Title of the Report:	Safeguarding Annual Report 2017-18
Author:	Maria Kilcoyne – Head of Safeguarding – Heart of England NHS Foundation Trust
Purpose of the Report:	To highlight achievements in relation to safeguarding within the Trust and to provide internal and external assurance of compliance with the statutory and regulatory requirements.
Date of the Report:	28th April 2018
Structure of the report:	Section 1 Background and Context to Safeguarding Section 2 Safeguarding Education and Development Section 3 Safeguarding Children- summary of activity in relation to safeguarding children Section 4 Safeguarding Adults (authored by Lorraine Longstaff) Section 5 Domestic Abuse Section 6 Conclusion

Section 1 Background and Context:

The overall organisational safeguarding approach is underpinned by the firm belief that every child or adult has the fundamental right to live a life free from harm or abuse.

Adult and Child Safeguarding in NHS organisations are statutory and regulatory requirments.

The Trust is accountable for delivery in relation to safeguarding requirements and this is monitored closely by Local Safeguarding Children and Adult Boards, CCGs and the CQC.
Statutory requirements relate to:

- Children Act 1989
- Children Act 2004- specifically section 11
- The Care Act 2014

In order to ensure that the the Trust is equipped to carry out it safeguarding responsibilities it has prioritised:

- Investment and development of a safeguarding infrastructure – the Trust has a safeguarding team of specialists to support all areas of business
- Sound safeguarding governance – continuously testing out the effectiveness of safeguarding arrangements focusing on learning and improvement
- Development of safeguaridng capability across the whole workforce to ensure that staff are fully equipped to deal with the demands of safeguarding work and can reliably identify and respond to safeguarding concerns in a safe and proprotionate manner.

HEFT's safeguarding philosophy is informed by the learning from all relevant reviews and large scale inquiries. These include: local Serious Case Review; Serious Adult Reviews; Domestic Homicide Reviews and lager scale inquiries including the Francis Inquiry (2013), Independent Inquiry into Child Sexual Exploitation in Rotherham (2014) and the Lampard Inquiry (2015). In particular the Trust promotes the principles of openness, transparency, and leadership as being integral to service delivery and positive safeguarding outcomes across the health economy.

While the safeguarding frameworks for adults and children are managed separately, nationally they do often link/crossover or can run concurrently, for example in domestic abuse; concerns regarding exploitation and the impact of adverse childhood experiences. The Trust reflects this in its local arrangements for safeguarding (a combined safeguarding adult and child team) and in its approach to safeguarding education for the workforce.

The Trust has key policy documents which support the delivery of effective safeguarding. These include:

- Safeguarding Adults and Children Policies
- Raising Concerns Incorporating Whistleblowing Policy
- Recruitment Policies

In addition the Trust has worked to develop close working relationships with local safeguarding partners including the police and social care.

National and local context

Children

During 2017-18 the Government continued to explore reforms to the Child protection system due to anxiety that the current systems to protect children continue to allow two many children to come to serious harm.

This includes:

- The introduction of the Children and Social Work Bill with changes to social work services, professional registration and regulation and and
- Consultation and revision to Working Together to Safeguard Children (publication anticipated in May 2018)
- Reforms to the legislation governing Local Safeguarding Children Boards.
- Continuation of the Independent Inquiry into Child Sexual Abuse (IICSA)

The national safeguarding discourse is concerned with growing evidence of wider forms of abuse affecting children and young people in society.These include exploitation through gangs; sexual exploitation and radicalisation/ extremism. There are concerns about the extent to which the current child protection system which is based on a model of 'intra-familial' abuse can respond appropriately to these issues.

A growing body of research has identified the harmful effects of Adverse Childhood Experiences (ACE's) on long term health. The ACE's include experiencing abuse; neglect; parental substance misuse; domestic abuse; mental ill-health;loss including having a parent imprisoned. Experiencing six or more ACE's can shorten life expectancy by 20years.

The movement to address this public health issue is growing for both children and adult services, raising awareness of both public leaders and organisations to promote the development of a united focus and services to support both the children and adults who have experienced ACE's.

The chair of Birmingham Adults Safeguarding Board has identified a Board aim for Birmingham to become the first Trauma Informed City in England with development of a 'city trauma hub' and network..

Birmingham has a young footprint with over 330,000 children in the City. The published Public Health Outcomes Framework (August 2017) illustrated the areas where Birmingham performs badly and these included:

- Infant mortality
- Low birth weight of term babies - this continues to be 50% higher than the England rate
- Children in low income families (both under 16s and all dependent children under 20)
- School Readiness: the percentage of girls achieving a good level of development at the end of Reception.
- Excess weight in 10-11 year olds
- Pupil absence
- First time entrants to youth justice system
- Continuing in education/ training or employment between the ages of 16-18 years.

The report also illustrates the issues impacting families in relation to unemployment rates; social isolation. Rates for completion of substance misuse programmes which are lower than the national rates and the rates of our 'statistical'neighbours.

All of the above creates an environment in which children are vulnerable in in which many families will need significant support in order to care adequately and safely for their children. The report can be accessed via this link https://www.birmingham.gov.uk/downloads/file/7993/jsna_strategic_phof_aug_2017

There are plans for the delivery or early years services which take into account the public health and social challenges and the school nursing specification will also be reviewed in 2018-19.
In April 2018 the City launched the Birmingham Children's Trust which is new provider of Children's Social Work services. The priorities for the Trust have been identified as:

- Quality Strategy: driving learning and improvement
- Workforce: recruitment and retention; learning and development; policies, procedures; culture
- Placements: Fostering; Adoption; market management and commissioning
- Vulnerable Adolescents: risk management; new service models

The newly formed Children's Trust hopes to benefit from the fresh start that being in a new organisation affords and that they will be able to streamline processes by being freed from the ties to the City Council. There are hopes that in the future they will be able to re-invest retained monies to develop services.

Adults

The Care Act 2014 from 1st April 2015 provides a statutory framework for adult safeguarding, setting out the responsibilities of local authorities and their partners. It places a duty on Local Authorities to establish Safeguarding Adults Board and also stipulates local authorities' responsibilities, and those with whom they work, to protect adults at risk of abuse or neglect.

The role of all Safeguarding Adults Boards (as detailed in schedule 1 of the Care Act 2014) is to help and protect adults in the board's area. This is achieved by coordinating the actions of partner agencies, and seeking assurances from them that those actions are effective.
Boards are also able to instruct partner agencies to carry out any function considered necessary or desirable for the board to reach its objectives. In addition Safeguarding Adults Boards must publish a strategic plan for each financial year and as soon as is feasible after the end of each financial year, must publish an Annual Report.

It has been recognised that processes and procedures in relation to Deprivation of Liberty Safeguards are unwieldly and not sustainable and waiting for Government to agree the proposals that were submitted by the Law Commission

HEFT

Heart of England NHS Foundation Trust is large provider of a wide variety of scheduled and unscheduled health services for residents of Birmingham, Solihull and parts of Staffordshire. The Trust provides the following services to patients: Emergency Care, Maternity and Neonatal Services, Acute Services for Adults and Children, Community Services within Solihull.

The Trust employs approximately 10,000 staff and, annually, sees and treats 1.2 million people and has over 261,000 attendances to the Emergency Departments 63, 127 of which are under the age of 19 years, approximately 10,000 new births annually and sees110,000 children (0-18 years across in and out-patient services).

The Trust has a Safeguarding Unit responsible for provision of advice, support, policy, supervision and education to the wider workforce on safeguarding matters. This Team support the multi-agency working groups by providing specialist health advice to the LSCBs that the Trust relate to and coordinate the Safeguarding Audit Programme and our input into safeguarding reviews (including learning reviews, SCRs, SARs and DHRs). The team is highly visible and accessible to clinical staff and provide an advice line between the hours of Monday to Friday nine to five.

The Team are managed by the Head Nurse for Safeguarding who reports to the Chief Nurse/ Interim chief Nurse as the Executive Lead for Safeguarding providing Board oversight of safeguarding arrangements.

The Trust oversees the governance arrangements for safeguarding through a quarterly Safeguarding Children Committee and Monthly Safeguarding Adult Steering Group.

HEFT has continued to work closely with UHB in relation to safeguarding plans due to the planned acquisition by UHB in 2017-18. The Trusts became one organisation on April 1st 2018 and the future safeguarding team structure is being finalised. HEFT services known from that point forward as HGS – UHB.

HEFT has also fielded safeguarding representation to participate in the strategic and tactical 'BUMP' proposals which will modernise maternity services in the City in 2017-18.

Key achievements during 2017-18 include:

- Increased specialist safeguarding supervision delivered to targeted children's and adult areas
- Review of key safeguarding policies and procedures and educational packages
- Maintaining a focus on audit and testing out the effectiveness of our arrangements through our audit programme.
- Increase in the Domestic Abuse infrastructure with an improved offer in relation to related training and advice.
- Hosting of an in house safeguarding adult conference which was well evaluated.
- Delivery of Mental Capacity Act Training to increased staff numbers
- Increasing the resources to support understanding of clinical holding and use of restraint
- Defining and delivery of an early help offer to families in receipt of maternity and community services.
- Increased scrutiny of attendances of high risk groups including frequent attenders and 16 -18 year olds.
- Exploring the safeguarding implications of transfer of services/ organisational changes.

Key Priorities for 2018-19 include:

- Establishment a new safeguarding staffing structure based on need
- Establishment of a refined governance structure to support safeguarding
- Harmonisation of Safeguarding Policies and Procedures
- Harmonisation of processes
- Assessing the impact on safeguarding of other organisational changes in relation to documentation/ system changes.
- Maintenance of all safeguarding services throughout the period of safeguarding team transition.
- Introduction of the FGM RIS (Risk Indicator System)
- Maintain and strengthen key partnerships at a time of change (both health re-organisation and new arrangements for provision on children's social work services)

- Develop the learning and development offer in line with the new priorities around the wider definition of exploitation across the workforce.

- Introduction of 'Redthreads' in BHH Emergency Department – a service to enhance youth worker support to children and young people between the ages of 11-25 years who have experienced severe violence, sexual exploitation or domestic abuse.

Section 2 Safeguarding Education and Development Adults and Children– Training Compliance

2.2 Safeguarding Education and Skill Development

The capability of frontline staff in relation to safeguarding relies heavily on their access to suitable education and skills development. The Trust is required by the Children Act 2004 and the Care Act 2014 to have suitable training packages in place and to monitor compliance rates and effectiveness of training.

The HEFT workforce must be competent and able to respond to adult and child safeguarding concerns.

There is a Safeguarding Training Needs Analysis which takes into account: the intercollegiate requirements; the generic requirements of the whole workforce and the individual needs of the adult and children's workforce.

There is a combined approach to safeguarding adult and child learning and development at Levels 1 and 2. The training makes it clear that the statutory frameworks for responding to child and adult safeguarding concerns are separate.

The table below illustrates the current training compliance rates for safeguarding within the Trust at the end of quarter 4 2016-17. These are monitored and reported quarterly internally and to commissioners.

Safeguarding Education Package 2017-18	**Staff number in this cohort**	**COMPLIANCE Percentage**
Compliance with Adults Mandatory Safeguarding Training (all staff) **Level 1**	**10016**	**98%**
Children's Mandatory Level 1 Safeguarding Training	**10016**	**98%**
Compliance with Adults Mandatory Safeguarding Training (all clinical staff excluding junior doctors and bank) **Level 2 Adults**	**4778**	**98%**
Children's Safeguarding - Level 2 Training or those staff identified in TNA	**4778**	**98%**
Mental Capacity Act/ Deprivation of Liberty Safeguards Training (as identified in TNA)	**800**	**78%**
% Compliance with Adult High Level Training (as identified in TNA)	**130**	**94%**
PREVENT Training	**9234**	**92%**
Children's Safeguarding - Level 3 Training for those staff identified in TNA	**1137**	**92%**

Children's Safeguarding - Level 4-6 Training for those staff identified in TNA (Specialist Safeguarding Staff).	**12**	**100%**
CSE	**824**	**85%**

All training for the Children's workforce is based on the safeguarding competences outlined in the recommendations in 'Safeguarding children and young people: roles and competences for health care staff' (RCPCH 2014)

Exceptions to note

- Bank staff were not included in our TNA for 2017-18 for reporting purposes however **86%** of 275 bank staff are compliant with Safeguarding Level 2 for Adults and Children and these staff will be part of the TNA for next year.

- The target of 85% for MCA training was not achieved fully due to difficulties in releasing staff during winter pressures and due to high levels of vacancies and high staff turnover. We had a phased trajectory which we achieved across the first 3 quarters of 2017-18 but did not achieve the projected trajectory in quarter 4.

- CSE compliance rate of 85% was achieved across the organisation in April 2018.

- All volunteers receive Level 1 training and this is updated every 3 years. This is monitored by the Head of Volunteers and reported via quarterly reports to Safeguarding Children Committee.

During 2017-18 all Children's Specialist training at Level 3 was updated to ensure that it included recent research and learning form SCRs and reference to the research on the impact of adverse childhood experiences (ACEs).

In addition domestic abuse training materials were revised and a bespoke domestic abuse training session was developed for community staff.

There are plans in 2018-19:

- To review level 2 for safeguarding adults and children

- To produce a PREVENT refresher course for a key cohort of staff

- To .expand level 3 training within gynaecology staff

- To continue to promote in house domestic abuse training offers

In November 2017 the Trust hosted a second Safeguarding Adult Conference across sites. There were 300 attendees. The conference was supported by internal and external speakers and included input from: Women's Aid, BLGBT (Birmingham Lesbian, Gay, Bisexual and Trans), HALO (honour based violence, forced marriage). RSVP (Rape and Sexual Violence Project). The conference included a talk from a survivor of abuse.

There is a plan to run a further Safeguarding Adult Conference across 3 sites in November 2018 with focus on 'True Partnership Working'. The planned speakers include: the Chair of the Safeguarding Adult Board; West Midlands Fire Service; The Mental Health Trust Rapid Assessment Intervention and Discharge team. There will be a specific session from the

Local Authority Team on improving information shared on adult referrals. The sessions are fully booked.

Evaluation

All safeguarding learning and development sessions are evaluated and below is a summary of comments relating to the different sessions:

PREVENT

Comments vary from staff who are highly appreciative of why this training is necessary to those that find it lengthy (it is one hour in length). All feel that it contributes to their ability to identify risk factors for radicalisation and their knowledge about how to respond to this.

Level 2

The vast majority of staff found this training extremely useful in improving their knowledge in Safeguarding inclusive of understanding the importance of partnership working, information sharing and knowing what to do if they have concerns about adult/child abuse. The knowledge of the trainers was deemed excellent/good. Some staff members have indicated that they would like more time for group discussion as they find this invaluable.

Level 3 Safeguarding Children Training

All staff rated the training Excellent/Good with positive comments towards the trainers. Evaluations confirmed that all staff knew who to contact if Safeguarding Advice & support was needed, how and when to mobilise early intervention, know what to document on patients records.

CSE

All staff who attended the sessions stated that their knowledge was enhanced and rated this as excellent. They stated that they had increased knowledge about: who to contact if they encountered a concern and the risk factors and signs of sexual exploitation. Some staff highlighted they would like a printed handout after the sessions in order to re-review in their own time and this will be put in place for 2018-19.

During the next twelve months the focus will be on harmonising the safeguarding education and development offer from UHB/HGS.

Safeguarding ‘walkarounds’ to clinical areas confirm that frontline staff have the following knowledge:

- Who to contact if they have a safeguarding concern
- How to identify a safeguarding need
- How to make a safeguarding referral
- Where to access safeguarding policies

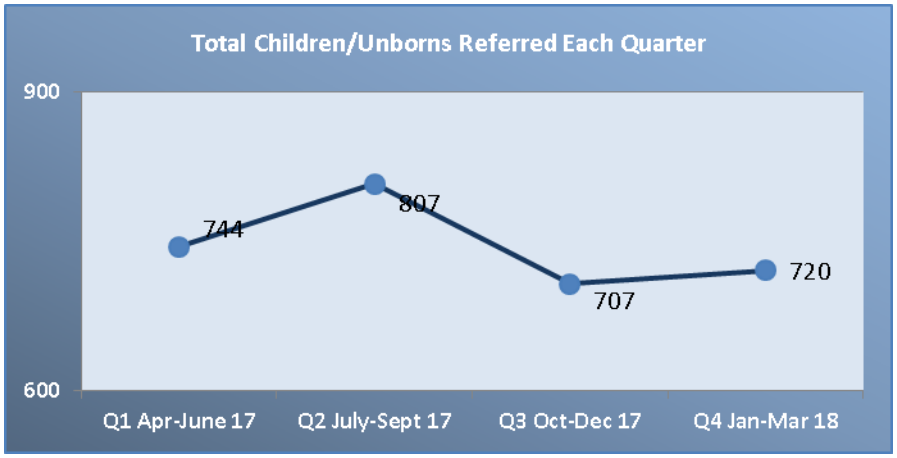
Safeguarding Adult Conference

The event evaluated positively with staff who attended particularly enjoying the exploration of the wider context of adult safeguarding including domestic abuse, sexual violence and forced marriage. The session provided by a survivor of abuse was particularly well evaluated and staff found this moving and affecting.

Section 3 Safeguarding Children – Activity and Learning

3.1.1 Safeguarding Children Activity 2017-18

This year the Trust saw an increase in the number of children referred by departments.
The graph below illustrates the numbers of children referred by HEFT services over a 12 month period. In total **2,978** children were referred for social work services by staff working in the Trust.



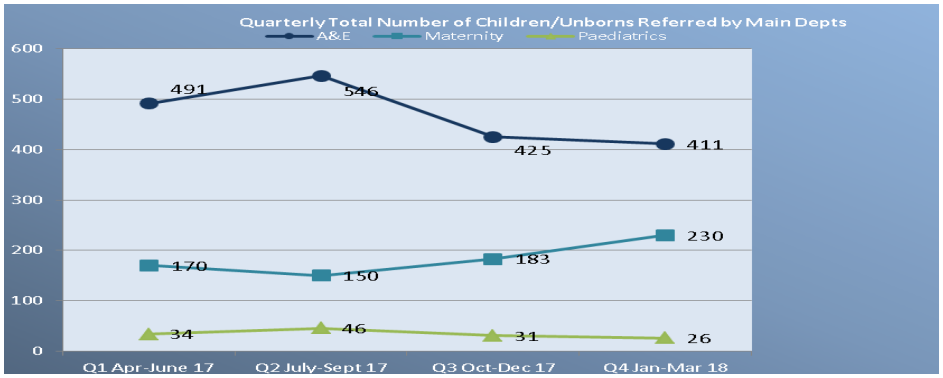
The tale below shows the **average** number of children where requests for social work referrals were made each quarter over the last seven years, illustrating a fairly consistent, year on year increase in requests for social work services.

2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
150	445	446	601	653	610	732	744

3.1.2 Departmental Referrals

As demonstrated in the graph below the largest increase in referral numbers is seen in the Maternity Services, despite a consistent birth rate. This indicates the level of need in the population presenting to maternity services.

ED are the the department which consistently generates the highest numbers of referrals.



#Smaller numbers were generated in Paediatrics although this is not reflective of their safeguarding workload as they have on-going responsibility for many of the cases referred by the Emergency Department until investigations are completed. During each quarter the Paediatric department will have around 110 inpatient cases where there are identified safeguarding concerns. Between 4 and 14 cases per quarter are subject to full investigation for Non-Accidental Injury which requires intensive medical input.

Year	2015-16	2016-17	2017-18
Number of CSE referrals	24	48	51
Number accompanied by screening tool	14	45	39

The Trust will continue to increase scrutiny of the attendances of 16-18 year olds as there is concern that CSE may not be reliably screened for in this age group. The safeguarding team have conducted 2 audits of attendances in this age group which have highlighted improvements required. Changes have been made to the ED system to ensure that the safeguarding assessment is automatically generated for all 16- 18 year olds. Prior to 2017 this required a manual workaround.

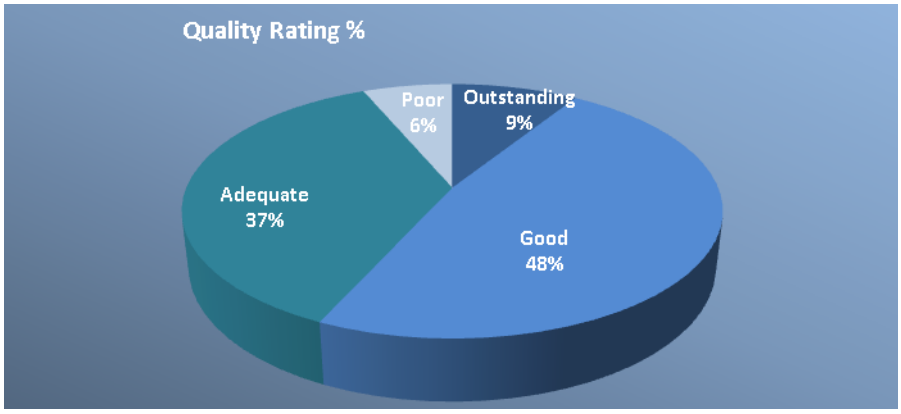
The Trust continues to train staff in relation to CSE but this has been hampered this year by staff turnover; ability to release staff at times of pressure and vacancies.

An audit of CSE cases that were identified during 2017-18 indicated that intelligence reports could be completed in some instances where trafficking could be identified and this learning has been implemented.

3.1.3 Quality of Safeguarding Referral Information

Improving the quality of referral information was identified as a priority previous years.

All referrals completed by staff in the Trust are audited against criteria to determine the quality of information provided. It is well recognised that the quality of referral information is key in determining the response that the child and family receive. The graph below illustrates the grading of referrals during 2017-18.

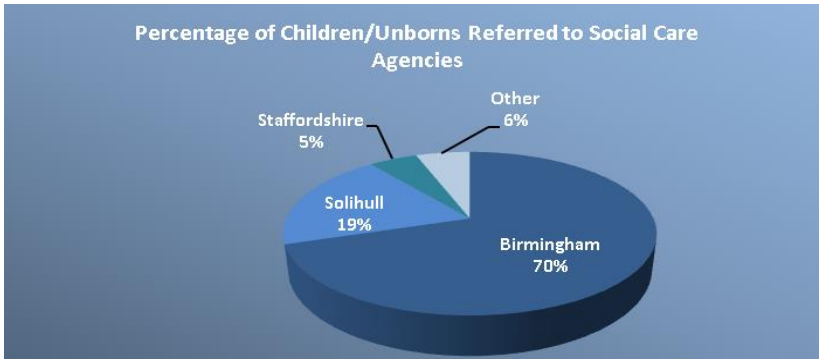


Feedback is given to staff where necessary and the Emergency Department has received workshops targeting the quality of referrals to drive improvement.

The Trust has introduced team nhs.net accounts in many areas to ensure compliance with information governance requirements when transferring information.

3.1.4 Safeguarding Children Referrals per Local Authority

The graph below illustrates the referral rates per Local Authority with the majority of children being referred to Birmingham.



3.1.5 Feedback from the LA in relation to the outcome of child safeguarding referrals

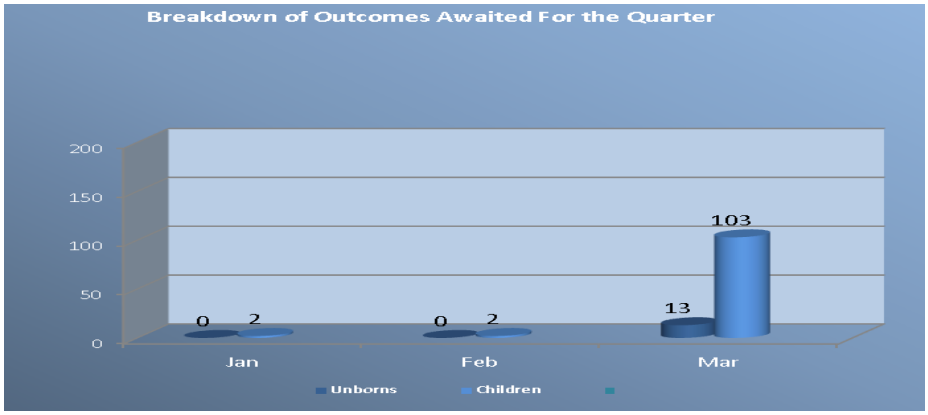
Feedback in relation to safeguarding referrals continued to be a problematic area during 2017-18 despite discussions with the LA.

However in quarter 4 the Safeguarding Team ran a pilot where they allocated time to pursue the outcomes (0.5 of a day per week) and this proved to be very successful but time consuming.

It allowed for challenge to some decisions that were made by Social Work staff that would not have been possible and it also enabled the child's record to be update, closing the loop on action initiated by clinical teams.

Qtr 1 2016-17	Qtr 2 2016-17	Qtr 3 2016-17	Qtr 4 2016-17	Qtr 1 2017-18	Qtr 2 2017-18	Qtr 3 2017-18	Qtr4 2017
40.4%	44.4%	46.1%	53.6%	53.8%	53.9%	53.9%	16.7%

The majority of cases where outcomes remain unknown relate to Birmingham LA reflecting the significant referral rates to Birmingham (see below). During this quarter the outcomes that remain unknown relate to requests for social work service sent in the latter end of March only.



The table below illustrates the outcomes during quarter 4 2017-18.

Outcome	Percentage of Total Request for SW service
Assessment led by a SW	**40.4%**
See further breakdown below:	
Already open to a SW and sent to them for further assessment	6.1%
Section 47	4.7%
Allocated for Single assessment	29.7%
Early Help Recommended	**10.4%**
See further breakdown below:	
Early Help to be provided supported by LA staff	6.3%
Early Help team (LA) already have the case open	1.1%
Early Help assessment to be completed by HEFT	0.1 %
Early Help Assessment to be completed by other provider	2.9%
No further action	**26.9%**
No further action with advice to parents provided by the LA	**6.7%**
Outcome unknown	**16.7%**

3.2 Safeguarding Supervision

Safeguarding Children Supervision is provided by the Specialist Nurses in a variety of formats.
Safeguarding Supervision for staff is associated with better outcomes for children and support for staff who are handling difficult and complex safeguarding cases.

There is evidence that supervision increases the ability of staff to think objectively about cases and that it may assist in preventing 'burn out' and increasing staff retention and effectiveness.

Compliance with the requirements is monitored quarterly and reported via the Safeguarding Children Committee. The target is 85% and is a KPI for the Trust. The KPI has been met throughout 2017-18 consistently.

The table below illustrates the rates at the end of quarter 4 2017-18

Staff Group	Compliance	Standard to be achieved
Acute Overall	**96%**	**Target met**
Paediatric Nurses	**96%**	**Daily supervision from duty worker on wards with weekly visit to GHH.**
Maternity Specialist Midwives	**100%**	**Quarterly session**
Maternity Community Midwives	**92%**	**Quarterly session**
NCOT	**100%**	**Quarterly sessions**
NNU discharge planner	**100%**	**Quarterly Sessions**
NNU	**100%**	**Weekly sessions for NNU and SCBU**
Chest Clinic	**100%**	**Quarterly session**
ED	**100%**	**Quarterly Sessions per site**
Clinical Nurse specialists (paeds)	**75%**	**Quarterly session- some staff were offered sessions but could not attend during quarter 4.**
Community Overall	**100%**	**Target met**
LAC	**100%**	**Quarterly session**
Special School Nurses including YOT	**100%**	
PLS - Solihull	**100%**	**Quarterly session**

What staff say about safeguarding supervision.

Safeguarding Supervision was evaluated three times during 2017-18, twice with an audit and once with a walk around to the clinical areas (paediatrics).

Staff identified the following:

- They found supervision helpful and developed their safeguarding knowledge and skills.
- They had often commenced gathering of information prior to being prompted in supervision.
- Staff welcomed the supportive challenge element of supervision.
- Staff sometimes struggled to manage the commitments of clinical work with the requirement for supervision of safeguarding cases and the safeguarding team work with staff in clinical areas to manage this effectively.
- All staff felt that out of hours safeguarding was more difficult to deal with as the advice/ support and supervision from the specialist team was unavailable.

The Supervisory Framework was updated in 2017 and all target groups and documentation associated with supervision reviewed.

Safeguarding supervision during 2017-18 was extended to the chest clinic due to the recognition of the vulnerable families that they are dealing with.

3.3 Complaints and Incidents

Complaints continue to tell us that parents of children undergoing the safeguarding process are unhappy with the information that they receive in relation to the safeguarding process post referral and the way in which this information is delivered.

This has led to specific changes to level 3 training which incorporates this feedback from families.

Leaflets have been developed and were introduced during quarter 3 2017-18. These have been designed to assist staff in communicating effectively with parents about the process that follows safeguarding referral. The leaflets clarify the post referral process; what parents should expect and what needs to have taken place before a discharge plan can be implemented. There is also a leaflet clarifying the Skeletal Survey Process as complaints indicated that families found this unnecessarily traumatic at times and did not feel they were well prepared for it when they consented to it.

A further complaint in quarter 4 2017-18 regarding a safeguarding alert on electronic patient records led to the identification of a an issue with some areas adding their own alerts and this has been addressed.

3.4 Incidents and learning reviews including Serious Case Reviews

A summary of Internal Management Reviews completed as part of the SCR process is detailed in the table below.

	LSCB	**Summary of Case Details**	**Summary of Learning**
1	Solihull	Toddler found dead in a high chair. Previous child protection investigation instigated due to an unexplained fractured skull.	Need to enhance recognition of domestic abuse in maternity services (delivery suite). The need for oversight of the discharge of children subject to section 47 investigations by the Safeguarding Team. Decisions not to be based on the Emergency Duty SW Team knowledge of a case. The need to ensure that there is documentation of multi-agency discussions in a child's records. Action Plan fully implemented.
2	Staffs	Death of a toddler	Challenge of practice of late ICPCs with LAs. Ensure risk assessment and management of Persons Posing a Risk to children processes.
3	Staffs	Death of an infant	Learning in relation to cross border information sharing issues for maternity services at two Trusts.
4	Birmingham	8 week old infant subject to a CP plan died in the care of her mother. Substance misuse a known risk factor with mother. Injuries on the child suggest non-accidental injury.	Need to ensure that cases in escalation with the LA are reviewed and subject to supervision. Need to ensure that staff follow documentation requirements to seek out and note the alert status on the electronic records. Action Plan in Progress
5	Birmingham	Child that dies in special guardianship arrangements.	Documentation issues in NNU. Need for a mechanism to record professional disagreements in MASH. Action Plan in progress

6	Warwickshire	Adolescent subject to sexual assault	Promotion of the Paediatric Sexual Assault Service. Continued training in relation to CSE to ensure consistent use of the CSE screening tool. Action Plan completed

3.5 Recruitment and Disclosure and Barring Processes

The Trust as robust processes in place to ensure that staff are recruited appropriately and this includes policies and procedures outlining expectations in relation to Disclosure and Barring processes.

DBS checks at enhanced level are reviewed and repeated every 3 years and this is managed within HR.

The Trust Safeguarding Children Committee receives and quarterly report detailing the DBS checks completed; any outstanding checks and the resulting outcome following review of any positive disclosures.
There is senior clinical oversight (medical and nursing) of any positive DBS disclosures to ensure that there is no risk to patients.

3.6 Managing Allegations against Staff Who Work with Children

Where an allegation is made against a staff member that indicates that they may be unsuitable to work with children there is a requirement to notify this to the Local Area Designated Officer employed by the Local Authority.

This occurs where a staff member works with or has contact with children under the age of 18 years and allegations suggest they may have harmed a child or that children could be unsafe in their care.

The process aims to allow full disclosure of information regarding concerns so that employers can complete a robust assessment of transferable risk with key partner agencies.
Further details on the criteria for referral are contained in the Safeguarding Children Policy (see section 15).

Allegations may come from a variety of sources including: complaints regarding a staff member; as a result of an internal investigation; as a result of information shared by other agencies in relation to a member of staff (for example the police or Children's Social Care). Allegations regarding the suitability of staff to work with children may arise as a result of the professional or personal lives of staff.

During 2017-18 the Trust referred a total of **12** people to the Local Area Designated Officers.

11 of the staff referred were employees of the Trust and one referral was generated in relation to another private provider following review of a patient's care and concerns regarding over reliance on physical restraint. This referral resulted in a review with Ofsted of the provider and a review of the patient's plan.

Of the 11 HEFT staff referred:

3 staff were dismissed following internal investigation and referred to DBS.

4 cases were stepped down from LADO post investigation.

1 staff member has returned to work with additional support and oversight.
1 staff member remains on leave.
1 staff member had given notice and their new employer was informed of the allegation.
1 was not accepted by LADO as an appropriate referral and was managed as an internal investigation.

3.7 Safeguarding Children Audit Activity

There is an extensive annual audit programme in relation to safeguarding children activity. Audit activity is driven by:

- Learning from local and national reviews/ internal management reviews/ serious case reviews
- Learning from previous audit activity
- Incidents

This includes regular audits completed quarterly in relation to referral activity; quality and outcome; transfer of safeguarding information at the birth of a child; domestic abuse activity in maternity services. There are annual audits in relation to quality of safeguarding assessments and information sharing at key points of transition – including notification to the LA at the point a 90 day stay is reached. There is continuous audit of the use of the Child Protection Information System in ED.

On completion of audits the full audit plus a summary report are submitted including all recommendations that need to be carried forward.

Audit activity and findings are reviewed and discussed quarterly.

Key audits that are reported quarterly for child safeguarding are:

Audit priorities for next year will include a quarterly focus on:

- Compliance with safeguarding assessments including uses documentation of previous safeguarding alerts
- Numbers of early help assessments generated in key areas.
- Quality of safeguarding assessments for vulnerable groups including frequent attenders and 16-18 year olds.

3.8 Risks – Safeguarding Children

There are three risks identified in relation to safeguarding children.

These are:

Information and Information Governance risk related to the reliance in the Trust on faxing of safeguarding referrals.
Mitigation includes:

Localised Team NHS not accounts have been established in areas completing the highest number of referrals.

De-commissioning of the Pan Birmingham Paediatric Liaison Service
This risk has been mitigated by employment of staff on temporary/ fixed term basis to assist with notification processes.
Pan Birmingham work has been progressing and this has established:

- A set of criteria for notification to community staff
- A template for notification
- A means of electronic notification

There is work in progress to embed the criteria with front line staff in ED.

Inappropriate use of clinical holding/ restraint.

To mitigate this risk the Trust has taken the following actions:

A moodle package and other learning resources have been developed for staff in paediatrics and 74% of staff have completed this package.

The Trust has worked with the Mental Health Trust to develop a package increasing awareness of common mental health conditions and how these may present in patients in paediatric care.

There are quarterly reports to the head of safeguarding on compliance of security staff with their specialist training on use of physical restraint.

3.9 New Developments

During 207-18 the Child Protection Information System CPIS became embedded in the EDs across HEFT and in Maternity. There is regular audit to ensure compliance with its use.

A business case was agreed to increase ward clerk hours making implementation of CPIS is CAU and PAU possible. It is anticipated that staff will be recruited and trained to use CPIS during quarter 2. The CPIS system sends an automated message to the LA if a child presents to the unscheduled care setting which enhances information sharing.

During 2017-18 the Trust launched preparations to implement the FGM RIS. This is a system that flags children deemed to be at risk of FGM. It involves risk assessment in maternity services and where risk is identified an alert is added to the SCR system. It is likely that this will be fully operational in May 2018.

Mandatory reporting of FGM was introduced in 2016 and the Trust has worked hard to raise awareness of this with training and communications to staff.

3.10 Partnership

The Trust is a full member of the LSCB in Solihull and sends representation as required to Birmingham Safeguarding Children Board who rationalised attendance during 2016-17.
The Trust participates with LSCB activity in Staffordshire as required,

We work collaboratively with partners, sitting in the Multi-Agency Safeguarding Hubs in Birmingham and Solihull to ensure that were a child is deemed at risk of significant harm relevant information can be shared in as timely a way as possible and that we have a joined up approach to risk assessment and safety planning. Since the loss of the Hospital Social Work Team in 2016 this has been critical to ensuring effective working for inpatient children with child protection investigations.

The Trust provides regular specialist advice and support to a variety of LSCB groups to advance working together. This includes participation in multi-agency audit and review, plans

for multi-agency training development, review of child deaths and strategic and operational groups tacking child sexual exploitation and FGM.

At an operational level the Trust provides health expertise to a variety of multi-agency meetings focused on safeguarding decision making and care planning for children.

There are substantial changes to the organisations in Birmingham planned in 2018-19. From the 1st April 2018 these include:

- Re-structuring and formation of a new CCG for Birmingham and Solihull
- Preparation for the launch of a new provider for Birmingham Children's Social Work Services – Birmingham Children's Trust
- UHB acquiring HEFT
- Changes to early years delivery and the formation of Forward Steps

There will need to be a focus on maintaining and strengthening partnerships in the next 12 months in the context of the changes.

3.11 Section 11 Children Act Compliance

The Trust has completed an annual audit against all section 11 requirements and reports a 93% compliance rate. The Trust recognises that this year there will be further work to do in relation to: restraint/ clinical holding; defining and delivery of an early help. Additional work will be required as policies and procedures are aligned with UHB in 2018-19.

The Trust undertakes a Peer Review Process with other health providers to quality assure the section 11 scoring and supporting evidence and this supported our internal assessment.

During 2017-19 this Peer reviewers commented favourably on our safeguarding audit programme and approach to education and development.

3.12 Summary of Safeguarding Children Arrangements

In summary the Trust has a solid infrastructure in relation to safeguarding which includes:

- Senior leadership
- A visible specialist team of safeguarding staff
- Oversight and governance of safeguarding arrangements
- Accessible policies and procedures
- A solid education and development offer to promote skill and expertise in the work force
- Accessible advice and support
- Safeguarding supervision in place for all key staff groups
- The Trust is benchmarking continuously against statutory and regulatory requirements and utilising this information to set priorities for development.
- The Trust has a rigorous audit programme to test the effectiveness of safeguarding arrangements.
- The Trust participates in a variety of partnership activities to support effective safeguarding outcomes for children.

Priorities for 2018-19 include:

a) Establishment a new safeguarding staffing structure based on need
b) Establishment of a refined governance structure to support safeguarding
c) Harmonisation of Safeguarding Policies and Procedures
d) Harmonisation of processes
e) Assessing the impact on safeguarding of other organisational changes in relation to documentation/ system changes.
f) Maintenance of all safeguarding improvement plans, key performance indicators and services during the period of change.
g) Introduction of the the FGM RIS in maternity services.
h) Maintain and strengthen key partnerships at a time of change (both health re-organisation and new arrangements for provision on children's social work services)
i) Introduction of 'Redthreads' in BHH ED.

Section 4 Safeguarding adults with care and support needs

Author: Lorraine Longstaff – Associate head nurse adult safeguarding

4.1 Adult safeguarding patient story:

Situation:

Associate head nurse (AHN) adult safeguarding was contacted by a staff nurse from W19 Sol site regarding Pt R, she was seeking advice and support around a safeguarding concern that had been raised by the pts sister, which related to possible domestic abuse, she says that the wife is verbally and physically abusive to him and worried about his safety

Background:

Pt is 81 years old, admitted with increased confusion possible UTI and community acquired pneumonia. Normally lives at home with his wife. There is nothing on his admission of any previous disclosures

Assessment:

- The AHN for adult safeguarding advised staff to speak with the patient, see if he would disclose anything, but also making sure that they followed principles of making safeguarding personal.
- Pt had capacity & staff didn't have cause to doubt his decision making
- Pt is given the chance to share concerns and he does open up to the staff and admits that he is "frightened "of her. Asked what he wanted to do and at the time agreed to the MA referral and to have help
- Staff also report that when the wife phones the ward she is shouting at them and is very hostile
- Ward staff make appropriate referral to the LA and SW is allocated
- Pt is included in the decision making throughout, however he was reluctant to take further and he finally decided he didn't want to pursue and wished to return home.

Case was closed but he was given various contact numbers for when he got home and advised on what to do if had further concerns. He also said he would contact Age concern at a later point.

Key Issues & learning

- Praise for the ward staff who identified the concern and acted upon it
- Evidence of keeping patient at the centre and making safeguarding personal and how linked to MCA
- Risks and consequences considered –
- Good partnership working with LA
- That it is not always the men who are the abusers.

4.2 Achievements:

4.3 Collaboration and multi-agency working:

Heart of England NHS Foundation Trust in the past year has continued to strengthen links with multiagency colleagues. The Chief Nurse has been the accountable officer for safeguarding adults and has delegated responsibility to the Head of Safeguarding, the Associate head nurse for adult Safeguarding and the Division 4 Head Nurse to attend the Solihull Local Authority Safeguarding Adults Board (SSAB) and the Birmingham safeguarding Adult Board (BSAB). In addition, a number of members of staff from HEFT also sit on the operational sub committees related to education and training; quality and audit;

Scrutiny and governance

The membership of HEFTs safeguarding adults steering group is chaired by the Associate Head Nurse Adult Safeguarding. It remains multiagency with members from SSAB, BSAB, representatives from educational leads, site head nurses and safeguarding adult's leads from both the Solihull and Birmingham CCGs

Standard agenda items at this board include:

- Reports relating to the number, location and themes of adult safeguarding incidents,
- Lessons learnt
- Progress on safeguarding adults education programmes,
- Partnership working
- Prevent

Other achievements in relation to multi-agency working include joint training initiatives. The Associate Head Nurse for adult safeguarding organised a "Roles, Responsibility and Accountability study day for Registered Nurses and had presentations from HM Coroner for Birmingham and Solihull and the CCG Adult Safeguarding Lead Nurse. In November 2017 the Adult Safeguarding team also held another very successful safeguarding conference and had speakers from Women's Aid, BLGBT (Birmingham Lesbian, Gay, Bisexual and Trans),HALO (Forced Marriages, Honour Based Violence & FGM)RSVP (Rape and Sexual Violence Project). The AHN adult safeguarding has also been working with RAID and police to improve practice for those patients that present with mental health and are at risk of absconding/self-harm. A practice guide was developed plus held a number of training sessions across the 3 sites to raise awareness of "clinical holding", police powers, this was a chance to challenge the myths and misconceptions and to build relations. This collaboration with our external colleagues is a further example of HEFTS commitment to work in

partnership with others to safeguard and improve care for our patients that have care and support needs.

Building Relationships - The adult safeguarding team has also been working regularly and closely with:

- Birmingham & Solihull Women's Aid
- RSVP
- West Midlands Police
- RAID
- Modern Day Slavery Regional Network

4.4 Policies and procedures –

HEFT has an up to date safeguarding adult policy and procedure in place which is aligned to the CQC regulatory standards and reflects the Care Act, the SSAB & BSAB policies and Pan West Midlands.The policy is available on the intranet site and the procedure has been uploaded on to the safeguarding adult web page. We have also continued to promote and raise awareness of a number of key policies that fall under safeguarding such as missing person, self harm, enhanced observation and clinical holding policy. After a successful trial the new Enhanced observation bundle was launched in July 2017 and safeguarding team have received positive comments from the staff

4.5 Incidents - Adult Safeguarding Incident data Acute Hospital

In total **1269** adult safeguarding concerns were reported to date Q1 (284), Q2 (342), Q3 (310) & Q4 (333), this was an increase of **86** from last year where there were **1183** safeguarding adult concerns were reported Q1 (307), Q2 (283), Q3 (320), Q4 (273). The AHN for AS suggest that the increase could be due to a number of reasons – awareness has grown across the organisation and we get referrals from all grades/professional bodies from admin staff to consultants. The training packages that are in place are robust and are given for all levels and have various forms (face to face, moodle, e-learning, leaflets, newsletters etc). Trust has also invested in the AS team and from July 2015 this went from 1WTE to 2 then December had further support with 2 further staff, this has enabled a stronger site presence and accessibility to the team. We also undertake audits to assess staff knowledge & understanding and this is also a chance to raise awareness and improve practice

Quarter	2014 - 2015	2015 - 2016	2016 - 2017	2017- 2018
Q1	246	260	307	284
Q2	222	237	283	342
Q3	218	252	320	310
Q4	231	298	273	333
Totals	**917**	**1047**	**1183**	**1269**

These were all categorised following initially reporting as either actual, potential or not safeguarding. An example of actual safeguarding would be financial abuse by a relative or

physical abuse by partner/carer. Potential safeguarding can be a non-hospital acquired or hospital acquired pressure ulcers, these would require a root cause analysis and fact finding to determine the cause and it may be that they then become actual. An example of an incident that may be initially described as safeguarding by staff but is not would be a staff injury (caught arm on door) or a cancellation of a clinic.

Category	**Q1 – Q4 2015-2016**	**Q1 – Q4 2016 - 2017**	**Q1- Q4 2017 - 2018**
Actual	570	737	830
Potential	154	134	174
Not	323	312	265
Totals	**1047**	**1183**	**1269**

Adult Safeguarding reporting per Division as follows:

Division	**Q1 Apr – June 2017**	**Q2 July - Sept 2017**	**Q3 Oct – Dec 2017**	**Q4 Jan – Mar 2018**	**TOTALS 2017-2018**	**Compared to last year**
1	24	22	13	23	**82**	**72**
2	11	14	13	5	**43**	**38**
3	190	239	220	226	**875**	**787**
4	36	40	33	39	**148**	**136**
5	23	27	31	40	**121**	**150**

Deprivation of Liberty (DOLS) applications:

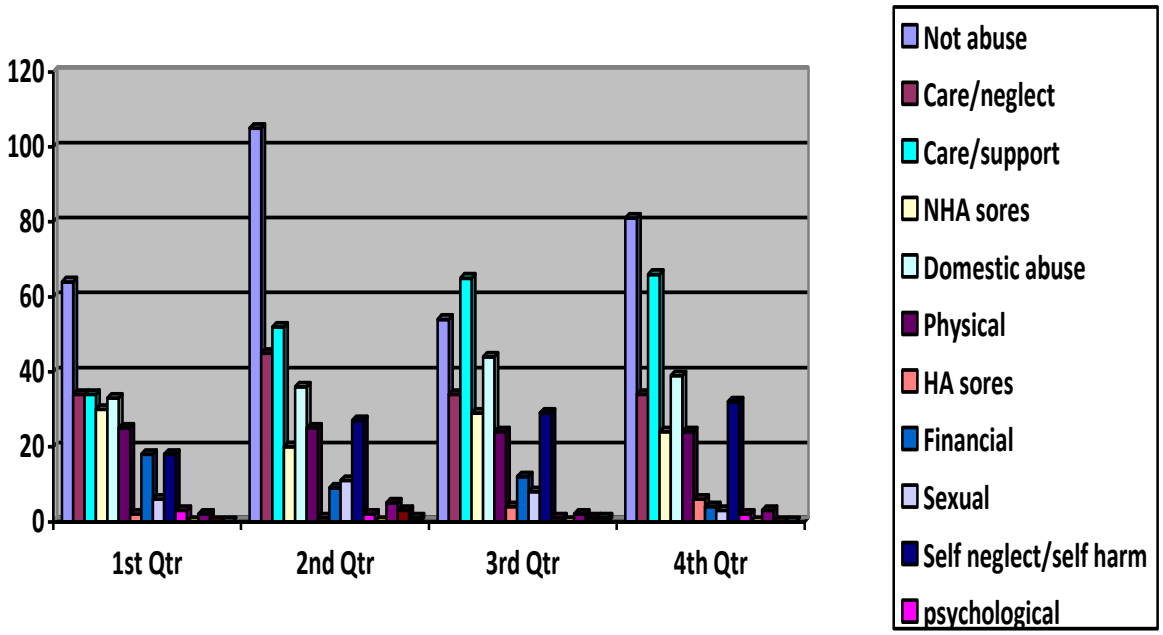
We have seen a steady increase in the number of applications over the year and detailed reports are completed quarterly and circulated to the members of the AS steering group, Head Nurses and champions. Copies are also uploaded onto the AS intranet page

DOLS applications	**2014 - 2015**	**2015 - 2016**	**2016 - 2017**	**2017-2018**
Q1	29	44	63	60
Q2	35	48	53	74
Q3	47	49	58	83
Q4	47	62	81	88
Totals	**158**	**203**	**255**	**305**

4.5.1 Themes and Lessons Learnt

The high proportion of the reported safeguarding alerts primarily fall into the category of care/neglect, physical abuse, financial, non-hospital acquired pressure ulcers. Monthly divisional reports have been developed and these are copied to the Head Nurses for them to share with Matrons and Sisters and would be discussed at the quality and safety meetings. Lessons learnt are then reported back to the bi-monthly safeguarding adult steering group.

The safeguarding adult web page is fully operational and the Associate Head Nurse for Adult Safeguarding is responsible for ensuring the site is up to date. Staff have access to various resources and information such as; audit results, newsletters, training, procedures for reporting, mental capacity assessment forms, and links to NMC, equality and diversity.



The safeguarding adult scorecard links to the DOH 6 principles of safeguarding these are: Empowerment, Protection, Proportionality, Partnerships, Accountability and Assurance. The scorecard is reviewed quarterly at the safeguarding adult steering group. Copies are distributed to all Head Nurses, Matrons and sisters for them to share with junior members of their teams and also uploaded onto the safeguarding adult website.

Ensuring that learning from SCR's/DHR's/safeguarding incidents are learned across the organisation this is a real challenge given the complexity and size of the organisation. Action plans are monitored via the Adult Safeguarding steering group & Domestic Abuse group meetings.

4.5.2 Adult Safeguarding Incident Data community setting:

There is now an established community scorecard in place and this is reviewed each quarter with the AHN for adult safeguarding, the Head Nurse for Division 4 and the Community Senior Nurse. There has been a steady increase in the number of concerns raised, and are raising awareness via our community adult safeguarding champions. Main themes reported care and support, skin integrity/pressure ulcers, self-neglect

Quarter	**2016 - 2017**	**2017 - 2018**
Q1	23	23
Q2	27	21
Q3	29	30
Q4	19	41
Total	**98**	**115**

4.6 Governance and Assurance

A detailed organisational safeguarding scorecard/activity report is provided for our commissioners and LSAB's which shows a breakdown of safeguarding activity by the individual Divisions. The report identifies key lessons learned, emerging themes and is supported by the use of case studies, which reflect on the application of the key safeguarding principles in practice. "Hot spot" areas are monitored and reviewed to ensure that actions are taken to mitigate any risks. See table below which has a summary of reports and various assurance tools, monitoring that is currently in place

Requirement/report	**Frequency**	**Who to**
Adult Safeguarding Activity - Scorecard	Quarterly	Adult Safeguarding Steering Group, Head Nurses, Clinical Leads, Matrons.
HEFTS Adult Safeguarding Annual Report	Annual	Trust Board, Local SABS
Audit programme - monitoring staff knowledge, understanding of Adult Safeguarding, MCA/DOLS and various policies associated with safeguarding such as clinical holding & Enhanced Observation (specials)	Quarterly	Adult Safeguarding Steering Group, Head Nurses, Matrons, Adult Safeguarding Champions
Implementation of action plans from case reviews DHR's, SAR's, SILPS.	Quarterly or as requested by Local SABs	Adult Safeguarding Steering Group, Local SABs (as requested)
Assurance reports to LSAB's	As requested by LSAB's	LSABS & Adult Safeguarding Steering Group
Complaint Monitoring	Quarterly	Head Nurses & AS Team
CCG contractual requirements in relation to Adult Safeguarding	Quarterly	CCG, Adult Safeguarding Steering Group
Safe recruitment practice & HR process (DBC-CRB checks) Disciplinary procedures	Quarterly	Adult Safeguarding Steering Group, Site Head Nurses
Hearing the Voice of the patients/Service users/Carers that access HEFT Services	Quarterly	Quality & Safety Meetings Adult Safeguarding Steering group

4.7 Audit

The impact of the implementation of policies and procedures and staff education programmes needs to be measured and HEFT have a robust audit programme, which has been gathering data related to adult safeguarding across HEFT during the last year. The Adult Safeguarding team have undertaken a number of audits and below is an overview of 2

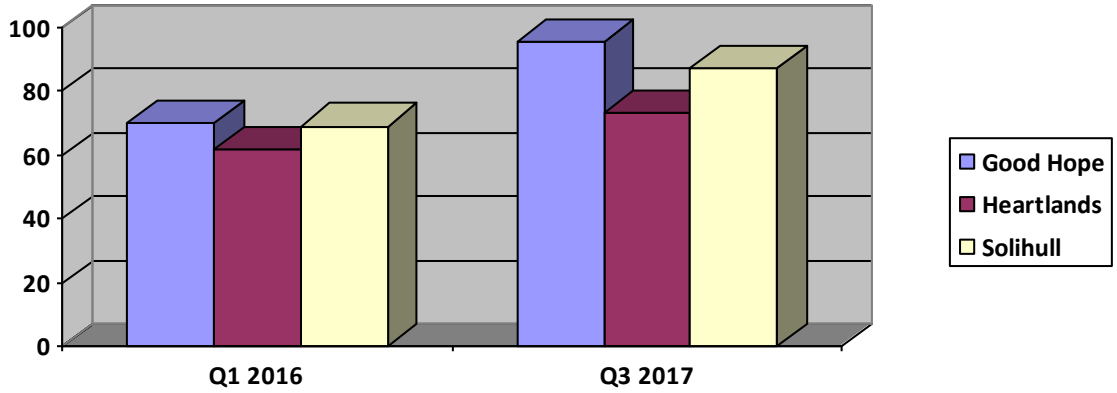
particular audits that were completed. One focus on a comparitive report regarding “clinical holding” and the 2nd relates to staff knowledge and understanding of the adult safeguarding policy and “making safeguarding personal”.

During Q3 the adult safeguarding team focused on staffs knowledge and understanding of the clinical holding “restraint” Policy and it’s application to practice. The team developed a structured questionnaire which had 9 questions and was scored out of 10. They randomly selected staff on all three hospital sites and interviewed staff in their clinical areas during

Results:
A total of 60 staff were interviewed, 20 at Solihull hospital(W8, AMU, AMUSS, 20a & 20b), 20 at Heartlands hospital(W2, 8 ,9, 11, 23, 24, 26, 20, 28) & 20 at Good Hope hospital (W8, 9, 11, 12, 14, AMU, AMUS). All the staff were trained registered nurses from B5 – B7. There were 19 members of staff that correctly answered all the questions in comparison to the previous audit whereby only 2 members of staff that scored 10 out of 10

Overall scores:
When all the results were analysed the overall percentage of correct answers were:

Good Hope hospital = 95% previous 70%; Heartlands Hospital = 73% previous 62%; Solihull hospital = 87% previous 69%.
Overall score was 85% in comparison to last year 66%



Key Findings:
Overall we were welcomed to the wards and the majority of staff were engaged and happy to be involved. In comparison to the audit that was undertaken in 2016 we can evidence that there has been an increase in staff knowledge, understanding of application to practice and staff more aware of the use of mittens. Main gap continues around awareness of the actual policy, the various forms of restraint and what staff should do post event, still many didn’t know about completion of IR1’s or of learning/debrief.

There were 8 staff (B5’s 6 BHH site & 2 SOL) that only scored between 4 and 5, they had varying levels of experience from being newly qualified to one with 34yrs.They gave very limited answers, were unsure and needed prompting. However for those staff that were unsure this was a good opportunity for the safeguarding team to raise awareness, promote the training and sign post to the various resources and share practice

19 staff scored 100% which was a vast improvement from last audit whereby only 2 staff answered all the questions correctly. .

Recommendations & Learning

- Discuss & share results with members of the Adult Safeguarding steering group
- Share report with Divisional Head Nurses, Champions & the Senior Nurses
- Continue to raise awareness of the policy
- Continue to promote the MCA training package (face to face & moodle)
- AS team to focus on BHH site to raise awareness

Audit re Adult Safeguarding Policy

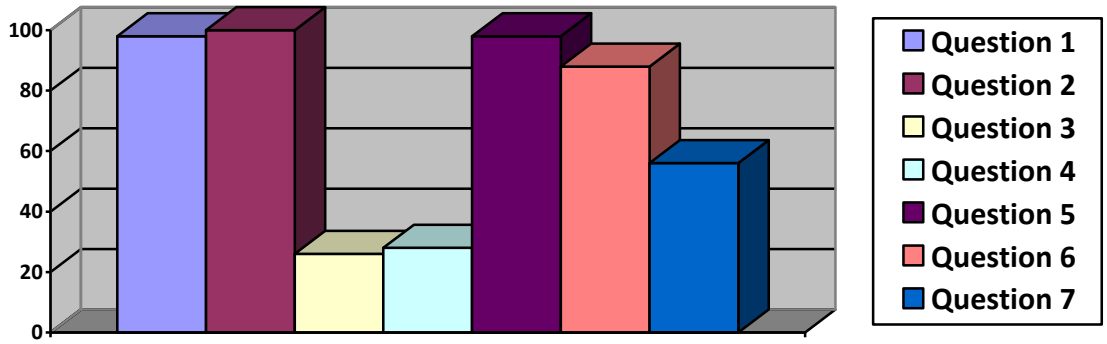
The Adult Safeguarding Champions also undertook an audit during Q3 and focused on the Hospital staffs knowledge and understanding of the Safeguarding Adult Policy and procedures. A structured questionnaire was developed which had 7 questions and was scored out of 10. The champions randomly selected staff on the Good Hope Hospital site (GHH) and interviewed staff in their clinical areas, this took place in October (Q3).

Results:

A total of 43 staff were interviewed on the following wards at GHH (W9, 11, 12, 14, 15, 16, 17, 18, AMU, 21,22 & 23). Of the 43 staff - 29 were registered nurses (B5's and above) but also a couple of Doctors and 14 untrained mainly HCA's but also the champions asked housekeeper and ward clerk.

Overall scores:

When all the results were analysed the overall percentage of correct answers were:
Trained 78% & Untrained 74%
Overall score was 77%



Key Findings:

Overall staff welcomed to the wards and majority of staff receptive and happy to be involved in the audit. The champions also stated they really enjoyed undertaking the audits and will share their observations when they return to own clinical areas, they also said it was valuable and would like to be involved in others.

From the audit there are 2 particular areas that we need to continue raising awareness of and those are Making Safeguarding personal, how it relates to practice and also the adult safeguarding advice line (Questions 3, 4 & 7)

Recommendations & Learning

- Discuss & Share results with members of the Adult safeguarding Steering group
- Distribute the report to SWS/Matrons/Head Nurses and champions
- HN's & Matrons to discuss at their governance meetings
- Continue to promote and raise awareness of the AS team and contact numbers
- Continue with the AS training Level 2 & 3 which does include MSP
- Recirculate the MSP practice guide for staff

4.8 CCG Assurance Visits

An unannounced visit to Ward 12 at Good Hope Hospital were jointly conducted on the 13th June 2017 by the Designated Nurse for Safeguarding, Melanie Homer and the Adult Safeguarding Nurse Beverley Chew. This visit formed part of an ongoing series of low key 'snapshot' assurance visits undertaken by the CCG in partnership with the trust, aimed at capturing how effectively safeguarding principles are being applied in practice across the trust.

During the visit they spoke to one of the wards Health Care Assistants who was able to talk about the safeguarding training she had received as part of the Care Programme she a had attended. The training was described as useful and the HCA was able to talk about how this makes her feel more confident to raise concerns and talk to staff. The HCA told us that it is often them (the HCAs) who as members of the team who have the most direct contact with patients, washing and feeding and attending to cares and that staff are aware of safeguarding on the ward and what it means, and that some people may experience physical abuse or neglect and they as staff members feel able to talk to the nurses about any worries or concerns they may have.

They also spoke to a qualified nurse who said sometimes they have patients on the ward who may try and wander off, and this nurse was aware of the basic principles of both MCA and DOLs. The nurse had a MCA prompt card on her Identification Badge which she showed us. There were contact details on the wall for the adult safeguarding team which were up to date and visible. The staff we spoke to were able to articulate that the team were very supportive, responsive and available and if they ever had any concerns they were able to raise them with the team. It was recognised that safeguarding can feel like a complex process at times, with all the different surrounding local authorities and all the subsequent varying paperwork and forms, however nurses we spoke to on that day were able to state the support from the safeguarding team was valuable.

Whilst we were on the ward one of the Nursing Sisters asked if she could speak to Beverley about a potential safeguarding situation on the ward, and had been about to contact the Safeguarding team for advice. This was a really good insight into how safeguarding "works" in practice and how the safeguarding nurse supports the team. The situation involved an elderly patient who had a previous history of financial exploitation and who was physically frail and unwell with no direct family. The conversations witnessed and the way in which the scenario was dealt with was positive overall and it was encouraging to see how the safeguarding nurse liaised with the ward staff and how ward staff were able to recognise potential vulnerability and safeguarding concerns and then voice these concerns. The

conversation with the patient in relation to safeguarding was very good, seeking the patients point of view and seeking her wishes and feelings. This then resulted in the nurses making the safeguarding referral to social service.

4.9 Role of the Adult Safeguarding Champions

During the last year the adult safeguarding team have continued to promote and support the champions. A number of successful study days were held across the sites and evaluated well. We had invited external speakers from Modern Slavery, Local authority, Mental Health services and they came and presented on domestic abuse, self- neglect/hoarding & exploitation.

4.10 Equality and Diversity

The highlights for patients and staff in 2017/2018 included:

Trust continues to foster links with other NHS, Public sector and Voluntary organisations to work collaboratively in Equality, Diversity and inclusion areas to promote and challenge inequalities.

Membership includes:

- West Midlands NHS Regional Equalities Network
- Birmingham & Black Country Chaplaincy Collaborative
- Pan Birmingham Faith Advocacy Group
- Regular staff engagement meetings were held across HGS which included meetings of the Inclusion Steering Group, Lesbian, Gay, Bisexual, Trans (LGBT) Staff Network (Rainbow Friends), Staff with a Disability or Long Term Health Condition Network , Black, Asian, Minority Ethnic (BAME) Staff Network. The groups continue to play a key role in the development and implementation of initiatives that promote inclusion, equality and diversity within the Trust in workforce and patient care areas. For example Trust's Neuromuscular Care Advisor for Paediatrics and Adults also the Chair of Disability and Long-term Health Conditions Network, a wheel chair user had identified lack of ''Changing places toilet facility'' for patients and staff with complex disabilities within the Trust. As a result of her campaign Trust allocated budget to develop the facility on Heartlands hospital site. The new facility was officially opened on 16th April 2018 by the Trust Chief Executive, Dame Julie Moore. This initiative has put the Trust in a unique position as the only healthcare provider in the West Midlands to have such a facility on site and one of only four other Acute Trusts across the UK to have this facility.
- NHS employers also featured HEFT ' Staff Role Model Campaign ' on their website and lauded the Trust's efforts to engage staff in an inclusive manner.
- The Stonewall Workplace Equality Index (WEI) is a benchmarking tool for employers to assess LGBT inclusion within their organisation. Over the past 12 months, the Trust has worked collaboratively to address the areas which were highlighted after we were placed at 328 in the 2017 index. This has meant working in partnership with Birmingham LGBT Centre to offer staff specific LGBT training, new policy development including a policy to support individuals who are transgender (staff and patients), the growth and success of a

LGBT staff network, the Role Model campaign and continually implementing initiatives in an effort to create an inclusive environment for our staff and patients. And these efforts have paid off with the results of the 2018 Workplace Equality Index seeing HEFT rise a 192 places up the index and we are now ranked 136 out of the 434 organisations who have taken part.

- Sexual Orientation Awareness and Trans Awareness half day training was delivered to 297 staff across the Trust. This was delivered between 1st August 2017 and 1st December 2017.

- The Trust Rainbow Friends once again participated in the Birmingham Pride parade. All staff and allies were welcomed to join the group on the day.. Rainbow Friends is the Trust's LGBT (lesbian, gay, bisexual and transgender) social and support group. A member of the group participated in the ' Role Models' campaign within the Trust to promote inclusion, diversity and equality within the workforce and patient care areas

- The Trust held it's first '' Sexual Orientation and Gender Identity – Future Focus Conference on '' 2nd February 2018. This conference with a line-up of prominent guest speakers included Trust's Chief Executive Dame Julie Moore, a national LGBT role model in health, Rikki Arundel, a professional transgender speaker, coach and diversity trainer, Peter Tatchell, a pioneer of Gay liberation movement and human rights activist, Gary Stack, West Midlands police lead for sexual orientation, Pete Mercer, Head of Membership Stonewall and two members of staff from University Hospitals Birmingham Foundation Trust and Heart of England NHS Foundation Trust. The speakers shared their powerful personal narratives. The conference was well attended by healthcare professionals from multi-agency local health economy and evaluated excellent.

- End March 2018, E&D Mandatory training achieved 95.28% completion target against 85%

- Inclusion & Diversity sessions were delivered at the Consultant's Induction programme The training was well received and evaluated excellent.

- Unconscious Bias has been included in the mandatory E&D Moodle training, Further plans to be developed to support the roll out of Unconscious Bias training for all staff.

- Acute Liaison Learning Disability Health Facilitation Service continued to see more patients

- Learning Disability Procedure was developed and implemented

- Learning Disability webpage on Trust intranet developed and implemented

- Interpreting and Translation procedure developed and implemented

- 9680 face to face and telephone interpreting sessions in 46 languages including BSL (British Sign Language) were provided to patients during the year

- In 2017, the Multi-faith chaplaincy service team made 31,820 patient/family contacts to provide a comprehensive range of pastoral, religious and spiritual care and support to patients, carers and staff from all faith or no faith backgrounds

Black History Month – October 2017

The Trust continued with it's tradition to celebrate the Black History Month to raise awareness and visibility of the underrepresented groups. In 2017, as it was the 30th anniversary of Black History Month, displays on all hospital sites of posters from the Official Black History Month magazine of iconic BAME figures over the past 30 years were set up. In addition, the displays included storyboards of Trust BAME staff who have worked in the NHS over the past 30 years to recognise their contribution to the development of an inclusive NHS where equality and diversity plays a key role in improving patient care and workforce areas.

Recognising the Carer conference - Carers Week

Recognising the Carer conference was held to coincide with the Carers Week. The wife of the hugely popular BBC radio personality Ed Doolan MBE, Christine Doolan was the key note speaker at the third annual 'Recognising the Carer' conference hosted by the Trust at Renewal Centre in Solihull on 16 June 2017. She talked about the beloved radio DJs ongoing battle with dementia .her talk entitled ''Don't lose it' – a Carer's journey'.

Another special guest at this conference was Birmingham's own Don Maclean MBE, the popular comedian and broadcaster and latterly a famed Panto dame, who also acted as host through the event and lead a Q&A panel session with the day's guests for the finale of the event. The Trust's Interim Chair, the Rt Hon Jacqui Smith, was in attendance to the open and close proceedings.

The conference was attended by carers, dementia/older people nurses , matrons, allied health professionals, charities, community health and outreach teams, dementia champions, directors/heads of adult social care and older people's services. The event was well received and evaluated excellent.

The Trust works closely with the Carers Trust the lead agency in Solihull as part of the Health Liaison Project in the Borough to raise awareness of healthcare professionals within the Trust about recognising the role of carers. As a result, the Carers Trust will soon be undertaking ward visits at Solihull hospital to promote the role of the carers. In recognition of the key role carers play in patient care areas the'' Carer '' was included in the Trust's Equality Impact Assessment Screening Checklist alongside the 9 Equality Characteristics (see below)

Mainstreaming equality is central to the work undertaken by the Equality & Diversity leads within the Trust in patient care and workforce areas. The principles of fairness, equality, respect and dignity for patients and staff is widely promoted through training and Equality & Diversity services and events to ensure patients and staff are not discriminated against.

The Trust's equality objectives for 2018 - 2020 are :

- We will work together with the local LGBT Community to improve and expand the quality of the information, knowledge and understanding we have about our LGBT service users. We will ensure their experience of our services is improved by being more responsive to their needs. We will ensure that our patients are communicated with in a manner that is appropriate to their specific need or requirement within the Trust. We will identify how patients prefer us to communicate with them from the earliest point of contact. Our objective will be to ensure that every time we communicate with them, that we use their preferred method.

- Work to reduce inequalities experienced by existing staff, as well as, those applying for jobs within the Trust from a LGBT background so as to improve the engagement and experiences of LGBT staff within the workplace.

- We will introduce Unconscious Bias and Inclusion training into the mandatory E&D training for all staff and offer an Inclusive Leadership Course for managers to gain the knowledge in order to ensure all staff are managed fairly and equally and to embrace difference

4.11 Priorities for adult safeguarding 2018 – 2019:
One of our key priorities will be to work in partnership with the QEH safeguarding team to review the existing safeguarding policies and procedures to ensure they are fit for purpose.

Secondly to develop a joint strategic plan. (Below are the priorities from last year which were linked to the 6 principles

Continue to work in partnerships with our Local Adult Safeguarding Boards

Priority 1 Empowerment	**Proposed Action**	**By Whom/Lead**	**Timeline**
Strategic Ambition: That Adult Safeguarding arrangements within HEFT are fully reflective of the needs and priorities of the patients and carers that access our services	• Seek regular feedback from patient and carers who have been engaged in safeguarding situations • Ensure findings of above are reviewed at steering group and used to inform development of practice • Explore how information about safeguarding can be presented to public in different formats; how friends, families and carers can be involved to help the individual understand the choices they face: "no decision about me without me" • Family & Friends Test results – share good practice	Adult Safeguarding Team Adult Safeguarding Team Adult Safeguarding Team & Comms Division Head Nurses Adult Safeguarding	On-going On-going On-going

	• Work in partnership with the LSAB's to embed making safeguarding personal (MSP)	Team	

Priority 2 & 3: Protection & Prevention	**Proposed Action**	**By Whom/Lead**	**Timeline**
Strategic Ambition: That HEFT has effective preventative practice in place, to minimise the risk of abuse or neglect occurring and that staff know how to respond to suspected abuse so that patient protected from further harm.	• Identify ambassador wards to promote best practice in dementia care, and for patients with LD or mental health problems • Use patient and public feedback to identify early indicators of potential concern • Use quality and incident reports to identify early indicators of potential safeguarding concerns • Work in partnership with community safeguarding leads to monitor trends across sectors • Develop a safeguarding learning hub. Ensure organisational training packages stress 'early help' interventions and defensible decision making • Map out alternative pathways (non- section 42) for addressing quality and clinical concerns robustly and proportionately • Implement learning from serious cases SAR's, DHR's, SILPS. Devise action plans to embed learning and cascade via AS steering group, NMB. Share with Head Nurses, clinical leads • Domestic Abuse – Work in partnership with Women's Aid to raise awareness Organise Conference Revise the policy & process Develop the Domestic abuse steering group • Continue to raise awareness of Prevent. Revise the HEALTHWRAP training. Monitor & implement actions from the self-assessment	Division Head Nurses Division Head Nurses Division Head Nurses & Adult Safeguarding Team Adult Safeguarding Team Safeguarding Trainer & AS Team AHN Adult Safeguarding with Adult Safeguarding LA Leads Division Head Nurses Adult Safeguarding Team Prevent Lead & Adult Safeguarding Team	On-going On-going On-going On-going & case by case

	document • Continue to raise awareness of categories of abuse & how to respond • Develop the role of the Adult Safeguarding Champions • AS policy and procedures in place that are robust and clear to staff	Adult safeguarding team Adult safeguarding team Adult safeguarding team	

Priority 4 – Proportionality	**Proposed Action**	**By Whom/Lead**	**Timeline**
Strategic Ambition Ensure that HEFT is compliant with the application of MCA, DOLS and use of restraint within practice	• Continue to promote the Moodle MCA package for all clinical staff • Monitor the work plan via the AS steering group • Re-audit compliance during Q2 & Q4 • Target training to the "hot spot" areas • Develop case studies • Work in partnership with the CCG project team for MCA & DOLS • Share practices from other Local trusts & network • Develop the Adult safeguarding champions	Division Head Nurses, matrons	On-going Quarterly completed On-going completed On-going Launch held Feb 2017

Priority 5: Partnership working	**Proposed Action**	**By Whom/Lead**	**Timeline**
Strategic Ambition That HEFT works collaboratively with the Local SAB's, other services, teams and agencies to ensure that all patients experience a personalised and individual response when safeguarding concerns are raised	• Explore representation from external groups on AS steering group • Cascade newsletters, bulletins, and resources from external links • Continue to develop working relations with hospital based social work teams • Establish local agreement on HEFT's contribution to sec42 enquiries • Develop improved systems for	AHN Adult Safeguarding Adult Safeguarding Team Adult Safeguarding Team	Completed On-going On-going

	picking up and communicating issues on admission, discharge with nursing homes • Update the messages on Trust Intranet safeguarding page to reflect the MSP agenda • AHN Adult Safeguarding & Lead for Social Care to present to Senior Nursing staff key messages (package developed in partnership with BSAB) • Training to be revised to link in with the Care Act & MSP Level 3 for Senior Srs, Matrons to be developed	Division Head Nurses Adult Safeguarding Team AHN Adult Safeguarding AHN Adult Safeguarding	 Completed Completed

Priority 6: Accountability – Assurance & Governance	**Proposed Action**	**By Whom/Lead**	**Timeline**
Strategic Ambition That HEFT is compliant with CQC regulations, the Care Act, and local & national guidance around adult safeguarding.	• Review membership of the Steering group & TOR • Maintain an accurate dashboard picture of safeguarding activity across organisation • Ensure key safeguarding challenges and risks are identified and escalated appropriately within organisation • Ensure there is suitable organisational representation in local Safeguarding Board structures; ensure key practice issues and local challenges /developments are fed back to steering group • Review and update policy and procedure as required • Publish an Annual safeguarding report which includes a review of organisational compliance	AHN Adult Safeguarding AHN Adult Safeguarding Division Head Nurses & Adult Safeguarding Team Division Head Nurses & AHN Adult Safeguarding AHN Adult Safeguarding AHN Adult Safeguarding	Completed Quarterly On-going On-going December 2018
Implement the Quality Assurance Framework to ensure HEFT has an effective system in place for Adult Safeguarding	• Develop the quality assurance framework • Review audit programme. Involve SA lead from CCG & compliance manager • Explore options for external	AHN Adult Safeguarding AHN Adult Safeguarding	completed completed

	peer review/audit • Work in partnership with PALS manager to capture feedback from patients and their carers • Produce training needs analysis and training data. • Report on patient outcomes • Report on training activity • Report on MCA activity • Report on DOLS activity	Adult Safeguarding Team Adult Safeguarding Team Adult Safeguarding Team	On-going Review annually Quarterly Quarterly Quarterly Quarterly

Section 5 Domestic Abuse

5.1 Domestic Abuse

Definition

Domestic Abuse is defined as any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- psychological
- physical
- sexual
- financial
- emotional
- controlling and coercive behaviour

Domestic Abuse is public health concern and a major safeguarding issue impacting on both adults and children with the associated costs for acute and mental health services well documented (see link below) http://www.safelives.org.uk/policy-evidence/about-domestic-abuse/how-widespread-domestic-abuse-and-what-impact

Domestic violence is identified as a cause of concern and significant harm in children.

- Identification of risk and early intervention/work with families can significantly reduce risk of escalation and is important for breaking the cycle of abuse (Pritchard 2005).
- The link between child abuse and domestic violence is high, with estimates varying from 30% to 66% depending upon the study.

Each year around 2.1m people suffer some form of DVA – 1.2 million women (8.5% of the population) and 700,000 men (4.5% of the population).

Adult deaths through suicide and domestic homicide are well documented as are the links with adult morbidity through increased mental illness and substance misuse.

The ability of health services to identify domestic abuse and to respond appropriately to it is heavily dependent on access of front line staff to appropriate training and supervision and to the ability of health organisations to have a structured approach to identification and to partner with and signpost to other organisations.

5.2 Infrastructure

The Trust has a Safeguarding Adult Lead Nurse for Domestic Abuse and a Specialist Midwife for Domestic Abuse. Their roles including the establishment of education and

development programmes to assist frontline staff with identification and management of domestic abuse, to provide advice and support in relation to individual cases and establishment of systems to support best practice.

The Specialist Safeguarding Team all provide advice, support and training to support best practice in identification and response to domestic abuse.

5.3 Governance
The Trust has a Domestic Abuse Steering Group that reports to the Safeguarding Child and Adult Committees.

It is chaired by the Head of Safeguarding.

The Steering Group fulfils the following functions:

- Benchmarking activity in relation to Domestic Abuse Standards and oversight of improvement plans
- Oversight of domestic abuse training needs analysis and education
- Oversight of the implementation of recommendations from Domestic Homicide Reviews.

5.4 Rates of Domestic Abuse Identified

5.4.1 Domestic Abuse identified through Child Safeguarding Activity
The Trust identifies adult domestic abuse as an issue in relation to child safeguarding in maternity, paediatric, the emergency departments and other settings. Domestic Abuse may be identified as the result of either an adult or a child attendance.

The table below illustrates the total number of **child safeguarding referrals that cited concerns regarding parental domestic abuse** during 2017-18 as one of the reasons that is causing concern for the safety of the children. This equated to 18% of the request for social work referrals completed for children by HEFT staff during the year. Many of these referrals are made by staff working in adult areas who identify that an adult patient is a victim of domestic abuse and that there is a transferable risk to their children.

	Qtr 1 2017-18	**Qtr 2 2017-18**	**Qtr 3 2017-18**	**Qtr 4 2017-18**	**Total**
No. of Child referrals citing DA	**126**	**128**	**114**	**178**	**546**

5.4.2 Adults identified as victims of domestic abuse where child safeguarding was not the primary concern
For the financial year April 2017- March 2018, **214** patients were identified as victims of domestic abuse across the 3 hospital sites by adult staff where no safeguarding child concerns were identified. An additional **13** patients were identified by the adult workforce in community services

- 187 (88%) were female victims and 27 (12%) male.
- The age range was from 17-91 years of age

The table below illustrates the distribution between sites for adult services identifying domestic abuse:

BHH	**GHH**	**Solihull**	**Community**
137	43	34	13
60%	19%	15%	6%

5.4.3 Rates of Domestic Abuse Identified in Maternity Services

Maternity services operate standardised routine inquiry in pregnancy. Through this mechanism and through the social assessment completed in the antenatal period they identify the majority of cases notified to the specialist midwife for domestic abuse (58%). This is recommended good practice as pregnancy is known to be a time when domestic abuse emerges or escalates.

The specialist midwife also receives notifications from other agencies (most usually the police – 23%). For 2017-18 the maternity service have noted a total of **499** notifications of domestic abuse for pregnant women.

Maternity received 19 notifications from MARAC (Multi-Agency Risk Assessment Conference for victims deemed to be at risk of harm. These were all from the police**.** Maternity Services generated 13 referrals into MARAC during 2017-18. The Specialist Midwife will attend MARAC (Multi-Agency Risk Assessment Conferences) in relation to any very high risk pregnant women to ensure that maternity services are fully cited on the safety plans for victims and that this is reflected in their care plans.

The majority of domestic abuse cases are identified in early pregnancy (61% identified before 26 weeks) allowing sufficient time for risk assessment; sign posting; early help or another appropriate intervention or statutory intervention aimed at ensuring planning for the safety of the victim, the unborn infant and other family members.

Routine inquiry is embedded in the new Maternity Badgernet System as is the approved multi-agency risk assessment (although further technical tweaks are required before this is fully functional).

Maternity Services report that Erdington and Chelmsley Wood are consistently the locations associated with pregnant women identified as being subject to domestic abuse. It is thought that the location of some refuges may influence this.

5.4.4 Co-morbidity

In many instances the concern regarding domestic abuse co-existed with other concerns regarding parents including mental health issues or substance misuse problems. Audits in HEFT maternity suggest that this is the case in approximately 55%- 60% of all cases where domestic abuse is identified.

5.4.5 Ages of patients affected by domestic abuse in maternity

Data from maternity indicates that the youngest victim seen in 2017-18 was 18 years old and the oldest was 42 years.

5.5 Policy and Procedures

- The Trust updated the Domestic Abuse Policy in 2016-17.
- This has been updated to include the new legislation in relation to coercive control.
- The policy includes how to support staff who are victims of domestic abuse and how to support male victims of domestic abuse and victims in same sex relationships
- The policy links appropriately to the Safeguarding Adult and Child Policies.

5.6. Positive Partnerships Supporting Domestic Abuse Improvements

- The Trust works closely with the Community Safety Partnership teams who have identified DA leads within the Local Authority.
- The Trust works closely with partners in social care and police on a case by case

basis to ensure appropriate information sharing and safety planning for victims and their children.

- The Trust ensures there is appropriate representation at MARAC, Domestic Abuse Triage Screening and participation in the Domestic Homicide review Process
- The Trust has participated in the consultation on the DA Bill

5.6.1 Partnership Challenges in 2017-18

- The Trust has a strong partnership with Women's Aid and they have provided an on-site service for HEFT patients in Maternity and in the Emergency Department. However this service was lost in 2017-18 due to funding cuts.
- Midwives have also reported during 2017-18 the difficulties that they have encountered through cuts in Refuge places. This has resulted in the women they identify as victims of domestic abuse being offered temporary accommodation where they do not have the same access to support as they would in refuge.
- A business case to have Independent Advocates within the ED as recommended in best practice (A Cry for Health): http://www.safelives.org.uk/sites/default/files/resources/SAFJ4993_Themis_report_WEBcorrect.pdf was unsuccessful in attracting funding in 2017-18– despite a successful service being delivered at a neighbouring Birmingham hospital.

5.7 Training

- All clinical staff receive basic information in relation to domestic abuse including the importance of safety considerations and, where necessary, use of interpreting services when making inquiries. This is included in level 2 safeguarding training,
- All of the Level 3 safeguarding children workforce (this includes all ED clinical staff) receive training in relation to domestic abuse and the impact on children and adults.
- The Trust delivers further specialist training in relation to domestic abuse in the maternity setting; the community setting and in the Emergency Department. This includes the impact of coercive control.
- Maternity staff receive additional domestic abuse updates annually and this included in 2017-18 risk assessment, MARAC referral and honour based violence
- In 2017 HEFT ran a series of successful safeguarding conferences across its hospital sites. The subjects that were taught included domestic abuse; sexual violence and forced marriage. The conferences were attended by 300 staff members from a diverse range of disciplines and evaluated very well.

5.8 Learning from Domestic Homicide Reviews

- During 2017-18 the Trust completed a number of internal management reviews as part of the Domestic Homicide Review Process.
  Learning highlights included:
- The need to consider the domestic abuse with patients present repeatedly with multiple vulnerabilities in relation to mental health, substance misuse, self-neglect.
- To consider the needs of children and ensure referral for children in relation to male patients with substance misuse and mental health issues.

4.9 Key Developments for Domestic Abuse for 2018-19

- Increased focus on the frequent attenders to ED presenting with substance misuse and mental health issues which will allow for exploration of whether domestic abuse is a contributory factor. This work is being done in partnership with RAID (part of the Birmingham and Solihull Mental Health Foundation Trust).

- Introduction of increased targeted questioning about experiences of domestic abuse in the ED in line with NICE guidance (2014).
- Redthreads Youth Work Project implementation in BHH will ensure support for children and young people who are affected by domestic abuse.
- Healthy Relationship sessions have been instigated for adolescent mothers include what constitutes domestic abuse and how to access support.
- Changes in Badgernet to ensure that midwives have access to all appropriate domestic abuse assessment documentation electronically on their hand held devices.
- Cohorts of staff to receive bespoke domestic abuse training to be extended to include gynaecology staff and increased numbers of community staff. Human Resource Managers will also receive some bespoke training to help them support staff where domestic abuse has been disclosed or identified.
- There are a further set of Safeguarding Adult conferences planned for 2018-19 and there will once again be a strong focus on domestic abuse.

Section 5 Conclusion

The Trust has developed a strong infrastructure and robust mechanisms to for safeguarding governance.

There is a critical mass of specialist safeguarding staff to offer advice and support at every level of the organisation.

There is an educational and supervision model to support development of capability and expertise across the organisation.

The Trust has highlighted above, key achievements and improvements for safeguarding adults, children and in the work that Trust staff do in relation to identification and response to domestic abuse.

In the next 12 months the newly merged Trust will be reviewing and revising safeguarding arrangements to meet the needs of the new organisation and aiming to improve safeguarding practice in the following ways:

- Establishment a new safeguarding staffing structure based on need
- Establishment of a refined governance structure to support safeguarding
- Harmonisation of Safeguarding Policies and Procedures
- Harmonisation of processes
- Assessing the impact on safeguarding of other organisational changes in relation to documentation/ system changes.
- Maintenance of all safeguarding services throughout the period of safeguarding team transition.
- Introduction of the FGM RIS (Risk Indicator System)
- Maintain and strengthen key partnerships at a time of change (both health re-organisation and new arrangements for provision on children's social work services)
- Develop the learning and development offer in line with the new priorities around the wider definition of 'exploitation' for children and adults
- Introduction of 'Redthreads' in BHH Emergency Department – a service to enhance youth worker support to children and young people between the ages of 11-25 years who have experienced severe violence, sexual exploitation or domestic abuse.