the chairing of the other partnership groups were confirmed and initial plans for the first meeting of the Nottinghamshire Safeguarding Children Partnership Forum were made.

The Safeguarding Assurance and Improvement Group will be met on 13th March 2019 –Service Director commissioning and Resources chaired this meeting and this is where the previous non statutory partners (including SFHT) now sit.

Moving into 2019-2020 SFHT will continue to engage with the Nottinghamshire Safeguarding Children Partnership – ensuring representation to the relevant groups and partnerships. We continue to play an active part in multi-agency audits and developments and use the information from these to influence the way forward for safeguarding children in SHFT.

Nottinghamshire Safeguarding Adults Board

There have been no changes to the structures for the safeguarding adult's board. The Trust continues to be represented on the strategic level Safeguarding Adults Board.

The Safeguarding Adults board reviewed its strategy and agreed its strategic priorities, building upon the agreements from the previous year.

Strategic Priorities

- **Prevention**
  To continue to identify and reduce risks of abuse and neglect to adults in Nottingham.
- **Assurance**
  That appropriate arrangements are in place and continue to develop within and between agencies to safeguard adults in Nottingham as effectively as possible.
- **Making Safeguarding Personal (MSP)**
  To continue to promote person centred and outcome focused work within and between agencies.
- **Working arrangements for the safeguarding partnership in Nottingham**
  To have Board arrangements in place that member organisations see as effective and efficient.

Delivery

The strategic plan will be delivered by the implementation of an Annual Action Plan for each of the 3 years of this Plan. Annual Action Plans will build on existing strengths developed over many years of partnership working in the City in order to maximise the benefits of current opportunities whilst seeking to minimise the impact of challenges that arise for the Board and / or its partner agencies in an era of austerity and pressures on public and Voluntary and Community sector services.

The Annual Action Plans will be managed by the Board's Business Management Group (BMG) with exception reports being provided to the full Board.

Objectives

The Board identifies core themes for these Annual Action Plans, which will evolve as work progresses.

Year 1 Initiating

In Year 1 we will engage partners and the Board's subgroups in initiating a detailed programme of work that has drawn on the experience of partners in implementing the last Strategic Plan and the changing context of Nottingham.

Year 2 Developing

In year 2 we will build on our actions in year 1 by continuing to implement change and seek assurance on safeguarding practice to promote the delivery of excellent arrangements for the safeguarding of adults who have needs for care and support.

Year 3 Consolidating and Reviewing

In Year 3 we will consolidate progress and improvements made in years 1 and 2 and develop the next strategic business plan for safeguarding adults in Nottingham City.

Moving into 2019/20 SFHT will continue to support and play an active part in the responses and developments against the NSAB strategic priorities we align these to our own internal priorities and they inform the way in which we work both as a health provider and a member of the multi-agency forums within Nottinghamshire.

Joint Nottinghamshire Health Partnership Meeting

The Named Nurse and Named Midwife for Safeguarding Children represent SFHFT at this group. The aim of this meeting is to provide a forum to discuss, share and facilitate learning and developments within local safeguarding practices, as well as to identify gaps and ways of overcoming obstacles.

Nottinghamshire MASE (Multi-Agency Sexual Exploitation) Meeting

The Named Nurse for Safeguarding Children represents SFHFT at the county MASE.

The aim of this group is to have oversight of individual young people who are on the police CAROSE list or subject to CSE strategy meetings, particularly where there is a high risk or a concern that existing plans may not be decreasing the level of risk. Where appropriate to provide scrutiny, challenge and guidance. The panel also shares intelligence and information relating to CSE activity, to inform mapping and analysing the profile of CSE in the County, generate intelligence for investigations and identify any trends or problem locations and ensure they are dealt with. This also includes oversight of known perpetrators within the County, particularly where they may be targeting multiple children.

Safeguarding Children Health and Social Care Liaison Meeting

This meeting is chaired alternatively between the Named Nurse for Safeguarding Children and Social care service manager. The aim of this meeting is to identify, discuss and resolve issues in relation to health and social care liaison across North Nottinghamshire and to develop new ways of working and to share learning, develop, support and embed best practice.

Safeguarding Adult Health and Social Care Liaison Meeting

This is a newly developed meeting which aims to identify, discuss and problem solve in relation to health and social care liaison. It will develop new ways of working and to share learning, develop, support and embed best practice.

Female Genital Mutilation (FGM) Board

The Named Midwife for Safeguarding Children is a member of the FGM Board.

Child Death Overview Panel (CDOP)

The Named Midwife for Safeguarding Children is a panel member of the CDOP.

Nottinghamshire Multi-Agency Safeguarding Hub (MASH)

The Named Nurse for Safeguarding Adults and the Named Nurse for Safeguarding Children attend the MASH Health Partnership meeting.

MARAC Steering Group

The Named Nurse Lead for Safeguarding Adults represents Sherwood Forest Hospitals NHS Foundation Trust at the Nottinghamshire MARAC steering group.

The Domestic Abuse Specialist Nurse represents the Trust at the North and South MARAC and occasionally attends the Derbyshire MARAC. Work involves close liaison with partner agencies including Domestic Abuse Police Teams and IDVA services for both Counties.

Moving forward in 2019/2020 we will continue to review how we engage with our partners and how we disseminate information/outcomes within the Trust.

7. Multi Agency & Internal Audits

SFHFT has taken part in 1 NSCB multi agency audits this year which focused on youth knife crime. The organisation had very limited involvement with the sample list for these audits.

Internal Audits

MCA/DoLS Audit

AS detailed above a bench mark audit was completed which established the baseline of MCA/DoLS across all divisions within the Trust and a development plan will be a focused intervention to embed three interlinked strands:

- Recognition of the Mental Capacity Act/ DoLS Framework as fundamental to care within the patient care pathway/ journey

- Process
- Ownership/ Sustainability

Moving forward in 2019/2020 the safeguarding team will continue to carry out a programme of audit and oversee the implementation of learning throughout the Trust.

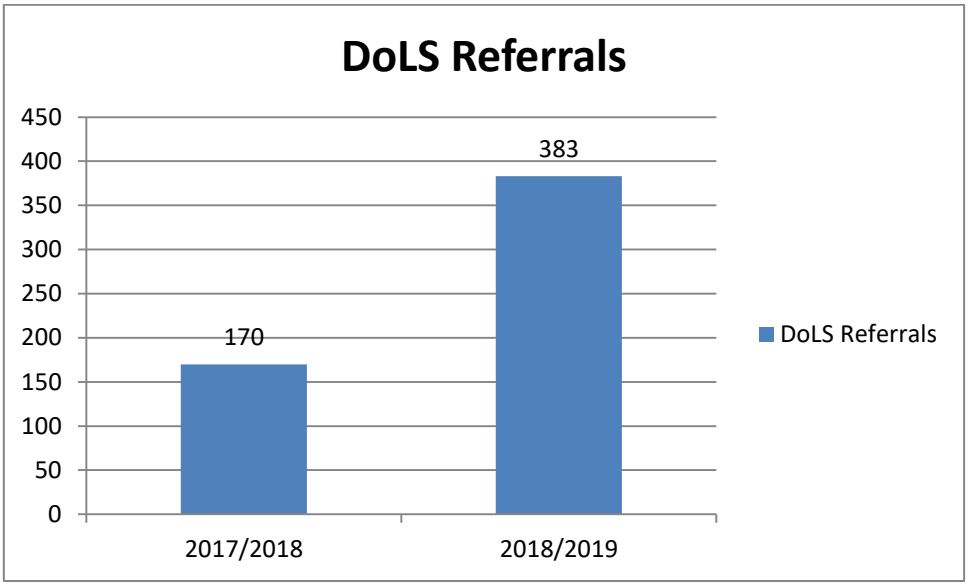
8. Divisional Activity and Progress

The data below highlights the activity we are able to evidence its relevance and responses. Moving into 2019/20 we will continue to review the data, review the evidence and information obtained and use the information to analyse what we do and what we need to develop further. This information is provided on a quarterly basis to the Patient Safety and Quality Group (PSQG) for overview and assurance.

Safeguarding Adult Referrals

	2017-2018	2018-2019
Adult Social Care Referrals	50	127
MARAC Referrals	72	109

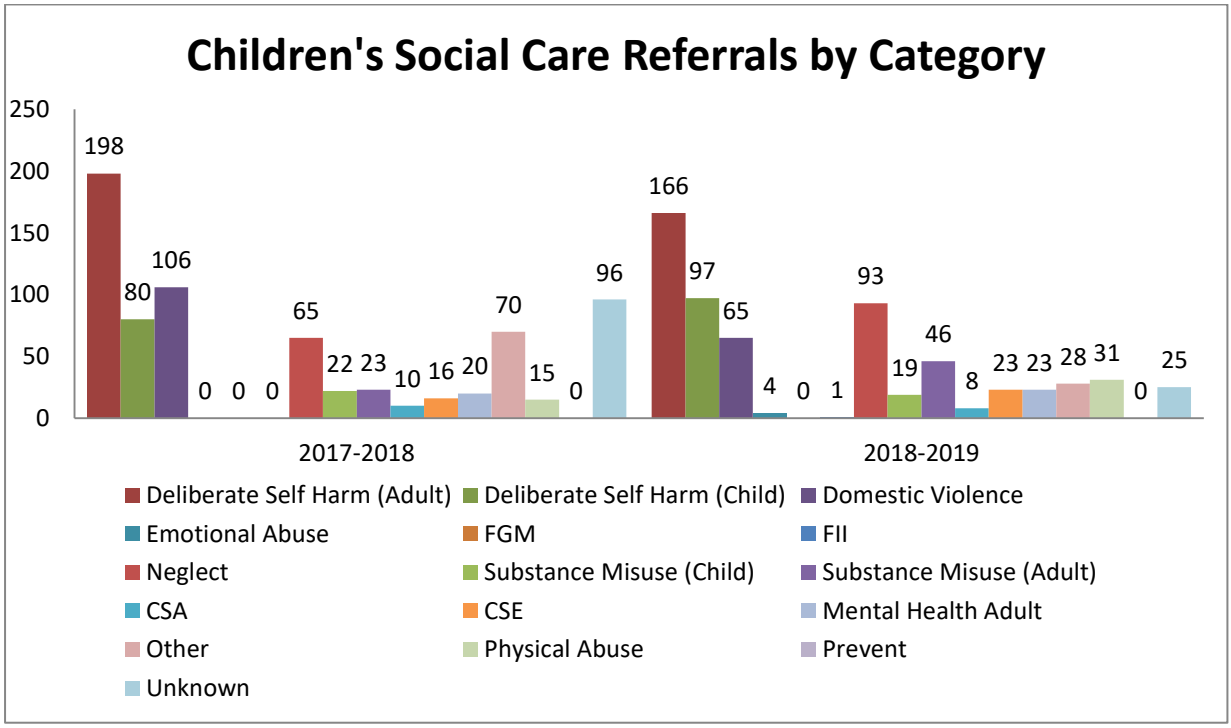
Mental Capacity Act and Deprivation of Liberty Safeguards (MCA/DOLs)



Safeguarding Children Social Care Referrals

2018/2019 has seen a decrease in referrals to children's social care being made by staff across the Trust. Through safeguarding training and supervision the safeguarding team have been working with staff around referrals; ensuring appropriate, good quality referrals are being made using the threshold pathways available. This was in response to the Nottinghamshire Safeguarding Children Board audit which identified SFH as being one organisation making a high number of referrals resulting in no further action. This work will continue to be a focus in 2019-2020.

Safeguarding Children and Young People Referrals to Children's Social Care.		
	2017 - 2018	**2018 -2019**
Total number of referrals made	721	**629↓**



Adult Deliberate self-harm remains the main reason for referral with deliberate self-harm in children and Neglect coming in second and third. This demonstrates staffs recognition of the impact parental mental health has on the child, positively reflecting the 'Think Family' model the safeguarding team have been promoting during 2018/2019.

Safeguarding Children Supervision

Safeguarding children supervision is a formal process of professional support and learning which enables practitioners to develop knowledge and competencies and assume responsibility for their own practice in a safe and supportive environment.

Safeguarding children have a robust process and policy in place for safeguarding supervision, which includes a programme of quarterly group and one to one supervision across targeted areas throughout out the Trust. The areas targeted are those where safeguarding children activity is likely to be higher, eg sexual health services, specialist paediatric nursing services, ED and Urgent Care and Midwifery. However, the safeguarding team also provides direct safeguarding supervision to ward leaders within paediatric wards/departments and to Safeguarding Children Champions across the organisation, as well as ad hoc supervision where necessary.

A Peer Review Group is run by the Named/Designated Doctors and meets monthly. The group is for paediatric medical staff to review specific safeguarding cases, and review documentation and medical reports that has been produced as part of the safeguarding process.

The Named Nurse provides quarterly safeguarding supervision for the safeguarding specialist nurse and the Named professionals receive safeguarding supervision 3 monthly via the Designated Safeguarding Professionals within the CCG.

Safeguarding Training

The safeguarding training has been developed in line with Learning and Development support; therefore, the safeguarding teams currently facilitate:

- Safeguarding level 1, 2 and 3 for both children and adults. A Mental Capacity/ Deprivation of Liberty study day is facilitated monthly.
- A Safeguarding Adults and Safeguarding Children champion's network is in place, with each department nominating Safeguarding Champions for their area. The Champions are supported by the Safeguarding Team. Specific training has been provided to give the Champions a wider base of knowledge to enable them to support staff in their area.
- All the training has been reviewed in line with National developments and also includes themes from safeguarding referrals.

The Trust target for training is **90%** compliance; however the national target is **80%.**

Mandatory Training Data Overview

Safeguarding Training Level	2017/2018	2018/2019
SGA	99%	98%
MCA Level 2	98%	98%
SGC Level 1	98%	95%
SGC Level 2	94%	94%
SGC Level 3	73%	94%
Prevent (Basic Awareness)	63%	97%
Prevent WRAP	90%	97%

Non Mandatory Training

Activity	2017-2018	2018-2019
DV Training	50	369 - Full Day 225 - Half Day
MCA Full day	175	486

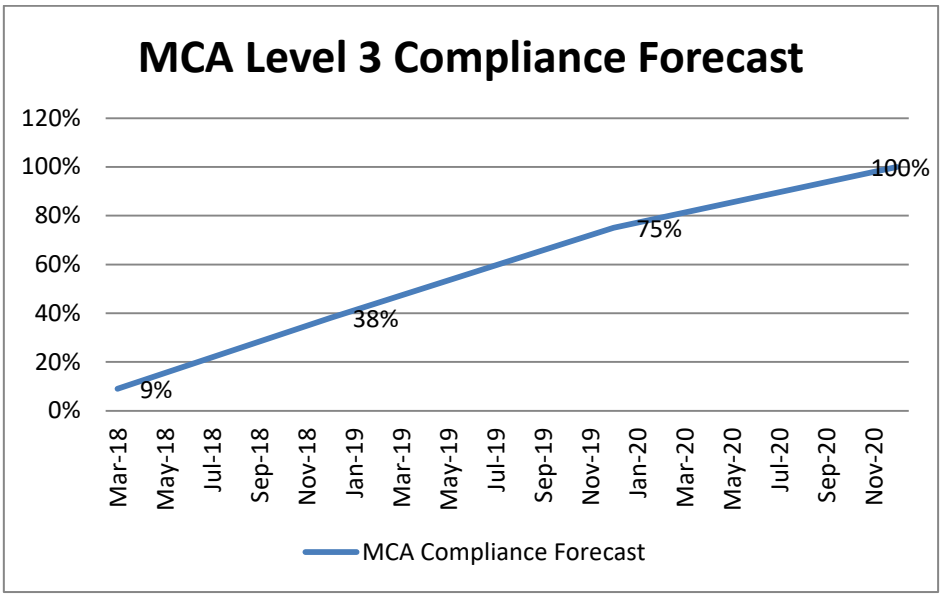
(NB. Figures relate to number of attendees)

Domestic Abuse Training

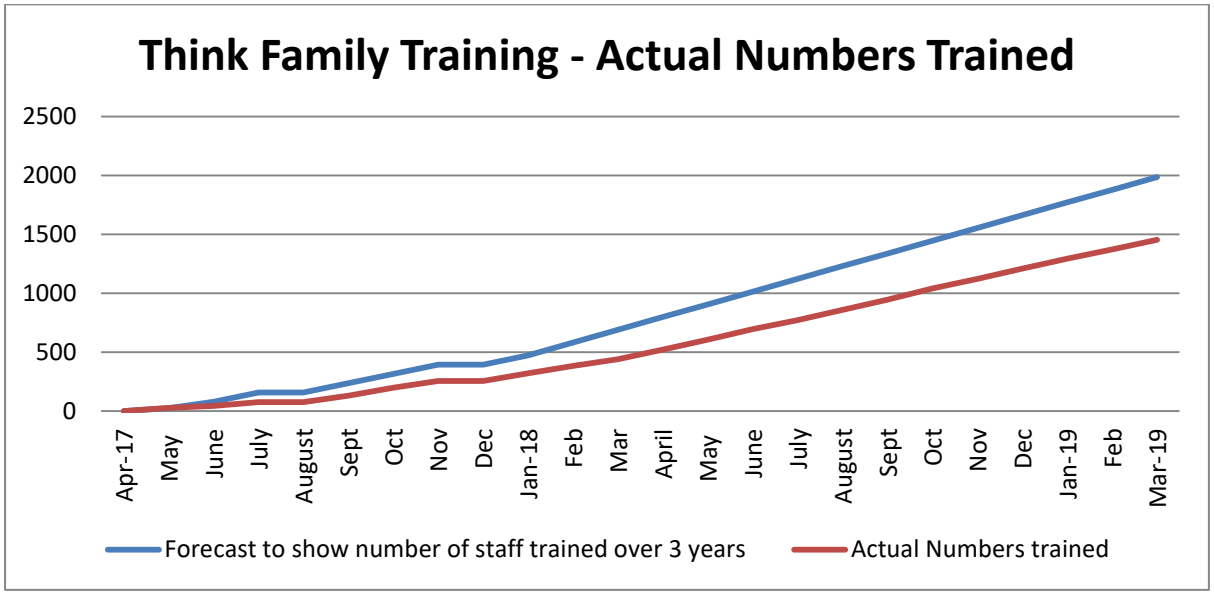
There has been a significant increase in the number of staff attending domestic abuse training. Support the Trusts assurance to the NICE quality standard 116 for recognising and responding to domestic violence and abuse, 2018-19 saw the introduction of focused training to embed responses to disclosures or suspicions of domestic abuse for adults and/or children and to improve assessment of risk. This training consists of a full day Domestic Abuse training alongside a half day DASH assessment training event delivered by Womens Aid. As a direct correlation of the domestic abuse training and Think Family safeguarding training the safeguarding team have received requests for support for staff experiencing domestic abuse and/or stalking.

Mental Capacity Act (MCA) Level 3 Study Day

This training is a full day's scenario based training which is offered to staff giving them the opportunity to practice the application of Mental Capacity Act and Deprivation of Liberty.



A total of 1829 staff across the Trust requires level 3 MCA training. The trajectory above shows the numbers to be trained over the next 3 years based on 12 sessions per year with 54 spaces on each day. So far 486 staff have gained the MCA level 3 competency by either attending the day or completing e-learning. During the event staff are asked to identify enablers and barriers in working with MCA/DoLS. Below are some examples of feedback received:



Summary

Think Family Training

2017/18 saw the development of the 'Think Family' training programme. This full day event incorporates both adult and children safeguarding competencies set out by the intercollegiate standards. This emphasises and further embeds the 'Think Family' safeguarding approach throughout the Trust. This day equates to level 3 Safeguarding competencies for all staff who work with adults and children or both.

A total of 2500 staff across the Trust requires level 3 'Think Family' safeguarding training. The actual numbers of staff trained are lower than the predicted trajectory during 2018/2019. This has been a consistent picture since the initial implementation of the Think Family Training in April 2017. This has predominantly been due to staff not attending booked sessions. The safeguarding team have addressed this issue by overbooking on sessions providing an additional 5 to 10 spaces per event and reporting non-attendance to senior divisional leads.

Evaluation of the Think Family training sessions have on the most part been very positive, below are some examples of comments received:

"Very informative and well presented"

"Great course – very informative with lots of practical elements. The local anecdotes and videos were interesting. The case studies put our new knowledge to the test…"

"Well presented and informative. I feel more confident should the need arise to report safeguarding issues"

Throughout the training event staff are asked to identify enablers and barriers to safeguarding, the idea behind this was to identify areas front line staff find helpful and supports them to safeguarding the patients/clients they work with, as well as those areas which they find hinders or prevents them from safeguarding. Some of the feedback was as follows:

ENABLERS

BARRIERS

PREVENT

Prevent is part of the Governments counter-terrorism strategy known as CONTEST. Raising awareness of the health sectors contribution to the Prevent strategy is crucial as we are best placed to identify individuals who may be groomed into terrorist activity. All clinical staff within the Trust are required to attend PREVENT WRAP (Workshop to Raise Awareness of Prevent) training, this is being provided through induction for new starters to the organisation and through Mandatory

training for existing staff across the Trust, this is a one off face to face session and thereafter staff are required to undertake a yearly update which is achieved through a on online eLearning training package. Non clinical staff are required to undertake Prevent Basic Awareness training; competency is gained from completing the online Channel course 3 yearly.

During 2018/2019 the organisation reached 97% compliance with Prevent WRAP training, with work planned to reach 100% compliance during 2019/2020. To maintain these high rates Prevent WRAP forms part of the New Safeguarding Think Family Induction training which started at the beginning of year. This means all new staff to the Trust will gain compliance immediately from induction. For existing staff updates will be provided yearly via the Trust Mandatory training programme.

Compliance for Prevent basic awareness has also reached 97% during 2018/19. Basic awareness is delivered through mandatory training via ELearning.

Safeguarding Children Level 1

Training is completed using POD Cast and E-Learning delivery through induction and mandatory training programmes. Compliance has fallen slightly during 2018/2019 but remains above the Trust target rate.

Safeguarding Children Level 2

Training is a component of mandatory update training which consists of a face to face 40 minutes session. Compliance at this level has remained consist from 2017/18 at 94%.

Safeguarding Children Level 3

Safeguarding Children training compliance at this level has continued to be a challenge during 2018 - 2019, however there has been an increase in compliance quarter upon quarter and has reached above Trust target rate for the first time at 94%, with further work planned to increase this further during 2019-2020. This is reflective of the hard work undertaken by the safeguarding team in supporting the divisions to achieve compliance.

Children in care service

SFHFT provides the initial health assessments for Looked After Children including Children with an adoption plan. These assessments are statutory and timescales are reportable. The 2 person clinical team see approximately 160 CYP per year including unaccompanied asylum seekers (UASC), children placed from other areas (OLAC) in Nottinghamshire and hold responsibility for Nottinghamshire children placed in other local authority areas (OOA). Within the service there is also a Named Dr for children in care to support the Trust and medical advisor for adoption. The team works with partner agencies in social care and other children in care health teams (NUH and NHCT). One of the consultants also holds the post of Designated Dr for children in care (mid Notts) working with the CCGs across County.

Current issues are the provision of timely assessments and a vacant second post for medical advisor for adoption. Monitoring and recruitment is in the work plan but we have been unsuccessful recruiting to community paediatric consultant posts so capacity remains an issue. We are in the process of establishing a robust internal reporting process for Women & Children Division and

Safeguarding executive and externally to NSCP and Designated professionals/CCG. We are completing a project funded by NHSE to create and use a database for reporting on health and health assessments of children in care. Quality measures and audit, creation of local pathways and continued liaison and raising awareness/training about children in care remains an ongoing work plan.

9. Learning Disability

2018 – 2019 has been a positive year for the learning disability service provision with winning the Trusts Kate Granger Award for Respectful and Caring, the Chairs Award, HSJ Award and shortlisted for the patient safety awards.

Work continues to reduce the amount of discrepancies between GP flags and our Trusts flagging and we have doubled the amount known to medway during this period.

Incident rates remain similar to previous years, although with the amount of training, awareness and increase in flagging, the correlation of these needs to be considered.

NHS improvement has remained heavily involved in our work stream, with requests being made of our support for other Trusts and the improvement standard launch. Similarly, NHS England maternity and sepsis networks have been keen to share our work.

The LD champion network continues to grow following the successful training in October 2018 with a total of 26 champions across the organisation.

LD Referrals

There have been a total of 315 referrals in the last year **an increase of 114**. Referral sources remain the same and remain to have commonality as in the previous report i.e.

- Help to support the hospital staff in recognising the Learning Disability issues, and helping to support community staff in understanding the medical/nursing care of the individual (support people to work together).
- Support with Mental Capacity issues – support assessment, help to plan best interests, support regarding Deprivation of liberty.
- To support regarding problems with discharge for patients.
- To recommend and support 'reasonable adjustments' for individuals in outpatients clinic and inpatient basis.
- To give patient emotional support during appointments

Learning Disability service user involvement.

Service user involvement remains pivotal in the development of the LD service. The local day service has supported with the development of 3 nationally released sepsis videos and continues to give regular feedback on any innovations had by the Learning Disability Specialist Nurse.

NHS improvement commissioned a quality check of the service and the report was outstanding.

West Notts College has supported the making of a soft signs of deterioration video for national dissemination.

LeDer

SFH has seen 13 deaths during 2018-2019 which are undergoing review. LeDer reviews remain delayed in respect of completion timescales.. NHS England has given the CCG's £26000 to reduce the amount of outstanding reviews.

9. Dementia

In the Prime Minister's Challenge on Dementia 2020 (Department of Health, 2015), David Cameron said that by 2020 he wanted England to be the best country in the world for dementia care and support, and for people with dementia, their carer's and families to live.

During 2018/19 the Trust worked towards embedding the principles of the dementia strategy launched in August 2017. This work was supported by the Dementia Steering Group. The key functions were oversight of the strategy core principles of:

- diagnosis
- person-centred care
- patient and carer information and support
- workforce education and training
- leadership
- environment
- nutrition and hydration

These are aligned to the Dementia Assessment and Improvement Framework (NHS Improvement, October 2017)

All staff who join the Trust receive a dementia awareness session (Tier 1) on orientation day that takes place fortnightly. Nurses, Allied Health Professionals (AHPs) and Health Care Assistants (HCAs) also receive a dementia focused session on induction 'Through a patient's eyes'. Staff who have regular contact with people who are living with dementia should receive Tier 2 training and a study day is held each month to enable staff to achieve this. We are required to report training statistics bi-annually to Health Education East Midlands.

Sherwood Forest Hospitals NHS Foundation Trust supports to the John's campaign. This focuses on allowing flexible visiting for the carers of patients living with dementia and other long term conditions, and carers receive a passport to support this. This is our pledge:

'Sherwood Forest Hospitals pledges our support to John's campaign. We are committed to providing support for people with dementia and long term conditions. We recognise that carers have a

valuable role in the reassurance and dignity of patients and we are proud to offer open visiting for them.'

The monthly dementia return focusses on the FIND, ASSESS/INVESTIGATE, and REFER (FAIR) care pathway that was a CQUIN between 2012 and 2016. We are required to submit statistics on this monthly and during 2018/19 we have consistently maintained compliance with the national data requirements of over 90% of each element of the assessment pathway. At present this data set is collated manually but moving into 2019/20 it is hoped this will be achieved via a nerve centre module.

Moving into 2019/20

The end of this year saw the dementia nurse post become vacant; we aim to recruit a new post holder in early 2019.

The post will be refined to ensure focus on patient care with revisions to the functions to a minimum of 50% patient facing.

We will undertake a 'stock take' of the needs of the patients with dementia who access our services and benchmark requirements drawn out via a needs analysis and service provision assessment. This will form a bench mark for the new post holder.

We embed our service provision with the support of our dementia champions who are very keen to ensure the best interest of our patients at all times.

We will work with the Integrated Care Services to ensure transition and support between primary and secondary care is smooth and effective, to support the patients and their families/carers.

11. Mental Health

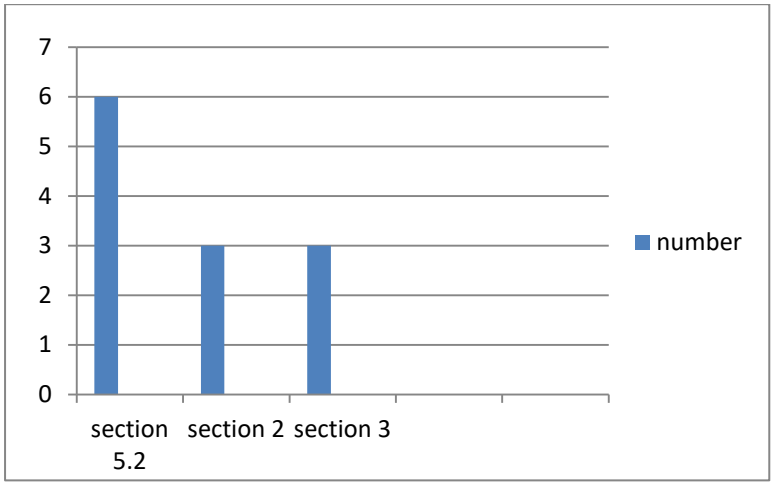
January 2018 saw the appointment of a Mental Health Think Family Specialist Nurse. The post was initially a secondment for 2 years but with the success of the post, this was made permanent in July 2018. The initial post holder left the team in December 2018 and we recruited a new post holder in February 2019.

The previous post holder began work on developing the awareness of mental health needs within the Trust, linking with our partners and strengthening our links to ensure that patients with mental illness received a robust package of care. The post holder began work on strengthening the Trust awareness of their statutory responsibilities in relation to the Mental Health Act.

This was supported by a 360 audit around mental health in June 2018 and the subsequent report which was received in December 2018. The audit identified a number of gaps thereby providing limited assurance.

In respect of such detentions, the table below indicates the number of detentions under the key parts of the Act

Number of patients detained under each section of Mental Health Act during 2018/19:



The new post holder spent initial time looking at closing down requirements that had evolved through the year as a priority

These included

- Revisions to the Mental Health Act Policy – this has been revised and circulated for ratification by the Safeguarding Steering group in May 2019
- Completion of the Service Level Agreement with Nottinghamshire Healthcare re administration of the Mental Health Act paperwork – this has been completed subject to sign off by Nottinghamshire Healthcare
- A check list for staff when receiving a patient under the care of the Mental Health Act – this has been completed
- Updating action plans in relation to the 360 Assurance audit of the Mental Health Act
- Updating action plans in relation to the CQC inspection

Application of the Mental Health Act is likely to be reviewed again by 360 Assurance during 2019. The changes to the Mental Health Act policy should allow for a more positive outcome, subject to the Policy being implemented appropriately. To support this a training package on how to deal with this has been created and is being rolled out to senior managers

The relationship with the Rapid response Liaison Psychiatry Team has had a positive end to the year. This service is provided through partnership with Nottinghamshire Healthcare to provide the clinical input to patients presenting with potential issues of mental ill health. Whist this was a little strained early in the year due to staffing difficulties within that team, these issues have been resolved and there is very positive interface on a virtually daily between RRLP and the Mental Health Specialist Nurse. The work being undertaken has proven to be valuable but at the current time RRLP have declined to share measurable data regarding this. They do state that it is shared formally with the Trust through other means

In terms of educating staff around issues pertaining to mental health, the primary means of achieving this has been through a teaching session provided by RRLP. This is considered to be a very useful presentation, particularly as given by those responsible for delivering key initial interventions alongside SFHFT staff. During the year 70 staff accessed the Mental Health Awareness training

To create a clear plan for developments around the mental health agenda during 2019/20, a brief Mental Health Strategy has been drafted, in keeping with the themes contained within the Trustwide Strategy – Healthier Communities, Outstanding Care. It is intended that this will be agreed as a framework for prioritising areas of focus for the coming year

We will

- Create and deliver a staged, effective and measurable Mental Health Strategy commensurate with the broader Trust strategy
- Implement the revised Mental Health Act policy and consistently quality check any implementation
- Work with colleagues to create a plan that will enable greater support for staff well being
- Deliver training around mental health awareness and utilisation of the Mental Health Act for senior managers
- Forge stronger links with our partners in respect of care for patients with Mental Health problems
- Positively engage with a re-audit of Mental Health Act application with 360 Assurance
- Work closely with Nottinghamshire Healthcare to evaluate the effectiveness of the SLA re the MHA
- Measure the success of the liaison psychiatry service in achieving its objectives
- Pursue the required improvements to the access to CAMHS or other supporting services for children and young people
- Consider specific practice and policy interventions to support staff dealing with patients, commencing with the issue of self harm
- Review the best way to support staff regarding knowledge of mental health issues, to include formal teaching and more informal mentoring and supervision

12. Conclusion

The integrated safeguarding team has continued to progress the safeguarding agenda significantly within the Trust during 2018/19. The 'Think Family' approach ensures that safeguarding is everyone's business and the impact on adults, children and families is clearly understood by all staff groups to identify and respond to concerns/disclosures in line with legislative and professional responsibilities.

Work to embed the Mental Capacity Act/Deprivation of Liberty Safeguards into clinical practice will continue, as will promoting a culture of 'Making Safeguarding Personal' and ensuring the 'Voice of the Child' is heard within care delivery at Sherwood Forest Hospitals.

13. Priorities for 2019/2020

In acknowledging the work that has already taken place and seeks to strengthen our approach to 2019-2020. The integrated safeguarding team have set targets alongside the Strategic objectives of the Trust, these will be:

To provide outstanding care

- Development of a Think Family audit plan, which will focus on being able to bench mark safeguarding standards set out in the Markers of Good practice and SAAF and be responsive to the priorities as set out by the NSAB and NSCB.

To Promote and support health and wellbeing

- Safeguarding priorities during 2019/2020 will continue to ensure where there are safeguarding concerns adults, children and carers are recognised as partners in the outcomes they wish to happen. This will focus around Making Safeguarding Personal, Voice of the Child and views of fathers.
- Further develop partnership working with Nottinghamshire Womens Aid to deliver a hospital Independent Domestic Violence Advocate (IDVA) model of recognising and responding to domestic abuse.
- Further develop and embed the 'Think Family' ethos throughout the organisation

To maximise the potential of our workforce

- Work will continue to be developed around safeguarding supervision**.**
- Support senior level staff around safeguarding and mental health processes out of hours**.**
- Focus during 2019/2020 on how as an organisation SFHFT supports the health and wellbeing of its workforce particularly in relation to domestic abuse and mental health.

To continually learn and improve to achieve better value.

- Further develop Lessons Learnt through Mandatory Training.
- Delivery of Modern Slavery training to Human Resource and Procurement department.