St George's Healthcare NHS
NHS Trust

REPORT TO THE TRUST BOARD

Paper Title:	Safeguarding Annual Report 2013/14
Sponsoring Director:	Alison Robertson, Chief Nurse
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Purpose:	To review the activity for safeguarding across the trust and to provide assurance that this is a significant part of the patient safety agenda.
Action required by the board:	For information
Document previously considered by:	Patient Safety Committee May 2014

Executive summary

1. Key messages

1. Safeguarding children and vulnerable adults and promoting their welfare is a priority.
2. The CQC found the trust to be compliant with the standard for safeguarding which is a further endorsement of the trust's safeguarding arrangements (February 2014). Although there is work to be done to ensure staff understand and know how to apply the principles of the Mental Capacity Act.
3. There is an appropriate structure of dedicated practitioners who provide a team approach to safeguarding and promoting their welfare. The team will expand in 2014 to include a specialist nurse (domestic abuse).
4. Compliance with the Safeguarding Children Training Strategy has been subject to a risk assessment and an action plan. It is noted that progress has been made in achieving a higher percentage of staff trained at each level and the difficulties in accessing training data are resolving
5. Actions from serious case reviews (SCR) and individual management reviews are being addressed and the learning is being shared. It is noted that there has been an increased activity in this area with the Trust contributing to several IMRs and SCRs
6. Priority areas such as child sexual exploitation, female genital mutilation (FGM), forced marriage, honour based violence, missing children and children with disability, are being addressed by the safeguarding team and partner agencies
7. The trust is actively represented in the wider safeguarding arena and is committed to integrated working with our colleagues from other agencies.
8. Referrals to the adult safeguarding lead continues to increase (37% rise in 13/14).

2. Recommendation

To note the report for information and to receive this as assurance that focus is given to safeguarding children, young people and adults.

Key risks identified: • To ensure that the Trust continues to meet the compliance standards required by the Care Quality Commission (next inspection due in the New Year) • To ensure that staff access the required level of training	
Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	Safeguarding is a fundamental component of the Quality Improvement Strategy.
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	Outcome 7 – people should be protected from abuse and staff should respect human rights.
Equality Impact Assessment (EIA): Has an EIA been carried out? **Relates to all patients**	

Service/Function/Policy	**Directorate / Department**	**Assessor(s)**	**New or Existing Service or Policy?**	**Date of Assessment**

1.1 Who is responsible for this service / function / policy?
Chief Nurse

1.2 Describe the purpose of the service / function / policy?
To ensure that the organisation complies with any statutory guidance and legislation and to have effective systems in place to safeguard children and young people and adults.

1.3 **Are there any associated objectives?**
There is a broad range of local and national guidance and legislation which must be taken into account.

1.4 What factors contribute or detract from achieving intended outcomes?
That staff are not aware and do not feel confident to know what to do if there are concerns about the safety and wellbeing of patients in relation to safeguarding.

1.5 Does the service / policy / function / have a positive or negative impact in terms of the protected groups under the Equality Act 2010. These are Age, Disability (physical and mental), Gender-reassignment, Marriage and Civil partnership, Pregnancy and maternity, Sex /Gender, Race (inc nationality and ethnicity), Sexual orientation, Religion or belief and Human Rights
Safeguarding arrangements are directed at all of our patients/service users.

1.6 If yes, please describe current or planned activities to address the impact.

1.7 Is there any scope for new measures which would promote equality?

1.8 What are your monitoring arrangements for this policy/ service
Via evaluation of learning and response to safeguarding issues. Audits to test practice against policy.

1.9 Equality Impact Rating [low,]

2.0. Please give you reasons for this rating

Safeguarding Children Annual Report April 2014

Introduction

This annual report provides an overview of the services and activities undertaken by the Trust in order to safeguard and promote the welfare of children who access services in all areas. The Trust is of the view that safeguarding children is everybody's responsibility and consequently the Trust aims to ensure that all services, departments and individual staff members are provided with appropriate information, training and support in order to be able to fulfil their role and responsibilities in this important patient safety area. The Trust is mindful of their corporate responsibilities as described in the following:

- The Children Act (1989) section 17 and section 47
- The Children Act (2004) section 10, section 11 and section 13
- Working Together to Safeguard Children, HM Government 2013

1. Safeguarding Children Organisational Structure

1.1 The chief executive has overall responsibility for the safeguarding of children and there is a clear line of accountability in place.

1.2 The safeguarding children team structure has expanded somewhat with an additional full-time post being funded in order to support the Multi-agency Safeguarding Hub (MASH). The MASH is a multi-agency team which is led by children's specialist services (CSS) and the police and is co located with partner agencies to ensure maximum information sharing and multi-agency decision making. The primary purpose of the team is to receive and screen all referrals to CSS and to then make timely informed decisions as to the response and action. The role of health in this new arrangement is pivotal in the facilitation of information sharing, providing evidence based health advice and in influencing the decision making process.

1.3 Apart from the MASH post, the acute service has also had some extra resource in that the named nurse has the support of a full time deputy named nurse for a limited period. The children looked after service now has a Designated Doctor for Looked after Children in place although; this is not as yet a substantive appointment.

1.4 A timely review of the safeguarding children service was commissioned by the Chief Nurse and Director of Operations who noted that there had not been a reassessment of the resource since the amalgamation of the community and acute services. An independent assessor has conducted a review and the report is presently being considered. It is anticipated that there may be recommendations in respect of resources and the structure of the team.

1.5 Bid for DV nurse specialist
In the acute service, a business plan/bid for a nurse practitioner for domestic abuse was submitted some time ago to the clinical commissioning group, the response to which is still awaited. This role would be primarily adult victim focused and managed as part of the vulnerable adults team, however the benefits of this role would be considerable in respect of child safeguarding as domestic abuse involving adults has a significant impact of the safety and emotional wellbeing of children. The role would include face to face work with the clients, supporting staff in their work with victims of domestic abuse, working alongside other

key agencies, attending Multi-agency risk assessment conferences (MARAC), and raising the profile of domestic abuse throughout the Trust as well as training staff in all aspects of domestic abuse. The Deputy Chief Nurse did re-present the case for the specialist role at a recent meeting of the CCG, where the above points in support of the bid were reiterated, in addition it was noted that a key finding of a recent serious case review highlighted the growing need to raise awareness in staff of the links between DV and the safety of children. The information was received with interest; however there has been no further update.

2. Clinical Policies, Procedures and Guidance

2.1. The Trust has appropriate policies, procedures and guidance in place, which are accessible to all staff via the safeguarding children site on the intranet. The last draft of the revised London Safeguarding Children Procedures has been issued for consultation and it is anticipated that the launch of the final version will be in the next few months. The St George's safeguarding children team will be guided by the new procedures and will be amending internal procedures to incorporate new guidance. The team are aware that various documents are pending revision, including the training strategy and the safeguarding children policy and that a number of guidelines are ready for updating, however the need to follow through on actions from SCRs and IMRs has taken priority over the policy work. The safeguarding team will be addressing the policy work over the next few months, which will also be influenced by the recommendations from the review of the service. Currently the revision of the safeguarding children and information sharing policy is underway, as well as the domestic violence guidance and guidance on the 'unseen child'.

2.2 The action plans from serious case reviews and actions that have been recommended by various safeguarding children related audits have resulted in additional pieces of work, including the introduction of a number of guidelines and tools to assist staff in the safeguarding activity. There are a number of actions plans underway, the progress of which is monitored by the strategic and operational safeguarding children committees.

2.3 With the introduction of the MASH arrangements and, as a consequence of a high profile court case (involving Haringey Children Specialist Services (CSS) v parents whose information was shared), information sharing has become more complex. Many local authorities will not now share information in relation to child safeguarding, without the consent of the parent or young person and often this has to be in writing. In addition, the MASH arrangements and several of the duty and assessment teams at CSS will not give out information over the phone and will only respond to emailed requests/referrals. These changes are already having an impact, most especially in the acute services where timely gathering information is vital often to assist with the decision making process. Consequently the safeguarding team are revising the Trust's approach to information sharing and the Safeguarding Children Information Sharing Policy is being revised.

2.4 It is noted that the national scheme being introduced by NHS England, *Child Protection – Information Sharing Project*, is progressing although it will not be fully functional until 2018. This project has been set up with the purpose of facilitating information sharing about vulnerable children between social care and key health departments. A national database will allow frontline health services such as emergency departments and GPs, to be able to access basic information about children who have child protection plans and those who are children looked after. The system will provide details of who to contact for more information or to share information. St George's Healthcare NHS Trust is about to start the process of registering to take part in this useful innovation.

3. Safer Recruitment

3.1 The Trust has a policy in place for safe recruitment practices that covers employment history and checks on criminal records, occupational health, registration and qualifications, and right to work. The policy is applicable to all staff - whether permanent, temporary, agency, contracted, self-employed or volunteer – and all roles including estates staff, staff granted practising privileges and volunteers who have contact with the people who use their service or who are undertaking a regulated activity as defined in the *Safeguarding Vulnerable Groups Act* 2006 have audit arrangements in place that check the policy is being implemented.

3.2 The Trust adheres to the guidance from the Home Office: Disclosure and Barring Service 2012 and ensures that all staff members have the appropriate checks pre-employment and for referring staff to the DBS if appropriate.

3.3 Human Resources staff and managers take account of the need to safeguard children and vulnerable adults when interviewing and employing staff.

4. Managing allegations against staff – safeguarding children

4.1 All agencies have a duty and responsibility to report allegations made against a person in a position of trust that works for them, whether that person works in a full-time, part-time, as a locum or bank employee. This also includes voluntary staff and all staff employed by the Trust. The Trust has an appropriate policy in place and has a Lead Officer who is responsible for the process and has oversight of all cases. An overview of the activity in respect of cases that have been raised is an agenda item for the Children and Young People's Safeguarding Committee and there is a regular meeting in the acute service between the safeguarding team and the Lead Officer to review the cases that are under investigation.

4.2 The Trust works closely with the Local Authority in managing allegations against staff. Within the borough of Wandsworth, the Safeguarding Standards Service (SSS) has the operational responsibility of managing and responding to allegations. Multiagency training to raise awareness about managing allegations against staff has been provided by the Wandsworth Safeguarding Children Board (WSCB) and several members of staff from St George's Healthcare NHS Trust were pleased to attend this training. A leaflet providing information regarding the management of allegations against staff has been widely shared and is given out during level 2 and 3 safeguarding children training.

4.3 Following the introduction of the revised policy in 2012 a more formal internal system of reviewing allegations made against staff members has been established as well as a confidential database where the progress in each case, (which can take some months to conclude) can be recorded. The database was established in January 2013 from which time until the end of March this year there have been eight cases. These eight cases have been investigated and concluded with reference being made in each situation to the Local Authority Designated Officer to ensure interagency overview. In April 2014 two further cases have arisen and are being investigated. It is noted that there would seem to be an increase in the number of cases being examined which may be the result of direct activity to raise staff awareness and share information about the process. The issues that have been investigated have ranged from an allegation made by a patient about a member of staff being inappropriate, to a matter in a staff member's own family life which may have had an impact on her role caring for vulnerable adults and children.

5. Training

5.1 The Trust wide compliance with safeguarding children training has been a matter that was added to the risk register. There have been two main problem areas associated with the safeguarding children training arrangements, these being lack of accurate data as to the level and number of staff trained and the actual number of staff who are compliant with training requirements.

5.2 The ability to evidence the safeguarding children training compliance has been a priority area for the Trust as it had been recognised that there was an inadequate means of recording data. The training and education department introduced the WIRED and TASK electronic systems which have been installed in order to facilitate easy access to details about training compliance for individuals, departments and the whole workforce. The safeguarding team have led on providing data and inputting this as well as undertaking a review of the various levels of safeguarding training required for each staff group. The initial problems with the system have been ironed out and although there are still some issues the accuracy and ease of accessing has improved.

5.3 The following information has been extracted from the WIRED system:

Percentage of staff trained at their appropriate level

	December 2013	February 2014	March 2014
Level 1	93%	92%	91.84%
Level 2	49%	79%	79.41%
Level 3	37%	45%	46.37%

5.4 An action plan is in progress which is addressing the short fall in the numbers of staff who have achieved appropriate training and this is reviewed regularly. Within the acute service there is also a quarterly meeting of the safeguarding children training group where the plan is revisited alongside all aspect of acute service training. A benefit therefore of the WIRED/TASK system is that training compliance can be monitored for individuals, specialism or departments as well as providing data in respect of the whole workforce. It has been noted that there are some areas where although training at level 3, such as maternity, has been achieved the data has not been entered onto the system as the support staff who would take responsibility for this had not been aware of the new database, therefore this is now being addressed. Areas which are to be targeted for level 3 training as identified by interrogation of the system are the Emergency Department, maternity and obstetrics and the ENT department.

5.5 Target groups for safeguarding children training
Following recommendations from a SCR the community named nurse has developed and delivered mandatory record keeping training to community practitioners, with it being mandatory for health visitors and school nurses to attend. This will be audited in Q1 2014
The results from the Section 11 audit identified that in the acute service specific groups should be targeted for training. The action plan and the specific group training are being arranged by the deputy named nurse.

5.6 The training programme

In the acute and the community service as well as in the maternity service, the training programmes have been revised in order to meet the needs of the workforce in line with current guidance and to draw attention to high profile safeguarding issues, such as female genital mutilation. In the acute service the current programme focuses on the vulnerability of babies and young children, domestic abuse and the impact on children, child sexual exploitation and the broader issue of neglect. It is recommended that when the level 3 training is revised towards the end of 2014, that the duration of the session will be increased to a whole day event rather than a half day which is the present arrangement. It has been previously argued that releasing staff for a whole day may be problematic due to pressures of other mandatory training and the need to ensure that patient care is the priority, however in order to satisfy the quality of training at level 3 the time allocated is considered necessary. With the increase in time provided it will then be possible to ask local partner agencies to contribute. The community division level 3 safeguarding training is a full day and includes, Identification of abuse, the law, information sharing, domestic abuse, FGM, Child Sexual Exploitation, Gangs, and learning from serious case reviews.

5.7 Interagency training
The Trust is represented on the training subgroup of the Wandsworth Safeguarding Children Board (WSCB) (which delivers on the strategic management of the WSCB training strategy) as well as contributing towards practical multi-agency training events. It is noted that staff from St George's, particularly from the acute service, are on the whole not registering for the wide programme of safeguarding training events provided by the WSCB. It is noted that best practice in child safeguarding training at level 3 and above is that it should be in a multi-agency context. The reason for the lack of staff registering for this training is not clear however it is recognised that the acute service staff have a substantial commitment to indispensable mandatory training designed to maintain their particular skills, thus identifying additional time to take part in training which may not be essential to role is not always possible. In order to address this matter the Trust has offered to provide training venues in the acute service, which will make multi-agency training more accessible for the acute staff and such an event in planned for May 2014. This multi-agency training is designed to explore the lessons identified from a recent IMR which is relevant to maternity, acute and community health staff.

6. Quality assurance

6.1 The Trust continues to ensure that arrangements are in place to meet the Section 11 of the Children Act 2004 (HMSO 2004) requirements and the inspection in January 2013 of the acute service by the Care Quality Commission (CQC) demonstrated that the standard for safeguarding was met. The outcome from the recent CQC inspection (February 2014) has been received with no significant concerns highlighted in relation to safeguarding children and young people..

6.2 The Board will note that the process of conducting inspections has been revised so that future Ofsted and CQC inspections will be unannounced; therefore it is positive that the Trust persistently strives to achieve high standards of safeguarding that can be evidenced, measured and is consistent.

6.3 Audit
Audit is a valued tool for monitoring safeguarding children practice. In the acute service there are a number of audits in progress related to different aspects of safeguarding practice as well as those audits that are linked to evidencing outcomes from serious case review (SCR) or individual management review (IMR) action plans. In the acute service the following audits have been completed:

Acute and maternity service audits completed March 2014

Audit topic	Purpose	Outcome	Actions
1. Safeguarding Issues Form	On going review of the compliance with the use of this form – links with SCR action plans	3rd audit Improved compliance in some respects Further embedding of good practice needed	Action plan in progress
2. Did not Attend Guideline	On going review of the process for managing failed appointments and information sharing	2nd audit Improved process and DNA coordinator in place Further work required in respect of ensuring that all departments comply with the process	Actions underway to include that the policy is due for revision
3. Emergency Department / CP plan alerts system	Review of the system to ensure a sound process is in place – linked with actions from SCR	5 localities are now providing list of children with CP plans A coordinator is in place and apart from some minor issues the results were encouraging	Action plan in progress
4. Maternity Services Domestic Violence Staff Audit	To audit whether midwives were asking women the question about domestic violence	Respondents across all grades found the routine enquiry difficult to carry out; not easy to get women alone; a sensitive issue; midwives struggling to phrase the question; midwives unsure of how to respond if the woman discloses domestic violence	Domestic violence training now includes scenarios and role play; lilac folder in all areas now includes a flow chart of actions for midwives if the woman discloses domestic violence; a proposal to have a short period at the beginning of each booking interview where the woman is seen alone, so that the question can easily be asked

The acute service has further audits planned for this year which includes an audit of the use of language line and interpreters for families where there may be safeguarding concerns and the child/parents do not speak English.

The community division has a record keeping audit planned for Q1 2014 which is part of an action plan following SCR. An audit of safeguarding supervision for health visitors and school nurses is planned for later in the year.

6.4 Both the acute and community service are taking part in a series of multi-agency audits that has been initiated by the WSCB. The WSCB have introduced this programme of multi-agency audits in order to examine specific practice issues from real cases. The format is designed to capture the different perspectives of the agencies and then to identify good practice and learning points. Thus far the topics have been thresholds, domestic abuse and currently the audit is focused on missing children. The subgroup reports the finding to the safeguarding board.

6.5 Section 11 audit
The WSCB has a responsibility for ensuring that partner agencies are fulfilling their obligations under Section 11 of the Children Act. To this end in February 2014 each agency was asked to complete a survey of their staff in order to provide evidence of the section 11 requirements being implemented. The survey was based on a questionnaire which, it was anticipated, would be completed by 10% of the organisation's workforce, with particular emphasis being on those workers whose work role did not specifically involve child safeguarding. The timeframe for the completion of this task, including analysis and reporting on the questionnaires, was very short and so it was not possible to achieve a survey of 10% of the workforce but the Trust did manage to survey over approximately 360 staff from a variety of disciplines such as security, speech therapists, receptionist, health visitors, consultants and many more. Given the tight timeframe this was a worthy achievement and provided an overview of safeguarding awareness from a broad spectrum of staff groups.

The results were encouraging with the majority of staff having an understanding of the principles of child safeguarding and how to access support and deal with specific situations. The survey was useful in that it has flagged up some areas where the Trust may want to focus input, such as targeted training for specialist groups e.g. security staff and producing a poster of who to contact in respect of the community safeguarding team. A concise action plan to address the issues that emerged from the survey has been produced but in summary the action/focus is as follows:

- General safeguarding children training raising awareness needs to be targeted at specific groups: MITIE staff, Security Staff, Adult medicine and Adult surgery
  NB: The MITIE staff are under contract therefore the manager has been advised that the staff need appropriate safeguarding children training to be completed ASAP.

- Other groups need training or specific access to information targeted at their needs such as; Radiology, Emergency Department, Paediatrics

- Adult staff on the wards, in ED and the community need more information about how certain health issues for parents may impact on their parenting and what action is needed

- Training data to be more easily accessible to ensure staff are aware of their own training history and take more responsibility for accessing training to suit their needs

- To ensure that the workforce are aware of the safeguarding teams in the community and the acute service

6.6 Clinical Commissioning Groups (CCG)

The Clinical Commissioning Groups aim to support provider organisations in their duty to promote the welfare of children and young people, which includes support with improving outcomes for vulnerable children and young people. To this aim, the CCG has a number of expectations or provider organisations, some (but not all) of those related to child safeguarding are as follows:

- That the provider Trust will provide regular performance and activity reports as well as an annual report on safeguarding children and looked after children
- That the provider Trust will have a public declaration of safeguarding children arrangements posted on its website and update this every 12 months
- That the provider Trust will submit a complete performance monitoring dashboard or other performance management data to the CCG on a quarterly basis and in a timely manner.
- That the provider Trust will ensure that the designated professionals at the CCG will be notified of referrals in respect of allegations against staff
- That the provider Trust will undertake a number of audits specific to child safeguarding
- That the provider Trust will inform the CCG of serious incidents in relation to child safeguarding as well as serious case reviews

St George's Healthcare Trust is committed to meeting the expectations of the commissioners as recorded above. It is noted however that there is an issue for the acute service in that St George's Hospital provides services for children from a number of CCG areas, thus the acute service may be subject to requests for evidence/data/information from several CCGs. Currently the Trust is providing data for Wandsworth CCG and Merton CCG. The Trust is keen to work with the CCGs but there is a resource implication as this is an additional demand on the safeguarding team, thus this is a matter that is under review, particularly as there are other datasets being produced by various other bodies which may also be submitted to the Trust.

6.7 Governance

In the acute service the Acute Service Children and Young People's Safeguarding Committee meets every six weeks and this committee functions as the operational body for safeguarding children. Information from this meeting is reported to the strategic committee chaired by the Chief Nurse and Director of Operations. The strategic meeting is the Children and Young People's Safeguarding Committee which is held each quarter. At this meeting safeguarding activity for the Trust is scrutinised and the safeguarding agenda is reviewed, challenged and monitored. Within the acute service there are also regular meeting of the training group, the paediatric emergency department (ED) meeting, the Child and Adolescent Mental Health and paediatric ED meeting and the weekly meeting of the safeguarding children team in the emergency department amongst others.

The community division has a Divisional Governance Safeguarding Meeting which covers both children and adult services in the community; this meets three times a year. The named nurse attends the community Children and Families Management Team meetings which are held monthly; this has a standing agenda item on safeguarding and feeds into the Divisional Governance Board and the Safeguarding Children's Committee for the Trust.
The Safeguarding team meets quarterly. The named nurse also attends the clinical team leaders meeting once a month and safeguarding is a standing agenda item.

7. Supervision

7.1 Supervision is an essential aspect of ensuring that staff are confident and supported in their work with vulnerable children and families. The safeguarding team of doctors and nurses are available to offer guidance and advice in both the acute and community settings. The details of contact numbers of the safeguarding children team have been widely distributed and the recent section 11 survey evidenced that the staff were aware of how to access support and supervision of cases. Although supervision of community staff and acute staff will differ in approach because of the differing roles of staff, e.g. health visitors hold caseloads whereas acute staff members generally do not, the principles remain the same.

7.2 In the acute service supervision continues to be provided on a case by case basis which is facilitated by daily ward round by the named nurse and also by the availability of the named nurse, named doctor and named midwife for support and advice. In addition there are safeguarding children leads in specific areas such as neonates and maternity providing direct supervision on a case by case basis. The Emergency Department (ED) safeguarding children meeting and the daily presence of the named nurse in the paediatric ED provides support and advice for ED staff as well as the supervision by the 5 leading consultants. The paediatric staff in all areas can also access individual supervision by the named professionals and the staff members from these key areas are invited to access one to one supervision on a regular basis, the recommended timeframe being annually.

7.3 The named doctor and the designated doctor provide a series of supervision sessions for paediatric consultants with the expectation that all of the consultants working in paediatrics will attend. There is also a weekly meeting led by the named doctor for child safeguarding where medical and nursing staff can drop by to discuss cases. This venue also facilitates learning from actual cases as well as facilitating teaching on specific safeguarding children issues such as managing child death.

7.4 In the community the model of supervision is varied. Health visitors, school nurses and specialist posts receive quarterly 1-1 supervision either from their line manager or a member of the safeguarding team. Community nursery nurses, therapy staff, haemoglobinopathies, and minor injuries staff have group supervision facilitated by the safeguarding team. Ad hoc supervision is provided on a case by case basis to all staff.

7.5 The maternity service holds monthly supervision sessions with the whole of the safeguarding team, including the specialist midwives for mental health, domestic abuse and drugs and alcohol misuse, the Named Nurse, and the Jade (teenage team) midwives.. The safeguarding specialist midwife also provides supervision to midwives and doctors on an ad hoc basis, particularly when there has been a difficult case.

8. Serious case reviews (SCR) Individual Management Reviews (IMR)
For information: a serious case review is conducted at the request of the local safeguarding children board (LSCB) when a child has died or been significantly harmed. It is a multi-agency review of how the agencies have worked with the child/ family as well as how the agencies worked together to support the child/family.
An individual management review can be recommended by LSCB when a case under review does not meet the criteria for a SCR but issues for one or more individual agencies has been identified. The agency identified will then conduct a single agency review in order to learn lessons.

8.1 The following is a brief summary of the current cases:

- A Surrey SCR in respect of a six week old baby with injuries, standard SCR process. The acute service provided an IMR report however although the final overview report

has been completed it will not be published until after the court case which is pending in June 2014

- A Lambeth SCR in respect of a four year old who died, using both standard SCR and SCIE process. The acute service has contributed to the SCIE process and has completed an IMR report for the NHS Serious Incident. The SCIE report is due for publication at the end of April.
- A Wandsworth SCR in respect of a 4 year old with serious injuries, using a combination of the standard SCR and SCIE process. The community service has produced an IMR report. The final overview report is being completed but will not be published until after the criminal matter – no date given at this time.
- A Greenwich SRC in respect of 13 month old who died, methodology not known, final report will be released once the court case which is current has been concluded.
- A Wandsworth IMR for Health only in respect of two children who died. The community and maternity services produced IMRs. The overview final report has been released and learning from the IMR is being presented in multi-agency learning events. An action plan is also progressing led by the Designated Nurse.
- A Sutton SCR in respect of a six year old who died of a head injury, the standard SCR format is in progress. The acute service has completed a chronology and an IMR. The final report is due at the end of April although this timescale is likely to slip as there is a huge amount of information from several organisations. Due to the criminal matter the final report will not be published for many months.

9. Looked After Children

A specialist nurse for Looked after Children was appointed following a previous period of unsuccessful recruitment. She is working closely with the doctors for LAC to review the processes and procedures which include the introduction of using BAAF forms for the health assessments. An audit of MMR immunisations was carried out and recommendations from this are currently being actioned. Work is continuing in conjunction with the local authority for the introductions of health passports for care leavers.

10. Child Death Overview Panel

The function of the Child Death Overview Panel (CDOP) is to provide an overview of all child deaths in the Wandsworth area to ensure that there is a rapid response meeting by a group of key multi-agency professionals for the purpose of enquiring into and evaluating each unexpected child death. The rapid response meetings will also identify what actions may be appropriate to support bereaved families including contact with the dedicated bereavement counsellor who provides this service for the CDOP. The CPOD produces an annual report which is shared with the WSCB. From 1st April 2013 to 31st March 2014 the Wandsworth Single Point of Contact has been notified of 65 child deaths -17 were Wandsworth residents and these deaths have been reviewed by the Panel. Out of the 17 Wandsworth deaths 5 were treated as unexpected, (an unexpected death is defined as the death of an infant or child (less than 18 years old) which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death, **Working Together to Safeguard Children, pg.79, chapter 5, point 12**). The five unexpected deaths were all subject to a multi-agency response meeting which took place within a week of the child's death.

11. Partnership Working

11.1 The Trust is represented on the Wandsworth Safeguarding Children Executive Board (WSCB) by the Chief Nurse and Director of Operations.

The Trust is also represented by the safeguarding children team at the following venues:

The Wandsworth Safeguarding Children Board
The Merton and Sutton Safeguarding Children Board
The Wandsworth SCB Training Sub group
The Wandsworth SCB Monitoring Sub Committee
The Wandsworth Adults and Children Sub Committee
The Child Death Overview Panel
The Wandsworth Serious Cases, Learning and Improvement Sub Committee
The Wandsworth Missing Children Group
The Wandsworth Sexual Exploitation Group and Panel
The Wandsworth LADO Group
The Wandsworth MARAC
The Wandsworth CLA Overview Group
The Merton Safeguarding Children Board

11. Local Safeguarding Children Board

11.1 The Local Safeguarding Children Board (LSCB) is the statutory process for agreeing how the relevant organisations will co-operate to safeguard and promote the welfare of children and young people in Wandsworth. Part of this role is to scrutinise the work of partner agencies in ensuring that services provided by the organisation/agency is suited to safeguarding and promoting the welfare of children and young people. (Please refer to 6.4 Section 11 audit) The LSCB plays an extremely valuable role in coordinating and evaluating the broader local response to meeting the safeguarding and welfare needs of children as well as being in a position to identify emerging problems through learning from practice and to oversee efforts to improve services. The LSCB has a three-tier structure, giving strategic overview and direction of the work undertaken by the Board, to the operational Sub-Committees that co-ordinate and carry out the work agreed by the LSCB within its Work Plan. As noted above St George's Healthcare NHS Trust is actively involved with the LSCB on all levels.

11.2 On 1 April 2014 Wandsworth Council's Adult Social Services and Children's Services Departments merged to become the Education and Social Services Department with the current Director of Adult Social Services leading the new department. The Education and Social Services Department will aim to provide the best possible outcomes for vulnerable children and adults, and to continue to improve children and young people's achievement in Wandsworth's schools. The new department will offer personalised care and support for all age groups. There will be a strong focus on commissioning and new, innovative service delivery models will be explored. The new arrangements will also provide an opportunity to improve the transition pathway from children to adult care, to ensure young people continue to receive the support they need once they reach adulthood. It is likely that this restructuring will have an impact on health in terms of the services provided to children and families and the possible transfer of multi-agency work with families, from children's specialist services to single agency work i.e. health. Of interest the Board will note that Children's Specialist Services will be reverting back to their previous title of Social Services.

12. Multi-agency Safeguarding Hub (MASH)
12.1 The Multi Agency Safeguarding Hub teams receive and handle all safeguarding contacts and referrals made to children's social care. The main benefit of the MASH is the ability for partners to share information securely to support better decision-making on cases. One of the aims is to improve early identification of risk meaning that the most appropriate

services can be put in place sooner, ultimately leading to better outcomes for children and young people. The MASH is the first point of referral for the majority of children's specialist services although once the referral has been assessed the case may then be transferred to the duty and assessment team or other service. St George's Healthcare NHS Trust has direct involvement with the newly established Wandsworth MASH in that a specialist health visitor is part of the team. This is an exciting new venture which should facilitate positive outcomes for children.

12.2 Multi-agency Risk Assessment Conference
The Multi Agency Risk Assessment Conference (MARAC) is a multi agency meeting where professionals share information about high and very high risk cases of domestic violence in order to put in place a risk management plan. The aim of the meeting is to address the safety of the victim, children and agency staff and to review and co-ordinate service provision in high risk domestic violence cases. The majority of the referrals made to the local MARACs by St George' Healthcare NHS Trust materialize from the emergency department where the staff have identified and risk assessed clients who have been subject to domestic abuse. The number of referrals for this financial year via ED remains noteworthy with 292 referrals being made. The introduction of the MARACs nationwide has made a significant impact on the numbers of victims being subject to further offences, however the risk assessment process, the referrals and the research in preparation for the MARAC is time consuming, thus if the bid to appoint a nurse specialist for domestic abuse is approved this would be most beneficial. Due to the different specialities involved representatives from community, midwifery and ED attend the meeting.

12.3 Antenatal safeguarding interagency meetings
The meetings are held fortnightly, and are attended by social workers from Children's Services in Wandsworth and Merton, as well as members of the safeguarding team, the child protection safeguarding advisor for the community, and the liaison health visitor. The aim of the meeting is to discuss current and future safeguarding cases where pregnant women are involved, and to exchange and share information.

13. Specific Issues

13.1 Child Sexual Exploitation

Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability.

13. 2 The Wandsworth Sexual Exploitation Multi-agency Panels (SEMAP) has been set up in order to tackle some of the local issues and to actively review cases involving vulnerable young people. The named nurse in the community is part of this multi-agency group.
In addition there is an Operational SEMAP that meets monthly. The specialist nurse for looked after children represents the community safeguarding team as a number of the young people referred to the panel are known to her takes part. The OSEMAP is responsible for reviewing cases in conjunction with practitioners; identifying available support and provision

for children and young people who are affected by sexual exploitation and to contribute to the development of these services; facilitating co-ordination and co-operation between all groups working with children and young people affected by sexual exploitation in Wandsworth in order to avoid duplication and maximise resources and share good practice; maintaining records and monitoring and reviewing cases.

13.3 Female Genital Mutilation (FGM), Forced Marriage (FM) & Honour Based Violence (HBV)

13.4 FGM comprises all procedures that involve partial or total removal of the external female genitalia or other deliberate injuries to the female genitalia for non-medical reasons. The practice is particularly prominent in migrant communities from parts of Africa, Asia and the Middle East. It is a violation of the girl's human right, a criminal offence in the UK since 1985, and has significant detrimental impact on the sexual, reproductive and mental health of girls and women.

13.5 In Wandsworth a multi-agency FGM Steering Group (chaired by the Director of Public Health) has been established to spearhead addressing the FGM concerns within the borough. A task group (including the St George's community health team), the FGM Strategy Development Group, has been set up to develop an action plan of activities aimed at eliminating the practice in the borough. The action plan produced by this group is due to be launched in April. In addition, new guidance has recently been issued by NHS England which clarifies the Health response and management of FGM which up until now has been ambivalent in respect of when to refer. What is not clear at this time is the likely response from other agencies once referrals have been made. The guidance and leaflets produced by NHS England and those prepared by the FGM steering group locally are being widely shared and FGM is a topic that is included in level 3 child safeguarding training.

13.6 A specialist perineal midwife is in place who takes the lead for FGM.
The perineal midwife delivers a presentation on FGM, describing her role and the role of the midwives as part of the monthly maternity specific level 3 safeguarding training which is aimed at increasing awareness in perhaps the leading staff group for this field.

13.7 Forced marriage

'A forced marriage is one in which one or both spouses do not (or, in the case of some adults with learning or physical disabilities, cannot) consent to the marriage but are forced into it using physical, psychological, financial, sexual or emotional pressure. ('Handling cases of forced marriage', HM Government 2008) It is distinct from an arranged marriage that both partners enter into freely.

13.8 Honour based violence

A crime or incident committed, (or possibly committed) to protect or defend the perceived 'honour' of a family or community. Often this term is enclosed in quote marks, or prefaced with 'so-called', to emphasise that the concept of honour in these cases is contested and that it is generally invoked as a means of power and control.

Community, maternity and the acute service staff are highly aware of the need to identify victims of the above crimes and to ensure that the appropriate actions are taken in order to safeguard children. Staff awareness has been raised about these specific areas by widely sharing specific guidance and information with staff and by encouraging staff to attend relevant training. These topics are also addressed in level 3 child safeguarding training.

13.9 Paediatric Liaison Specialist Practitioners

A&E at St George's continues to have increasing number of attendances for children averaging 80 – 130 per day.
A new paediatric liaison specialist practitioner has been recruited and the service is awaiting any recommendations for review from the safeguarding review.

13.10 Missing children

The missing children's group meets regularly and missing children is the subject of the current multi-agency audit. Recommendations from this audit are awaited.

14. Review of previous priority areas

14.1Acute

- Progressing the bid for a Specialist Nurse Practitioner for Domestic Abuse
- Progressing the actions plans from serious case reviews and completing the associated audits in order to evidence outcomes
- Strengthening the recognition and management of health issues of young people related to sexual exploitation, gang activity and mental health issues

The progress in the above priority areas have been referred to throughout the report.

14.2 Community

- Progressing the actions plans from serious case reviews and completing the associated audits in order to evidence outcomes
- Reviewing the service for Looked after Children.
- Development and recruitment to the MASH post.

14.3 Maternity

1. Actions relating to the recognition, care and management of FGM.

15. Safeguarding children priority areas trust wide for 2014 – 2015

1. The team to continue to ensure compliance with section 11 requirements and to meet the requirements of the CCGs
2. Achieve and be able to demonstrate safeguarding children training compliance
3. Continue to progress the revision of policies and procedures, including the policy for children looked after
4. Continue to work with our partner agencies
5. Follow through on the learning and actions from serious case reviews and individual management reviews in order to improve the outcomes for children
6. Embed the recommendations from the Trust's safeguarding children review of the service

ST GEORGE'S HEALTHCARE NHS TRUST SAFEGUARDING CHILDREN ACTION PLAN 2014 - 2015					
Issue identified	**Action required**	**To be addressed via**	**Time-scale**	**Responsibility**	**Date action completed/ progress**
1. The Trust is compliant with Section 11 requirements, CQC standards and national and local guidance The Trust is compliant with the requirements of the Clinical Commissioning Groups	• Complete Section 11 audit if required • Continue to ensure the child safeguarding standards are met • Ensure the changes to policy and procedures that may result from the issue of Working Together to Safeguard Children 2013 are implemented • Address the requirements of the CCG and facilitate the evidence required – identify a lead and process for this	• The safeguarding team will report to the Children and Young People's Safeguarding Committee (CYPSC) as well as WSCB • Named Professionals to review guidance • Identify a lead and process for meeting the requirements of the CCGs	April 2014 – March 2015	Named Professionals and safeguarding team	**April 2014** WSCB section 11 audit complete Recent guidance is being applied to policies and practice
2. The Trust ensures that the workforce is appropriately trained in safeguarding children and that information about staff training is accessible and transparent	• Ensure all training data is entered onto WIRED • Staff at all levels to be appropriately trained Ensure minimum compliance for training is 80% at all levels is achieved • Ensure that the new induction process captures	• Staff training will be monitored by the Children and Young People's Safeguarding Committee (CYPSC) and the Acute Service (AS) CYPSC • Alert all staff and managers to check data base • An action plan is in progress to address the shortfall in staff training Training team to work with Education and Training to	1. December 2013 2. April 2015	D	**April 2014** There has been an improvement in recording and the accessibility of data and training compliance is progressing – however this needs to continue to be a targeted area

	the safeguarding children training needs for all staff	achieve this			
3. The Trust will ensure that the service provided to meet the needs of children who are looked after is robust and in line with NICE guidance.	• A nurse specialist for children looked after is in place • Revision of Children Looked After policies and procedures • Produce a children looked after policy • A permanent Designated Doctor is required	• Complete revision by new post holder • The Trust will appoint a Designated Doctor	September 2014	Nurse Specialist CLA St George's Healthcare NHS Trust Management	October 2013 Nurse Specialist has been appointed and is reviewing the service and will be reviewing the policy Designated Doctor about to be appointed **April 2014** A children looked after policy needs to be produced A Designated Doctor has been appointed although this is not the a substantive arrangement
4. The Trust will work with our partner agencies to address specific aspects in child safeguarding and will take part in multi-agency forums, audits	• The Trust will be represented in all multi-agency forums • The Trust will contribute towards learning opportunities from serious case reviews, individual management reviews and multi-agency audits	• Feedback from the various forums will be included as agenda items (CYPSC) • Learning will be widely shared and included in training opportunities • Action plans and audits will be monitored by the AS CYPSC and the CYPSC	April 2014 – March 2015	Named Professionals Safeguarding Team	**April 2014** The safeguarding children team are fully committed to their interagency responsibilities and are actively involved in the multi-agency

and action plan					arrangements
5. The Trust ensures that the actions and learning from Serious Case Reviews (SCR) and Individual Management Reviews are embedded in practice	• Lead professionals will be identified for each case • Reports, action plans and progress will be monitored both in house and with our partner agencies • 6 monthly and yearly reports to Trust Board • Identify clear pathway to share learning from complex and serious cases	• All reports – SCR or IMR will be approved by the Chief Nurse and shared with the CYPSC • Action plans will be monitored by the CPYPSC as well as AC CYPSC • The training team and WSCB training sub group will lead on shared learning	April 2014 – March 2015	Named Professionals Safeguarding Team	**April 2014** This continues to be a priority area which is generating significant input from the safeguarding children team
6. The recommendations from the safeguarding children service review	•	•			**April 2014**

Safeguarding Adults –Annual Report
April 2013 – March 2014

1. Introduction

St George's Healthcare NHS Trust has a commitment and responsibility to ensure that all patients receive safe, effective and dignified care. In particular we have a duty under Outcome 7 of CQC regulations to ensure that those adults most at risk are "protected from abuse and that staff should respect their human rights". The last twelve months have seen further reports and media exposure of neglect and abuse within the health and social care sector which have understandably had an impact on how adult protection responds to concerns. A significant aspect of adult safeguarding is to ensure we have the necessary processes and systems in place when responding to allegations of abuse and neglect, both within our organisation and externally within the communities we serve. The recent CQC report recognises the safe and effective practices; in particular it provides reassurance with regard to St George's safeguarding practice whilst acknowledging the improvements needed around the implementation and staff's knowledge of the Mental Capacity Act.

This report highlights how St George's responds to and reports on allegations of abuse and neglect and how we ensure that safeguarding is integral to everyday practice.

2. Safeguarding Structure and Policy

We are currently awaiting a final decision by Government as to how local Safeguarding Adult Partnership Boards will function following the implementation of the Care Bill which gives the boards a statutory footing.

St George's utilises the Pan-London Adult Safeguarding Procedures which were introduced in 2011 in an attempt to provide a consistent approach and response from all agencies involved in adult safeguarding across London. These procedures are likely to be reviewed later this year following the implementation of the Care Bill

Locally the adult safeguarding structure remains as it has been for the last 12 months. The Lead Nurse for Adult Safeguarding provides operational support to the wards and departments across the Tooting site and provides advice to colleagues across the whole organisation. There are leads within community teams who provide operational advice within the Community Division and the Lead Nurse for Adult Safeguarding attends the Community Safeguarding Governance Meetings.

The Lead Nurse for Adult Safeguarding reports directly to the Deputy Chief Nurse and provides quarterly reports to the Adult Safeguarding Monitoring Committee. In addition a six monthly report is presented to the Patient Safety Committee and the trust board. Each of the divisions are provided with summary briefings as part of their governance reporting structure on a quarterly basis.

3. Safeguarding Alerts April 2013-Mar 2014

There have been a total of 825 referrals to the Safeguarding Lead Nurse over the last 12 months. This compares to a total of 602 reported the previous year (a 37% increase). A number of referrals are made that do not constitute or necessitate a full safeguarding investigation but involve a degree of information gathering and screening. This is in line with both Department of Health and Pan-London governance guidelines.

Of the 825 referrals, 294 were formally referred to and investigated by social services as safeguarding incidents. This represents around 37% of all contacts and is consistent with

comparable figures both locally and nationally. There is ongoing work within our local authorities to address the issue of thresholds and what constitutes a formal safeguarding referral

Year	2010-2011	2011-12	2012-13	2013-14
Number of referrals	201	502	602	825
Number of formal safeguarding investigations	57	133	240	294

Breakdown of referrals

Neglect	240
Physical	96
Emotional	56
Discriminatory	1
Sexual	12
Institutional	1
Financial	46
Mental Capacity Act advice	39
Deprivation Of Liberty advice	23
Domestic Violence	27
Discharge advice/concerns	68
Self neglect	28
Pressure Ulcer screening	180
Other (including serious case reviews)	8

Summary of incidents relating to St George's Healthcare:

3 allegations related to concerns about the behaviour of family members/carers towards inpatient's at St George's. In all cases protection plans were put in place to ensure the patients safety and social services were notified of the details of the incidents

72 alerts relating to care and treatment were formally referred and investigated (where necessary) by Wandsworth Social Services:

- 51 cases were closed following further information gathering and were deemed to be unsubstantiated.
- 10 cases were found to be unsubstantiated after a formal strategy meeting was held
- 3 cases were found to be inconclusive after a formal strategy meeting and case conference were held.
- 4 cases remain open to investigation as of 31st March 2014
- 4 cases were found to be substantiated.

Unsubstantiated –not proved to be true after investigation (on the balance of probability)
Substantiated – proved to be true after investigation (on the balance of probability)
Inconclusive – unable to record an outcome after investigation

Substantiated Cases

- A patient's discharge was poorly planned resulting in lack of district nurse input. Subsequently the patient was readmitted with diabetic related illness. Although there was no indication of long term harm, it was judged after investigation that the re-admission could have been prevented and hence there was evidence of omission of care. The ward concerned produced an action plan to mitigate against future occurrences and a specific discharge protocol is now in place for this particular patient
- 2 patients developed avoidable pressure ulcers under the care of St George's that were also considered as safeguarding concerns. Following the instigation of normal Serious Incident procedures, the investigatory reports were shared with social services and it was agreed that in both cases it was deemed that there was evidence of omission of care. Social services were agreeable to the action plans produced as part of the SI reports
- A client in the community lent some money to a community nurse which the nurse willingly took. This was a clear breach of professional duties and HR procedures were instigated. Police were also notified although the client did not want to take any further action and the money was returned

Themes

- The relationship between safeguarding and the development of pressure ulcers continues to provide a significant number of referrals. At present there is no clear agreed guidance/protocols that can utilised across all health and social care organisations. There is currently a local forum (led by Wandsworth CCG) and a wider forum across London that are looking at refining the processes and agreeing a consensus approach so that we can try and address whether a pressure ulcer is evidence of neglect without putting clients/patients at increased risk
- The discharge of patients with complex needs continues to present challenges, particularly were multiple agencies such as social care, mental health and community nursing are involved. As recognised by the CQC mental capacity can also have a significant impact on a patient's ongoing care plan and discharge planning. The complexities of balancing risk with respecting patient's wishes can present significant challenges to families/carers and professionals alike and these cases can often involve a significant impact on time and resources to ensure an effective discharge.

Patient Story

An 82 year old gentleman was admitted to the acute medical unit following a fall. Although the injuries and bruises were consistent with the history the patient gave staff, staff were concerned around some of the comments he made about his carers. These comments were around their lack of respect for him, their inability to meet his hygiene needs, their "rough" handling of him and their poor meal preparation. Although there was no evidence that significant harm had occurred we contacted the allocated social worker who agreed to do a joint visit on the ward with the lead nurse for safeguarding to discuss these concerns. In particular there were concerns that, as the gentleman had a personal budget and was ultimately responsible for "employing" his carers, we needed to discuss with him both the concerns raised, the risks involved and what action we could take to help support him in his decision making. The gentleman felt that his concerns had been slightly exaggerated and he was happy to return home to his current carers with an agreement that the social worker would do a home visit after discharge to help facilitate discussion between patient and cares around his care plan.

4. Partnership Working

The Lead Nurse for Adult Safeguarding is a member of both Wandsworth and Merton Safeguarding Partnership Boards. Wandsworth Borough Council is the trust's 'host' borough and there is a close and effective working relationship between the various leads within health and social care. The Deputy Chief Nurse and the Trust Safeguarding Lead attend the quarterly Partnership Board meetings. The Trust Safeguarding Lead attends the Wandsworth Sub-Groups, one of which he chairs. There are also strong working relationships with our local CCG's around adult safeguarding and commissioning.

At a local level, the Lead Nurse for Adult Safeguarding attends strategy meetings and case conferences coordinated by local authorities following disclosures of abuse. In addition, members of the ward or community teams who may be caring for the patient at the time attend and provide information (such as medical evidence) to assist in the investigatory process.

5. Training

A new adult safeguarding e-learning package was introduced in October 2013 and all staff are assessed on adult safeguarding at induction via this package. Adult safeguarding is also part of the mandatory training cycle ensuring all staff have a basic understanding and awareness of how to respond to safeguarding concerns.

In addition the safeguarding lead nurse, with valuable support from practice educators, provides additional training to wards and departments as part of their developments days. These sessions provide an opportunity for staff to explore the complexities of safeguarding using case examples in more detail. A basic overview of the Mental Capacity Act is also presented but it is acknowledged that more needs to be done in this area as reported in the recent CQC report. These sessions are also an opportunity to highlight situations that have been handled well by staff.

Training figures (total number of staff trained)

Induction/E-MAST basic awareness	6923
Clinical sessions (including MCA and Deprivation of Liberty)	580
Students (nursing and medical)	120

This represents a total of 89% of staff receiving basic awareness this last year.

There are no defined levels of adult safeguarding training nationally and it is left to each individual organisation to agree what and how its training needs can be met in conjunction with its local safeguarding adults partnership board (SAPB). Wandsworth SAPB has produced a draft training strategy for 2014/15 based on a national competency framework (produced by Bournemouth University and recommended by Association of Directors of Adult Social Services).It recommends that all staff have some form of basic awareness. It also makes reference to additional training for those involved in investigations within health which Wandsworth local authority provides for us.

6. Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS)

The Mental Capacity Act (2005) was implemented with a view that adults should always be supported to make their own decisions and that in situations where an adult is deemed to lack capacity then decision makers, such as health and social care practitioners, make

a decision in the person's best interest at that time. In its recent report the CQC found that "staff were not sufficiently aware of the Mental Capacity Act 2005" and that this "was impacting on the care delivered to patients." These findings reflect a wider view across the whole of the health and social care sector reflected in a recent and very comprehensive post legislative review of the Mental Capacity Act by the House of Lords. The Trust is currently putting together an action plan to address these issues which will include improved awareness training and action to ensure best practice is shared across the organisation.

There is a clear duty under the Mental Capacity Act (2005) that patients who lack capacity cannot be deprived of their liberty to be treated without appropriate safeguards being in place. The hospital as a 'managing authority' has a responsibility to ensure that all those patients who could potentially meet the criteria of deprivation are referred to the 'supervisory authority' (the appropriate local authority) for independent assessments. There is a requirement that any assessment or authorisation has to be reported to the Care Quality Commission.

The Trust has had 4 urgent DOLS over the last year, 2 of which were given standard authorisations. Urgent DOLS are utilised for those situations where staff are concerned for the welfare and safety of patients who a) lack capacity over a decision to leave hospital, b) the risk of discharge is such that they may suffer significant harm and c) it is in their best interests (and least restrictive) to remain in hospital. Urgent DOLS last for up to 7 days whilst a standard authorisation is considered. This involves independent assessments facilitated by the local authority to ensure the law is applied appropriately.

One significant factor that presents challenges to staff's understanding is that there is no definition of what constitutes a Deprivation of Liberty. It is very much defined by current case law. A recent judgement in the Supreme Court has provided an "acid test" that practitioners can initially use to identify whether a DOLS authorisation should be requested but this has raised questions around how wide the scope of DOLS is and its implications on resources. We are awaiting further national guidance on the implications of this judgement prior to the Trust revising its DOLS guidance

7. Learning Disability Service

In July 2013 the consultant nurse for people with learning disabilities left St George's. The Trust has been able to secure increased funding from our commissioners and now has 2 full time learning disability nurses in post. The service is now able to provide a more comprehensive response to requests for advice, support and liaison across the Tooting site and from our colleagues within the various community teams we work closely with. In particular work is under way at improving discharge planning and ensuring that patients with learning disabilities are supported with their wishes and decision making. The community learning disability team and acute service produced a joint report which was received positively at the recent Patient Experience Committee.

8. CQC Registration and Assurance

Requirements to have robust policies practice and procedures in place are part of CQC registration. The report produced by CQC, following their visit in January 2014, indicated that St George's was compliant with Outcome 7 – "People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening."

The Department of Health has produced a new safeguarding adult's audit tool which assists in ensuring organisations can provide evidence of effective outcomes regarding adult safeguarding. The audit will be rolled out this year via the safeguarding boards.

9. Conclusion

Last year saw a significant rise in adult safeguarding referrals. This reflects a high level of awareness within our own organisation and in our local communities. Patients (and their families) should feel that the care and treatment they receive at St George's is of a safe and dignified standard and reflects our core values. To reflect these aims, safeguarding needs to embedded within practice and seen as everybody's business. The safeguarding action plan (2014/15) is available from the Lead Nurse for Adult Safeguarding.

The board is asked to note this report and continue to support the adult safeguarding agenda.