East and North Hertfordshire NHS
NHS Trust

Annual Report

Safeguarding Children and Adults

2018/19

Safeguarding Children Team
Maternity Safeguarding
Safeguarding Adults Team

June 2019

Executive summary

The Safeguarding Annual Report 2018/19 outlines the work undertaken by the Trust during the past year. Safeguarding is the term used for protecting children and adults from abuse or neglect.

The Director of Nursing is the Executive Lead for Safeguarding. Safeguarding within the Trust is led by the Safeguarding Children team and the Safeguarding Adults team. Each team has a Named Nurse and Named Doctor. Each Division has a leadership team who are responsible for ensuring the systems and frameworks for safeguarding are proactively supported and embedded into practice in their service areas.

Safeguarding is a whole systems approach and the Trust is a partner agency of the Hertfordshire Children's Safeguarding Partnership (HCSP) and the Hertfordshire Safeguarding Adult Board (HSAB). The Trust is represented on the boards by the Director of Nursing. Within the Trust each Division has a representative on the Safeguarding Committee which meets every 2 months.

In 2018/19 the following policies were updated:

- Mental Capacity Act
- Deprivation of Liberty Safeguards
- Care of patients with a Learning Disability
- Female Genital Mutilation
- Safeguarding Children from Abuse
- Supervision and peer review

There were:

- 215 Child protection medicals
- 558 Child protection referrals
- 1680 information requests about children

- 40,492 liaison/information sharing with health visitors and school nurses
- 4 child deaths reported to Child Death Overview Panel
- 13 cases of FGM reported
- 5374 births and 1172 concerns information sharing
- 327 Adult Safeguarding referrals
- 38 Adult Safeguarding concerns about care in the Trust, 18 were substantiated
- 95 referrals to the Independent Domestic Violence Advisors
- 11 deaths of adults with Learning disability reported to LeDeR, one of which has been investigated as a Serious Incident Review
- 211 families have been supported by the Admiral Nurse in Dementia care
- 123 new carers were referred to Voluntary Carer organisations

Staff Training compliance shows:

- 96% compliant L1&2 Children
- 87% compliant L3 children
- 90% compliant L1 Adult and Prevent awareness
- 89% compliant L2 Adult, MCA and DoLS
- 86% compliant Prevent L3

Training in safeguarding has included: Domestic Homicide and coercive controlling behaviour, domestic abuse, acutely unwell patient with LD, mortality in patients with LD, modern slavery, county lines, CYP gangs, families feeling safe, sexual health and harmful sexual behaviours, the empathy project.

Service developments have included:

- Perinatal mental health midwife appointed
- Safeguarding champions in Children and Maternity developed and received ongoing training
- 4 clinical areas now have Purple Star accreditation and 2 more are in progress
- The development of the Enhanced Nursing Care Team has saved the Trust £45,000 per month by not employing agency workers
- ENCT won the 'Health Heroes' award for workforce planning in 2018
- ENCT now working with children and adults
- Carers handbook developed
- Young carers App developed and launched
- Young Carers awareness day held with theme of supporting mental health
- Butterfly 'end of life' Volunteers represented Midlands and East at the NHS 70th birthday celebrations
- Site Safety Huddles, highlighting the needs of vulnerable patients and expediting any required actions

The CQC inspection said overall the Trust 'requires improvement' and improvement is required with

- All staff completing mandatory training and staff having the right training for their roles
- Staff caring for patients up to age 18 having the right level of child safeguarding training
- Effective systems for recognising and responding to deteriorating patients' needs.

- Staff recognising and reporting incidents in a timely manner.
- Consistency of staff understanding of their responsibility with regards to the duty of candour requirement
- Some areas not having enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment

However CQC also found that:

- Most of the services within the trust prescribed, gave and recorded medicines in line with best practice.
- Patients generally received the right medication of the right dose at the right time
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so
- Midwifery staff exceeded the trust's completion targets for all safeguarding training
- Staffing levels were regularly reviewed and staff were redeployed within the clinical areas, when needed.
- The Trust almost always had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse, and to provide the right care and treatment most of the time.
- Generally, staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- Services generally used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors, and used the information to improve the service.

Acknowledgements:

We would like to thank all the contributors to this year's Safeguarding annual report:

The Children's Safeguarding team
Looked After Children, Medical Advisor for Adoption and Fostering
The Safeguarding Midwife
The Adult Safeguarding team
The Carers Lead
The Admiral Nurse
The Enhanced Nursing Care Team

1.0 Introduction

This is the Annual Report for Child and Adult Safeguarding for East and North Hertfordshire NHS Trust for 2018/19. The report outlines the work undertaken by the Trust since April 2018 to support the frameworks for Safeguarding.

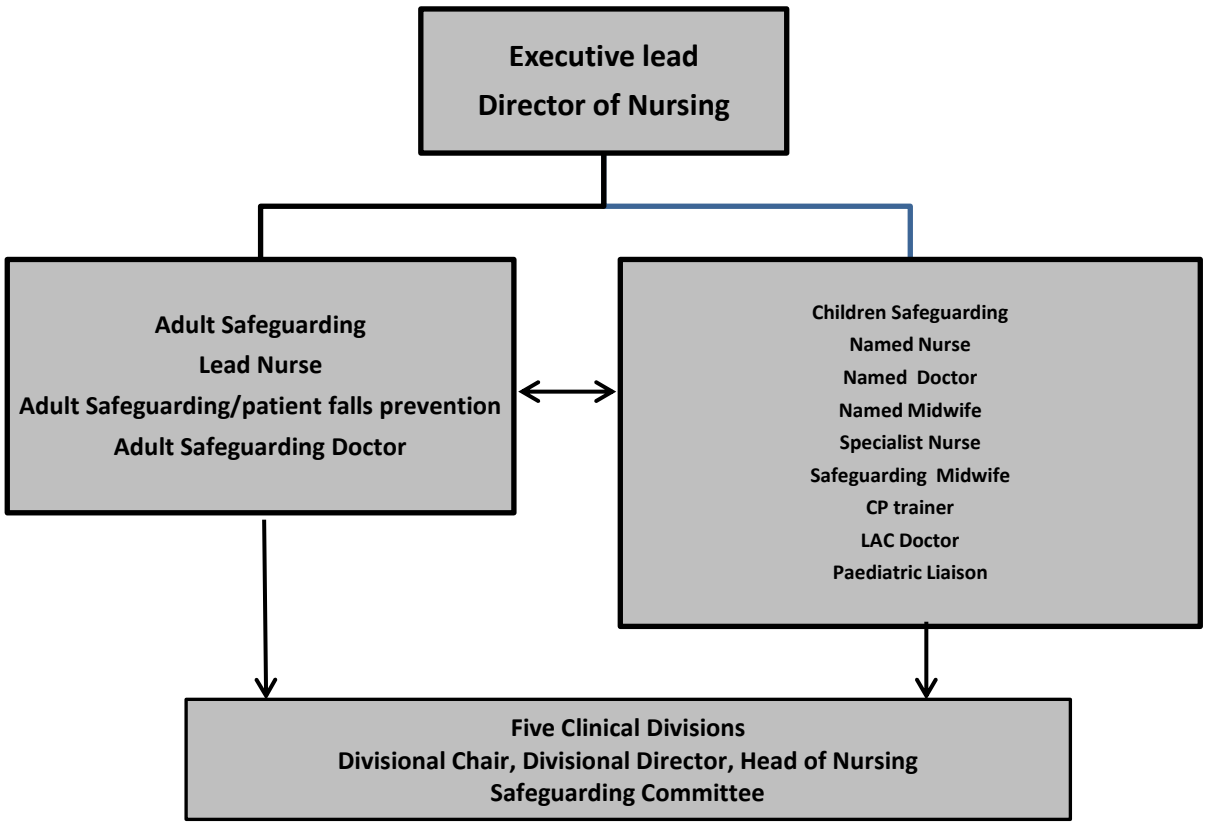
Safeguarding children and young people and protecting them from harm is everyone's responsibility and remains a fundamental element of care. Safeguarding children promotes the welfare of children and prevents them from harm. Children and young people are defined as those under the age of 18 years, however, if the young person has 'special needs' the age incorporates up to the young person's 19th birthday.

Adult Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about working with adults who have care and support needs, who may be in vulnerable circumstances and at risk of abuse or neglect and unable to protect themselves. Multi-agency teams work together and with the individual, to prevent and stop the risks and experience of abuse or neglect.

Making Safeguarding personal means that an adult's wellbeing is promoted and that there is regard for the adult's views, wishes, feelings and beliefs in deciding on any action to be taken, wherever possible.

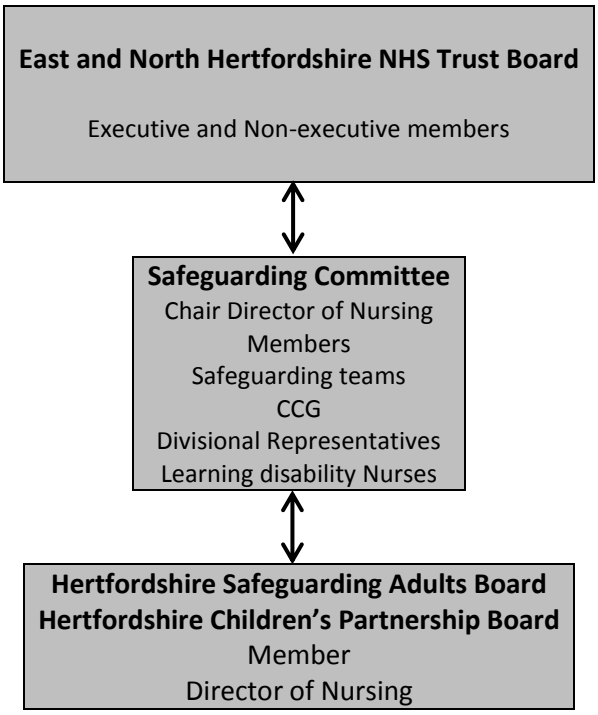
The Care Act 2014 definition of an adult at risk is: a Person aged 18 years and over, who has needs for care and support (whether or not the local authority is meeting any of those needs) and is experiencing, or is at risk of, abuse or neglect, and as a result of their care or support needs is unable to protect him or herself against abuse or neglect, or the risk of it.

2.0 Safeguarding structures



Rachael Corser, Director of Nursing and Patient Experience is the Executive Lead for Safeguarding. The Director of Nursing is the member of the Hertfordshire Children's Safeguarding Partnership and the Hertfordshire Safeguarding Adults Board.

2.1 Safeguarding committee structure



2.2 Safeguarding teams

Safeguarding teams			
Children		**Adults**	
Named Nurse	Cheryl Lewis	**Named Nurse**	Bernadette Herbert
Named Doctor	Dr Vinod Tyagi	**Named Doctor**	Dr Emma Lines
		Adult Safeguarding Nurse/falls prevention nurse	Enda Gallagher
Named Midwife	Teresa Drakes		
Specialist Nurse	Sarah Corrigan		
Safeguarding Midwife	Emma Bell		
Child protection trainer	Kim Rundell		
Looked After Children Doctor	Paula Moore		
Paediatric Liaison	Tina O'Sullivan		

Within the Clinical and Non-Clinical Divisions the Divisional Director, Divisional Chairs, Heads of Nursing or Senior Managers are responsible for the implementation of and

compliance with Trust policies and procedures and maintaining standards of practice and quality of care provision with clinical and non-clinical teams.

The Safeguarding teams work closely and collaboratively with the Independent Domestic Violence Advisors (Refuge), Social Services, Local Authority Safeguarding teams, CCG safeguarding teams and other Health safeguarding teams in Hertfordshire.

2.3 Trust policies and procedures which support the framework for Safeguarding are:

- Safeguarding Children from Abuse
- Safeguarding children and young people in Urgent Care Settings
- Safeguarding Children Supervision and Peer Review policy
- Safeguarding Adults from Abuse and Neglect and Prevent policy
- Hertfordshire procedures for Safeguarding Children from Abuse
- Hertfordshire procedures for Safeguarding Adults from Abuse
- Female Genital Mutilation policy
- Mental Capacity Act policy
- Deprivation of Liberty Safeguards policy
- Care of Adults with Learning Disability policy
- National LD mortality review Standard Operating Procedure
- Domestic Abuse policy
- Chaperoning policy
- Employee and workforce policies and procedures
- Disclosure and Barring checks and disclosure of information, Trust policy
- Raising Concerns at Work policy – 'Whistleblowing'
- Statutory and Mandatory training policy
- Equality, Diversity and Human Rights Strategy
- Safer Staffing
- Serious Incidents policy and clinical incident reporting
- Complaints policy
- Dementia policy
- Delirium policy
- Trust Carers policy

2.4 Safeguarding referrals and liaison

2.4.1 Children Safeguarding

The work of the safeguarding children's team can be divided into 5 areas within the Trust:-

- Acute paediatrics including emergency care, inpatient care, and day services – including paediatric day surgery, outpatients and Chronic Fatigue
- Community paediatrics including child development centre, continuing care, special schools nursing, community children's nursing – including Diabetes, Epilepsy and special needs health visitors
- Community Child Protection (CP) on-call rota – medical and nursing rota for CP medicals
- Adult services – where concerns are identified regarding an adult's attendance and the impact of that presentation on a dependent child – Think Family. The majority of

this activity takes place within the Trusts unscheduled care settings, but is applicable to all adult areas of the hospital.
- Maternity Services including inpatient services and community midwives

The Safeguarding team monitor performance through the use of a comprehensive dashboard updated monthly, the information is used to review the work plan, and is shared with the relevant boards and committees for monitoring purposes.

2.4.2 Adult Safeguarding

The role of the adult safeguarding team in the Trust is to:

- lead on the strategy for adult safeguarding, ensuring the framework for adult safeguarding is in place to comply with statutory and regulatory requirements
- to review, update and implement Trust policies and guidelines
- to provide advice and guidance to staff about Adult Safeguarding matters
- to review adult safeguarding referrals and refer to the appropriate safeguarding team or agency
- to advise staff on safeguarding protection plans or actions for Trust patients
- to participate in providing statutory/mandatory training for staff
- to review and advise on serious incidents relating to adult safeguarding
- to work collaboratively with Trust staff and teams to provide high quality, safe services for patients, and in particular those at risk of abuse or neglect
- participate in Safeguarding Adults Reviews
- participate in Domestic Homicide Reviews
- participate in Section 42 enquiries
- provide information and clinical advice to Social Work teams on safeguarding cases
- investigate incidents of abuse or neglect raised against the Trust
- represent the Trust and participate in sub-groups and activities of the Adult Safeguarding board
- lead on Prevent safeguarding

2.5 Trust Safeguarding Committee

The Safeguarding Committee is chaired by the Director of Nursing. Representation is provided from the clinical divisions across the Trust, the Trust Child Safeguarding team, the Trust Adult Safeguarding team, the CCG Designated Nurses for Child and Adult Safeguarding, Learning Disability Liaison Nurse, Trust Education team, Admiral Nurse, and Tissue Viability team.

The Safeguarding Committee meets bi-monthly and reports to the Trust Board via the Director of Nursing.

The Learning Disability Working Group is a sub-group of the safeguarding committee and meets bi-monthly.

3 Safeguarding activity 2018/19

3.1 Safeguarding Children

3.1.2 CQC inspection April 2018

ENHT underwent a CQC inspection in April 2018. The results showed overall the Trust requires improvement – actions in relation to safeguarding were around level 3 training compliance and additional training for staff caring for 16 to 18 year olds. As a result of the findings, a bespoke workbook package for staff caring for 16 to 18 year olds was developed and distributed to the surgical division as a priority, and roll out for all other staff on the Trust vital training programme. This additional training has been identified as a separate level 3a competency.

3.1.3 Arrangements to Safeguard Children under Section 11 of the Children Act 2004

A Section 11 audit visit was carried out in April 2019 by East and North Hertfordshire CCG to the Trust to ensure compliance with our responsibilities under the Children's Act to safeguard children. Positive feedback was received with clear actions identified to further improve the service. The audit established that the Trust was able to demonstrate that it was meeting the statutory requirements. A detailed action plan will be developed in due course and monitored through the divisional board and joint safeguarding committee.

Appendix 1 shows previous reporting years section 11 plan completed.

3.1.4 Child Protection Medicals

Child protection (CP) medicals are undertaken as per the guidance of Royal College of Paediatrics and Child Health. All child protection medicals are done by a consultant or a senior trainee under consultant supervision. Child protection medical proforma is in line with the revised RCPCH guidance.

Child protection medicals are done by both acute and community paediatrics team. Children referred by social care team to community paediatrics team are seen in the Bramble child protection unit.

Before any child protection medical examination takes place consent is taken. We explain in details about the process and also the right to withdraw consent at any stage of child protection medicals. We have a separate consent form for medical photography and a subsection for use of medical images for peer review and teaching and both subsections are explained to the consent holder. Consent form for skeletal survey is being designed and should be implemented by August 2019.

There were 189 CP medicals completed in 18/19 compared to 228 in 17/18. Physical abuse remains the most prevalent reason for Child Protection medical referrals. This includes sibling medicals.

From April 2019 Child sexual abuse examinations will not be done at East & North Hertfordshire NHS Trust and will be done at the Hertfordshire Sexual Abuse Referral Centre. The Children Safeguarding team continue to work closely with the Joint Child Protection Investigation Team and Social Care to safeguard children and offer advice and service in the spirit of Working Together guidelines.

Number of CP Medicals April 2018- March 2019								
Acute			31		Community (Bramble Suite)		150	
April 2018 – Mar 2019	**Physical**	**Neglect**	**Sexual**	**Emotional**	**Sibling medical**	**Mixed - Physical, Neglect, Emotional**	**Review**	**Total**
Acute	31	0	2	0	0	0	0	
Community	105	8	9	0	34	0	0	
TOTAL	**136**	**8**	**11**	**0**	**34**	**0**	**0**	**189**
Compared to 2017/18	151	4	30	0	43	8	0	228

3.1.5 Child Protection Referrals

Recognising and referring vulnerable children and families is a key role and responsibility of all staff working for ENHT.

Referrals are made to Children's Services when a professional considers a child or unborn baby to be at risk of significant harm – these include children attending with possible non-accidental injury, and concerns involving neglect. Referrals are also made when adults present for care and issues identified around domestic abuse, mental health, and drug and alcohol issues (Think family agenda).

The number of referrals made to children's social care from the Trust fluctuates depending on need and if staff share their referral with the Safeguarding team, therefore it is likely there are more referrals than reported. Referrals and process, is discussed in all levels of training, supervision, and weekly psychosocial meetings.

The following table outlines the numbers of referrals made compared with the previous reporting 2 year periods. It demonstrates a significant increase in referrals made to children's social care for paediatric referrals (55%) compared to the same reporting period the previous year – the reasons for this increase is multi-faceted - an increased awareness around the think family agenda within the emergency department, a review of the paediatric liaison criteria and the terms of reference for the weekly paediatric psychosocial meeting, and a greater awareness of staff in recognising vulnerabilities through training (including bespoke training on key societal challenges and pressures – for example Child exploitation), and an increase in childhood mental health presentations.

There has been a decrease in the number of maternity referrals to children's social care – this again follows a change in practice around the screening of information sharing. Cases are taken to the maternity information sharing meeting (multi-agency) for cases where threshold is not clear. For cases where a threshold is clearly met –these are referred prior to taking to an information sharing meeting.

Year	Q1	Q2	Q3	Q4	Total
2018-19	**107**	**123**	**153**	**175**	**558**
Maternity	44	30	33	33	140
Paediatrics	63	93	120	142	418
2017-18	**129**	**109**	**111**	**142**	**491**
Maternity	82	50	49	81	262
Paediatrics	47	59	62	61	229
2016-17	**129**	**109**	**111**	**142**	**491**
Maternity	82	50	49	81	262
Paediatrics	47	59	62	61	229

3.1.6 Requests for Information – S17, 47 and Multi-agency safeguarding hub (MASH)

Where requested to do so by local authority children's social care, practitioners have a duty to co-operate under section 27 of the Children Act 1989 by assisting the local authority in carrying out its children's social care functions – including information sharing.

Information sharing requests from children's services for Section 17, Section 47 and MASH inquiries has decreased overall, however fluctuates throughout the year and can add considerable pressure to the safeguarding administrator's role when demand is high. Along with vacancies within the team, this has led to a backlog at times in response rate for section 17 and MASH requests. An action plan is currently in place to address the backlog.

Year	Q1	Q2	Q3	Q4	Total
2018-19	459	508	713	296*	1680
2017-18	651	707	522	463	2343
2016-17	530	516	420	595	2061

- *Backlog in response rate – final figures may change, however this figure reflects the number responded to for the time period.*

3.1.7 Paediatric Liaison

The paediatric liaison service has undergone significant changes over the past year, with a bigger focus on the early help agenda - taking action to support a child, young person or their family early in the life of a need, or as soon as it emerges, with the aim of meeting a need early, preventing escalation of need and presentations requiring more specialist interventions.

Changes which have been implemented during report period;

- The Information Sharing Criteria (ISF) referral criteria was updated and distributed to all Acute Paediatric departments; which details a clear list of when an ISF would be completed by the clinician involved with the child's care. This criterion was introduced to act as an accessible aide memoir for staff to ensure that appropriate attendances and information relating to the care/safety of a child is passed to the safeguarding team.
- Discharge Summaries are now screened alongside this criterion and flagged to the Liaison Nurse for review, ensuring that a clear safety netting process is in place for all children who attend North &East Herts NHS Trust. Feedback is provided in training, supervision and to individual staff members to ensure that learning is shared and the correct process is followed when cases present that meet the criteria.
- All Discharge Summaries that have gone through the safety netting process and highlighted to have met the criterion for liaison, are now reviewed by the Liaison Nurses, written on psychosocial database and actioned. Historically, this discharge summary would be shared with the School Nurse/ Health Visitor and written on the psychosocial database. These Discharge Summaries are now actioned; as they would should we have received an ISF – Many of which highlight young people attending adult ED with mental health difficulties. We now receive updates and outcomes of the child's care on all of these Discharge Summaries.
- Further posters and literature informing parents, children and young people about our desire to support families following discharge from the hospital have been put up

throughout the department, to inform on information sharing and our desire to 'care for children and their families, after they've left the hospital'.

- Information Sharing Form has been reformatted to provide clear direction on adult 'think family' attendances, clear consent and social care involvement.
- All children who attend East & North Herts with mental health difficulties and are reviewed by CCAT – Close liaison between the CCAT & liaison team occurs for all cases to establish whether any further safeguarding concerns have been raised and children's service referrals have been completed. This communication is essential for the identification of additional liaison information; plans of future follow up care of children and provide a forum for escalation and challenge.
- Regular CCAT attendance at psychosocial has been achieved.
- Improving safeguarding for young people (including 16-17 year olds) remain a high priority for the team, where issues relating to the attendance reflect concerns such as, substance misuse, challenges in the young person's relationships and or concerns surrounding assault – the Discharge summary will be assessed by the liaison team and where appropriate a letter will be sent to the young person, signposting onto relevant services which may be able to support them further. Further links have also now been identified in trying to improve the ED experience for young people in the organisation and supporting them with accessing youth services locally.
- The liaison team now have stronger partnership links with our partner agency CGL. This has improved the identification of 'think family' attendances, relating to parental substance misuse. CGL attend our paediatric psychosocial meetings on a weekly basis and flag any adult attendances relating to substance misuse to the liaison team – who then ensure that appropriate Children's Service Referrals have been completed and effective liaison to community services has occurred.
- Psychosocial database has been reformatted to capture data which will assist in facilitation of examining patterns of where ISF opportunities have been missed and where further teaching/training is needed in the trust.
- Young carers lead regularly attends psychosocial and cases identified where they meet the criteria for young carers – referrals made and additional support is provided to young carers and their families.

The table below highlights the activity for paediatric liaison in relation to the number of attendances liaised to Health visiting and school nursing teams (data collection only began in 2017 in relation to this area of work). The changes implemented have a seen a significant increase (39% compared to previous reporting years activity) in information sharing forms received and intervention offered. These figures demonstrate how both the aide memoir and staffs increased awareness of vulnerability and risk factors, is resulting in additional review and oversight, identification of support services to meet earlier need, and improved sharing information with other agencies that hold further information to interpret the admission in context of the child's holistic care.

There has also been a 17% increase in administration activity around the number of overall attendances liaised with school nursing and health visiting teams.

This increase in work has not come with additional resources and has placed additional burden on the safeguarding and paediatric liaison team. IT solutions are being explored to support the paediatric liaison service help meet this increased workload.

Year	Q1	Q2	Q3	Q4	Total
2018-19					
LIAISED CHILD ATTENDEES	**10579**	**9177**	**10830**	**9906**	**40492**
NUMBER OF PSYCHO-SOCIAL REFERRALS	**648**	**710**	**781**	**855**	**2994**
2017-18					
LIAISED CHILD ATTENDEES	**5441***	**8242**	**10368**	**9906**	**33957**
NUMBER OF PSYCHO-SOCIAL REFERRALS	**426**	**499**	**424**	**506**	**1855**

**Service only provided for East Hertfordshire (North Hertfordshire provided by HCT – this service was decommissioned and commissioned for the North to be provided by ENHT from Q2 onwards).*

3.1.8 Looked-After Children Health Assessments

Looked After Children (LAC) are seen on a regular basis for Health Assessments (HA). These take place within 28 days of the child coming into care (Initial Health Assessments-IHAs), then every 6 months (under 5yrs) or annually (5yrs+) (Review Health Assessments - RHAs). Paediatricians carry out all LAC IHA for under 10yrs and RHAs for all children where Adoption is in their care plan. HAs are requested by the child's social worker and arranged through the LAC team (Local Authority team).

Timescales in 2018-19 were that IHAs should be completed and returned to the LAC team within 10 working days of the request and that RHAs are completed and returned within 5 weeks.

It was agreed with the LAC team and commissioners that children in special schools would have their LAC Health reviews in school at the same time as their annual health review even if this was out of timescales as it is in the child's best interest.

The LAC team now routinely give us the names of any children who "breach". This enables these breaches to be investigated and where appropriate, covered through exception reporting. Exemption reports are completed for breaches for which we are not responsible for example; last minute DNAs or carers refusing to bring the child.

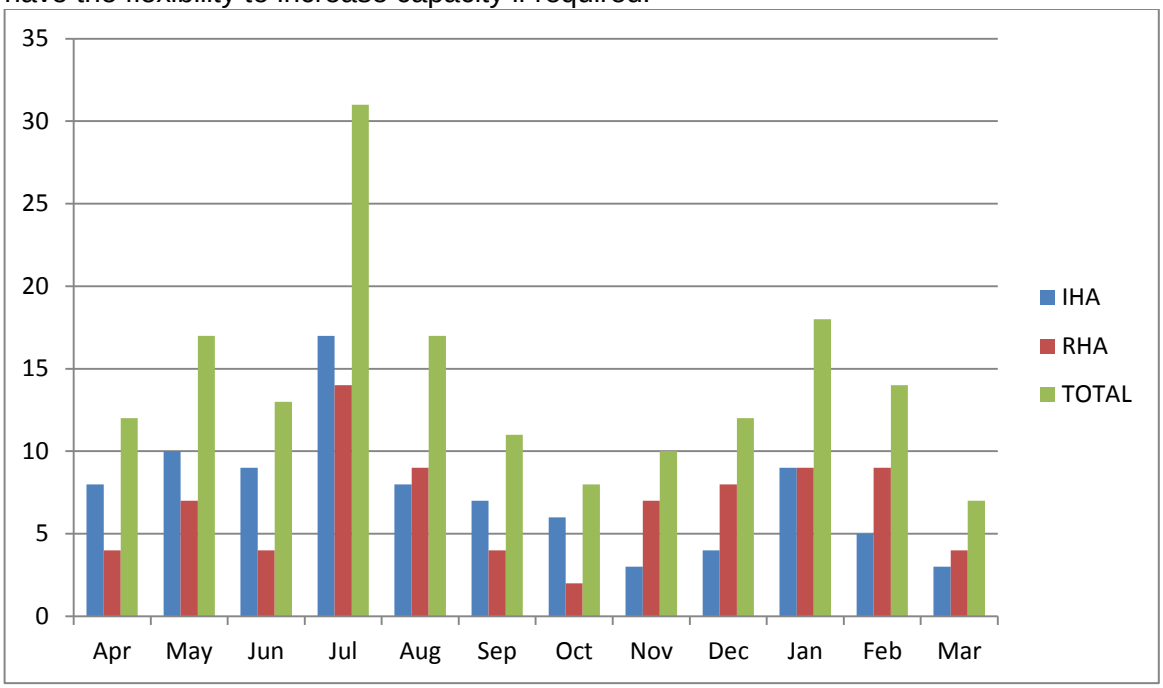
The target is 90% for both IHAs and RHAs. Performance is reported to the Trust Safeguarding Committee on the Child Safeguarding dashboard. The data is also provided for the Health of Looked After Children Leadership group which meets quarterly.

The Courts are continuing to favour placements within the extended family and Adoption is considered very much a last resort. This has led to a reduction in the number of children becoming Looked After and also a reduction in the number of Adoptive Placements.

Another Government Directive has led to the setting up of “Adopt East” which has brought six agencies within the region to work together more closely. The process is now on hold due to a lack of funding but Hertfordshire Local Authority will be working very closely with Luton Local Authority going forward. The merger was due to happen in April 2019, however, has also now been put on hold making the future of the Adoption process in this area uncertain.

3.1.8.1 Activity 2018/19

170 LAC medicals were carried out, 89 IHAs and 81 RHAs. This was broadly similar to the previous year. The Trust has continued to review available capacity for LACs and we do have the flexibility to increase capacity if required.



The table above shows considerable variation in the demand for health assessments across the year with a significant peak in July (this also happened in 2017/18) and a low point in March. These highs and lows are not predictable and the variation in the workload presents a considerable challenge in offering timely appointments whilst at the same time utilising vacant appointment slots.

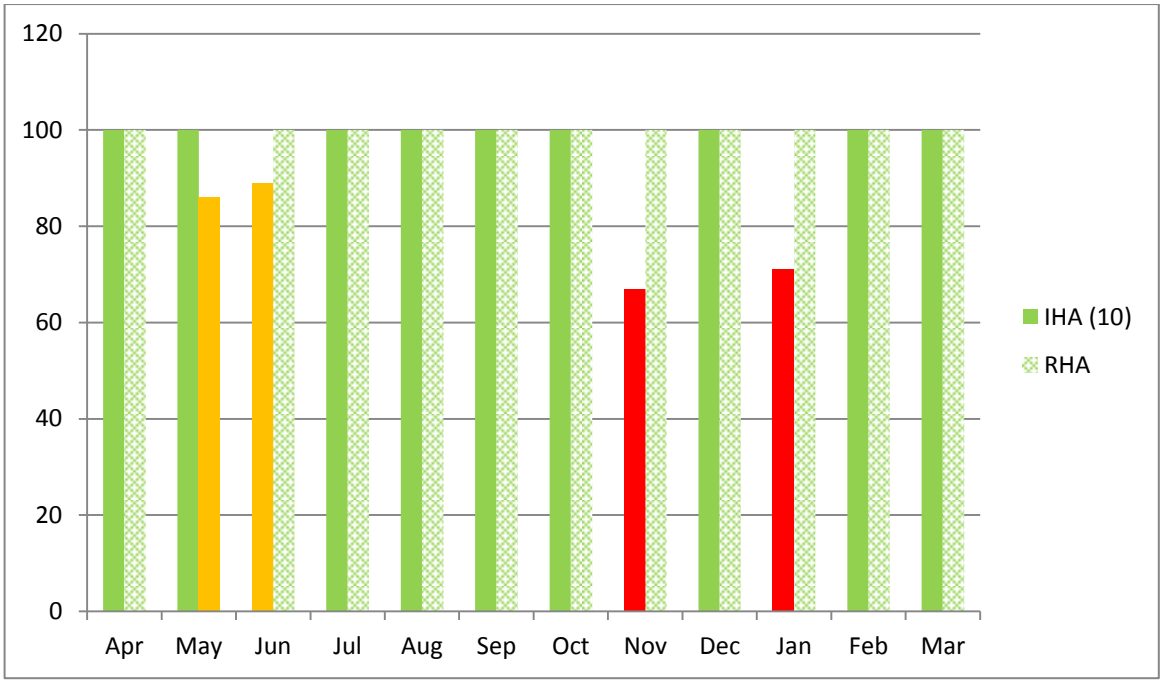
3.1.8.2 Timescales for health reviews 2018/19

The table shows the percentages of HAs meeting the timescales. The columns are RAG rated (red = <80%, amber = 80-90%, green = >90%). The first column for each month represents IHAs returned within 10 days, and the second RHAs returned within 5 weeks.

As the HAs are often less than 10, 1 breach of the timescale will put the monthly average below 90%. The overall averages for the year were:

IHAs 94% (84 out of 89 meeting timescales)
RHAs 96% (78 out of 81 meeting timescales)

Thus over the year the timescales as agreed with commissioners are being met.



Changes in admin support to the medical advisor during the year has impacted on the timeliness of reports being returned compared to the previous year, however, as the admin support has stabilised this is not expected to be a continuing problem.

3.1.9 Child Deaths

Since the 1st April 2008, it has been mandatory for Local Safeguarding Children's Boards (LSCB) Child Death Overview Panels (CDOP) to review all deaths of children (birth up to their 18th birthday), to identify if there are any preventable factors that contributed to their death.

One of the Trust's paediatric liaison nurse's is the link professional for CDOP along with the link nurse for paediatric emergency department. This is supported by the named nurse for safeguarding children and the Head of nursing for paediatrics. These link professionals represent the Trust at CDOP meetings and share agency summary reports.

During the reporting period, the ENHT reported 4 deaths of children, all of which were unexpected.

All child deaths are now reported on Trust datix and reviewed by the Serious Incident Review Panel who support the decision making process if further investigation is required. In all cases 72 hour reports are completed and taken to panel for further decision making on any further review required. One case went on to have an SI completed.

3.1.10 Partnership Working - Hertfordshire Safeguarding Children Partnership

The Trust has continued to demonstrate a high level of commitment to partnership working through active participation in key partnership meetings. The Director of Nursing continues to represent the Trust on the HSCP Safeguarding Children's board, and members of the safeguarding children's team attend the sub-groups of the HSCP.

Hertfordshire is an early adopter of the new Working together arrangements, which has led to some sub groups being merged to create a more streamlined and effective partnership. A lead from the safeguarding children's team continues to represent the organisation at all the sub-group meetings and contributes to the work and decision making as necessary and appropriate. Work has continued this year on the pre-birth protocol, and a focus on gangs and knife crime learning and strategy.

3.1.11 Policies and Procedures updated

All safeguarding policies and procedures remain accessible to all Trust staff via the Trust intranet (Knowledge Centre), along with links to HSCP policies and procedures.

The following polices have been updated during this time frame:-

- Safeguarding children's Policy
- Supervision and Peer Review

3.2 Maternity Services Safeguarding

In June 2018 there was a change in staff due to a year secondment secured by the Safeguarding Midwife to an outside organisation. Following successful interview a year secondment to the Maternity safeguarding team has seen the development and growth of a midwife able to support the service. In March 2019 the Interim Safeguarding midwife was successful for the position of a year secondment for Perinatal Mental health midwife. This position will involve collaborative working with the maternity safeguarding team and support the service for women with mental health issues.

The Named Midwife remains in post. The Maternity safeguarding service provides a service 0800-1700 Mon-Fri. Named midwife continues to work 34 and the hours have increased for the safeguarding midwife to 22.5 hours a week following discussion with the Head of Midwifery to meet the demands of the service. Risk assessment and supervision continues to be integral to the work.
Multi-agency maternity information sharing meetings are well embedded and continue twice a month.

3.2.1 Partnership Working

Participating in the HSCP subgroups is the strategic role the Named Midwife is involved in regularly; specifically the audit and performance group held on a two monthly basis and shared with the Name Doctor. This involves feeding back to the Named Nurse and safeguarding teams and on the team meeting agenda.

The Named midwife has participated in multiagency meetings with the CCG, Hertfordshire Children's Service and Named Midwives from West Hertfordshire (Watford) and Luton and Dunstable to update the Pre-birth protocol and discuss information sharing been organisations. This input has led to the development and revision of the pre-birth protocol which in 2019 will be ratified by the HSCP. The guidelines for the Concealed pregnancy and late booking for pregnancy will be the next HSCP policy and procedure to be updated which the Named Midwife will participate in the review.

The Local Maternity Service (LMS) involves Watford maternity unit, Princess Alexander Maternity unit and the Diamond Jubilee Maternity unit, and the Named Midwife has met and liaised with Named Midwives within these trusts to share processes and information share.

3.2.2 Female Genital Mutilation (FGM)

In February 2019, the Female Genital Mutilation information system FGM-IS was enabled on the NHS spine to be inputted by the Safeguarding team when indicated. The FGM-IS launched by NHS is a requirement for an indicator to be put on the summary care record (SCR) of a female infant born to a mother who has had FGM. The indicator will be taken off the SCR at age 18 years old. This has been implemented within our Trust. The Trust wide FGM policy has been updated and ratified by the safeguarding committee to reflect the new process. The maternity unit staffs have been updated in a newsletter, team meetings and in supervision.

There is a new lead consultant obstetrician in post who is continuing with the process of dedicated clinic slots and physical assessment of the women who have undergone FGM and risk assessment tool is completed. This risk assessment is discussed at the maternity information sharing meeting. There is a social worker seconded from the National FGM centre who is point of contact to discuss cases to identify the need for referral for assessment by children's services, which is evidence of multiagency working.

In 2017 the numbers of cases of FGM were 13 and also the same 13 in 2018.

3.2.3 Risk Assessment

Risk assessment is undertaken through assessing Information Sharing Forms (ISFs) completed by Midwives and other professionals. Following an audit last year of the themes raised through information sharing forms in 2017 there was evidence the highest was maternal mental health.

This year the information sharing form has been updated to include a section on mental health information. By providing more focused information this has aided risk assessment and joined up working with the perinatal mental health team. The prominence of maternal mental health as an important theme has highlighted the need for the provision of a mental health midwife.

The number of births in the period 1st April 2018 to 31st March 2019 was 5374 and the number of ISFs was 1172. This is slightly higher than in the period last year. The ISFs are classified into two categories: returned to midwifery for monitoring or placed on the database for discussion at multiagency meetings. The numbers of ISF's discussed at the Maternity information sharing meetings were 634. Cases also discussed are from social care information, and domestic abuse notifications.

The purpose of the Maternity information sharing meeting are to risk assess cases and make decisions regarding the action to be taken. Social worker presence is vital to process. For the East of Hertfordshire women who book to birth at Princess Alexander the safeguarding midwife for Harlow attends the East area meeting.

The risk assessment may indicate referral to Children's services, or more information required from midwives or other agencies, for example mental health services, IDVA service, leaving care worker, CGL worker or Families first triage. If no current safeguarding concerns identified then case is moved to universal/ Midwife led care for monitoring.
Current cases are also discussed at this meeting and information shared regarding outcomes of assessments, child in needs plans, child protection plans and thresholds for legal planning.

In the period 1st April 2018 to 31st March 2019 there were 54 Initial Case Conferences, 51 which were attended by a Community Midwife or safeguarding Midwife

The Named Midwife participated in an audit by the CCG in August 2018 regarding communication between primary care and the Maternity Unit which was in response to a Serious Case Review SCR in West Hertfordshire. The outcome was to improve communication to GP's. This action has been put in place by the safeguarding team. The triaged information sharing forms are forwarded to the GP surgery emails as well as to community team emails, named community midwife, and health visitor service. The second action was to email all received Early Bird referrals received for booking at the maternity unit to be forwarded to the GP email addresses. All community midwifery team also receive the Early bird referrals. The email also carries a strap line for the GP to email the maternity safeguarding team if they are aware of any safeguarding information or issues.

3.2.4 Mental health

A Perinatal Mental health Midwife post was appointed to in March 2019 and will commence as a one year secondment in June 2019. This role will involve collaborative working with the maternity safeguarding team as indicated as a high theme in East and North Hertfordshire. The plan is for development of a continuity pathway for women with metal health issues in line with Better Births. The aim is to improve perinatal mental health in women.

The Hertfordshire Perinatal mental health team have increased their staff positions with the appointment of an additional team leader and psychiatrist. There are two joint obstetric and metal health clinics held in the Trust each month for women with significant mental health difficulties.

Information sharing regarding mental health (maternal and paternal) has been handled by the safeguarding team but with the post of mental health midwife there will be a dedicated link between midwifery and the community perinatal team. In the future there will partnership working between the mental health midwife and the safeguarding team.

Meetings are held with the community perinatal team/safeguarding team and Consultant midwife to improve working processes have increased to every two months. The meetings were initially informal discussions but have evolved and now minutes are shared to all members of the group. An agenda will also be prepared prior to meetings.

The safeguarding midwife with input from consultant midwife and perinatal team has developed the mental health pathway which has been discussed at the mental health meetings. The pathway will clarify mental health issues in three areas mild/green, medium/amber and significant/red. This pathway will aid midwives and professionals which service to refer to wellbeing team or Community perinatal team.

3.2.5 Substance Misuse Policy

The Trust Policy for the Care of Women Who Misuse Drugs and Alcohol which was ratified in January 2018 is due to be audited and presented to the audit meeting in May 2019 to demonstrate compliance with the guidance within the policy.

3.2.6 Safeguarding Information to Maternity unit

To increase safeguarding awareness and provide regular updates the safeguarding team attend the community midwives monthly meetings and have a standing agenda item. In 2018 the Named Midwife attended the Band 7 midwife meetings and from April 2019 will attend the monthly specialist midwives meetings to disseminate information and safeguarding updates. Information and updates have been included in the Maternity weekly

newsletter and also on the closed group staff Facebook page. A newsletter was sent out in March to update on changes of FGM-IS and the new information sharing form.

The Named Midwife meets with the Head of Midwifery on a monthly basis to discuss and update safeguarding information and issues.

3.2.7 Supervision

Supervision is carried out every four months for community midwives who carry a caseload. The rates remain consistently 94% and above for community midwives. Ad-hoc face-to-face supervision and advice is provided to midwives in all inpatient areas of the maternity, during daily attendance Mon-Fri by the Named Midwife and Safeguarding Midwife. Both are contactable by mobile phone for advice and support. Ad-hoc supervision is recorded in a communication record held by the maternity safeguarding team.
The named Midwife receives supervision face to face from the deputy Safeguarding children's nurse in the CCG 3-4 monthly.

3.2.8 Safeguarding Champions

Champions meetings have continued bi-monthly throughout this period of the report. Representation from maternity is from four midwives from the following areas, antenatal clinic, post-natal ward, antenatal ward and the community. The information imparted from the teaching sessions from invited speakers is demonstrated by safeguarding folders completed by the champions on the antenatal and postnatal ward and in all three antenatal clinics. On the postnatal ward there is a safeguarding board in the handover room. The community champion produced an information sheet on one of the sessions.

3.3 Safeguarding Adult Concerns

From April 2017 to March 2018 the Trust recorded 327 Safeguarding Adults at Risk concerns; these include all concerns reported by Trust staff as well as those raised about care in the Trust.

38 were about care in the Trust, 18 concerns were substantiated against the Trust.

The categories of alleged abuse or concerns for safeguarding adults included: neglect and acts of omission, self-harm, self-neglect, financial, physical, sexual and psychological abuse, domestic abuse and modern slavery. Domestic abuse is a feature in a high proportion of cases referred for safeguarding, however in some cases on further investigation the situation that has arisen is due to the care needs of one or other of the parties involved, e.g. where an elderly couple are struggling to look after each other, or family members are struggling with care, and the available supportive services are not involved with the family. In these cases care needs review and provision of support services can help to resolve the problems.

Concerns about the Trust which were substantiated included:

- Discharge of patient with LD with insulin without notifying the district nurses where there was a risk the person would self-harm. Insulin would normally be provided by the district nurses
- Re-opened safeguarding enquiry about the death of patient with Learning Disability in 2017 which was instigated during the SAR process which started in 2018
- Safeguarding enquiry about the death of patient with LD who died from sepsis in 2018

- Omissions in critical medications during hospital admission for a patient with an endocrine disorder.
- Discharge of patient to the community without District Nurses being informed of the need to administer anticoagulation
- Poor communication to care/nursing homes about wound care needs, tissue viability or skin integrity of patients discharged from hospital
- Patient discharged to mental health hospital with cannula still in place and patient subsequently bit end off cannula

Actions taken within the Trust have included:

- Discharge group established to review process for discharges to ensure safe discharges
- Site Safety huddles introduced to ensure that there is a whole systems approach to the needs of vulnerable patients, e.g. with LD are known about by the senior site team and actions are taken to escalate concerns or solutions to treatment requirements or procedures, including where any blockages may be occurring. Also attended by the LD nurses
- LD working group set up and chaired by Director of Nursing, sub group of safeguarding committee.
- LD improvement action plan implemented with support from NHSI
- Staff study day held to raise awareness about Sepsis and the acutely sick person with LD – led by the Sepsis Nurse

3.3.1 Prevent – referrals to Channel Panel

During 2018/19 one referral was made to the local authority channel panel following concerns raised by a doctor. The channel panel criteria was not met and alternative safeguarding support was provided to the individual.

4.0 Domestic Abuse

4.1 Independent Domestic Violence Advisor (IDVA)

During 2018/19 we continued to have an IDVA based in the hospital to provide support to victims of Domestic Abuse, risk assessment for patients and advice or guidance to staff and training for staff.

During 2018/19 the number of referrals made to IDVA services was: 95

The IDVA will see patients who are still in hospital or will follow up with them in the community if they have already been discharged.

4.2 Raising awareness about Domestic Abuse

A multi-agency presentation of a case of suicide of a young mother following coercive controlling behaviour from her partner was presented to the Grand Round in April 2019. The patient had been brought into the Trust as an attempted suicide in August 2017 and she died 2 days later. It became apparent to the police in the first few days that the

suicide was the result of the behaviour she experienced from her partner. The perpetrator was convicted of coercive controlling behaviour and assault in 2018.

The presentation was delivered jointly by the Adult Safeguarding Nurse, Child Safeguarding Nurse, Herts Police and the IDVA. 93 staff attended with very positive feedback about the learning they experienced from the presentation.

4.3 Domestic Homicide Reviews (DHRs)

DHRs are a statutory requirement under the Domestic Violence, Crime and Victims Act 2004. DHR means 'a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

a) a person to whom he/she was related or with whom he/she was, or had been, in an intimate personal relationship, or a member of the same household as him/herself
b) held with a view to identifying lessons to be learnt from the death' (Home Office 2016).

The Trust has provided information for three domestic homicide cases during 2018/19, all three cases are ongoing DHR and no specific actions have been identified for the Trust.

The adult safeguarding nurses is a member of the HSAB domestic homicide review sub-group.

5.0 Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act is an important part of everyday practice in the NHS and it is the responsibility of all Trust staff to have regard for the requirements of the act.

The Trust MCA and DoLS policies were updated. New MCA assessment forms were introduced using the Hertfordshire multiagency assessment and best interests forms.

All staff receive training about the MCA and DoLS in their statutory and mandatory training, provided at induction and in two yearly updates. At the end March 2019 89.8% of staff were compliant with statutory/mandatory training requirements.

Additional training sessions are provided to staff to improve their skills and knowledge in the practical use of MCA and DoLS. During 2018/19, 261 staff attended the 2 hour practical workshops held either at Lister or Mount Vernon sites.

In addition MCA and DoLS is now included in the study days held for Preceptorship Nurses and Preparation to practice clinical support workers led by the nurse education team.

5.1 Deprivation of Liberty Safeguards (DoLS)

DoLS provide legal protection for those people aged 18 years and over who lack the mental capacity to consent to the arrangements for their care or treatment in a hospital, or care home, and in whom, within the meaning of Article 5 of the European Convention of Human Rights (ECHR), are deprived of their liberty, in their best interests, to protect them from harm.

The Supreme Court established the 'acid test' in March 2014 and stated that a deprivation of liberty should be considered where:

- The person is under continuous supervision and control **and**
- is not free to leave **and**
- lacks the mental capacity to consent to remain in hospital or a care home

The person does not have to be saying or showing that they want to leave for a deprivation of liberty to be considered.

During 2018/19 296 Urgent DoLS applications were made by the Trust, which was 27 less than the previous year. In 2018/19 none of the urgent applications received Standard Authorisation by the local authority DoLS teams.

6.0 Serious Case Reviews (SCR), Safeguarding Adults Reviews (SAR), Partnership Case reviews (PCR)

6.1 Children

In accordance with national guidance, serious case reviews, partnership case reviews and domestic homicide reviews (SCR/PCR/DHR) are requested by the HSCP when a child dies or is seriously injured in circumstances where there are concerns and the case requires a whole system review. All children who are seriously injured or die as a result of injuries are reported as a serious incident to the HSCP and CCG regardless without any failing being attributed to the Trust.

Working Together to Safeguard Children 2018 introduced changes to the SCR process – to local and national reviews. The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children.

During the reporting period, ENHT submitted two chronologies for rapid review (one for Hertfordshire, and one for Norfolk) – neither case progressed to a child safeguarding case review (local or national). One SCR undertaken from the previous reporting year has been completed and waiting publication – all recommendations have been implemented.

Four rapid incident reports within the organisation were undertaken, with one escalating to an SI being declared and one request for RCA. All learning from SI implemented, RCA still awaiting completion.

6.2 Maternity

Serious Case Review for a Child, born at a hospital in Essex is awaiting publication. A learning event was held in December 2019 and possible recommendations explored but awaiting confirmation. This was attended by the Named Midwife and named community midwife.

The learning event has been shared in team meetings and supervision.

6.3 Adults

During 2018/19 the Trust has participated in one multiagency SAR and one PCR. Both are for patients with Learning Disability.

The SAR is for a patient who died in the Trust in 2017 where a number of failings in care by the Trust were identified. The SAR was due to conclude in 2018 however has been delayed as the Section 42 enquiry was reopened. The section 42 enquiry concluded that neglect and acts of omission and organisational abuse were substantiated against the Trust. The SAR publication is due in 2019. The Trust had implemented a comprehensive action plan in relation to this patient's death during 2017-18.

The LD improvement action plan will be highlighted in the section about deaths of people with LD.

The PCR was convened in March 2019 and is still at the stage of information gathering. The review is to look at the circumstances where the person went to live in a care home rather than being supported to stay living in their own home during 2016-17 as was their wish.

7 Audit

7.1 Safeguarding Children Audits

During the reporting period, a comprehensive audit programme was undertaken and action plans developed to address the recommendations. Here follows a brief summary of the audits completed:-

7.1.2 Mental Health

The main aims of this audit were to explore if clinicians working in the emergency department considered safeguarding risks to children presenting with mental health issues, if referrals were made if threshold met to children's social care, and if referrals to C-CATT team are shared with the safeguarding team for further risk review.
Outcome: Overall the audit demonstrated good clinical practice of all the children being seen by mental health services (out of the children not seen - the child had self-discharged but was followed up by the GP).

Referrals to children's social care were made as appropriate for the cases that met threshold, in the cases where threshold was not met; liaison around the case had taken place.

Not all referrals made to the C-CATT team were shared with the safeguarding team; however the safety netting process in place ensured that the safeguarding teams were aware of all the attendances where mental health had been identified as feature in the child or young person's presentation.

7.1.3 Re-audit Quality of Referrals Audit

To assess how agencies refer vulnerable families to Children's Services. To assess how concerns identified by clinicians are recorded and referred and to ascertain there is adequate information provided to allow an assessment of need.
Outcome: The audit demonstrated that there is still a lot of work to do to ensure referrals are sent in a timely fashion with all the relevant details. More work needs to be done around

Think Family as well as understanding the difference between the Safeguarding team and Children's Services. Many clinicians continue to think that by contacting the safeguarding team, a referral has been made to CS. There is also work to do around informing families that a referral has been made and documenting the rationale behind not gaining consent.

7.1.4 Think Family audit

To ascertain if 'Think Family' processes are embedded in assessment and record keeping in ED.
Outcome - Whilst there is evidence of Think Family in some records it is still not being consistently recorded or the data that is recorded is not sufficient. Plans are to repeat the audit following implementation of electronic record and mandatory completion of 'think family' toolkit.

7.1.5 Child Sexual exploitation audit

To explore the effectiveness of safeguarding practice when CSE is identified as a risk for a child.
Outcome:-

- Risks to child identified and addressed
- Evidence seen of appropriate information sharing of findings and significant events
- Details of the assessments and the information shared and recorded was seen and evident
- Clear plans of action were implemented in all 12 cases and clearly recorded
- No males identified!
- No risk assessment tools used by frontline staff
- Over half cases front line staff did not identify CSE as a risk – although did identify concerns for the child.

7.1.6 Was not Brought Audit

The purpose of the audit was to examine if the policy is embedded in practice when children and young people have not been brought to their appointment.
Outcome:- The audit highlighted that it was not clear in the documentation if further appointments were to be offered to a child, little evidence could be seen of letters informing the GP or referring clinician of non-attendance, and little evidence of risk analysis for the child – i.e. impact of the non-attendance to the child's health and wellbeing, or if the referring clinician needed to consider this.

7.2 Adult Safeguarding audits

Audits undertaken in 2018/19 were about Discharge processes for adult patients, the audits showed that a number of processes within the discharge arrangements were not working as effectively as they could, leading to risks of unsafe discharge processes and in some cases patients being readmitted to hospital. A task and finish group was established to review the processes and the following actions were taken

- Process for discharge letters made simpler and quicker to complete
- Discharge lounge processes were reviewed and actions taken to ensure the patient was being discharged with all the necessary documentation and medications
- Discharge and transfer policy updated

Review audits will be undertaken in 2019/20 to check the new and updated processes are embedded and effective.

8.0 Training, Supervision, Peer review

8.1 Children

To protect children and young people from harm, all healthcare staff must have the competences to recognise child maltreatment and to take effective action as appropriate to their role. ENHT is committed to ensuring that all staff receives the correct level of training to safeguard children (0-18) from harm and abuse. The Trust also actively promotes a "Think Family" approach.

The Trust has a Safeguarding Children's Training Strategy and Training Needs Analysis in place which is based on the Intercollegiate Document, Safeguarding Children and Young People: Roles and Competencies for Health Care Staff. Fourth Edition (2019). The strategy outlines the levels of training staff require to be compliant and frequency of training.

8.1.2 Training Compliance

During the reporting period, the Trust worked towards achieving 90% compliance (set by CQC and CCG) for all levels of safeguarding training, and has maintained an overall compliance rate above 90% for all levels combined for the year. However, Level 3 continues to remain below 90%, despite the safeguarding team continuously raising this at board level, divisional level and manager level.

The final end of year position is outlined in the table below

Safeguarding Children's Training: year to date (end of March 2019)	
Level	**Overall Trust compliance (target 90%)**
1 & 2	96%
3	87%
Directorate – level 3 compliance	
Women's	89%
Children's	87%
Medicine	85%

Training content is reviewed throughout the year to incorporate any changes in legislation and guidance. In addition training is updated to reflect findings from national and local Serious Case Reviews and audit findings. Different modes of training are available: this includes face to face classroom sessions, e learning and workbooks.

The team launched a new Level 3a learning package in the form of a workbook specifically for staff working with 16 up to 18 year olds providing an additional level of training to level 2. This has been launched within the surgical division and is expanding to all Trust staff via the vital training programme.

8.1.2 Additional Training

Staff are encouraged to attend external training events provided by Hertfordshire Safeguarding Children's Partnership this contributes to training compliance for the staff member.

Additional specialised sessions have continued to be provided for staff within ENHT Sessions provided during the reporting period have included:-

- Modern Slavery

- County Lines
- Domestic Abuse
- Domestic Homicide Review case study
- CYP gangs Unit
- Empathy Project
- Families Feeling Safe
- Sexual health
- Harmful Sexual Behaviours
- FII
- Perinatal mental health
- FGM awareness

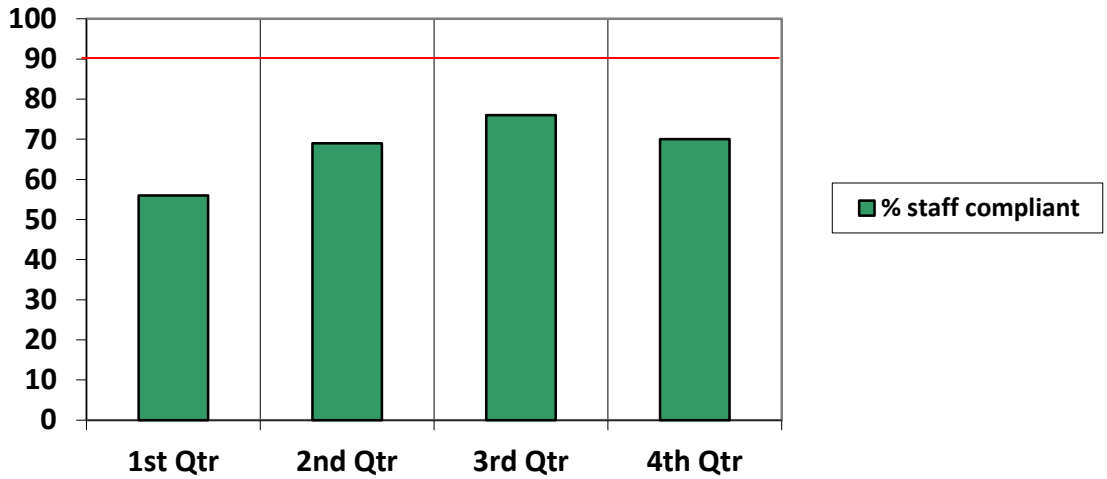
8.1.3 Supervision

Working Together 2018 acknowledges the importance of staff safeguarding supervision to enable staff to reflect on practice, learn from case discussions and obtain support for the emotional aspects associated with their work. It is known that attendance at supervision increases staff knowledge, skills, and supports emotional consequences of face to face contact with child protection cases. It also aids staff to assume responsibility for their own practice in a safe and supportive manner.

ENHT has a Safeguarding Supervision and Peer review policy which was updated in 2018, which outlines how staff can access supervision and peer review. The safeguarding team provide formal and informal supervision is available to provide support and also challenge to practitioners who are managing a vulnerable caseload.

The Trust target for compliance as set by the Clinical Commissioning Group (CCG) is at 90% for Band 6 and 7 staff and caseload holders working within community setting.

The following chart shows compliance with supervision for the reporting period. It is worth noting that these figures do not always reflect the ad-hoc supervision provided to staff – which is the safety net for when concerns present and support and advice is required by the safeguarding team.



An action plan is in place to address the compliance with regular monitoring of staff who are non-compliant. In addition to safeguarding supervision, clinical supervision is provided to staff who are caseload holders - combined with safeguarding supervision, this results in staff receiving supervision every 6-8 weeks (clinical supervision figures are not included within the safeguarding supervision report).

8.1.4 Peer Review

Peer review is held twice a month and is a form of reflective practice. The goal is to provide a proactive culture of shared learning, supervision, education and training and improvement of service and multiagency processes. It is a core competency for all clinical staff working with children to undertake regularly documented reviews of practice, including peer review.

It is a component of the Clinical Governance Framework and is expected by the GMC and professional bodies. It helps to decrease professional isolation and improve sharing of best practice.

Peer review for junior and senior medical staff is led by the Named Doctor for Child protection on a fortnightly basis. All the child protection medicals are discussed including reports. Peer review is used as a training format using case discussions and is well attended by acute and community paediatricians and their medical teams. Supervision is also offered and is delivered as a combination of individual and group sessions as well as ad-hoc supervision on a needs case basis. Peer review attendance is recorded on electronic staff record (ESR) at level three and is monitored. Peer review survey was done this year showing a positive experience and positive contributor to shared learning.

8.1.5 Peer Review attendance

2018/19	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Acute Consultants	2	4	*	2	*	5	*	7	4	3	2	5	**34**
Community Consultants	15	20	8	16	*	16	13	24	24	14	20	18	**188**
Neonatal Consultant	1	1		2	*	1	*	3	3	0	1	1	**14**
Total	**18**	**25**	**8**	**20**		**22**	**13**	**34**	**31**	**17**	**23**	**24**	**236**

*attendance sheet could not be located

8.2 Adult Safeguarding Training

Adult Safeguarding training is provided for all Trust staff through the statutory/mandatory training programme and new staff induction programme. All staff receive mandatory updates every two years, Adult Safeguarding level 1 & 2, MCA, DoLS and Prevent awareness.

All staff in a clinical role and on call senior managers receive Prevent training up to Level 3. The Trust achieved the NHS England target of 85% of eligible staff trained by the end of quarter 2. By the end of quarter 4 compliance was 86.1% of 3344 eligible staff.

Compliance with training attendance is recorded on the Electronic Staff Record and monitored through monthly reports to line managers, the Statutory-Mandatory Training Committee and the Safeguarding Committee.

Adult Safeguarding training	Training compliance 18/19
Level 1 (all staff)	89.8%
Level 2 (Clinical staff)	89%
MCA and DoLS (Clinical staff)	89%
Prevent awareness (all staff)	89.8%
Prevent Level 3 (Clinical staff and on call senior managers)	86.1%

During 2018/19 the Adult Safeguarding team reviewed adult safeguarding training requirements against the new intercollegiate document for roles and competencies in Adult Safeguarding. A gap analysis was completed and proposals for a Safeguarding study day to be undertaken with the Children Safeguarding team have been developed. A proposal has been submitted to the Finance committee as there are implications for increased resources to provide and deliver Level 3 Safeguarding training for registered staff as this is over and above training already provided. Initial study days have been implemented with the Preceptorship Nurses and this will be developed further in 2019 to implement incrementally with the remaining registered staff.

9.0 Care of Adults with a Learning Disability

The Acute Liaison Learning Disability Nurses (Hertfordshire Health and Community Services) are involved with supporting patients with Learning Disabilities (LD) and their carers when using hospital services. They will assist Trust staff in making reasonable adjustments for patients, advising staff about what reasonable adjustments might be required, using appropriate communication tools for people with LD, enabling appropriate discharge packages of care, end of life care and will provide training for staff around the needs of patients with a learning disability.

The Trust uses an LD alert on the electronic patient records – alerts are available to use on Nerve Centre and Lorenzo. During 2018/19 the IT stabilisation team was able to resolve the issue of being able to report activity for patients using the LD alert. The following table shows activity for patients with an LD alert during 2018/19.

Learning disability alert	2018/19
ED attendances	898
Inpatient admissions	384
Day case attendances	159

The alerts on the Nerve centre are now used to produce a daily report which is emailed to the LD nurses and matrons so that they are aware of the patients who are in hospital. At the daily site safety huddle on the acute site (Lister Hospital) all the patients with LD are discussed to ensure that if there are any concerns about care or any delays which need to be resolved these can be acted on by the right people in a timely manner. The LD nurses now participate in these meetings.

Work to accredit services with the Purple Star award has continued in 2018/19 and the following services have achieved/maintained Purple Star accreditation:

- Day Surgery
- Diabetic Eye Screening
- Ophthalmology services
- QEII ambulatory care

Services currently working towards accreditation are the Emergency Departments and Endoscopy. Purple star is the accreditation given in Hertfordshire to services which are deemed, following assessment and evaluation, to be meeting the needs of people with LD.

9.1 Learning disability working group and improvement action plan

During 2018/19 there has been focused work on improving care for patients with learning disability. This followed on from serious incidents with the deaths of patients with LD and concerns about how care was being provided.

Work was undertaken with the support of NHSI Learning disability leads and NHS England to review practices within the Trust and to benchmark against the LD Improvement standards for Acute Trusts and the Trust developed an improvement action plan supported by the Health Liaison Nurses.

The Learning Disability Working Group was set up and is meeting bi-monthly; it is chaired by the Director of Nursing. The membership includes the commissioners, representatives from the clinical divisions, the LD nurses, safeguarding teams, family carers, sepsis nurse, equality and diversity lead,

The LD improvement action plan has been attached as Appendix 2

9.2 Improving Health Outcomes

The Trust has continued to participate in the Hertfordshire 'Improving Health Outcomes' group, the multi-agency group leading on the implementation of strategies to improve health outcomes for people with LD as part of the work of the LeDeR mortality review steering group. .

The Lead Adult Safeguarding Nurse and the Trust Lead Sepsis Nurse are members of the multi-agency Hertfordshire health outcomes group which meets quarterly.

9.3 Sepsis and patients with Learning Disability

As Sepsis remains a significant factor in the mortality rates for patients, including those with LD, the Sepsis nurses have continued to progress work to raise awareness about the risks of sepsis. During 2018/19 this work has included:

- Participating in the Hertfordshire Health Outcomes group
- Working with the Hertfordshire Health Liaison Team to raise awareness about sepsis and the signs of sepsis within the community of people with learning disabilities
- Working with the 'Purple All Stars' to develop a song about Sepsis – to be used as part of educating people about sepsis. The song was launched on Youtube in May 2019

The Sepsis lead nurse organised a study day, held in May 2019, for staff on care of the acutely sick patient with LD to help staff to understand the risks for patients with LD and about being able to recognise and identify the sick and deteriorating patient so that timely and appropriate actions can be taken.

9.4 Deaths of people with Learning Disability

9.4.1 National Mortality Review for people with Learning Disability (LeDeR programme)

From April 2017 Hertfordshire began to notify the deaths of people with LD, aged 4 years and over to the National Mortality Review programme. The aim of the programme is to review the deaths of people with LD to identify the learning for policy makers and services, so that improvements can be made for the health outcomes of people with LD, improve mortality rates and reduce the risks of premature death.

The Trust participates in the Hertfordshire LeDeR steering group and the Health Outcomes group. The Lead Adult Safeguarding Nurse and Lead Sepsis nurse also participate as reviewers for the LeDeR programme in Hertfordshire.

Deaths of patients with LD within the Trust are notified to LeDeR and will also be reviewed internally by the mortality review process.

During 2018/19 there were 11 deaths of patients with LD in the Trust

- Median age 70
- Men 9 – median age 69 years
- Women 2 – median age 78.5 years
- Pneumonia, aspiration pneumonia and sepsis were a feature in a number of these deaths

A presentation was given to the Grand Round in September 2018 by the Safeguarding Nurse and Sepsis nurse to highlight the risks of premature or avoidable mortality in patients with LD, emphasising the importance of the right people taking the right action at the right time to prevent deterioration. Also the importance of involving the family and carers in assessing what is happening with the person and listening to and acting on the concerns raised by the carers who know the person better than hospital staff.

9.4.2 Serious incidents

During 2018/19 there was one serious incident declared for the death of a patient with learning disability due to safeguarding concerns about the care of the patient whilst in hospital. The outcome of the safeguarding enquiry was partially substantiated for neglect and acts of omission due to poor documentation regarding food and fluid charts and involving the paid carers during the hospital admission, also delay in sending an outpatient

follow up appointment. The learning from this SI is part of the Trust LD action plan and part of the quality and safety initiatives in the Trust being led by the Quality and Safety team.

10.0 Dementia Care, Supporting Carers, Enhanced Care Team and Butterfly volunteers

10.1 Dementia care

The Admiral Nurse, Hannah Gardner, has been in post since January 2018. Year 1 evaluation was published in January 2019. The Admiral Nurse provides specialist dementia support for families and patients, working alongside them and giving 1 to 1 support when things get challenging or difficult. The support can be psychological support or providing expert advice and information to help families understand and cope with their thoughts feelings and behaviour, and to adapt to the changing situation when caring for and living with someone with dementia. Covering also the practical side of caring for someone who has dementia or advanced dementia.

During year one these are some of the activities undertaken by the admiral nurse:

- worked with 211 family carers
- developed new care pathway for patients with dementia from hospital admission to discharge to the community
- delivered 996 activities to support best practice in dementia care
- trained 436 professionals to Tier 1 dementia knowledge
- 95% of professionals trained have improved their confidence in interacting with people with dementia and 93% improved their skills in working with people with dementia
- trained 56 professionals to Tier 2 knowledge

The admiral nurse works across the main inpatient site alongside ward staff and clinical teams. Patients are identified from the Dementia alert on Nerve Centre, the electronic patient record by Hannah or she receives referrals from professionals in the Trust or community services. The primary reason for referral is to provide information about available services but also she will receive referrals for patients experiencing high levels of distress or changes in the person's presentation or condition. An average of 18 referrals per month were received during the 12 month period. Interactions with family carers may be face to face or by telephone, attending clinic appointments, supporting on the wards at the bedside or advocating on behalf of families with other health or social care professionals.

The admiral nurse will also provide advice and guidance to health and social care professionals, for example:

- promoting person centred care
- supporting with mental capacity assessments and deprivation of liberty safeguards
- maintaining records of hydration and nutrition
- monitoring for constipation or bowel habits
- managing pain
- managing changing behaviours, including confusion and agitation and using distraction methods or activities that help to calm or reassure the person
- promoting the use of dementia specific pain rating tools
- promoting best practice, kind and compassionate care for patients with dementia
- developing the role of dementia care champions

The admiral nurse has also:

- developed and implemented the Dementia and Delirium care pathways, these have received recognition from CQC
- supported the work for the National Dementia audit
- worked with the palliative care nurses to ensure the needs of patients with dementia were being met and to set up the appropriate support in the community
- supported 80 dementia champions and produced a bi-monthly newsletter and bi-monthly champions meeting
- provided training for new student nurses working in the Trust
- led the dementia strategy meetings with clinical teams
- promoted the care of people with dementia through publicity and information events – such as for Dementia Awareness week, the Trust annual general meeting and celebrating 70 years of the NHS

The support provided by the Admiral Nurse to staff in caring for patients with Dementia has seen positive benefits with 95% of the professionals trained saying that they more confident in interacting with people with dementia and 93% of professionals saying it had improved their skills in caring for people with dementia.

10.2 Supporting Carers

Supporting carers is an important part of safeguarding people's wellbeing; safeguarding the wellbeing of the person being cared for or safeguarding the wellbeing of the carer.

The 2011 Census reported that there were 108,615 unpaid Carers in Hertfordshire, equivalent to 9.7% of the total population. Carers provide care for children or adults who have care and support needs; carers themselves can come from all age ranges – from young carers to elderly carers providing care to family members, relatives or friends.

Carers provide valuable support to the people they care for and being able to undertake that role in a way that does not put the person they care for, or themselves, at risk of harm, abuse or neglect is fundamental to the wellbeing of people.

The following summary is from the Carers Lead, Jodie Deards:

Throughout 2018/2019 there has been a continued emphasis to increase carer awareness within the Trust. Hertfordshire and West Essex STP have adopted a five step pathway for carer support. The steps include identification; welcome; assessment and support; involvement; and transition. These steps have been the basis of the carer strategy and work within the Trust.

Activities in 2018/19 included

- Carers policy updated and the five step pathway included
- Consultation with health professionals from within the Trust, Health Liaison Team, carer voluntary organisations and carers
- Monthly carers stand at the Lister Hospital with local carer charities, Carers in Hertfordshire and Crossroads. This enables carers within the hospital to come and get good advice and signposting to relevant agencies to ensure they can continue to care safely and well.
- The carer awareness stands is being replicated at the Mount Vernon Cancer Centre.
- 123 new Carers were identified and referred to voluntary carer organisations.

- Carer focus group held and as poor communication and lack of health information had been a common feedback theme from carers a Carers handbook was agreed as a way to attempt to address these concerns.
- Co-production approach to developing the Adult Carers Handbook. The handbook contains information explaining what carers can expect, common hospital processes, discharge processes and the 'get up get dresses approach. It also explains common legal terms used in health. The handbook is now in use across Hertfordshire and West Essex STP within NHS organisations. It enables carers and visitors to be signposted to the right organisations to enable them to gain advice and support when they require it, preventing crisis points and reducing the risks to the person they care for.
- The NHS initiative of #endpjparalysis has been adopted throughout the Trust. Valuing patients' time and ensuring every day contributes to good care, supports this initiative. With this, afternoon teas were introduced on 6A with the support of volunteers. This is to encourage patients to get up and get dressed and have some activity stimulation and to make laughter part of the patient's day.

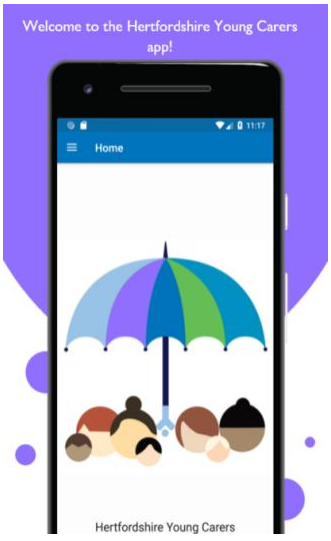
10.2.1 Young Carers and safeguarding children

The Young Carers 'App', was co-produced with Young Carers in Hertfordshire and North Hertfordshire College and was launched during Carers Week in June 2018. It is available on 'googleplay'. The response from young carers has been very positive with 95% of those asked at the annual Young Carers Conference recommending it.

The content of the app was decided by the young carers and paramount to this was ensuring information about keeping them safe was included. Childline, internet safely, who to go to for help are all included. Young carers are considered a difficult to reach and vulnerable group, but with the use of an app, the young carers can access the right information and signposting 24 hrs a day.

A research application to Nursing and Midwifery Council of England in 2018 to investigate how Young Carers access information and feedback on the app was accepted. The feedback was 'I enjoyed reading this application that proposes important work to evaluate improved support for young carers, who represent complex and substantial unmet needs. The development of an app…is an intelligent use of technology to improve access and service provision for this group.'

Applications and ethical approval to commence the research was signed off in March 2019 and first round interviews commenced. This research is intended to last 2 years with further versions of the app being developed.
This work has also enabled close partnership working with our local secondary college, John Henry Newman. Working together, we are raising Young Carer awareness within the school.



The Young Carers App

10.2.2 Children, Young Carers and maintaining mental health

The carers lead, now is a key member of the Safeguarding children's weekly pyscho-social meeting. This is enabling young carer awareness and identification in a hard to reach group.

At the weekly pyscho-social meeting held in the children's ward case studies, including safeguarding concerns and vulnerable children in contact with the Trust are discussed. The multi-agency approach better ensures the child is protected with wrap around support. This early intervention and proactive approach to the family unit aims to prevent the further escalation / deterioration of the child's wellbeing. As part of the discussion is consideration of whether there is a carer in the situation. This may be a young carer or a parent carer. Through this approach we have been able to escalate greater support for families within the community.

Young Carer Awareness Day was held on 31 January 2019. The theme was mental health. Being a young carer is a risk factor for mental ill health of children and young people. We had displays in the main hospital corridor and on Bluebell, the children's ward.

10.3 Enhanced Nursing Care team

The enhanced care team lead by Matron Emily Watts and Team Leader, Tibio Rizaldy continues to provide an enhanced level of care and support to patients who need either 1 to 1 support or enhanced supervision during their hospital admission. This can be with patients who are confused and agitated, at high risk of harm from falls, have dementia or delirium or are at risk of self-harm or wandering away from a ward. The team now provide care for children and adults

The team continues to receive positive feedback about the care provided both from the patient's family/relatives and other professionals in the Trust. In terms of improving the quality of care for patients there is now more consistency in providing care and support to some of the most vulnerable patients in the Trust. There is less reliance on ad hoc staffing to provide support for patients, including sustained reductions in the use of agency staff. Staff have received additional training for care of people with dementia, learning disability and mental health illness therefore the level of enhanced support is more appropriate to the needs of the patient. The team can provide care 24 hours a day, seven days a week and can be flexible and responsive to the care needs of the patient wherever the patient is situated.

During 2018/19 the team has:

- Eliminated the need to use agency staff for 'specialling'
- Won the Health Heroes (Skills for Health) award for Workforce planning in November 2018
- Provided support for patients of all ages – children to elderly, and now provide support for patients with mental health illness
- Undertaken additional training to broaden the scope of the care they provide e.g. for children and patients with mental health illness
- Used Baywatch to support patients at risk of falls
- Participated in the Site Safety huddles to ensure the needs of vulnerable patients are highlighted and any blockages in providing care or treatment resolved
- Published an article in the RCNi Older People Journal

- Worked in collaboration with the volunteer service to provide support for patients with dementia and provided training for volunteers about Dementia
- Enabled the Trust to save £45,000 per month by not needing to use agency staff to cover 1 to 1 support

In 2019 the team will be working with the Professor of Nursing to evaluate the service and outcomes.

10.4 Butterfly volunteers

The butterfly volunteers continue to provide support for patients, their families and friends when patients are coming to the end of their life in hospital. They can provide a supportive environment for family or friends or sit with the dying patient when they do not have family or friends who can stay with them.

The volunteers were chosen to represent Midlands and East in the NHS 70th birthday awards in May 2018 and attended a special celebratory service at the palace of Westminster.

11.0 CQC inspection 2018

The 2018 inspection report was published in July 2018 with a 'requires improvement', the summary of the outcomes showed improvement required in:

- All staff completing mandatory training and staff having the right training for their roles
- Staff caring for patients up to age 18 having the right level of child safeguarding training
- Compliance with infection prevention and control procedures
- Environment at the Mount Vernon Cancer Centre to reduce infection risks
- Availability of suitable premises and equipment and the maintenance and care of both – ward 11b and security on the children's ward
- Effective systems for recognising and responding to deteriorating patients' needs.
- Staff not always recognise and report incidents in a timely manner.
- Consistency of staff understanding of their responsibility with regards to the duty of candour requirement
- Some areas not having enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment
- Effective governance arrangements in place to ensure controlled medicines and storage temperatures were checked daily, and that out-of-range temperatures were acted upon, when indicated.

However CQC found that:

- Most of the services within the trust prescribed, gave and recorded medicines in line with best practice.
- Patients generally received the right medication of the right dose at the right time
- There were systems and process in place to provide Systemic Anti-Cancer Therapy (SACT) safely.

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so
- Midwifery staff exceeded the trust's completion targets for all safeguarding training
- Staffing levels were regularly reviewed and staff were redeployed within the clinical areas, when needed.
- The trust almost always had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse, and to provide the right care and treatment most of the time.
- Generally, staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- Services generally used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors, and used the information to improve the service.

The Trust has implemented its improvement plan and is due to be inspected again in 2019

12.0 Safeguarding Service developments

Developments to improve safeguarding practices across the Trust over the reporting period include the following:-

- Safeguarding Champions are in place across Adults, Children and Maternity Departments providing safeguarding advice and support to their peers. Extra training, case discussion and accessibility to Safeguarding Team is in place to support Champions.
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- Paediatric Liaison Post - evidence demonstrated a positive impact on information sharing across the organisation and has greatly improved from last year. An electronic system is under discussion between HCT and ENHT and it was agreed that the PHLV funding would remain in place.

- The Child Protection suite works well, particularly as it is located nearby to Clinical Paediatricians which promotes communication. Peer Reviews are in place and reported to work well, attended by acute and community Paediatricians/doctors. It is an open forum for case discussion. It was noted that there are dips in attendance which are being monitored and followed up. Learning from the peer review was reported to be useful for doctors with a plan to include teaching on relevant topics.

- Letters are sent to Hertfordshire Community Trust for Health Visitor/School Nurses and to the child's GP following child protection medicals.

- Carers lead attending weekly psychosocial meeting to liaise about young carers– increase in referrals for additional support seen. Service evaluation planned.

- Trust Site Safety – daily meetings look at patient presentation, all patients with a learning disability and any adults presenting with additional issues. The meeting takes place at 11.00am and is led by the Heads of Nursing.

- FGM-IS – this is implemented within maternity and is also scheduled to be implemented within unscheduled health care settings (ED and Urgent Care).

- Supervision – Safeguarding Children Supervision takes place every 3-4 months. Combined with Clinical supervision, this results in staff receiving supervision every 6-8 weeks. Additionally 1:1 and ad hoc supervision is available as requested. The Safeguarding Team attend sites across the Trust's estate to ensure visibility and accessibility.

- Information sharing – Monthly Children's Safeguarding Team meetings to share information and promote learning from Serious Case reviews and training.

- Information is shared by Maternity with the GP on all booked vulnerable women at an early stage. The expectation is that GP's will reciprocate and share information with the Maternity Unit. A mental health midwife has been appointed with an expectation that this will also improve information sharing. All policies are up to date –safeguarding and training are currently being updated.

- ENHT are proactive in raising safeguarding profile across Executive and Non-Executive board roles. A plan for more bespoke relevant training to enable understanding of role in safeguarding is in progress.

- Promotion of 'Whose Shoes' an engaging board game across Maternity encourages everyone to walk in other people shoes and understand the service users, carers and staff experience.

- Evidence of good examples of safeguarding issues across the Trust raised by Diabetes Team, Learning Disability demonstrating effective working relationships with Safeguarding Team. LD team are raising awareness amongst staff on Learning Disability. Learning Difficulties are increasingly noted whilst they do not meet criteria of Learning Disability criteria the Team support through education of staff.

- An audit of frequent flyers led to discussions to develop a transitional unit for children with complex health needs. The numbers of CYP are increasing with behavioural risks increasingly significant. Whilst many patients do not require Tier 4 admission they do require an increased level of mental health support. ENHT acknowledged support from HPFT has improved, however often families re attend ED if their child's behaviour escalates.

- Communication between LAC Health team, Children's Services is promoted with escalation as relevant.

- CSE: referrals have increased. An audit highlighted front-line staff are not routinely using the risk assessment, however the review of documentation indicated that children are being identified to be at risk. Work is in progress to promote the use of risk assessment tool.

- CSE Tool –The term "exploitation" covers sexual, criminal, contextual safeguarding with an increase in county lines, trafficking, gangs, and increased awareness in Hertfordshire. It was agreed that a multi-agency approach is the best approach to tackle the issues.

- CSA - Pathway to SARC is updated and will be presented to ENHT Executive. Plans to hold a joint teaching session with collaboration of SARC professionals for front line staff are in place. ENHT report good engagement with SARC professionals.

- Working together – Adults and Children working more closely together – dashboards have been merged. There is a plan to have a single hub for all safeguarding. A merged team working together should have a more positive impact.

- Better Births – maternity safeguarding is sharing information, communication with PAH and West Herts has improved and ENHT have met safeguarding nurses from other trusts to help improve communication. There is a notable increase in patients attending Lister from St Albans, instead of West Herts.

- Concealed Pregnancy – This is worded in the pre-birth protocol. ENHT do not use the word “concealed” but “un-booked”. There is a formal procedure for concealed pregnancy and the plan is for the mental health midwife post to follow up on this improving links between mental health and maternity.

13.0 Risk register

During 2018/19 risks related to safeguarding were:

- Care of people with LD, failing to recognise the deteriorating patient

- Risk of unauthorised DoLS as the Supervisory Body cannot meet the standard authorisation requirements

- Children safeguarding compliance

- Think family

- Child sexual abuse medicals

- Child protection-IS not available in outpatient departments

Appendices

Appendix 1 – Section 11 action plan 2018/19
Appendix 2 - Learning disability improvement action plan 2018/19