West Hertfordshire Hospitals NHS
NHS Trust

TRUST BOARD MEETING
1 October 2015

Title of Paper:	**Safeguarding Annual Report 2014 - 2015**
Agenda Item:	**13/30**
Lead Executive:	**Tracey Carter, Chief Nurse & Director of Infection Prevention and Control**
Author:	**Michelle Mulvaney Named Nurse Safeguarding Children** **Dawn Bailey Named Nurse Safeguarding Adults** **Maxine Mcvey Deputy Director of Nursing** **Dawn Stevenson Named Midwife for Safeguarding** **Tammy Angel Consultant** **Wendy Brophy Clinical Nurse Specialist Dementia**
Trust Objective:	Tick as appropriate: ☒Achieving continuous improvement in the quality of patient care that we provide and the delivery of service performance across all areas; ☐Setting out our future clinical strategy through clinical leadership in partnership and with whole system working; ☐Creating a clear and credible long term financial strategy.
Purpose:	This paper is to provide a report to the Trust Board about Safeguarding practice and activity across the Trust for the period between May 2014 to May 2015

Please add which panel and/group that the paper has been previously discussed:

	Panel	**Group/Committee**
Name/Date:	Safeguarding Panel 11th September 2015	Quality & Safety Group 17th August 2015
		Safety & Quality Committee 22nd September 2015

Benefits to patients and patient safety implications
Safe and effective processes and procedures are in place to ensure patients accessing services across the Trust are effectively safeguarded

Risk implications for the Trust	**Mitigations actions (controls)**
Failure to comply with Section 11 of the Children Act; Adult assurance framework. Increased awareness of adult safeguarding resulting in increased workload. Requirement to reach a training target of 95%	Full establishment of safeguarding personnel in place at the time of writing the report. Training strategy is in place and training established on the mandatory training matrix

Links to Board Assurance Framework, CQC outcomes, statutory requirements
CQC Regulation 13 : Safeguarding service users from abuse and improper treatment
CQC Regulation 12 : Safe care and treatment
Section 11 Children Act 2004
Working Together to safeguard Children 2015
Care Act 2014
Mental Capacity Act 2007
Deprivation of Liberty Safeguards 2009

Legal implications (if applicable)
See above – statutory requirements.

Financial implications (if applicable)

Recommendations (delete as appropriate)
For information and assurance - this item has been thoroughly discussed by a group and should not need significant review/debate

Agenda Item: 12/30

Trust Board Meeting - 1 October 2015

Annual report on safeguarding

Presented by: Tracey Carter, Chief Nurse and Director of Infection Prevention and Control

Executive Summary

This report gives an account of safeguarding activity across West Hertfordshire NHS Hospital Trust (WHHT). The annual report demonstrates the organisations commitment to protecting children and young people and vulnerable adults at risk from harm across all age ranges and service areas. The focus has been on integrating the adult, children and maternity safeguarding team and the clinical governance process across WHHT.

Key developments within this annual report include:

- Ensuring the right infrastructure and processes are in place and re-establishing the safeguarding team of named professional leads.

- To embed the programmes for deprivation of liberty safeguards (DoLs), Mental Capacity Act (MCA) and Female Genital Mutilation (FGM) into our safeguarding education and training programmes.

- Safeguarding training requirements across WHHT have been reviewed and changes to training delivery made. The Safeguarding Adults, Children and Young People Education and Training Strategy was approved and launched across the Trust to provide a blueprint for the training requirements for each staff member across WHHT.

- A focus on obtaining training rates to 95% and ensuring all volunteers have safeguarding training.

- Safeguarding audit strategy was expanded to include adults for assurance evidence.

- The development and reviewing of Trust wide Safeguarding Policies and Training.
- Female Genital Mutilation
- VIP Policy
- Chaperone Policy
- Surrogacy Policy
- Domestic Abuse
- Raising Concerns
- Policy for safeguarding children
- DoLs

- External reviews have focused the adult safeguarding team to focus on Mental Capacity Assessments and documentation of Best Interests.

- To embed Kate Lampard's Themes and Lessons Learnt report from NHS investigations into matters relating to Jimmy Savile (February 2015)

- All Staff in the Trust have been checked to ensure they have the appropriate DBS clearance.

Future priorities for the period May 2015 to May 2016 include:

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- To work in partnership with local agencies to progress both the Adult and Safeguarding Boards business plans and joint inspection recommendations on safeguarding.

- Work with the Trust Informatics Service to develop secure information sharing systems to support transfer of patient identifiable information with partner agencies.

- Strengthened the *Think Family* delivery to improve outcomes for children and families, through the development and implementation of a Trust wide action plan.

- Greater involvement of the Trust safeguarding team within sub groups of the HSCB and the HSAB

- Prevent included within safeguarding training and 'Healthwrap' training rolled out across the trust

- Continued work to increase staff knowledge around mental capacity and deprivation of liberty safeguards

- Ensure trust is compliant with mandatory statistical recording of FGM and ensure consideration of safeguarding for all cases

- Raise awareness of CSE across all areas of Trust particularly within unscheduled care and paediatrics

- Review and update the Safeguarding Children Supervision Strategy

- Establish database to record adult SIs to enable analysis and thematic reviews

- To progress the Safeguarding Audit Strategy

Contents Page

July 2015

Safeguarding Children and Adults Annual Report 2014 - 2015

Presented by: Tracey Carter Chief Nurse & DIPC

1. Introduction

West Herts Hospitals NHS Trust understands and acknowledges that safeguarding children and adults is everybody's business and that everyone working in health care has a responsibility to help prevent abuse and to act quickly and proportionately to protect children and adults where abuse is suspected. Safeguarding is a fundamental component of all care provided within the Trust. The purpose of this Annual Report is to provide an overview of Safeguarding activity across the Trust in the last 12 months (May 2014 – May 2015). This incorporates the work of the named safeguarding teams. These Teams are supported by the divisions within the Trust through membership of the safeguarding panel. In addition this report will provide assurance that the Trust meets its statutory responsibilities in relation to safeguarding children and young people and vulnerable adults at risk from harm across all age ranges and service areas.

2. Background

Safeguarding continues to have a high national priority. There is now even greater scrutiny of the way in which organisations carry out their safeguarding responsibilities. The final Lampard report investigating Jimmy Saville was published in 2015 making recommendations for NHS providers to consider which ensures patients and visitors are safeguarded. The Casey Report 2015 that investigated Child Sexual Exploitation in Rotherham highlighted substantial concerns about how the Council and local organisations dealt with significant and sustained sexual exploitation of young people living in the area over a number of years. The Francis Report (2013) and the Winterbourne View Report (2012) continue to have a significant impact on how vulnerable adults are treated within health care settings. The Care Act 2014 came into force this year in April which reforms the law relating to care and support for adults and support for carers. It clearly defines health providers' responsibility to make provision for safeguarding adults from abuse or neglect. Failure to ensure effective safeguarding within NHS funded services carries significant risk to patients and service users, providers and commissioners alike.

All health providers are required to have effective arrangements in place to safeguard vulnerable children and adults at risk and to assure themselves, regulators and their commissioners that these are working.

These arrangements include safer recruitment, effective training of all staff, effective supervision arrangements, working in partnership with other agencies and identification of a Named Doctor, Named Nurse, Named Midwife and named lead for MCA/DoLs.

The requirement of Acute Trusts to safeguard and promote the welfare of children as set out in section 11 of the Children Act 2004 and Working Together (2015) are monitored by the Care Quality Commission (CQC) NHS England and the Clinical Commissioning Groups (CCG).

Ultimately the Trust Board requires assurance that the Organisation is fulfilling its obligations to make arrangements to safeguard and promote the welfare of children and vulnerable adults. The Trust remains compliant with Section 11 of the Children Act. The Trust is committed to developing a joined up approach to safeguarding all our patients whatever their age.

All providers of health services are required to be registered with the Care Quality Commission (CQC). In order to be registered, providers must ensure that those who use the services are safeguarded and that staff are suitably skilled and supported
In April 2015 the Care Quality Commission changed their regulation framework. Two regulations are now specific to safeguarding within the Trust:

Regulation 12: Safe Care and Treatment.
Regulation 13: Safeguarding service users from abuse and improper treatment.

3. Safeguarding Strategic Work plan

A safeguarding strategic work plan underpinned by the Trusts core values and the 6 Cs has been developed for the period 2014 – 2016. This is contained in Appendix 1. The strategy will ensure the Trust drives forward the safeguarding agenda across the organisation. It details progress against a number of strategic objectives. Actions from audits and external reviews are added to this document.
The work plan is monitored, reviewed and challenged by the Safeguarding Panel.

4. Overview of National Safeguarding Policy/Legislation Changes during 2014-15

During the reporting period, several significant reports have emerged nationally and new legislation has come into force. These have all had an impact on the safeguarding agenda.

4.1 Lampard Report (2015) in response to Jimmy Savile

In the Lampard report the themes from 28 NHS Trust investigations related to Savile were analysed and themes with recommendations made for the NHS.

The Safeguarding Team have produced a report for the Trust in response to Lampard including a gap analysis. Risks identified for the trust include,

- Ensuring the VIP policy is used across the Trust
- Training figures in the Trust are not at the 95% for both adult and children safeguarding
- Volunteer Manager and regulation of volunteers to be monitored.
- DBS checks for all staff are not at the recommended 3 yearly interval recommended by Lampard

- Safe use of social media
- Sub contractor staff employment process to be aligned with Trust safe recruitment process.

An action plan is in place and incorporated into the Trust strategic work plan. which is monitored by the safeguarding panel and reported to the Patient Safety Quality and Risk subcommittee of the Trust Board.

4.2 Working Together 2015

In January 2015 the Department for Education undertook a consultation process regarding proposed changes to Working Together 2013. Following consultation, the new Working Together statutory guidance was released on 26 March 2015. Although not a major rewrite, the new guidance took into account recent legislation changes and made changes to some definitions. The Named Nurse for Safeguarding Children reviewed the guidance. A plan was produced to ensure the Trust is compliant with the changes in the guidance and is monitored via the safeguarding panel. Changes include ensuring that all agencies have whistle blowing procedures and have clear policies on allegations of abuse against a staff member

4.3 Jay and Casey Reports into Child Sexual Exploitation (CSE) in Rotherham

The above reports examined the child sexual exploitation (CSE) that occurred in Rotherham since 1997. Professor Jay's independent inquiry into CSE estimated that 1400 children were sexually exploited over the inquiry period of the report. This was felt to be a conservative estimate. Casey's subsequent report revealed past and present failures to accept understand and combat the issue of CSE, resulting in a lack of support for victims and insufficient action against known perpetrators. The reports recognised the significant difficulties in dealing with CSE. It requires spotting the signs, helping young people to recognise their experience as abuse and getting them to trust public services instead of their abusers, often in the face of serious threats.

Within the Trust, work around CSE had been predominantly based within contraceptive and sexual health services. This work had involved staff training by Operation Halo (Hertfordshire's CSE police team) and work around developing and utilising a CSE proforma which was used for all under 16s attending sexual health services. During the reporting period, the commissioning arrangements for Sexual Health Services changed, which resulted in the Service leaving the Trust.

Due to the impact of the Casey report and subsequent Serious Case Reviews within Oxford, awareness of CSE needs to be raised across the whole Trust. CSE awareness is now included in all Levels of safeguarding children training. The CSE proforma has been adapted and is to be launched in our unscheduled care settings to assist staff in recognising potential concerns. The Named Nurse for Safeguarding Children now sits on the Strategic Safeguarding Adolescent Group, a sub group from the HSCB (Hertfordshire Safeguarding Children Board).

4.4 The Care Act 2014

The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect. This Act replaces the "No Secrets" guidance. The safeguarding duties apply to an adult who has need for care and support, is experiencing or is at risk of abuse and neglect and as a result of those care and

support needs is unable to protect themselves from either the risk or the experience of abuse and neglect. Safeguarding is about people and organisations working together to promote the persons well being. The Care Act states that local authorities must:

- Make enquiries or cause others to, if it believes and adult is at risk or is experiencing abuse and neglect. The aim of adult safeguarding is to stop abuse/neglect where possible, prevent /reduce the risk, raise awareness, provide information and support.

- Set up a safeguarding adults board (HSAB).This is now a statutory requirement. The trust is represented by the Chief nurse and board papers are circulated to the safeguarding team

- Arrange for an Independent Advocate to represent and support the adult who is subject to a safeguarding enquiry. The Trust has used Powher to provide Independent Mental Capacity Advocates (IMCA) for those that have no other suitable person.

- Co-operate with partners in order to protect adults at risk. The safeguarding team has worked in partnership with social services, police, and housing departments, attended MARAC meetings and worked with other Trusts.

Safeguarding adult boards must arrange a Safeguarding Adults Review (SAR) when an adult in its area has died as a result of abuse or neglect, whether known or suspected and there is a concern that partner agencies could have worked more effectively to protect the adult. The named nurse for safeguarding adults is part of Safeguarding Adults Review panel. There are currently two cases that are being investigated.

4.5 Confidential enquiry into premature deaths of people with Learning disabilities (CIPOLD)

Mencap published a paper: death by indifference which described the circumstances surrounding the death of six people with learning disabilities who died while they were in the care of the NHS, exposing institution discrimination. The Confidential Inquiry into Deaths with Learning Disabilities (CIPOLD) was tasked with investigating the avoidable or premature deaths of people with learning disabilities through a series of reviews. The aim was to review patterns of care that people received in the period leading up to their death, identify errors or omissions contributing to these deaths. Areas of good practice were also identified to improve evidence of avoiding premature death. The report concluded that the quality and effectiveness of health and social care given to people with learning disabilities has been shown to be deficient in a number of ways. The study has shown the continuing need to identify people with learning disabilities in a health care setting and to record, implement and audit the revision of reasonable adjustments to avoid disadvantages. People in the report had a range of complex needs that were fragmented and communication between agencies required improvement.

Following the death of a 21 year old patient who had learning disabilities in West Hertfordshire Hospital Trust a Serious Incident investigation was commenced as a result of his unexpected death. An independent investigation was commissioned by the Chief Executive. This was carried out by Christina Edwards. Recommendations from her investigation were to arrange a learning disability conference within Hertfordshire with the purpose of increasing knowledge and awareness, improving relationships/communication between the community and the acute Trusts. This took place on 10th March. As a result a

multiagency plan has been agreed. These actions have been added to the Learning disability sub group action plan and are presented and monitored at the safeguarding panel.

5. Safeguarding Leadership and Accountability

The Chief Nurse is the Trust Executive Lead with responsibility for safeguarding within the trust. She takes responsibility for governance, systems and maintaining organisational focus on safeguarding.

Appendix 2 shows the current reporting structure and accountability for the safeguarding team.

The Safeguarding Panel is chaired by the Chief Nurse and meets bi monthly. The panel oversees all safeguarding work across the Trust. The panel is attended by the safeguarding team, divisional Head Nurses/Midwifery and members of the designated teams within the CCG. The panel reports safeguarding activity and provides assurance to the Quality and Safety Group within the Trust.

During the reporting year, the Head of Safeguarding (incorporating the Named Nurse for Safeguarding Children) resigned. The Safeguarding adult nurse also retired during this period and the Named Midwife resigned. The Named Nurse, Named Midwife and Lead Nurse for Safeguarding Adults posts have been undertaken by experienced staff on secondments.

Following unsuccessful attempts to recruit into the post of Head of Safeguarding, it was decided to restructure the post and revert to a Named Nurse for Safeguarding Children. Following successful recruitment, both the Named Nurse for children and the Lead Nurse for safeguarding adults are now substantive post holders.

The safeguarding team within maternity is being restructured to develop a team for vulnerable women. During the reporting year, a Complex Needs Midwife was recruited into post working with the Named Midwife.

The Trust has experienced Named Doctors for children and adults in post.

The Named Professionals have a key role in promoting good professional practice within the Trust providing advice and expertise for fellow professionals and undertake duties to safeguard children and adults in line with guidance and legislation (Working Together 2015 and the Social Care Act 2014).

The job descriptions and personal specifications for the Named professionals for children are complete and are aligned to the Intercollegiate Document (2014).

The Named professionals have a key role in ensuring a safeguarding training strategy is in place and is delivered across the organisation. They also lead on the safeguarding audit strategy, carrying out regular audits looking at process and outcomes.

6. Inspections and reviews

6.1 CQC visit November 2014

In November 2014 the Trust had an unannounced visit from the Care Quality Commission (CQC). During the inspection concerns were raised by the CQC in relation to the Trust's process surrounding the application of the Mental Capacity Act and ensuring adherence to Deprivation of Liberty Safeguards (MCA/DOLS).The Trust required assurance that MCA /DOLS best practice was being adhered to. Therefore detailed audits were carried out which included the process of consenting patients and the documentation of mental capacity within the patients records. A retrospective and prospective DOLS audit was carried out.

Recommendations from these audits included reviewing policies, mental capacity assessments becoming part of matron quality checks and regular audits to monitor progress, including MCA paperwork within pre op assessment records and providing pre printed consent forms. Action plans were completed and shared with Divisions. Progress is monitored with compliance at the Safeguarding Panel and is part of the Improvement plan in the Trust.

6.2 External review of safeguarding policies, procedures and assurance (peer review)

Following the unannounced CQC visit in November 2014, a peer review and inspection was arranged to provide the Trust with assurance that safeguarding policies, processes and procedures were safe and fit for purpose. The visit was carried out by a Chief Nurse with significant safeguarding experience and her safeguarding lead. The review found that robust policies are in place to safeguard vulnerable adults and children, that appropriate Named Professionals are in post to provide expert advice and that an audit programme is in place to ensure that clinical practice is in line with the expected standards. Recommendations were made around improving policies and this has been completed. Training rates are monitored through learning and development and reviewed at the Safeguarding panel..

6.3 Arrangements to safeguard children under Section 11 of the Children's Act 2004

A Section 11 visit was carried out in March 2015 to the Trust to ensure compliance with our responsibilities under the Children's Act, to safeguard children. The visit was carried out by a Chief Nurse in the CCG and the Deputy Designated Nurse for Safeguarding Children. The audit tool was completed by the Named Nurse and covered all safeguarding children activity within the Trust.

Findings from the audit included

- The Trust has robust systems and processes in place to identify risks and to identify children who DNA appointments.
- The Named Nurse position has been filled as a secondment post, the substantive post is currently out for advert.
- Named Doctor's PA's have not been increased, the Trust and the Named Doctor feel the current PA's are sufficient and the Named Doctor is able to fulfil his duties within the PA's.

- The safeguarding team is reviewing the safeguarding children policies to include FGM, Surrogacy and Chaperone policies.
- The safeguarding team has a good working relationship with the Trust's division leads.

Areas of good practice were highlighted, including the following

- The Trust has clear safeguarding children lines of reporting to the board through the Safeguarding Panel which is held 6 weekly.
- The Named Doctor offers safeguarding children support to junior doctors. Peer reviews being introduced and will be held every 8 weeks
- Training strategy has been reviewed and aligned to the Intercollegiate Document 2014, and level 1 and 2 training will be part of induction for every new starter.
- Non-compliance list will be introduced to target members of staff who are not accessing training.
- Volunteers within the Trust are being provided with safeguarding children and adults training
- A referral to children services is completed for all children under 16 years who overdose or self-harm.
- There is an easy to read safeguarding children guide for staff which is available on the Trust's intranet page
- Supervision in Maternity is more formal and being recorded
- Monthly meetings held between social care and maternity to discuss high risk/concerning cases.
- The Trust is going live on the CP-IS system on the 31st of March 2015.

Recommendations from the audit were:

FGM to be included in level 2 training
Progress – FGM is now included in all safeguarding training – a basic awareness at Level 1 and covered in more depth in Levels 2 and 3

To achieve 95% training target compliance for all levels
Progress - there is a continued upward trajectory for training compliance levels, which are monitored closely by the safeguarding panel

The Safeguarding newsletter to be produced bi annually instead of annually
Progress – plans are in place to produce the staff safeguarding newsletter bi annually

Audit programme to include Children's Services referrals from maternity department.
Progress – the safeguarding audit strategy was reviewed and amended in May 2015 and agreed by safeguarding panel. It sets out a comprehensive audit plan for the next two years, including audits for in maternity.

A section 11 dip sample audit of notes was also carried out during the reporting year by the Designated team. They audited records from Starfish, SCBU, A and E, CED and Sexual Health Services. The results were generally good, showing a high level of safeguarding awareness in record keeping. Action plans for each area were completed and were included in the safeguarding strategic work plan.

6.4 Adult Safeguarding Assurance Visit to West Hertfordshire NHS Trust

An adult safeguarding assurance visit was carried out in February 2015. The visit was carried out by the Chief Nurse and the Head of Adult Safeguarding Nurse within the CCG.

Some of the key findings from the audit are

- The trust has a strategy in place which reflects the organisations values and is currently being reviewed incorporating actions identified from audit.
- The trust has a values based appraisal system in place in which all managers have been trained.
- Whistle blowing incidents and allegations of abuse against staff are reported to a sub group of the trust board.
- The trust is reviewing the Raising Concerns policy in light of Saville.
- The trust is proposing to change the midwifery structure to allow more posts to include specific safeguarding responsibilities.
- In response to regular concerns raised regarding NHSP staff, the trust holds contract meetings with NHSP to monitor and resolve these issues.
- The trust proposes to train four people in WRAP3 Prevent training.
- The trust is developing a domestic abuse policy.
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Areas of good practice were:-

- The Lead Consultant for Safeguarding adults provides training to junior doctors at induction and as part of the on-going training programme.
- Learning from serious incidents evidenced through the increase in deprivation of liberty safeguard applications.

Recommendations from the visit were

WHHT need to achieve the necessary training levels set out in the Quality Schedule for safeguarding adults and MCA for all divisions.
Progress - there is a continued upward trajectory for training compliance levels, which are monitored closely by the safeguarding panel

To triangulate the outcomes from serious incidents with the strategy and action plan.
Progress – themes and trends are closely monitored and risks identified with the safeguarding and risk team

The trust to ensure that adult safeguarding is embedded within appraisal and supervision processes.
Progress – mandatory safeguarding training is reviewed as part of staff appraisals

The trust need to develop an improved system to monitor themes and trends emerging from adult safeguarding and quality issues.
Progress - themes and trends are closely monitored and risks identified with the safeguarding and risk team

7 Safeguarding Children

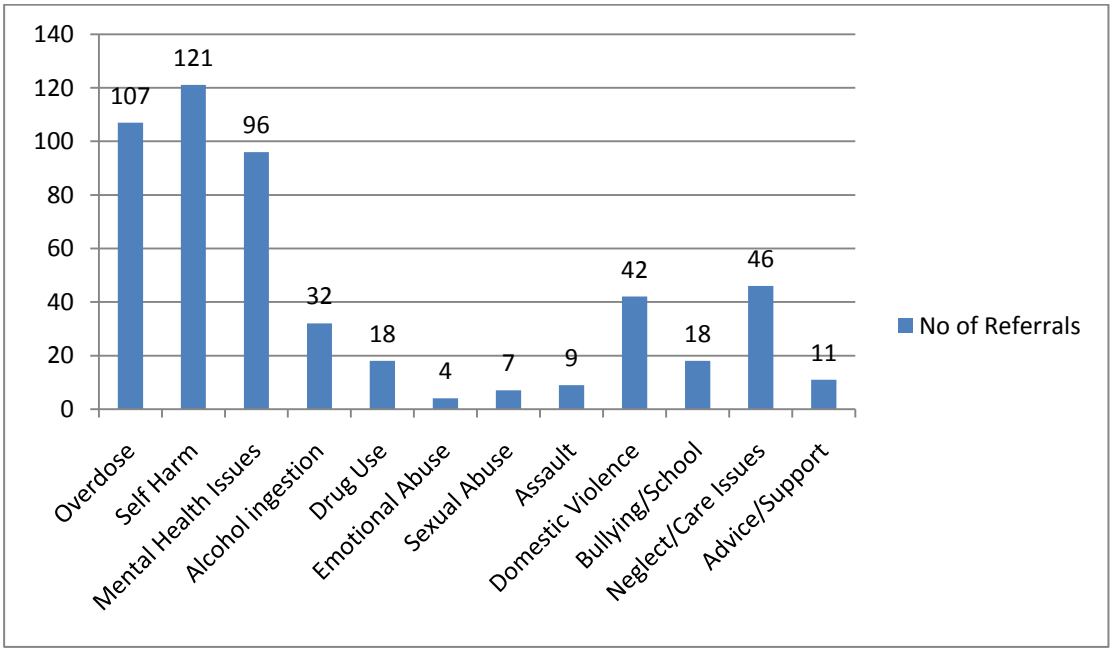
7.1 Safeguarding children's activity can be divided into 3 areas of work within the Trust

- Acute paediatrics including emergency care, inpatient care, day patients and paediatric out patients. This would also include children seen in Urgent Care and Minor Injuries and in other departments within the Trust
- Maternity services including inpatient services and community midwives
- Adult services - where concerns are raised about an adults attendance and the impact of that presentation on a dependent child

7.2 Referrals to Children's Services

Identifying and referring vulnerable children and families is a key role of all Trust staff in all areas of the hospital.
Referrals to children's services for children under 18 by the Trust are either due to child protection concerns or for information sharing. The majority of referrals made by the Trust are for child protection concerns and are detailed in Graph 1.

Graph 1 - Total Number of Child Protection Referrals made for children less than 18yrs made by WHHT staff from May 2014 – May 2015

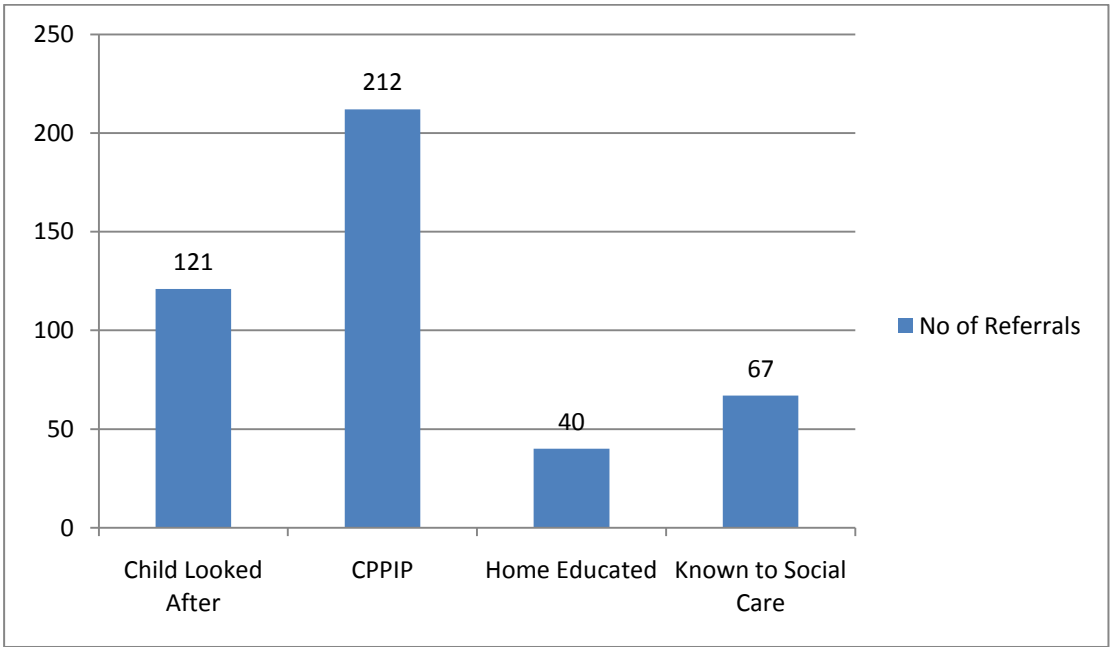


Referrals for young people attending with mental health issues, particularly self harm and overdose continue to be high. The table below looks at trends over the last four years. Numbers of referrals for self harm are just slightly lower than last year's but remain significantly higher than previous years. There has been a significant rise in young people attending with overdoses since last year. There are clear pathways within A and E for young people attending with mental health. None the less, the increase in numbers has a significant impact on the workload of the department. Many of these young people need admitting to the wards as a place of safety for further medical care or review by the psychiatric teams.

Referrals Table 1 Showing the referral rates for young people attending for mental health issues,

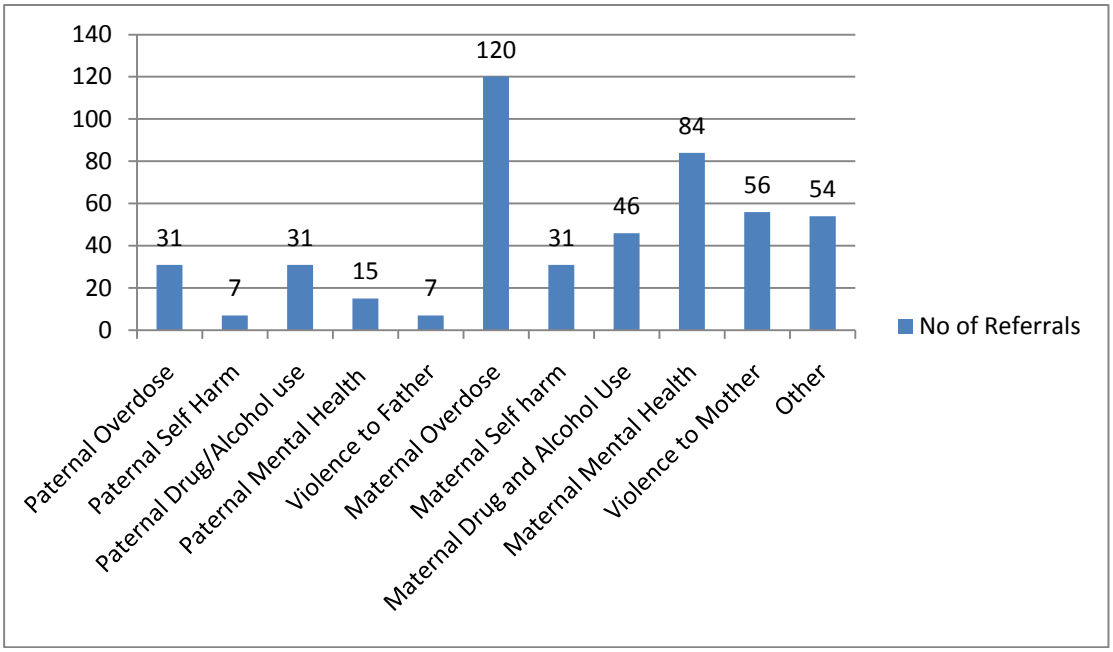
Period	Self Harm	Trend	Overdose	Trend	Alcohol ingestion	Trend
2014 - 15	121		107		32	
2013 - 14	130		47		24	
2012 - 13	74		68		31	
2011 - 12	63		74		47	

Graph 2 - Total Number of Information Sharing referrals made for children less than 18yrs made by WHHT staff from May 2014 – May 2015



Information sharing referrals remain high, which are detailed in Graph 2. The majority of referrals are for children with a child protection plan in place. The high referral numbers indicate that Trust staff are identifying these vulnerable children and our systems for recognising them, particularly within unscheduled care are working.

Graph 3 - Total Number of Child Protection Referrals made for adult attendances by WHHT staff from May 2014 – May 2015



Referrals Table 2 Showing the referral rates about parental concerns.

Period	Father overdose	Trend	Father self harm	Trend	Violence to father	Trend	Father mental health	Trend
2014 – 15	31	⇔	7	⇑	7	⇓	15	⇔
2013 - 14	32		1		10		15	
2012 - 13	23		8		14		14	
	Mother overdose	Trend	Mother self harm	Trend	Violence to mother	Trend	Mother mental health	Trend
2014 - 15	120	⇔	31	⇓	56	⇓	84	⇔
2013 - 14	122		58		74		88	
2102 - 13	93		47		43		53	

Referrals made about parental concerns (when the parent is the patient) are predominantly done by A and E. Other areas of the Trust that generate referrals due to parental concerns include AAU, ITU and Cassio ward. The table above looks at trends across the last 3 years. Numbers of referrals made are fairly similar to previous years, with a fall in referrals for maternal self harm and violence to the mother. Work needs to continue across the Trust about 'Think Family' and that 'safeguarding children is everyone's responsibility'. This will ensure that all areas of the Trust are able to recognise concerns about vulnerable children from adult attendances and make referrals appropriately.

Staff receive guidance during safeguarding training about the information that needs to be included within a referral to Children's Services. Standards of referrals to Children Services are audited regularly and any issues are fed back into practice.

The majority of referrals made by the Trust continue to be faxed to Children's Services. The safeguarding team send referrals electronically. Children's Services would prefer an electronic referral from all staff but with our current IT systems this could not be a safe or timely transfer. Systems have been put in place to mitigate the risks of faxing referrals which ensure as safe a system as possible. IT project leads continue to investigate possible options for a Trust wide system to allow electronic referrals to Children's Services.

The Trust provides activity data quarterly to the designated team with the CCG. The activity information is reported via a safeguarding dashboard. These have been completed and submitted quarterly within agreed timescales. The activity data includes safeguarding referrals, training compliance rates, supervision rates, audits, SCRs, child deaths and medicals.

7.3 Multi agency working

There are three ward rounds that run weekly across the Trust and look specifically at vulnerable children.

- Starfish psychosocial ward round every Friday is a multi agency meeting attended by hospital staff, CCATT (CAMHS Crisis Assessment and Treatment Team) and a social worker from the local assessment team. The meeting reviews all children who have been admitted to the ward over the preceding week. Staff are also able to bring cases of concern to be discussed. The meeting is chaired by the safeguarding team and remains well attended.
- SCBU psychosocial ward round every Tuesday is a multi disciplinary meeting attended by SCBU staff and the safeguarding team. Cases on the unit are discussed, with plans and actions clearly defined.
- CED/A and E child protection meeting every Wednesday is a multi disciplinary meeting that reviews all referrals made to Children Services the proceeding week. The review process ensures that all referrals are dealt with appropriately, with information shared effectively to protect children.

7.4 Safeguarding Work within Unscheduled Care

The safeguarding nurses continue to support staff working within unscheduled care. A safeguarding nurse reviews the notes of all children attending CED on the next working day to ensure all safeguarding policies were followed and staff acted appropriately. All referrals made to Children's services are also reviewed daily in case of any urgent action or further information sharing needed. There is also a review system in place of notes of adults who have attended with concerning presentations who may have dependent children. Consideration is then made about the risks to any children and a referral made if appropriate. A review process also exists weekly within the Urgent Care Centre.

7.5 Child Protection Information Sharing (CP – IS)

During the reporting year, the safeguarding team worked closely with the CCG IT leads, Local Authority Leads and the HSCIC to launch CP – IS into our unscheduled care settings.
The Child Protection – Information Sharing project is an NHS England sponsored work programme dedicated to developing an information sharing solution that delivers a higher

level of protection to children who visit NHS unscheduled care settings. The project links the IT systems of NHS unscheduled care to those used by social care child protection teams, so that information can be shared about three specific categories of child:

- those with a child protection plan
- those classed as looked after (i.e. children with full and interim care orders or voluntary care agreements)
- Any pregnant woman whose unborn child has a prebirth protection plan.

The information is held on the Summary Care Record (SCR). A clinician can access the information by using an NHS Smartcard to look up the patient on a web based viewer. When the correct patient is identified, a page is displayed that contains their demographic details, and an alert tab is shown if the child is subject to a protection plan or has looked after child status. On opening the alert tab information about the plan, local authority and contact details will be available. This also sends an alert to the local authority social worker that the child has attended our Trust.
Hertfordshire is in the first wave of Local Authorities using CP-IS. National roll out over the next 2 years will ensure that we are able to access child protection information about any out of area child who comes into one of our unscheduled care settings.

7.6 Safeguarding Children Audits

The Safeguarding Audit Strategy 2013 – 2015 was reviewed during the reporting period and was approved and agreed by the Safeguarding Panel. The current audit gives a robust framework for safeguarding audits for the next 2 years. The review also ensured alignment to recent recommendations from local Serious Case Reviews.

The Safeguarding Panel monitored and scrutinised progress against the Audit Strategy 2013 – 2015. The following audits were completed in the reporting year and presented at Safeguarding Panel.

7.6.1 Review of safeguarding documentation in Unscheduled Care settings across the trust

Outcome - Completed audit forms were received from all settings, with a total sample of 50.Overall, the findings were very positive with a good standard of record keeping across all three emergency settings. Recording of demographics remains good. Areas of good practice include good documentation around mechanism of injury, considering safeguarding for all attendances and 100% recording of whether a child is subject to a Child protection Plan.

7.6.2 Review of the standard of referrals sent to Children's Services from key areas across the Trust.

Outcome - The total number of referrals audited was 50. Overall, the findings of the audit show that the standard of written referrals to Children's Services across the Trust is generally good. This is an improvement on previous audits, particularly in 2013 when the audit showed written referrals to be inconsistent and patchy.
Basic demographic information is recorded well across all areas. Recording of information about ethnicity, religion and spoken language though, is not as good.
Recording Information about concerns was good with 98% of referrals stating clearly the reason for referral. This is a significant increase on the audit in 2013, when 86% stated the

reason, 94% of staff were able to identify risks in the referral, again a significant increase from 2013 when it was 71%.

7.6.3 Audit to examine the Did Not Attend (DNA) policy within children's out patients

Outcome - The results suggest that the DNA policy is largely adhered to and safeguarding concerns are recognised for those children that DNA. Paediatric outpatients have a high DNA rate for a number of reasons and the vast majority of these are not related to safeguarding issues. In children with safeguarding issues, there are invariably multiple other factors which are known throughout the wider professional network. Recommendations of the audit included a review of the policy with amendments and awareness raising of the policy within the paediatric medical team.

7.6.4 Audit to examine referrals made and documentation of under 18's attending A and E with mental health issues

Outcome - 22 records were included in the audit. The results of the audit show very good practice and documentation for young people who attended A and E with mental health concerns. All the young people who were included in the audit had referrals made to CCATT and to Children's Services. All young people in the audit had a mental health assessment before they left the hospital which was clearly documented in the hospital records. The review of records by the Safeguarding Nurse on the next working day is an excellent safety net to ensure all referrals have been done. This review now includes all 16 and 17yr olds who attend with mental health issues.

7.7 Serious Case Reviews

1. The case of Young Person B, a 17 year old girl, was referred to the Hertfordshire Safeguarding Children Board (HSCB) in April 2013. The girl had been diagnosed with an eating disorder in 2012 which had resulted in her being detained under the Mental Health Act in a clinic outside Hertfordshire which specialised in managing eating disorders. Whilst detained, she committed suicide in the clinic. The Chair of HSCB commissioned an independent lead reviewer, to complete a SCR for the case. His SCR Report was formally accepted by the Strategic Board of HSCB at its meeting on 23rd July 2014. The Trust had involvement with the girl and was asked to provide a chronology to the SCR which was completed within agreed timescales. The girl attended A and E on 2 occasions and was seen by the medical team and then by the psychiatric team (Hertfordshire Partnership Foundation Trust). Recommendations made from the SCR relevant to the Trust were around how psychiatric teams use Trust A and E records and the importance of all staff considering referrals to Children's Services for young people with mental health issues attending unscheduled care. All learning, recommendations and actions were presented to the Safeguarding Panel.

2. In March 2015, Bradford Safeguarding Children Board (BSCB) commissioned a SCR following the death of a 22 month old girl who had been living in Bradford. The criminal investigation concluded into her death in March with her mother pleading guilty to manslaughter with diminished responsibility. Prior to moving to Bradford, the family had lived within Hertfordshire and had had involvement with the Trust. This was predominantly for the mother's maternity care. The Trust was requested to identify an author and contribute to the SCR process by providing a chronology, Individual Management Review (IMR) and Action Plan. The Named Midwife was the nominated author and completed all requests within

timescales. The IMR and Action Plan have been presented at Safeguarding Panel and Maternity Governance meetings. The final SCR report is expected later in the year.

7.8 Serious Incidents for Safeguarding Children

During the reporting period there have been the following Serious Incidents within Safeguarding Children

Month	Number of SI	outcomes
May 2014	**1**	**Complete**
July 2014	**1**	**Internal -complete**
August 2014	**1**	**Internal.-completed**
February 2015	**2**	**1 completed and 1 Investigations is ongoing**
Total	**5**	

All Serious Incident reports and completed action plans are monitored and scrutinised by the Safeguarding panel. If appropriate, they are also monitored at divisional governance meetings.

7.9 Safeguarding Children Training

Safeguarding children training is a fundamental part of the Trusts duty to safeguard and promote the welfare of children within Section 11 of the Children's Act (2004) and Working Together 2015. Staff need to be trained and competent to recognise potential indicators of abuse, know what to do about concerns and fulfil their responsibilities in accordance with the Hertfordshire Safeguarding Children Board procedures.

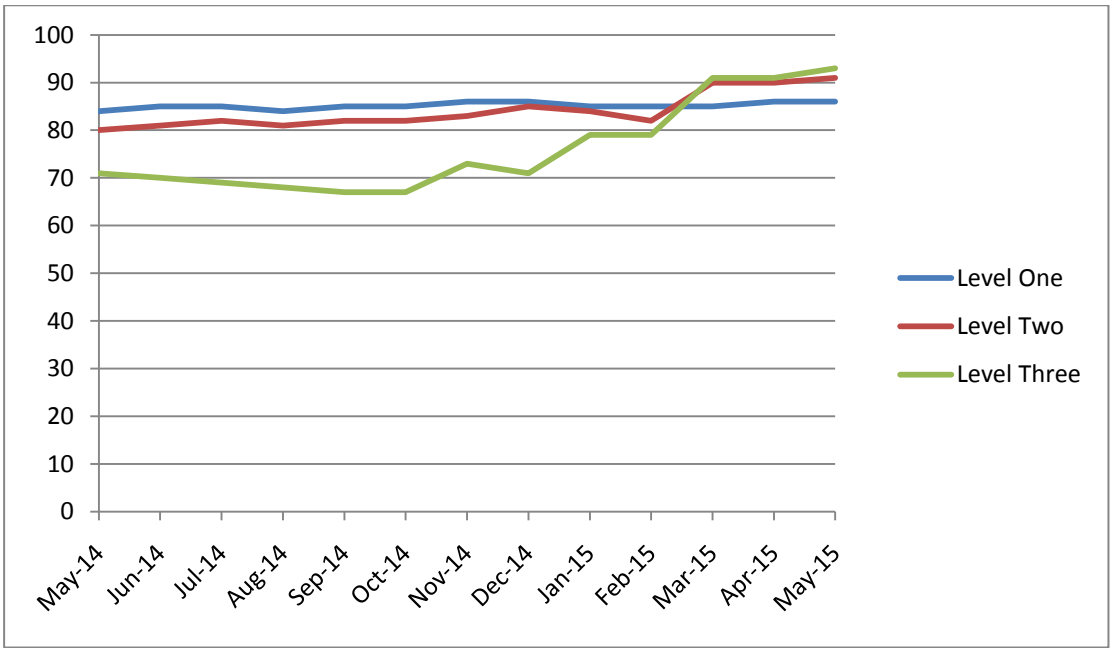
The Trust has a Safeguarding Training Strategy in place, informed by a training needs analysis and is in accordance with Levels outlined within the Intercollegiate document (RCPCH 2014). During the reporting period, the strategy was reviewed, with particular scrutiny of staff groups who were required to do Level 3. Following a comprehensive review and in line with the Intercollegiate document (RCPCH 2014) the strategy now clearly defines the members of staff who require Level 3. The strategy was ~~a~~ approval at the safeguarding panel.

Currently within the Trust, Level 1 and 2 safeguarding training is delivered as part of the 3 yearly mandatory clinical and non clinical days. Level 2 training is delivered to all new staff as part of a 'Safeguarding our patients day' which is part of the Trusts mandatory corporate induction programme. The safeguarding team can also offer ad hoc sessions of Level 1 and 2 to clinical areas where compliance with training is low.
Level 3 training sessions are held 1 – 2 times a month. They are organised by the safeguarding team and a programme of sessions is advertised in key clinical areas for staff to book places.

Staff can also access safeguarding children training via the Trusts e learning system. There is access to local packages at all 3 levels which are updated regularly by the safeguarding team, as well as access to national packages.

Training compliance rates are reported monthly by the Trust Training Department and these figures are reported to the Safeguarding panel. During the reporting year, there has been a significant improvement across all Levels of training, particularly Level 3.

Graph 4 – Safeguarding Children Training Compliance rates



Compliance figures as of May 2014 and May 2015 are:

Level 1 – 84% and increased to 86%
Level 2 – 80% and increased to 91%
Level 3 - 71% and increased to 93%

In practice, the significant increase in compliance rates means that a high number of Trust employees are better able to recognise signs of abuse and more importantly feel more confident in knowing what action to take if they have a concern.

There has been significant work across the Trust by the safeguarding team, supported by the divisions, to increase the compliance figures. This has included increasing training sessions, reviewing lists of non compliant staff, contacting non compliant staff and booking training, clinical facilitators and clinical managers supporting staff attendance. The CCG target for all Levels of training is 95%. Work to achieve these targets will continue in the coming year.

The Named professionals and the Specialist nurses have undertaken level 4 refresher training commensurate with their roles in accordance with the Intercollegiate document (RCPCH 2014).

Multiagency training provided by the Hertfordshire Safeguarding Children Board (HSCB) enhances the single agency training provided by the Trust. The Board provides a programme of day courses and Lite Bites on a variety of subjects e.g. neglect, children with disability, bruise protocols, parental mental health. Staff are encouraged to attend the HSCB training with courses advertised via clinical facilitators. During the reporting year, paediatric nurses on the rotation programme have attended several HSCB courses. The benefits of multi agency training within safeguarding children are significant and would benefit Trust staff greatly. It is important that the safeguarding team continue to highlight the training and

encourage staff attendance. The Safeguarding Children Nurse within the Trust continues to be a member of the HSCB training pool and delivers courses on the multi agency training programme several times a year.

7.10 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. The Trust has a clear Safeguarding Supervision Strategy 2013 – 2015 in place, which outlines the Trusts commitment to providing high quality supervision and how it is delivered across the Trust.
Supervision is delivered by the safeguarding team to paediatric, neonatal and maternity staff across the Trust. It is delivered either as group supervision or in one to one sessions.
During the reporting period a peer review group has been developed that meets bi monthly for paediatric doctors. The group is led by the Named Doctor for Safeguarding and the Safeguarding Children Nurse. The Named Nurse and Midwife access safeguarding supervision from the Designated Nurse in the CCG regularly.

7.11 Policies and Procedures

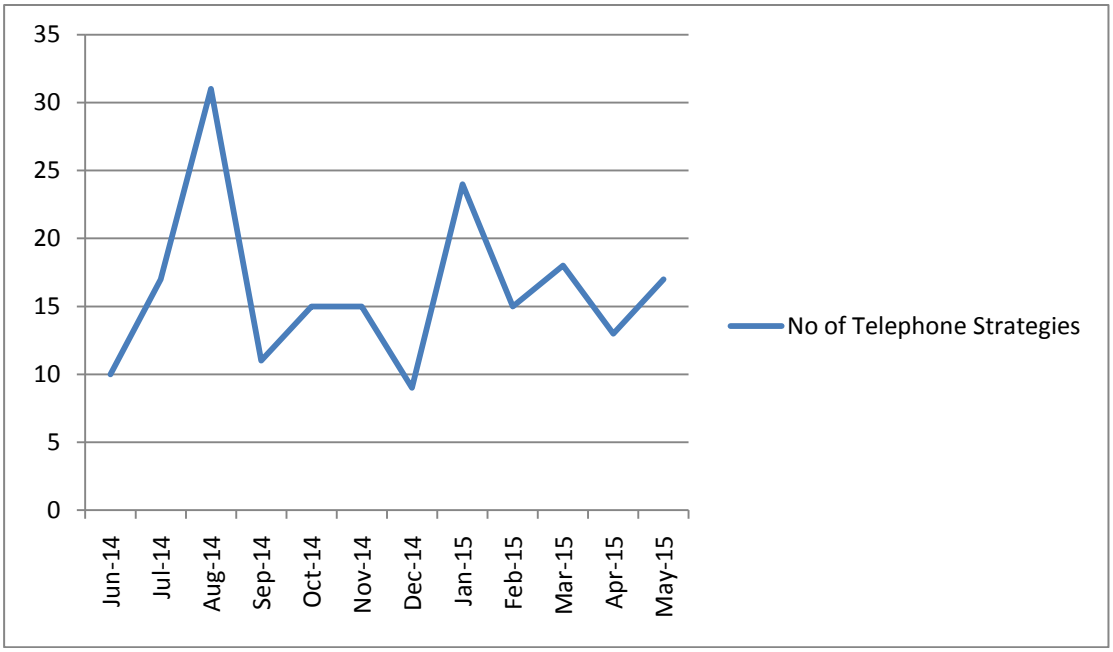
Safeguarding policies are in place and are accessible to staff. Hertfordshire Safeguarding Children's Board policy and procedures are available via links on the staff intranet site.
During the reporting period the Trusts Safeguarding Children Guidelines were reviewed and amended in line with current legislation. They were also converted to a Policy for Safeguarding Children. This policy was ratified via the Safeguarding Panel and Quality and Safety Group. It is accessible on the staff intranet.
The Raising Concerns at Work (whistle-blowing) policy was amended by the Safeguarding Team to reflect current legislation.

7.12 Partnership Work

The Trust has a responsibility to cooperate with the Local Authority in the operation of the Hertfordshire Safeguarding Children Board (HSCB) as a statutory partner. It needs to share responsibility for the effective discharge of its functions in safeguarding and promoting the welfare of children by ensuring there is appropriate representation at the HSCB Board meetings and sub groups. The Trust continues to be represented at the HSCB by the Chief Nurse or her nominated deputy. During the reporting year, there was minimal involvement by Trust staff within the sub groups of the HSCB. Following a review of the sub groups, members of the Safeguarding Team have been nominated to be members of 6 groups for 2015.

The Safeguarding Team in the Trust contribute to telephone conference strategy calls regularly with Children's Services and police. Telephone strategies were introduced in Hertfordshire following the publication of Working Together 2013 that stressed the importance of having much greater input from health agencies at strategy meetings. The Safeguarding Team are able to make a significant contribution to sharing of vital information at an early stage and contribute to the initial assessment of risk for vulnerable children by taking part in the conference calls.

Graph 5 - Number of Telephone Strategies by month that the Safeguarding Team have contributed to as health representation.



During the reporting period, the Trust made no referrals to DBS or to the Local Authority Designated Officer (LADO) for allegations of abuse against staff working with children. Advice was sought from the safeguarding team about 2 cases that involved staff who were based in the hospital but were employed by other Trusts/Agencies. In one case, the person was dismissed and in the second case the person was removed from the Trust premises pending further investigations. On both occasions, advice was given to the respective HR departments about contacting the Designated Office.

8. Named Midwife Report

8.1 Maternity safeguarding activity

Number of referrals to Children's Services in reporting period - 167
Number of info sharing forms in reporting period - 105

The HSCB Pre Birth Protocol is followed across maternity services in the Trust. As part of the protocol the Named midwife or Complex Needs midwife attends the pre birth information sharing meeting and then takes part in the telephone strategy discussion. Initial Case Conferences are attended by the Named midwife and subsequent conferences by the community midwife.
Community midwives and the Complex Needs midwife attend the core group meetings. If the case is deemed as high risk then the Named midwife may also attend.
After 30 weeks gestation the Named midwife attends the discharge planning meeting where the birth plan is finalised and then distributed to all the clinical areas within maternity services, including the neonatal unit.

Each clinical area has a social files that is updated by each ward manager – the Named midwife emails each new birth plan to them .The database is updated as each referral is received. During the reporting year, there have been several high risk cases that have necessitated involvement with the Trust security and mental health teams from Herts Partnership Trust, to plan a safe delivery and put a risk assessment in place for each case.

The Named Midwife works closely with the assessment teams within Children's Services. Monthly meetings are held with social workers and health visitors to review all new referrals of pregnant women.

8.2 Safeguarding training

Level 3 safeguarding training for all midwives takes place annually as part of a one stop study day. This is mandatory for all midwives. All other maternity staff complete Level 1 or Level 2 training on the mandatory clinical or non clinical days.

Current compliance figures for maternity staff as of May 2015 are
Level 1 – 90%
Level 2 – 94%
Level 3 – 96%

Safeguarding training is carried out by an experienced safeguarding midwife who has completed a Train the Trainer course. During the reporting year, Level 3 training has been amended to include information on FGM, discussing data collection and the necessity to consider safeguarding risks to wider family members. During the reporting year, training was provided by the Named Nurse and Named Doctor to the Obstetricians and Gynaecologists to ensure their compliance with Level 3.

8.3 Safeguarding Supervision

The Trust has a Safeguarding Supervision Strategy (2013 – 2015) in place. The Named midwife provides supervision for the midwifery team leaders within community every 4 – 6 weeks. The information and agreed plan is then shared within the wider community teams.

8.4 Female Genital Mutilation

Mandatory statistical reporting of cases of FGM by the NHS came into force on 1st April 2015.

The FGM Enhanced Dataset requires organisations to record, collect and report detailed information about FGM within the patient population, as treated by the NHS in England. The FGM Dataset mandates that FGM must be recorded in all clinical areas. The FGM dataset will use patient identifiable information (specifically the NHS number). The Named Midwife working with the clinical coding department have produced a data collection form that complies with all the expectations of mandatory reporting. During the reporting period, a task and finish group was set up to progress the work around mandatory reporting and how this will be rolled out across the Trust.

A further consultation paper, 'Introducing mandatory reporting for female genital mutilation: a consultation', was published on 5 December 2014. Its purpose was to enable the Government to scope and explore fully how to introduce a mandatory reporting requirement for cases of female genital mutilation (FGM). The recommendations include mandatory reporting to the police, by health professionals, for all cases of FGM that present in girls under 18. The recommendations are due to form amendments to the Serious Crime Bill and are due to become law later in the year.
During the reporting period an FGM policy was developed. The policy has been reviewed at the Safeguarding Panel and within maternity governance and is due for ratification at the

Quality and Safety Group.FGM awareness is now included in all Levels of safeguarding training across the Trust.

8.5 Policy and procedures

Following concerns raised during the care of a surrogate mother in the Trust, the need for a surrogate policy was highlighted. A surrogate policy was written by the Named midwife, which was reviewed at Safeguarding Panel and ratified at the Quality and Safety Group.

9. Safeguarding Adults

9.1 Safeguarding Adult activity

Referrals
Safeguarding referrals raised within the Trust are processed by the named nurse for adult safeguarding and the hospital social work team. The investigation of a safeguarding referral is led by Hertfordshire Adult services as per Hertfordshire safeguarding Adults from Abuse procedures.

Referrals are currently received via a safe fax from the clinical areas. From August 2015 there is a plan to change the referral system so that they are electronic.

From April 2014 to March 2015 101 safeguarding vulnerable adults from abuse referrals were received. Reasons for referral include allegations of financial abuse, physical assault, neglect (including pressure ulcers), and poor discharge practice.

9.2 Deprivation of Liberty safeguards

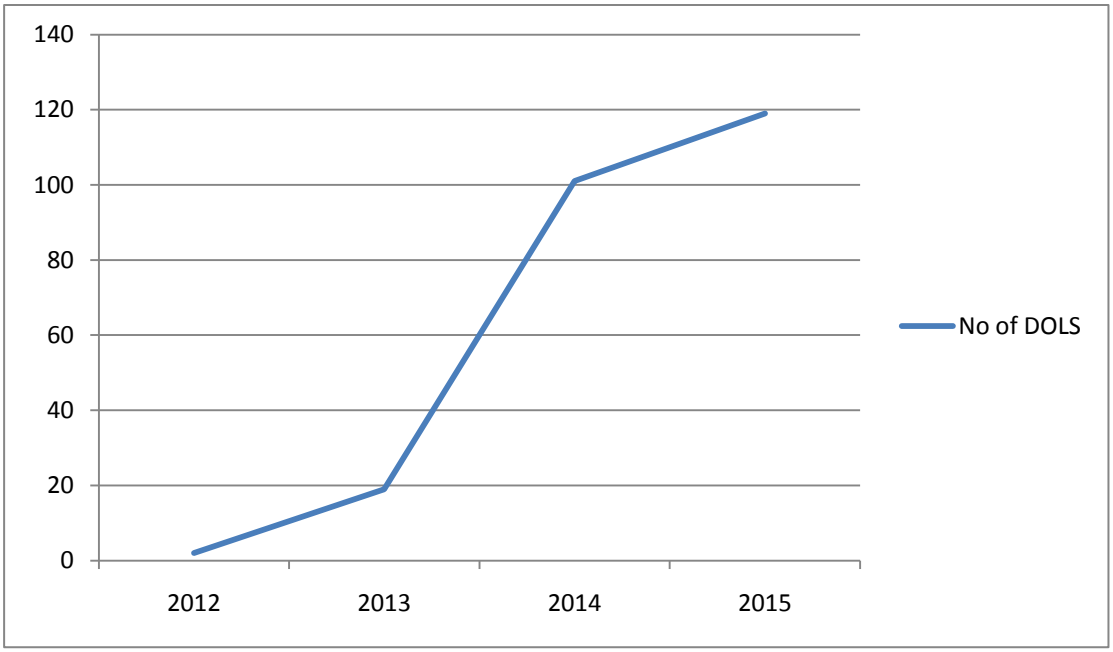
Deprivation of Liberty Safeguards (DoLS) were created to provide legal protection for vulnerable people aged 18 years and over who lack mental capacity to consent to the arrangements for their care, who are deprived of their liberty other than under the Mental Health Act 1983. The safeguards came into effect in April 2009.

In March 2014, following the cases of P v Cheshire West and Chester Council and P and Q v Surrey County Council, the Supreme Court handed down its judgement. The judgement was significant for deciding whether an individual who lacks capacity to consent to those arrangements constitutes a Deprivation of Liberty with the formulation of the ‘acid test’. There are two key questions that constitute this test:

1. Is the person subject to continuous supervision and control? And
2. Is the person free to leave?

Following the Cheshire West ruling has led to an increase in the number of DoLS referrals received within the Trust

Graph 6 – increase in the number of DoLS made by Trust staff



For the last year the Trust has applied for 161 authorisations. Out of these 151 were not authorised due to patients regaining capacity, being discharged or becoming deceased. This has led to a focus on increasing training relating to deprivation of Liberties and mental capacity.

9.3 Audits

The Safeguarding Audit Strategy 2013 – 2015 was reviewed during the reporting period and was approved and agreed by the Safeguarding Panel. The following audits for safeguarding adults were carried out:

9.3.1 Consent Audit - Including General Surgical Patients & those identified with capacity deficits.

The purpose of this audit was to establish compliance with the expected standards of consent. The audit reviewed consent form one & four where a patient has been identified as lacking capacity to decide on treatment and the adherence to best practice standards.

Overall the general surgical consent met the expected standards. It was however noted that at times due to handwriting the surgical procedure was not clear and the notes had to be reviewed further to establish the exact nature of the surgery. The age ranges of the patients were from 14years old – 89 years old. In all cases the appropriate consent form was completed including pre printed consent forms identifying all risks for the individual procedures. In all cases the consent form was signed by the appropriate health care professional. In 7/20 records there was no evidence of a WHO safety check list. In all except two cases the risks identified within the consent were appropriate. In the other two cases the auditors believed that the risks were only partially identified.

9.3.2 DoLS Retrospective & prospective Audit

The purpose of this audit was to review the processes of Mental Capacity Assessments and Deprivation of Liberty Safeguards applications (DoLS) in the NHS Trust. An audit was carried out of prospective audit of notes, to review the current documentation standards across the Trust for assessing the mental capacity of patients whose capacity may be compromised as a result of confusion delirium or dementia. A further audit was undertaken retrospectively to compare the results of the prospective audit with the processes and known DoLS applications made within the Trust.

The results of the retrospective audit demonstrated there is a clear documented process for DoLS applications and there was good evidence that patients requiring Form 1 had been forwarded electronically to the Safeguarding Named Nurse for action. There was only one case where this could not be evidenced. There was good evidence that staff concerned about a patient's capacity were liaising with the Safeguarding Named Nurse; however this could not always be evidenced in the notes but could be evidences by reviewing the DoLS application data base.

9.4 Domestic Homicide Review

During the reporting period, the Trust has been asked to contribute to a domestic homicide review (DHR). The DHR has been suspended awaiting further advice from the CPS.

9.5 Adult safeguarding SIs

During the reporting period there have been the following Serious Incidents within Safeguarding Adults:

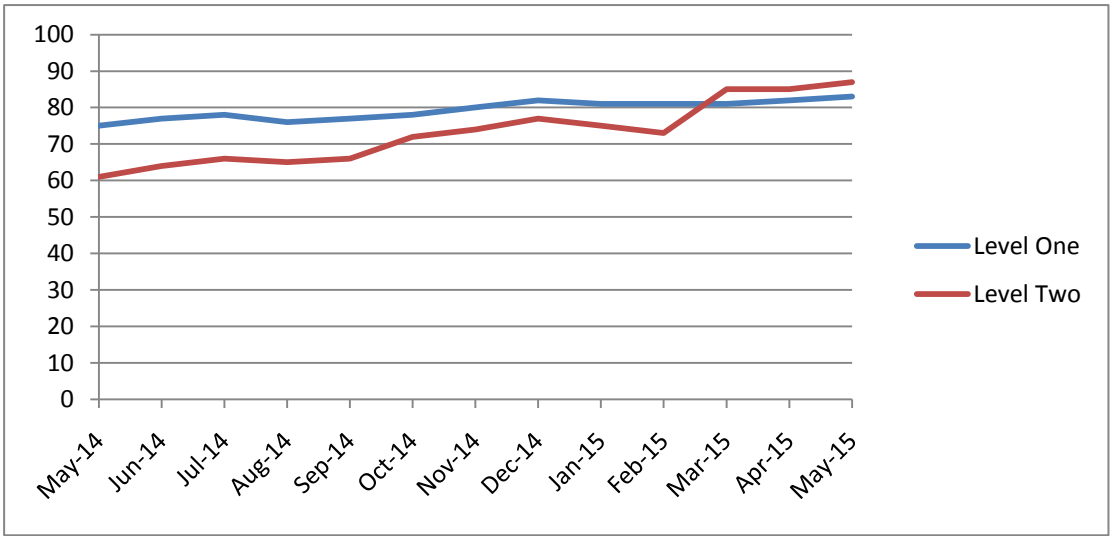
Month	**Number of SI/safeguarding alerts**	**outcomes**
October 2014	**1**	**Unsubstantiated**
November 2014	**3**	**All 3 unsubstantiated**
January 2015	**1**	**Unsubstantiated**
February 2015	**2**	**Investigations are ongoing**
March 2015	**4**	**3 Investigations still ongoing**
Total	**11**	

9.6 Training

All Trust staff are provided with a Safeguarding training day through the Induction training programme. All staff undertakes periodic mandatory updates 3 yearly. Level 2 training is provided for clinical staff to enable recognition of abuse and to be able to make referrals, requirements of the mental capacity act and deprivation of liberty safeguards. Level 1 training is provided for non-clinical staff and volunteers to raise awareness of Adult Safeguarding.

There has been a gradual increase in training figures throughout the year. Compliance figures for mandatory training are set by the Clinical Commissioning Group at 95 %. Throughout the year the compliance has risen from 75% to 86% for level 1 training and 60% to 90% for level 2 .

Graph 7 - Safeguarding Adult Training – Trust Compliance Rates



In addition to mandatory training, two “train the trainer” sessions have been provided for mental capacity and Deprivation of liberties. In total 29 senior staff have been trained. They were provided with the power point slides and both codes of Practice with the expectation that this information will be cascaded.

9.7 Policies and Procedures

Safeguarding policies are in place and are accessible to staff. Hertfordshire Safeguarding Adults Board policy and procedures are available via links on the staff intranet site. During the reporting period the Trusts Safeguarding Adults Guidelines and Mental Capacity policies were reviewed and amended in line with current legislation. Following the Lampard report the Trust VIP policy was reviewed and updated. This policy was ratified via the Safeguarding Panel and Quality and Safety Group.

Domestic abuse was an additional category of abuse identified as a result a Domestic abuse policy was written and shared at safeguarding panel. This was ratified via the panel and the Quality and Safety Group.

Due to changes in the law in March 2014 following the “Cheshire West” ruling, the DOLS policy was reviewed and updated.

9.8 Domestic Violence

The County Community Safety Unit, with funding from Hertfordshire’s Police and Crime Commissioner, commissioned the independent charity SafeLives (formerly CAADA) to thoroughly review how domestic abuse services in Hertfordshire could be improved.

Funding from the Office of the Police and crime Commissioner Community Fund was confirmed to Victim Support in May 2014. The funding was increased to enable the project to run until March 2016 to enable WHHT to have an Independent domestic Violence Adviser (IDVA).

WHHT Independent Domestic Violence Adviser has been in post since July 2014. She supports high risk victims of domestic abuse. The role of the IDVA is to support clients who disclose Domestic Abuse. The IDVA works in a multi agency setting supporting clients with a range of support, including Safety Planning and Risk Assessment. Part of the IDVA role is to

attend MARAC to represent clients needs and wishes through the process, attending Specialist Domestic Violence Courts to support the client ensuring that their wishes and needs are taken into account, advocating on behalf of clients with other agencies where required, supporting them to obtain civil orders to help protect them. Providing support letters where needed. The IDVA supports clients who do not wish to report to the Police and usually are High Risk, as she works with the highest risk clients it is very important that she does work within a multi agency framework. The IDVA service also works with all clients who are referred to the MARAC, therefore she works with clients who may be referred via the police or Victim Support where they are patients of the Trust, and have attended A&E following the incident of Domestic Abuse.

From July 2014 to December 2014 there were 74 referrals from various departments, including , A&E, Maternity, PALS, General Wards, AAU, Social Care, Drug and Alcohol team, radiology, and Victim Support where the client is already a patient of the Trust.

Standard operating procedures were agreed with the safeguarding lead nurse. Work took place with the Hospital Trust to promote the service within departments – leaflets have been produced to inform staff, A&E, Maternity Sexual Health and ICU have folders that contain information about the service, referral pathways and referral forms. The IDVA facilitated a session with Junior Doctors in A&E to raise awareness of the service; she attends the Children's Emergency Department meetings where referrals to CSF are reviewed. Clients have been seen in the Hospital or community including Local Authority accommodation, St Albans Hospital, Doctors Surgeries, and clients own homes, where safe to do so. For Clients who do not want an on-going service we are able to signpost them to other support if required such as counselling and emotional support. Even where clients do not want ongoing support the IDVA will discuss safety with them and ensure they are aware that they can report what is happening to them to the police and other agencies, we are able to ensure that they know where they can get support in the future if the need/ want to, including their health professionals and the IDVA service. Therefore no client is left without at least the knowledge of where they can get support, as long as there are contact details given to the IDVA. All clients who have received a service are asked to complete an end of service evaluation The Numbers of referrals received was quite high for a new service. The IDVA service has been well received by the Trust and the commitment to it from the safeguarding team and other staff has ensured it has been a success. The fact that referrals are coming from different departments shows that staff knowledge is improving about the IDVA service.

Referrals Information for IDVA

Referral Source	Total
Adult Safeguarding Nurse	13
Children's Safeguarding Nurse	5
A & E	41
Maternity, includes safeguarding midwife and antenatal clinic	6
OP Clinics	1
Drug and Alcohol Service	1
General Wards	4
PALS	1
Family Planning Clinic/ sexual Health	1
Radiology	1
Total	74

Gender	Total
Female	68
Male	6
Total	74

Ages	Total
16-17	1
18- 24	17
25- 34	19
35- 44	15
45- 54	10
55- 64	3
64+	6
Not known	3
Total	74

Ethnicity	Total
White British	39
White Irish	6
Black African	7
Indian	4
White Other	12
Pakistani	5
Unknown	
Afro Caribbean	1
Total	74

9.9 Learning Disabilities

There are two Acute Liaison Learning Disability Nurses in the Trust. They are involved with supporting patients with Learning Disabilities (LD) and their carers when using hospital services. They work in collaboration with the named nurse for adult safeguarding to assist Trust staff in making reasonable adjustments for patients. This includes advising staff about what reasonable adjustments might be required, using appropriate communication tools for people with LD, planning elective admission and enabling appropriate discharge packages of care. They also provide training for staff around the needs of patients with a learning disability.

There is a Trust learning disability group sub group that meets bi-monthly. This is chaired by the named nurse for adult safeguarding. A work plan has been established based on the recommendations from the confidential inquiry of premature deaths of people with learning disabilities (CIPOLD). Within this group patient user feedback is discussed and shared with the divisions.

The Trust has signed up to the MENCAP Charter “Getting it right”. The aim is to ensure that:

- All people with a learning disability have an equal right to healthcare.
- All healthcare professionals have a duty to make reasonable adjustments to the treatment they provide to people with a learning disability.
- All healthcare professionals should provide a high standard of care and treatment and value the lives of people with a learning disability.

By signing this charter, we pledge to:

- ✓ Make sure that hospital passports are available and used
- ✓ Make sure all our staff understand an apply the principals of mental capacity laws
- ✓ Appoint a learning disability liaison nurse in our hospitals
- ✓ Make sure every eligible person with a learning disability can have an annual health check
- ✓ Provide ongoing Learning disability awareness training for all staff
- ✓ Listen to, respect, involve families and carers
- ✓ Provide practical support and information to families and carers
- ✓ Provide information that is accessible for people with a learning disability
- ✓ Display the getting it right principal for everyone to see

In addition the Trust has introduced easy read information and a carer's policy. The acute Liaison Learning Disability Nurses have access to the trust special register to enable them to see how many and which wards learning disabilities are on.

West Hertfordshire Hospitals NHS
NHS Trust

The table of learning disability activity is shown below:

Month 2015	No of referral West Herts	West Purple Box referrals	Emergency admissions	Planned admissions	Data collection only	Advice & Liaison	Outpatients	Out of County Referrals	Reasons for admissions
January	19	7	12	0	0	0	0	0	Seizures, respiratory infections, falls
February	19	2	12	4	0	0	1	0	Seizures, respiratory infections, falls
March	35	3	26	1	2	3	0	0	Safeguarding, diabetes, fractures, falls
April	24	8	10	4	0	0	0	0	Seizures, respiratory infections, falls
May	13	5	4	3	0	1	0	0	gynaecology, respiratory infections
June	35	6	19	3	5	2	0	0	fractures, falls PEG issues, respiratory
TOTAL	**145**	**31**	**83**	**15**	**7**	**6**	**1**	**0**	

:

9.10 Reasonable adjustments

Reasonable adjustments may be required for patients with Learning Disability to achieve equitable access to services. During 2014/115 examples of reasonable adjustments made include:

- MDT planning meetings with carers and care plan implementation for patient with complex care needs attending MRI scanning
- MDT planning meeting for patient with complex needs requiring scanning and possible surgery.
- Pre-planned visits to ward area and meeting staff to ensure patient did not become distressed when attending hospital appointment
- MDT meeting to plan discharge for patient with complex needs
- Adjustments made for side rooms and put first on procedure lists
- Agreement that LD patients are seen as a priority in Accident and Emergency

During 2014/2015 there have been audits of the care delivered for patients with a learning disability.. These have been presented in the form of user feedback and shared at the Safeguarding panel. These have also been shared at senior sister and matron meetings.

In the late part of 2015 and 2016 there are plans for reasonable adjustments audits will be undertaken and “walk the ward audits” with the health liaison nurses and the safeguarding team.

9.11 Dementia

WHHT has been actively involved in Dementia service development since 2009 following publication of the National Dementia Strategy.

It is recognised that 60-70% of acute hospital beds are occupied by people over 65 years and of these 40% will have dementia.

Developments in Dementia within West Herts Hospitals for current period

- National Dementia Audit – WHHT took part in round 1 and 2; see attached analysis and action plan.
- FAIR: Find Assess Investigate Refer- monthly reporting to CCG- have successfully met CQUIN targets. See section below.
- Cognitive Screening embedded into clerking proforma- to document/ categorise patients over 60 years: Known dementia; acutely confused (delirium); family/ patient concerns over declining memory over the last year.
- Started the Delirium Recovery Programme- has been written and submitted for publication- as a Proof of Concept- getting patients home with delirium with 24 hour live in carer has better outcomes than ‘usual’ care.
- Regular Carer surveys undertaken of patients with known dementia. There are also Carer Guidelines entitling carers to benefits such as parking when they help care for their relative on the ward.

- Developed a guideline for Acute Agitation/ Delirium and BPSD (Behavioural and Psychological Symptoms of Dementia) in partnership with Hertfordshire Partnership NHS Trust.
- Audits have been undertaken on the Use of antipsychotics in dementia. Currently in progress is the use of non pharmacological techniques in BPSD and adherence to best practice for investigation of cognitive impairment. A further review of incidents against staff is also underway.
- A Training Strategy for Trust. This is a critically important and challenging Dementia awareness is part of mandatory training, in addition there are Dementia training days for staff with direct patient contact.
- An e learning package has been written for Dementia for training of medical staff
- Regular meetings with Commissioners take place.
- Blue Clasp concept has been introduced. This is so that patients with known dementia who have to be transferred out of base ward e.g. for CXR/ CT scan are identifiable as vulnerable and in need of additional time and patience.
- In development and nearing completion: documentation: about behaviours and non pharmacological means of management.
- Multidisciplinary care notes – have been piloted on Bluebell in 2014.

9.12 Mental Health

WHHT are part of a diverse group of organisations that has joined in a county-wide partnership to implement the key aims of Crisis Care Concordat, under the governance of the Health & Wellbeing Board. As a partner organisation, it is desirable that we work together to implement the principles of the national Mental Health Crisis Care Concordat to:

- Improve the care and support available to people in crisis because of a mental health condition, so that they are kept safe and receive the most effective interventions swiftly.
- Work together to help people find the help they need − whatever the circumstances − from whichever of our services they turn to first and accept our responsibilities to reduce the likelihood of future crisis and to support people's recovery and wellbeing.

An action plan has been produced by the signatories of Hertfordshire's Mental Health Crisis Care Concordat with the overall aim of working together to make changes to systems and processes that reduce the numbers of people who experience crisis and to improve the outcomes for people who do use services.

10. Prevent

Prevent health WRAP3 is part of the governments counter terrorism strategy CONTEST and aims to stop people becoming terrorists or supporting terrorism. This is led by the home office. Prevent focuses on all forms of terrorism and operates in a pre-criminal space. The aim is to provide support and re-direction to vulnerable individuals and communities who may be at risk from being groomed into violent or terrorist activity before any crimes are committed. NHS organisations, within the HEALTH wrap Prevent agenda, are required to work with other agencies to safeguard the vulnerable of being drawn into extremist activities.
Three members of the safeguarding team have been trained to deliver WRAP3. Although prevent training is delivered as part of safeguarding additional session have been arranged for priority groups of staff. This will delivered over a 4 month period. Referrals into the CHANNEL process will be through the Hertfordshire Safeguarding Unit.

The Named Nurse Adult Safeguarding is the operational lead for Prevent lead for the Trust; The Chief Nurse has Executive responsibility; quarterly reports on Prevent activity are provided to the Prevent Lead in NHS East of England and the CCG.

11. Safeguarding Profile

There is a dedicated safeguarding site on the Trust intranet. The site is divided into two sections, adults and children. The site is updated regularly with policies, procedures, guidelines and relevant documents.

The Safeguarding Team produce a newsletter annually that is distributed across the Trust to all staff highlighting changes in legislation that are relevant to practice and highlighting national cases of interest.Posters are available in all clinical areas, detailing names and contact details of all members of the Safeguarding Team.

12. Employment Practice

The Trust has safer recruitment practices with policies in place for DBS checks. All necessary staff working within the Trust have had DBS checks, with certain groups of staff having DBS with enhanced checks (those working with children or vulnerable adults).

All volunteers within the Trust have also had DBS checks and following the Lampard (2015) report recommendations the Trust is also seeking assurance that all contractors working within the trust have also undergone safe recruitment practices.

All new job descriptions issued within the trust include a clause which reflects requirements for staff to have due regard for safeguarding adults and children.

The Trust has a policy for allegations of abuse against a member of staff. During the reporting period the policy was updated to reflect the new guidance within Working Together 2015. The Policy is due for further updating later in the year.

13. Risks

Safeguarding Children and Adults training at all Levels remains below the target of 95%, which has been set by the CCG. Significant improvements have been made during the reporting period but there is still significant work to be done particularly for Level 1 and 2. in both children and adults.

Training uptake of safeguarding adults in regard to DoLS and MCA appears to be low at 66%. The recording of this training only commenced in April 2014. A risk based approach is being taken to target where the greatest need is for this awareness and training is required. It is reassuring that the rates of DoLS applications have increased over the year which signifies a greater awareness. A train the trainer scheme has been put into place to address this risk and ten individuals are being trained to be best interest assessors to increase the knowledge base and understanding across the Trust. Training has continued to improve with inclusion of the Mental Capacity Act training into the medical induction and access to a designated person for advice.

Documentation remains a challenge. These risks following the CQC November 2014 report are on the risk register and are monitored by the safeguarding panel. Developments in 2015

have seen the introduction of new nursing documentation and new medical clerking proforma. In addition there has been a change to consent 4 to make it clearer on how MCA is documented. In addition a MCA assessment book has been developed and is being trialled to assist with improving documentation.

14. Recommendation

The Trust Board is asked to note the report and support safeguarding and the implementation of the strategic work plan 2015 - 2016

Acknowledgements

Report compiled by

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Appendix 1

Safeguarding Strategy 2014 -16

INTRODUCTION

West Hertfordshire Hospitals NHS Trust is committed to safeguarding all vulnerable patients who access services across the Trust. The term safeguarding covers everything that assists a child, young person or vulnerable adult at risk to live a life that is free from abuse and neglect and which enables them to retain independence, well-being, dignity and choice. It is about preventing abuse and neglect, as well as promoting good practice for responding to concerns on a multi -agency basis.

There was significant change in the NHS landscape during 2012-13 which saw Primary Healthcare Trusts (PCT) and the Strategic Health Authority (SHA) abolished on 1 April 2013 and the creation of Clinical Commissioning Groups (CCGs). Local Authorities took on a bigger role, assuming responsibility for public health. The Government published guidance to all NHS organizations on their responsibilities to safeguard children and adults at risk and in March 2013, published an Accountability and Assurance Framework for Safeguarding Vulnerable People in the Reformed NHS.

All providers of health services are required to be registered with the Care Quality Commission (CQC). In order to be registered, providers must ensure that those who use the services are safeguarded and that staff are suitably skilled and supported:

CQC Outcome 7: Safeguarding people who use services from abuse. The objective being that, people should be protected from abuse and staff should respect their human rights.

In April 2015 this will be **Regulation 13: Safeguarding service users from abuse and improper treatment.**

Outcome 4: Care and welfare of people who use services. The objective being that, people should get safe and appropriate care that meets their needs and supports their rights. Included in both outcomes is the implementation of the Mental Capacity Acts and the Deprivation of Liberty Safeguards

In April 2015 this will be **Regulation 12: Safe Care and Treatment.**

As a health provider we are required to demonstrate that we have safeguarding leadership and commitment at all levels of their organisation and that we are fully engaged and in support of local accountability and assurance structures, in particular via the Local Safeguarding Children Boards (LSCB), Safeguarding Adult Boards (SAB) and commissioners. Most importantly, we must ensure a culture exists where safeguarding is everybody's business and poor practice is identified, tackled and eliminated.

All health providers are required to have effective arrangements in place to safeguard vulnerable children and adults and to assure service users, carers, themselves, regulators and their commissioners that these are working. These arrangements include safe recruitment, effective training of all staff, effective supervision arrangements, working in partnership with other agencies and identification of a Named safeguarding professionals.

Our vision is to embed safeguarding across all divisions and in every aspect of the Trust's work. Safeguarding will be considered in all interactions with patients and their carers. The welfare of patients is the paramount consideration of all staff across the Trust and should be given priority above all else.

The Trust aims to achieve excellence in safeguarding and this strategy builds on the Trusts successes in safeguarding but recognises that we must strive for continuous improvement. We have taken into account the recommendations of the Francis report:

'Patients must be the first priority in all of what the NHS does by ensuring that, within available resources, they receive effective care from caring, compassionate and committed staff, working within a common culture and protected from avoidable harm and any deprivation or their basic rights

Francis Report 2013

This safeguarding strategy is aligned to the values and behaviours covered by the "6Cs" in that they naturally focus on putting the interests of the patient at the heart of the care and services given:

- Care
- Compassion
- Competence
- Communication
- Courage
- Commitment

In addition this safeguarding strategy is clearly linked to the Trust values:

Trust Values:

1. **We involve others - in all that we do our patients, their families and carers are involved and their voices are clear and influential.**

2. **We are transparent – it's safe to admit mistakes and speak out when things don't seem right, this helps us learn and improve.**

3. **We are all leaders - we value our teams and we value each other, investment is made in all of us because, in our own way, we are all talented and we all lead.**

4. **We are proud - we are proud of our hospitals and ambitious when it comes to the quality of our services and calibre of staff we employ.**

5. **We work in partnership - we work together as part of a bigger team with people within and outside our hospitals to join things up for individual patients and the wider community.**

6. **We add value - through being innovative and spending our time on the things that matter we each add value and continuously look to improve what we do.**

The Trust will use this strategy over the next 2 years to drive forward the safeguarding agenda across the organisation. In order to deliver this strategy the WHHT Safeguarding Panel will actively monitor, review and challenge the following safeguarding action plan.

West Hertfordshire Hospitals NHS
NHS Trust

The action plan is based on key objectives:

1. **We will provide positive assurance that safe and effective processes and systems are in place to effectively safeguard all patients who access services across the Trust**
2. **We will have effective systems for prevention, reporting, responding and learning**
3. **We will work in partnership to ensure effective safeguarding**
4. **We will ensure safeguarding is given a high priority**
5. **We will be a learning and improving organisation**
6. **We will have a safe and effective workforce**
7. **We will be responsive to changes in the safeguarding landscape**
8. **We will be proactive in taking the Dementia strategy forward**
9. **Safeguarding Action plan for 2014 -2016**

KEY

GREEN rating – completed but needs on going reviews
AMBER rating – in progress with issues and risks being assessed and actions in place.
RED rating – cause for concern.

STRATEGIC Objective 1 Positive assurance	**Required action**	**Action owner**	**Progress/comments**	**Time frame**	Evidence of impact/change in practice Dated September 2014	
The Trust Board and external monitors such as Hertfordshire Safeguarding Boards, the CCG and CQC will receive assurance that safe and effective processes to safeguard all vulnerable patients who access our services across WHHT are in place.	**Ensure compliance with Section 11 Children Act 2006**	**Safeguarding Lead and WACS**	**Section 11 visits take place twice yearly. Section 11 audit has taken place May 2014**	**March 2015**	The Trust is able to demonstrate compliance with Section 11 of the Children Act Section 11 inspection carried out March 2015 – recommendations made – actions within workplan	**Green**
	Ensure compliance with CQC regulation 12 and 13	**Divisional leads in conjunction with safeguarding**	**Evidence to be placed on file**	**Review at each safeguarding panel meeting**	Safeguarding activity is recognised as part of everyday practice and there is evidence to support this In the Annual Report – Training	**Amber**

STRATEGIC Objective 1 Positive assurance	Required action	Action owner	Progress/comments	Time frame	Evidence of impact/change in practice Dated September 2014	
➢ **The Trust will be prepared for unannounced and expected CQC inspections**					rates; audits; safeguarding alerts; DoLS; Sis External Safeguarding review by Chief Nurse Febuary 2015. CQC inspection April 2015 – awaiting report	
	Monitor and manage the 2013 -14 CQC safeguarding children inspection action plan for WHHT	**Safeguarding Panel**	**Updated and returned to the CCG as required. Any actions not on target will be brought to the safeguarding Panel**	**Review at each safeguarding Penal meeting**	CQC action plan completed April 2015. All actions for WHHT green with exception of training levels of compliance that remain amber.	**Green**
	Hertfordshire Safeguarding Adult Board Annual Safeguarding Audit	**Named Nurse Safeguarding Adults**	**To be completed within the required time frame and to be ready for inspection by CCG**	**January 2014**	CCG inspection took place January 2014 – action plan developed for recommendations	**Green**
	Annual Safeguarding report to be supplied to the Trust Board.	**Safeguarding Leads**	**Data being collected for report. Report complete - needs final sign off by Chief Nurse**	**Due to go to September TLEC prior to Board- Needs to go to the safeguarding panel August 2015**	Annual Report for 2013-2014 complete	
	Exception reports to be supplied to TLEC sub-groups as requested	**Deputy Director of Nursing/ Named safeguarding leads**	**Reports to be provided after each safeguarding panel**	**Reports to be provided after each safeguarding panel. Quarterly reports required for the Quality and Safety Group**	Clear Governance structures are in place Papers and Minutes	**Green**

STRATEGIC objective 2 systems for prevention. response, reporting and learning	Required action	Action owner	Progress/comments	Time frame	Evidence of impact/change in practice Dated September 2014	RAG rating
➢ RECLinked to Trust values 4 and 6 **There will continued improved intervention and practice in safeguarding vulnerable patients across the organization** **Effective and robust monitoring systems will be in place to support the safeguarding agenda**	**Audits to be carried out in line with the WHHT safeguarding audit strategy** **Develop methods of "dip dive" sampling on patient records.** **Thematic review of safeguarding incidents** **Thematic review of complaints relating to safeguarding**	**Safeguarding team**	**Annual safeguarding record keeping audit underway**	**January 2014**	**January 2015 Panel Minutes/ Report reviewed.** **Actions in progress.**	**Green**
			RECOMMMENDATIONS **1.Training and awareness raising of documentation of witnessed/unwitnessed injury** **2. Training for A and E/CED FY2 doctors to complete safeguarding box for every attendance** **3.. Re audit in line with WHHT audit policy and regular dip sample audits to panel**	**ACTION/RESPONSIBILITY** **1. Include in SG training to relevant staff and individual awareness raising after daily checking of cards by SG team** **2.Training by SG team on induction every 4 months** **3. To be done in 6 months by SG team. Dip samples to be brought to panel every 6 weeks**	**TIMESCALES/EVIDENCE** **1. Review at next audit Aug 2016 Audit plan within Safeguarding audit Strategy** **2. Ongoing on induction** **3. Aug 2015**	**Green**
			Deep dive audits to be carried out for Section 11 (Children Act). Similar approach being developed by CCG for safeguarding adults	**TBC by CCG**	**Audit Reports completed by CCG Neonatal deep dive audit in progress Reported to Safeguarding panel January 2015 with recommendations and action plans**	**Green**
			CED/AE AUDIT RECOMMENDATIONS **1. All children's notes should have a record of who has parental responsibility.** **2.Assessment checklist tool for referral to paeds to be considered**	**ACTION/RESPONSIBILITY** **1. Review of records to incorporate box for documentation of who holds PR by CED manager/safeguarding team** **2. Consideration by SG team as to whether a checklist tool is necessary in view of current practice/policies**	**TIMESCALE/EVIDENCE** **1. Review by March 2015 and change at next record reprint – reviewed and changes to recording PR will now be included at next record print** **2. March 2015 – reviewed by SG team – current guidelines/policy adequate for when to refer a child to paeds**	**Green**
			STARFISH AUDIT RECOMMENDATIONS **1. All staff to have access to an nhs.net email account for referrals to Children's**	**ACTION/RESPONSIBILITY** **1. IT to run project to investigate options**	**TIMESCALE/EVIDENCE** **1. Project commenced March 2015 by IT. Controls in place to mitigate**	**Amber**

STRATEGIC Objective 1 Positive assurance	Required action	Action owner	Progress/comments	Time frame	Evidence of impact/change in practice Dated September 2014	
➢ Linked to Trust values 4 and 6 **There will continued improved intervention and practice in safeguarding vulnerable patients across the organization –cont.** **Effective and robust monitoring systems will be in place to support the safeguarding agenda – cont.**			**Services**	**Continued daily review of all referrals sent and received**	**risks of paper referrals.**	
			SCBU AUDIT RECOMMENDATIONS **1. Internal measures to be implemented to ensure staff use contact sheets** **2. Internal measures to be implemented to ensure staff record parental responsibility for all babies** **3. SG team to consider/evidence Think Family Toolkit or SG checklist for use by department**	**ACTION/RESPONSIBILITY** **1. Formal process/guidelines about use of contact sheets to be developed by SG team and Snr nursing team SCBU** **2. Review of existing records to consider introduction of area to record PR by Snr SCBU staff** **3. Review by SG team and consider relevance for use in neonatal unit**	**TIMESCALE/EVIDENCE** **1. March 2015 – Guidelines developed by SCBU staff and in place** **2. Rv by March 2015 to consider including in next record print – reviewed and will be included in next print** **3. March 2015 – reviewed safeguarding info available in department and plan for documentation available**	**Green**
			AUDIT OF STANDARD OF WRITTEN REFERRALS TO CS	**Complete for children 2014 – report to go to October 2014 panel**	**Reported to Safeguarding panel January 2015**	**Green**
			RECOMMENDATIONS **1. Level 3 training to include information on correct completion of referrals** **2. Trust to provide safe, timely electronic system for referrals to CS**	**ACTION/RESPONSIBILITY** **1. Inclusion in all training by SG team** **2. IT project to examine options in Trust by IT department** **SG team to refer electronically if**	**TIMESCALES/EVIDENCE** **1. ongoing** **2. Ongoing – action noted earlier in workplan and will be reported**	**Green**

STRATEGIC Objective 1 Positive assurance	Required action	Action owner	Progress/comments	Time frame	Evidence of impact/change in practice Dated September 2014	
			3. Re audit in line with WHHT audit policy and regular dip sample audits to panel	**access to secure system avavilable** **3. To be done in 6 months by SG team. Dip samples to be brought to panel every 6 weeks**	**3. July 2015 – Audit plan within safeguarding audit policy**	
			AUDIT OF DNA POLICY FOR PAEDIATRIC OUT PATIENTS	**Complete as recommendation of Sct 11 audit. Report to go to panel Jan 2015**	**Reported to safeguarding panel January 2015**	**Green**
			RECOMMENDATIONS **1. Review of letters to be sent and who needs to receive a copy and ensure a DNA letter is sent to CS if there are safeguarding concerns.** **2. Awareness raising of policy within paediatric out patients and medical team** **3. More formal processes for DNA to be developed in high risk areas in the Trust**	**ACTION/RESPONSIBILITY** **1. Review existing policy by SG team** **2. Following review - policy to be sent to all paediatric consultants , registrars and outpatient secretaries.** **3. DNA process for fracture clinic by clinical treams and SG team**	**TIMESCALES/EVIDENCE** **1. March 2015 – review done by Named Consultant and Named Nurse** **2. March 2015 - done** **3. April 2015 – done – virtual fracture clinic being developed – Safeguarding issues and follow up children who are non contactable to be written into operating policy**	**Green**
			Mental capacity assessment audit complete.	**In progress for 2014- report to go to June Panel 2014 – Action plan under development February 2015 Quality and Safety Group. Next Safeguarding Panel**	Improved awareness and understanding of how to apply the MCA is practice. MCA training is part of the vulnerable patients study day.	**Green**

STRATEGIC Objective 1 Positive assurance	Required action	Action owner	Progress/comments	Time frame	Evidence of impact/change in practice Dated September 2014	
				March 2015.	MCA audit completed and reported to safeguarding panel January 2015. Audit on consent completed in February 2015 Action plan under development	
	WHHT safeguarding strategy to be reviewed and to be combined for both adults and children.	**Safeguarding Leads**	**This audit strategy to be reviewed and to include smaller more frequent audits to give a wider range of assurances regarding clinical practice.**	**May 2015**	Draft audit strategy presented to panel April 2015 – awaiting comments and final strategy to panel May	**Green**
	The Trust will be responsive to findings and recommendations from the Jimmy Savile enquiry	**Safeguarding Panel**	**Review all investigation reports and recommendations currently available from other Trusts involved and draft report for the WHHT safeguarding panel**	**October 2014 safeguarding panel Further work being completed on the gap analysis. March 2015.**	Current practice, policies and procedures will be reviewed to ensure relevant learning and recommendations from investigations are implemented. Gap Analysis being produced for the March 2014 safeguarding panel Report with local gap analysis and action plan reported to panel April 2015	**Green**
			Gaps **1. All subcontractors working within WHHT should have undergone safe recruitment proceedures with assurance provided to the Trust** **2. Recommendation from Lampard report that DBS checks should be done 3 yrly – current WHHT policy is 5 yrs** **3. Trust internet policy needs to include safe use of social media incorporating safeguarding and needs to**	**Action needed** **1. Assurance provided and monitored via Safeguarding panel** **2. Consideration needed regarding review and change of existing WHHT policy** **3. Policy in place – mobile**	**Responsibility/Time frame** **1. Director of Estates/ Head of Trust Security – July 2015** **2. Workforce and Human resources –July 2015 – Review of DBS policy through Workforce committee**	**Amber**

STRATEGIC Objective 1 Positive assurance	Required action	Action owner	Progress/comments	Time frame	Evidence of impact/change in practice Dated September 2014	
			include staff, patients and visitors	**phone information for visitors to be available across Trust**	**3. Communications/informatics – July 2015**	
			Final report with recommendations for Health is not yet available from DOH	**Safeguarding Panel to review when report is available**	VIP/celebrities policy ratified at the September 2014 safeguarding panel.	**Green**
	Safeguarding adult database to be maintained and cross referenced with hospital social workers and tissue viability	**Named Nurse safeguarding Adults**	**This is maintained by safeguarding admin and the Named Nurse Safeguarding Adults**	**Review effectiveness July 2015**	Referrals and patients being admitted from Care homes with high grade pressure ulcers are tracked. Reported at the CCG quality contract meeting. Review to be undertaken by March 2015 to go to panel.	**Green**
	A database recording authorizations for deprivation of Liberty safeguards will be maintained	**Named Nurse safeguarding Adults**	**Maintained by safeguarding admin support. DoLs forms are hyperlinked to the spreadsheet**	**Review July 2014**	The Trust is able to demonstrate that appropriate number of DoLS applications are made and that CQC nonfiction forms are completed and sent off in a timely manner. Data base./ Annual Report/ CCG quality contract meeting and QSR group.	**Green**
	A database recording midwives attendance at child protection conferences will be maintained	**Named Midwife safeguarding**	**Database maintained by safeguarding admin support**	**Data required for next Section 11 visit – date TBC**	Midwives will attend conferences for unborn babies and/or supply a written report. Non attendance is challenged and monitored Report available	**Green**
	The psychosocial file for maternity safeguarding will be maintained	**Named Midwife safeguarding**	**Database maintained by Named Midwife and safeguarding Admin, could be improved by adding hyperlinks of the birth plans**	**May 2014** **Ongoing as a live a document**	Allows the most recent and up to date information to be added. The birth plans are hyperlinked in and are accessible to the midwives who have access to the G drive Database.	**Green**

STRATEGIC Objective 1 Positive assurance	Required action	Action owner	Progress/comments	Time frame	Evidence of impact/change in practice Dated September 2014	
	WHHT will be responsive to requests to participate in safeguarding children telephone strategy meeting	**Safeguarding children team and Named midwife**	**All requests for telephone strategy meetings go into the WHHT safeguarding NHS.net in box. This is checked several times per day by safeguarding team**	**Number of telephone strategy meetings that WHHt have participated in is reported to every Safeguarding panel**	WHHT are involved in safeguarding discussions/decisions at the earliest opportunity - demonstrates effective partnership working Records of the strategy discussions available.	**Green**
	All current birth plans for UBB with child protection concerns need to made available electronically to the midwives	**Named Midwife Safeguarding**	**Improvements in the current system are being made**	**April - May 2014**	Information regarding high risk cases is readily available in a different format therefore increasing accessibility to relevant information in a confidential manner Database.	**Green**
	All referrals will be imputed on "Infoflex" to provide data for reports and monitoring	**Safeguarding administrator**	**Ongoing action as a live system**	**Data to be supplied in the form of safeguarding annual report September 2014** **July 2015**	Annual report.	**Green**
	Awareness of FGM needs to be increased across the organization ➢ **Develop an FGM policy** ➢ **Ensure FGM is included in relevant safeguarding training** ➢ **Ensure the Trust is compliant with reporting requirements of FGM within the NHS and mandatory reporting**	**Named Midwife for Safeguarding and Safeguarding Team.** **Named midwife for Safeguarding Children**	**Draft policy under review** **Review content of level 3 safeguarding training to ensure FGM is adequately covered** **FGM information to be included in Level 2 Safeguarding children training – recommendation from S11 visit 2015** **Task and Finish group to be set up with key Trust personnel to ensure full compliance with NHS reporting.** **Mandatory reporting to**	**March 2015** **Done – training reviewed** **Done – FGM slides incoporated within Level 2** **Ongoing – data collection form developed** **August 2015**	FGM policy awaiting final ratification – via WACS Paper presented to panel March 2015	**Amber**

STRATEGIC Objective 1 Positive assurance	Required action	Action owner	Progress/comments	Time frame	Evidence of impact/change in practice Dated September 2014	
			commence within 2015 – trust to ensure clear reporting process in place to enable staff to fulfill the legal requirement		outlining plans for mandatory reporting	

STRATEGIC objective 3 partnership and collaborative working	Required action	Action owner	Progress/comments	Time frame	Evidence of impact/change in practice	
➢ **Linked to Trust value 5** **We will work in Partnership with Hertfordshire Safeguarding Adult and Children Board and other external organisations in order to improve outcomes for all vulnerable patients who access our services**	**Trust representation at Exec level at the Safeguarding Children Board**	**Executive lead for Safeguarding**	**Chief Nurse is a member of the Safeguarding Children Board**	**Ongoing requirements**	The trust will be able to demonstrate effective partnership working Minutes noted at the Trust safeguarding panel.	**Green**
	Trust representation at Safeguarding Adult Board	**Executive lead for Safeguarding**	**Currently attended by Deputy Director of Nursing and Head of safeguarding**			**Green**
	Trust representation at HSAB and HSCB sub-groups	**Executive lead for Safeguarding/Deputy Director of Nursing**	**HSAB/HSCB training subgroup attended by Named Nurse safeguarding adults. HSCB training evaluation sub-group attended by Lead Safeguarding Nurse**			**Green**
	The Domestic abuse strategy will be developed across the Trust ➢ **Domestic abuse policy needs developing** ➢ **IDVA to be in post from July 2014 for 9 months**	**Adult safeguarding lead**	**Independent domestic violence advisor has been commissioned by the Police and will be in post at WHHT for 6-12 months. Update report to January safeguarding Panel. Funding has been continued for next 6 months from April 2015 – IDVA resigned and awaiting new recruitment and appointment**	**September 2014** **March 2015**	Increased awareness of the impact Domestic Abuse across the organization IDVA reports at the safeguarding panel. Training database to be developed. Increased referral rates.	**Amber**

STRATEGIC objective 3 partnership and collaborative working	Required action	Action owner	Progress/comments	Time frame	Evidence of impact/change in practice	
			Domestic Violence policy done and awaiting ratification May 2015			
			MARAC is attended regularly by safeguarding team	**N.A**	Vulnerable patients including children who are exposed to domestic abuse are recognized by the Trust, agencies work together effectively to reduce risk. Minutes record involvement.	**Green**
	The Trust will be responsive to participate in Serious Case Reviews and Domestic Homicide reviews		**No SCR's or DHR's during 2014 so far. This will be updated as required** **2 SCRS with WHHT involvement in 2015 (one historical case)** **1 DHR in 2015**	**Feedback from WHHT required on 2 SCR's in E&N HERTS by December 2014 Completed.** **Response requested from HSCB re recommendations for WHHT – submitted April 2015. Chronology and IMR requested by Bradford SCB – May 2015** **Awaiting request for info**	WHHT will review practice against recommendations in reports Completed.	**Green**
	The Trust will ensure that court orders and requests for records relating to child care proceedings are efficiently dealt with		**A system has been set up which allows the local authority legal office to email requests to the WHHT NHS. Net safeguarding in box**	**Review effectiveness and use of the in box December 2014 – done. All processes working well**	Court orders and requests for information from local legal offices will be handled in a timely and efficient manner.	**Green**

STRATEGIC objective 3 partnership and collaborative working	Required action	Action owner	Progress/comments	Time frame	Evidence of impact/change in practice	
➢ **Learning Disabilities** **Patients with learning**	**The Trust will ensure increased awareness in regard to CSE**	**Safeguarding Leads**	**Increasing awareness in the Trust in regard to CSE** **CSE included in Level 2 and 3 Safeguarding Children training** **Examine the utilisation of under 16 proforma within paediatrics**	**July 2015** **Done** **July 2015**	Report to Panel January 2015 re Rotherham. Sexual health staff have had training by Op Halo.	**Amber**
	Close partnership working with the Acute Health Liaison team and community learning disability team.	**Safeguarding team**		**July 2014**	LD Action Plan. Minutes of the sub group. Examples of good practice cases.	**Green**
	A learning Disabilities sub – group of the safeguarding panel needs to be effective and responsive	**Chair LD sub - group**	**Action plan for the sub –group is being developed - done**	**October 2014**	The needs of patients with learning difficulties of this patient group will be met and reasonable adjustments made	**Green**
	The "Purple Strategy" needs to be implemented on all wards and department – action plan to address this is required.	**Health Liaison Team/learning disability sub-group representatives**	**Reasonable adjustments audit is underway. Will be reported into the LD sub-group**	**August 2015**	Audit needs to be completed	**Amber**
	Further easy read leaflets are required	**Health Liaison Team**	**The LD sub –group to map and assess what further leaflets are required** **Signage projects in place.**	**December 2014** **August 2015**	Patients with additional needs will be able to access information relating to their care needs lead by the adult safeguarding lead.	**Amber**

STRATEGIC objective 3 partnership and collaborative working	Required action	Action owner	Progress/comments	Time frame	Evidence of impact/change in practice	
disabilities and autism will be assessed to ensure reasonable adjustments are made based on their individual needs	**Further information for patients with learning disabilities is needed on the Trust Internet home page**	**Head of safeguarding in conjunction with Patient and public involvement and communications team**	**Needs further discussion with Communications team**	**September 2015**	Patients with additional needs will be able to access information relating to their care needs and hospital services	**Amber**

STRATEGIC objective 4 Safeguarding all patients has a high priority across the organization	Required action	Action owner	Progress/comments	Time frame/evidence of impact	Evidence of impact/change in practice	
➢ **Linked to Trust value 5** **We will have a clear focus on safeguarding all vulnerable patients who access services across the Trust and share information appropriately**	**Our commitment to safeguarding all vulnerable patients is clearly stated in relevant documents and policies.**	**Safeguarding Panel**	**Our commitment to safeguarding is included in all staff contracts.**		On file in HR dept.	**Green**
	A safeguarding newsletter will be produced bi –annually that will be distributed to all staff across the 3 sites of the Trust	**Safeguarding Team with contributions from wider teams eg learning disability, tissue viability**		**September 2015**		**Amber**
	Our commitment to safeguarding is clearly stated on the Trust Intranet home page	**Head of Safeguarding in consultation with Director of Communications**		**December 2014**		**Green**

	Safeguarding risks across maternity services will be recognized and acted upon	**Named Midwife Safeguarding and Head of Maternity Services**	**Risk assessment s have been completed highlighting increased number of unborn babies subject to CPIPP, changes to community midwifery structure and role of safeguarding adult midwife** **Name Midwife post vacant from mid September.** **Interim structure in place Reported to panel November 2014.** **January 2015.**	**Immediate Reporting to safeguarding panel. Under Review.**	There will be safe and effective safeguarding processes across maternity services. Mitigations : Head of Midwifery developing an action plan. NICE guideline gap analysis being completed. Management of Change of the workforce. Restructure of the community midwife system to ensure more named midwives The post of named safeguarding midwife is being covered on an interim basis. Risks be monitored by the WaC Division and escalated accordingly.	**Amber**
STRATEGIC Objectives 5 The Trust will be a learning and improving organisation	**Required action**	**Action owner**	**Progress/comments**	**Time frame/evidence of impact**	Evidence of impact/change in practice	
➢ **Linked to Trust value 2** **We will have consistent and high standards for responding to, reporting and learning from safeguarding incidents** **We will systematically learn and improve practice through experience**	**Safeguarding incidents will be escalated appropriately**	**Divisional leads and Risk leads**	**Raised awareness of safeguarding results in higher number of incidents and referrals**	**Information provided for the safeguarding annual report**	There is raised awareness of safeguarding. Annual Report. QSR reports. CCG reports.	**Green**
	The safeguarding Panel to monitor SI action plans relating to safeguarding.	**Safeguarding Leads**	**SI action plans related to safeguarding to be a standing item on the Panel agenda**	**Reports will provided to the safeguarding committee via divisions**	There is effective learning and changes in practice Minutes of the safeguarding panel.	**Green**
	A thematic review which will include triangulation of outcomes from safeguarding incidents will be provided for the safeguarding panel.	**Safeguarding Leads/Deputy Director of Nursing**	**To be included in safeguarding annual report for the Board 2015** **Review to be reported back to panel**	**April 2014 – July 2015**	There is an overview of safeguarding practice which reflects awareness of safeguarding across the organization	**Amber**

STRATEGICObjective 6 Effective and safe workforce is in place	**Required action**	**Action owner**	**Progress/comments**	**Time frame/evidence of impact**	Evidence of impact/change in practice	
➢ **Linked to Trust Values 3 and 6** **a. We will have a suitably trained workforce who recognize and respond appropriately to safeguarding.** **b. Staff will demonstrate the values and competencies required to effectively safeguard and promote the welfare of patients** **c. The Trust will be responsive to new training**	**Mandatory training rates will be monitored by the Safeguarding Panel and we will build on progress made over the last 2 years.** **Target of 90% compliance across all safeguarding training CCG requiring 95%**	**Divisional leads in conjunction with the Safeguarding Panel**	**Training needs analysis has taken place** **Safeguarding training strategy in place for 2014 -16** **Safeguarding training is mandatory for all staff and reported monthly**	**Reported monthly and monitored by the safeguarding panel.** **Each Division is aware of the groups of staff that they need to target.**	Current training rates December 2014: Children level 1 – 86% Children Level 2 – 85% Children level 3 – 68% Current training rates May 2015 Level 1 – 86% Level 2 – 91% Level 3 – 93%	**Amber**
					Adult level 1 82% Dec 14 Adult level 1 – 81% Mar 2015 Adult Level 1 – 83% May 2015	**Amber**
					Adults Level 2 – 65% Adult level 2 – 77% Dec 14 Adult Level 2 – 85% Mar 2015 Adult Level 2 – 87% May 2015	**Amber**

requirements resulting from the national safeguarding agenda			**A safeguarding vulnerable patients day has been established as part of the mandatory training framework**	**Review evaluations since January 2014 in June 2014**	The profile of safeguarding for all staff is raised and staff are aware of their responsibilities to safeguard all patients. Current evaluations of the safeguarding day are very good. Training Database	**Green**
	Divisions will be required to report training rates to the safeguarding panel	**Heads of Division**	**Template has been designed and circulated. Not all divisions are engaging with this requirement**	**Review at each panel**	The divisions will take responsibility for ensuring safeguarding remains a high priority	**Amber**
	PREVENT agenda requires certain groups of staff to receive training **PREVENT training to be mapped against the Intercollegiate Document 2014** **WHHT PREVENT(healthwrap) strategy needs developing**	**Named Nurse Safeguarding Adults**	**Prevent training has been mapped against the Intercollegiate document 2014. This is reflected in the safeguarding training strategy 2014** **Training yet to rolled out** **Safeguarding team with training depart to develop plan for rolling out of Healthwrap 3**	**September 2015**	The Prevent agenda will be part of mandatory safeguarding training Train the trainer completed by 3 members of safeguarding team	**Amber**
	Level 2 safeguarding vulnerable adults e. Learning package needs developing	**Named Nurse Safeguarding Adults**	**Level 2 package has been commissioned and currently under development by an external consultant**	**Sept 2015**	Improved uptake of level 2 to reach a target of 95% compliance	**Amber**
	Ensure that adult safeguarding is embedded within the appraisal and supervision process	**Named Nurse safeguarding adults, Deputy Chief Nurse, Executive Leads**	**The value based appraisal system checks on compliance with mandatory training. Safeguarding adults is part of mandatory training framework**	**August 2015**		**Amber**

	Regular review of the safeguarding intranet site to ensure it is relevant and up to date	**Safeguarding Leads Named Nurse Safeguarding Adults**	**The safeguarding intranet site is well used and relevant to staff**	**September 2014 Recent review march 2015**	Staff are able to access useful and relevant information relating to safeguarding easily	**Green**
	All Volunteer staff (400)require level 1 safeguarding children and adult training in line with the Intercollegiate document 2014	**Volunteer manager and safeguarding team**	**Data has been cleansed to ensure accurate number of volunteers. Action plan and training plan has been devised. Plan to commence roll out of training from October 2014**	**Due for completion end May 2015 All current volunteers in post have completed safeguarding training.**	All staff whatever their role will be aware of their safeguarding responsibilities Action plan at the safeguarding panel September 2014 and minutes. Presented to panel January 2015	**Green**
	Social Care Act comes into force in April 2015	**Adult safeguarding leads**	**Review of relevant policies to ensure they reflect the Social Care Act**	**April 2015**	Done – all policies altered to reflect changes	**Green**
STRATEGIC AIM 7 The trust will be responsive to changes in legislation that impact the safeguarding agenda	**Required action**	**Action owner**	**Progress**	**Time frame/evidence of impact**	Evidence of impact/change in practice	
We will be responsive to new legislation resulting from the Care Act 2014 **We will be responsive to changes in the Deprivation of Liberty Safeguards legislation (March 2014)**	**The definition of Deprivation of Liberty Safeguards (DOLS) was revised in March 2014 following High Court ruling** **The number of urgent and standard DOLS applications made by the Trust will increase and the organization needs to be responsive to this.**	**Deputy Director of Nursing and Named Nurse Safeguarding Adults**	**Legal advice taken. DoLS policy revised**	**April 2014**	The Trust will make appropriate DOLS applications in line with the new ruling Annual Report. CCG report.	**Green**
			The number of DOLS applications has significantly increased. A database has been set up to manage and track the applications. CQC notifications are sent in a timely way. Recent Train the Trainers event to include more senior staff to support the process within the Trust	**September 2015**	More patients are now subject to DoLs and there is an efficient method of managing this. Train the Trainer completed – 9 attended. Programme being developed to roll out may 2015	**Green**

	External audit required to provide assurance around examine mental capacity assessments and Trust documentation	**External Agency via CCG**	**Plan for 28th and 29th May on Sarratt Ward. Report back to trust with findings and recommendations**	**September 2015**	Scrutiny and challenge visit completed. Report has been reviewed at panel. Action plan to be completed.	**Green**
	Trust needs to have a greater number of best interest assessors.	**Deputy Director of Nursing and Named Nurse Safeguarding Adults**	**Funding secured via CCG. 10 places available. Information out to all relevant staff and awaiting applications**	**Course commences July 2015**		**Amber**
	Consider development of an information booklet/card MCA and DOLS	**Safeguarding panel Posters**	**In progress**	**July 2015**		**Amber**
	WHHT DOLS policy needs amending to reflect the changes	**Named Nurse safeguarding Adults**	**WHHT policy has been amended to reflect the recent changes**	**Ratified at October safeguarding Panel**	On Target In light of new information being reviewed.	**Green**
STRATEGIC AIM 8 The Trust will be responsive and proactive in taking the Dementia Strategy forward	**Action Required**	**Action owner**	**Progress**	**Time frame/evidence of impact**	Evidence of impact/change in practice	
CQUIN targets (Find, assess investigate and refer)	**Dementia implementation group action plan in place**	**Dementia Implementation Group**	**Minutes of the DIG are sent to the safeguarding panel. Dementia lead nurse attends the safeguarding Panel**	**On going to April 2015**	The specific needs of patients with dementia are recognized and care/practice is improved	**Green**
	The Trust will work in partnership with the Alzheimer's Society	**Lead Nurse Dementia**	**As from April 2014The Alzheimer's society will be visiting Bluebell ward on the last Friday of every month.**	**July 2014**	Carers will be supported in the community post discharge. Living well with Dementia will be promoted	**Green**

			Monitor progress and report to the DIG			

Appendix 2

Safeguarding Structure