Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 25 October 2017

Title and Author of Paper: Annual Safeguarding & Public Protection Report

Jan Grey, Associate Director of Safer Care

Executive Lead: Gary O'Hare, Executive Director of Nursing and Chief Operating Officer

Paper for Debate, Decision or Information: Information

Key Points to Note:

The Trust Safeguarding and Public Protection annual report covers the period from April 2016 to March 2017.

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.

The following regulations require compliance

- CQC Regulation 13 : Safeguarding service users from abuse and improper treatment
- CQC Regulation 12 : Safe care and treatment
- Section 11 of the Children Act 2004
- Working Together to Safeguard Children 2015
- Care Act 2014
- Mental Capacity Act 2007.
- Deprivation of Liberty Safeguards 2009
- The CQC fundamental standards safeguarding from abuse

The report outlines the progress that has been made in safeguarding the health and wellbeing of patients and carers. It highlights areas where the safeguarding and public protection team are continuing to develop and offers an insight into the safeguarding priorities for the organisation.

Risks Highlighted to Board : None

Does this affect any Board Assurance Framework/Corporate Risks? No

Equal Opportunities, Legal and Other Implications: None

Outcome Required: The Board of Directors to note the content of this report.

Link to Policies and Strategies:

- Care Act 2014,
- Working Together to Safeguard Children 2015
- Children's Act 2004

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Safeguarding and Public Protection Annual Report 2016/2017

Shining a light on the future

Contents

Introduction

This annual report gives an account of the safeguarding activity across Northumberland Tyne and Wear NHS Foundation Trust. The report covers the period April 2016 – March 2017. The annual report demonstrates the organisations commitment to protecting children, young people and vulnerable adults at risk of harm across all service areas. It provides an overview of some of the key safeguarding activity that is supported, co-ordinated and scrutinised by Clinical Commissioning Groups (CCGs), Local Safeguard Children Boards (LSCBs) and Local Safeguarding Adult Boards (LSABs). 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 safe recruitment, effective training of all staff, effective supervision arrangements, working in partnership with other agencies and identification of a Named Doctor and a Named Nurse.

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.

Safeguarding continues to have a high national priority. There have been several high profile cases and reviews in the reporting year. This has led to greater scrutiny of organisations safeguarding responsibilities.

Safeguarding activity across the Trust continues to increase in volume and complexity. Safeguarding concerns are positively being recognised more frequently across clinical areas. Trust staff need to always consider that there is a child behind every parent and a parent behind every child.

"Safeguarding is everybody's business"

Safeguarding and Public Protection Team (SAPP)

Operational Management Developments

In 2016 post corporate transformation the Safeguarding and Public Protection Team (SAPP) reviewed and developed a revised "triage front door" for both trust staff and external partners in all aspects of safeguarding and public protection advice and support. Trust staff now access the SAPP *front door* by the completion of a web based report replacing the previous access via a telephone call. Urgent concerns continue to be taken via telephone. The SAPP triage worker timely reviews every web based incident, provides advice and documents in service users health records any actions and outcome required to safeguard.

From January 2017 the new triage operational model has been in place and in the first quarter the safeguarding concerns reported have almost doubled. This increase was

anticipated as the review of the triage system indicated the telephone calls into the SAPP team did not equate to the web based reports requested post advice from the triage worker.

In 2015 the SAPP team were able to support two new secondments. The first was for a SAPP Practitioner to be seconded to Gateshead Adult MASH (multi- agency adult safeguarding hub) to work closely with partners agencies, of serial victims of domestic abuse and complex safeguarding cases. This post has added an additional layer of safeguarding support and advice for clinical staff in NTW as well as crucially an additional layer of support to service users, signposting to the most appropriate and relevant services to meet their needs. The post within the MASH has enhanced, timely, information sharing and communication between different agencies when the client is complex ensuring NTW clinical staff are provided the information to assess, address and wherever possible reduce risk. The post also informs professionals accessing MASH about referral pathways so that they access the relevant service in a timely way, reducing impact of inappropriate referrals to mental health services to ensure the best outcome for the client. The SAPP worker provides supervision of cases to MASH professionals to support clients effectively reducing contact with NTW Crisis Services. This secondment is currently ongoing.

The second secondment was within the SAPP team as a Case Review Report Writer for safeguarding Serious Case Reviews and Serious Adult Reviews. The main task of this post was to compile agency reports on behalf of the Trust which would contribute to Serious Case Reviews (SCR) for Children, Safeguarding Adult Reviews (SAR) and Domestic Homicide Reviews (DHR). The SCR and SAR reports were predominantly in relation to sexual exploitation of vulnerable adults and children of which reports were compiled identifying risks across single and multi-agencies and where appropriate making recommendations and developing action plans for trust services. The SAPP Report Writer also contributed to the development of and facilitation of the 'risk to others' training package for CYPS staff, based on a local DHR. This post ended March 2017.

Key achievements 2016/2017

The safeguarding and public protection team have and are continuing to work with safeguarding multi agency partners in reviewing the current models of safeguarding and public protection to reduce the amount of duplication of meetings and streamline resources to be able to provide timely plans to safeguard and protect individuals and families.

The SAPP team continue to assist in the review of the LSCBs with health colleagues, police and local government to determine multi-agency arrangements for protecting and safeguarding children post Wood report.

The safeguarding and public protection team have contributed to serious case reviews, serious adult reviews, and domestic homicide reviews, embedding learning into

practice, including the development of storyboards to share the learning across the organisation.

The SAPP Practitioners have developed knowledge, skills and expertise to provide advice, support and supervision across all areas of safeguarding and public protection in respect of their new roles and responsibilities post corporate transformation.

The Head of Safeguarding and Public Protection has facilitated two multi agency Learning Reviews for two Local Safeguarding Children Boards with an associated report and multi-agency recommendations.

The SAPP Practitioners and several staff from CYPS have undergone two days training in Child Protection Supervision to enable clinicians working with children and young people on a Child Protection Plan to receive required supervision.

The Head of SAPP and SAPP Report Writer have undertaken the Trust "Risk to Others" train the trainers course and have developed a bespoke training pack for CYPS in respect of recommendations from a Domestic Homicide Review. In turn several CYPS staff have undergone the bespoke train the trainers pack and are currently rolling this training out across CYPS trust wide.

The SAPP team in 2016 have improved the process for all 6 local authority areas Children's Social Care departments to identify if any children are known to the Trust. The SAPP Admin then ensure that all clinician's involved with the child and family are invited to the Initial Child Protection Conference and are required to provide a report.

The SAPP Team have deputised for Trust Directors in attendance at Safeguarding Boards as well as completing multi-agency work required from those boards, e.g. Audits, Task and Finish Groups, Consultations and complex strategy meetings.

Public Protection /Safeguarding Adults

The Adult at Risk Policy and the MAPPA policy have been reviewed as per Trust requirements ensuring any local learning from case reviews and any national legislative changes have been incorporated.

The team continues to attend MAPPA meetings, facilitates robust referrals thus ensuring the Trust contributes effectively in safeguarding both patients and the wider public in doing so.

Female Genital Mutilation- an amendment to the Serious Crime Act 2015, introduced a new mandatory duty from the 31st October 2015. It requires regulated health professionals to report `known` cases of FGM in under 18 year olds. This includes if a professional is informed by a girl that an act of FGM has been carried out on her, or if they observe physical signs to show that an act of FGM has been carried out. The professional has to report the case as soon as possible to the police via the 101 phone

line. Failure to do so could result in the health professional being reported to their regulating body, under fitness to practice. FGM awareness is included in the Trust Induction and refresher training.

Domestic Abuse/Safeguarding Children

The Safeguarding Children and the Domestic Abuse policy have been reviewed as per trust requirements, ensuring any local learning from case reviews and any national legislative changes have been incorporated.

The current MARAC process continues to be discussed with all agencies and its impact on victims protection. Several options have been considered of revising the current MARAC arrangements from a fortnightly meeting with a suggested pilot of a daily MARAC that is awaiting commencement in one LA area.

The LSCBs in 2016/17 have adopted the DfE suggested new models of undertaking Serious Case Reviews including multi agency practitioners who were involved with the family to attend learning events to inform an Independent Reviewers report including recommendations. NTW practitioners involved in the care and treatment have attended the learning events and played an integral part in identifying learning in both single and multi-agency action planning. Their commitment to safeguarding and identifying learning from cases has been exemplary.

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. A process has been put in place within CYPS and the SAPP team to identify via health records the children on a Child Protection Plan to ensure practitioners receive the required safeguarding supervision.

CQC Inspection

The CQC report published in September 2016 highlighted Safe Care being rated as good. Staff across services have a good understanding of safeguarding and were able to explain the safeguarding procedure. There was evidence of appropriate safeguarding referrals to local safeguarding teams and attendance at multi-disciplinary meetings with the local authority. Safeguarding policies were in place and in date. The Inspectors identified routinely within Inpatient wards, nursing handovers took place at each shift change and that staff discussed each patient's current presentation and issues such as risk management or safeguarding.

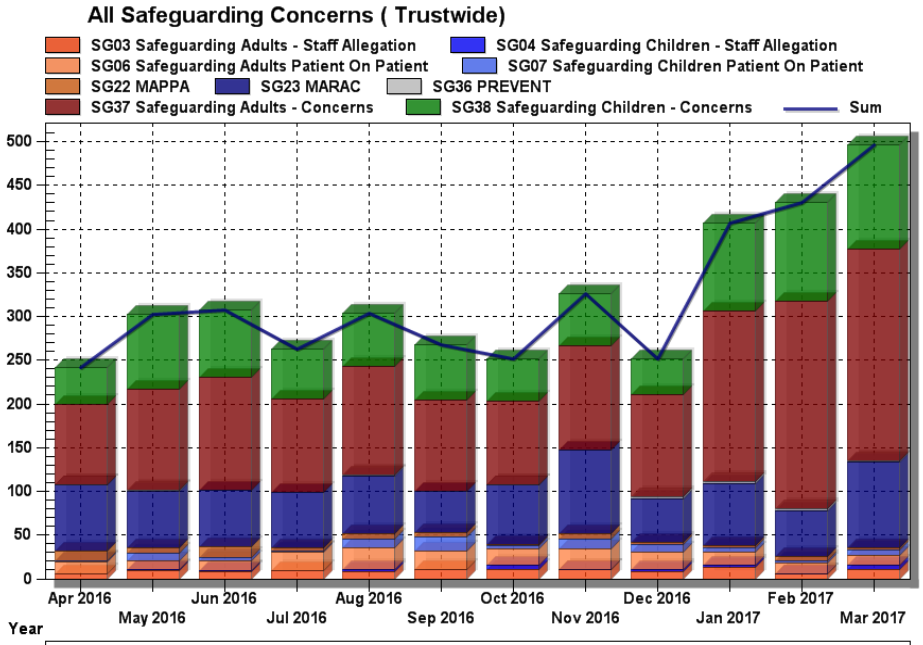
Statistical Safeguarding and Public Protection

The SAPP team uses data generated from the web based incident forms used across the organisation. The incident forms track appropriate actions. They categorise the

cause of concern, threshold of concern, where the concern was raised and the outcome.

This information is collected into quarterly dashboards, scrutinised and is used to identify “hotspots “target training and provide supervision by the SAPP team.

The safeguarding performance dashboards are shared with the Trust Quality and Performance Committee as well as SAFE groups.



Year	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017
SG03 Safeguarding Adults - Staff Allegation	5	9	8	9	8	11	11	10	8	13	5	10
SG04 Safeguarding Children - Staff Allegation	0	2	1	0	3	0	4	1	3	2	1	5
SG06 Safeguarding Adults Patient On Patient	14	10	12	21	24	21	19	23	19	15	12	12
SG07 Safeguarding Children Patient On Patient	2	8	3	2	10	16	4	11	9	6	3	6
SG22 MAPPA	11	6	13	3	7	5	1	7	3	2	4	3
SG23 MARAC	75	65	64	64	66	47	68	95	49	71	53	97
SG36 PREVENT	1	1	0	0	1	0	1	0	3	2	2	2
SG37 Safeguarding Adults - Concerns	92	116	129	107	124	105	95	119	116	195	238	242
SG38 Safeguarding Children - Concerns	42	86	78	57	61	63	48	60	42	101	113	120
Sum	242	303	308	263	304	268	251	326	252	407	431	497

Over the last 12 months there were *3852* Safeguarding and Public Protection concerns reported into the SAPP team. This is an increase from last year of *3366*. 999 of those concerns raised were low level that did not meet the threshold for multi-agency involvement with a single agency safety plan put in place to safeguard. It is anticipated with the revised model of access into the triage front door from January the incidents for 2017/18 will be approximately 5500. This will concur with the triage review of the numbers of telephone calls to the SAPP team on a daily basis not being reflected in the web based incidents being completed by practitioners post advice. It is not an indication of safeguarding concerns across the organisation increasing significantly but evidence of a robust process of reporting and management.

From the analysis, all “allegations against staff” are taken seriously; initial fact find taken place and referrals to the Local Authority are made where necessary. If required internal investigations are undertaken, with feedback provided to the Local Authority of the outcome of any investigation.

The safeguarding incidents “patient on patient” for both children and adult are those concerns on wards where in the main psychological or physical abuse occurs between patients requiring internal safety plans to be put in place to safeguard. The Local Authority safeguarding teams are contacted if necessary.

MAPPA activity are the cases that Trust staff have referred into the MAPPA process and /or the cases discussed in MAPPA meetings where the Trust are involved with the service user. Over the year 65 new cases were presented to panels with multi agency safeguards put in place.

From the analysis safeguarding and public protection activity MARAC activity has continued to fluctuate over the 12 month period. Within the MARAC meetings held 824 cases over the year were current service users whom are either victims or perpetrators of domestic abuse. Multi agency safety plans are put in place to safeguard the victim.

PREVENT referrals by Trust staff in comparison to other safeguarding and public protection activity is low however the Trust are the highest health referring agency and are seen as a good reporters by Northumbria Police. All referrals are discussed with the Police in the first instance as well as SAPP attendance at a Prevent/Channel Panel chaired by the Local Authority.

Our Commitment to Partnership Working

Over the last 12 months the SAPP team continued to work with partner agencies on a day to day basis to ensure robust safety plans and risk management are in place to safeguarding and public protection.

The Trust has a responsibility to cooperate with the Local Authority in the operation of the six Local Safeguarding Children and Adult Boards as a statutory partner. It needs to share responsibility for the effective discharge of its functions in safeguarding and promoting the welfare of children and adults by ensuring there is appropriate representation at the LSCB and LSAB meetings and sub groups. Currently, the Trust Medical Directors, Nursing Directors and the SAPP Team have played an integral part in relation to partnership working. This has been achieved by assisting in Ofsted and peer inspections, representation on Local Safeguarding Boards and sub-groups, as well as attendance at the Police and Probation statutory meetings for Public Protection.

Audits for Safeguarding

Section 11

The Trust completes annual Section 11 Self-Assessment Assurance Audits in relation to their duties under Section 11 Children Act 2004. This tool aims to assess the effectiveness of the arrangements for safeguarding children at a strategic level. The safeguarding team have completed several Section 11 and Quality Assurance Framework audits in respect of the trust arrangements for safeguarding. The Head of SAPP and SAPP Team Manager have attended challenge events within LSCBs. This promoted constructive challenge to Trust safeguarding arrangements and provided assurance that the Trust is meeting its safeguarding responsibilities.

Quality Assurance Framework (QAF)

The Trust completes annual Quality Assurance Framework Audits in relation to their duties under the Care Act 2014. This tool aims to assess the effectiveness of the arrangements for safeguarding adults at a strategic level. Assurance has been provided to the LSABs that the Trust is meeting its safeguarding adult responsibilities.

Policies and procedures

Safeguarding policies are in place and are accessible to staff via the Trust intranet. The six Local Authority areas safeguarding and public protection policies and procedures are also available via links on the staff intranet site. During the reporting period, the following policies have been written / updated:

- Domestic Abuse
- Safeguarding Children
- Adults at Risk
- MAPPA

Case Reviews

All reviews are reported to the Trust Board on a bimonthly basis and lessons learnt are cascaded throughout the organisation and/or built into future training. Bespoke training has also been provided for those service areas involved to ensure all staff have received the lessons learned.

Serious Case Reviews (SCR)

Serious Case Reviews (SCRs) are undertaken by Local Safeguarding Children Boards (LSCBs) for every case where abuse or neglect is known or suspected and either: a child dies, or a child is seriously harmed and there are concerns about how organisations or professionals worked together to protect the child.

Over the last twelve months there has been one Serious Case Review.

Safeguarding Adults Review (SAR)

A Safeguarding Adults Review is a process for all partner agencies to identify the lessons that can be learned from particularly complex or serious safeguarding adults cases, where an adult in vulnerable circumstances has died or been seriously injured and abuse or neglect has been suspected. The purpose of a SAR is to learn lessons, review effectiveness of procedures, improve practice.

Over the last twelve months there has been one Serious Adult Review.

Domestic Homicide Reviews

The Statutory requirement related to domestic homicide reviews came into force in April 2011. The focus is a multiagency approach with the purpose of identifying learning. Lessons from the DHRs are shared with services, recommendations are actioned and learning provided within Trust training.

Over the last twelve months there has been one Domestic Homicide Review.

External Inspections

A number of OFSTED inspections have taken place within Local Authorities that NTW have assisted with information for the inspections as well as multi-agency interviews to support the process. Any action plans post inspection that have been developed and where necessary the Trust have assisted within the allocated time frame.

Safeguarding Annual Work Plan 2016/17

All of the actions in relation to the 16/17 Annual Work Plan have been achieved.

Priorities For The Forthcoming Year

The SAPP team are working with partners in exploring a revised process for MARAC meetings. It is recognised that the current process is extremely administration heavy and time consuming. It is hoped that the revised process will be more reactive to the needs of the victim in real time with multi-agency action planning in place.

The six Local Authority areas the Trust works within are in the process of developing Multi Agency Safeguarding Hubs (MASH). The hubs are envisaged to be in the main co located multi-agency teams where any safeguarding concerns are discussed with safeguards put in place to protect. The Head of SAPP is currently involved in the development stages to ascertain what is expected from health providers.

The SAPP team will embed the *Making Safeguarding Personal* principles across the Trust when a concern has been raised.

To undertake a thematic review of all Prevent cases to identify and share lessons learned across the organisation.

Conclusion

This annual Report provides the Trust Board, partners and stakeholders with an overview and assurance of the activity for Safeguarding and Public Protection during the periods 2016/2017.

The Safeguarding and Public Protection Team are looking forward to the year ahead in ensuring safeguarding is maintained as a high priority for the Trust and is everyone's business.

Jan Grey, Associate Director Safer Care
2017