

Safeguarding Annual Report 2021-22

Introduction

The year 2021 to 2022 has seen a particularly challenging time for the safeguarding team, as they had many changes of management following the retirement of the Head of Safeguarding, a gap in the named midwife post position in covering maternity leave, a vacant post for the named nurse for children's safeguarding a vacant band 6 part time adult position and vacant hours to cover for the band 6 children's nurse maternity leave. This was all during COVID 19. This situation also impacted on the administrator and personal assistant roles who have worked sterlingly to support staff to hold processes together.

The Associate Director came into the position in February 2022 which has mitigated some of the identified risks however there continues to be challenging times with 1 post still vacant, and the high acuity and complexity of the cases which are coming through via all areas, maternity, children's and adults and in the broader team, Learning Disability Dementia and Mental Health.

It is to the team's credit that they have continued to support staff with safeguarding concerns and specialist advice to meet reporting requirements and make changes to improve the service.

Safeguarding Adults

The Safeguarding Adults Collection (SAC) Annual Report 2019-20 published by NHS Digital in September 2021 stated that 498,260 safeguarding concerns were recorded in England during the reporting period of 1st April 2021 to 31st March 2022. 152,270 of those referrals met the threshold under the Care Act for a Section 42 enquiry. In 89% of all concluded Section 42 enquiries where a risk was identified, the reported outcome was that the risk was reduced or removed.

At a local level, published data by SAC it shows that Northamptonshire County Council (NCC) received 5,120 Safeguarding concerns. 1,265 of those referrals met the threshold under the Care Act for a Section 42 enquiry. Furthermore, upon analysing at the data, Northampton General Hospital inputted 10% of all safeguarding referral concerns received by NCC. In addition, for all Section 42 enquiries reported to NCC, Northampton General Hospital accounted for 11% of all referrals being named as the source of risk.

Activity

During the reporting period of April 2021 to March 2022 there were 141 safeguarding adults' referrals made by Trust staff. This is a decrease of 34% in the previous year whereby staff raised 213 referrals.

67% of referrals were made by the Emergency Department. This is representative of Trust Policy that safeguarding concerns are acknowledged and reported at the first point of contact with a patient.

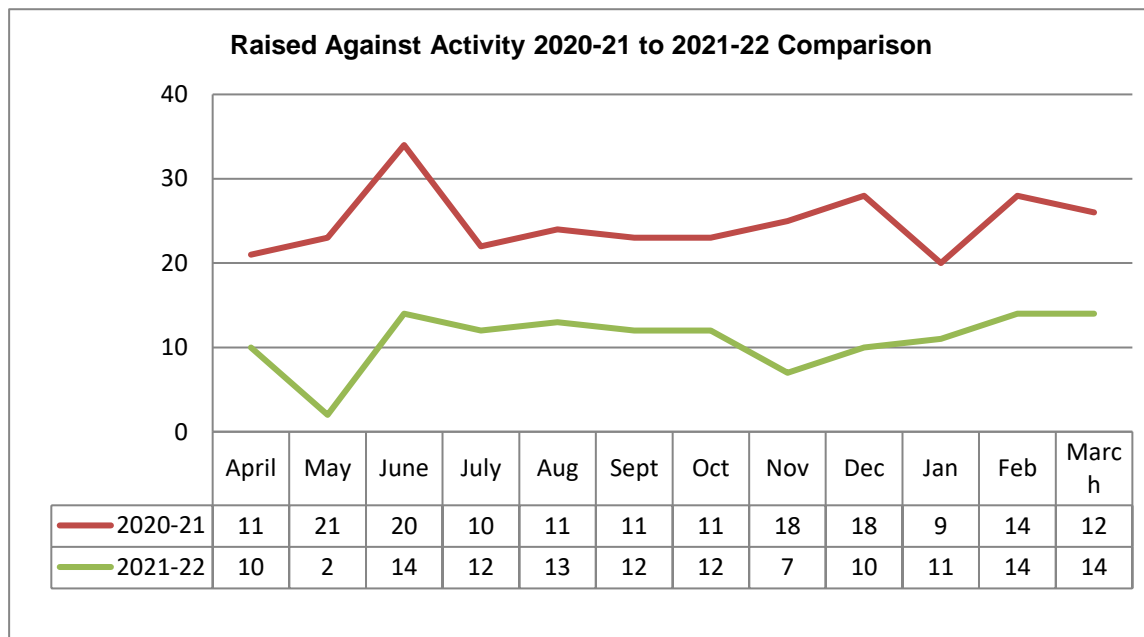
However, due to the significant decrease in referrals made in the previous financial year, the adult safeguarding team have published communications regarding the reporting process. This has been sent via the safeguarding bulletin sent to all staff, screensavers accessible to all staff using the computer, the staff Facebook page and within training to ensure that staff know when and how to report a concern.

As per policy, staff should report any safeguarding concerns raised on behalf of a patient to the safeguarding team with the completion of a Datix incident reporting form. However, staff also contact the safeguarding adult's team directly or referrals are communicated at the daily safety huddle. The safeguarding team do not receive a copy of every referral made from the local authority and therefore are reliant on staff communicating that they have raised a referral.

The safeguarding team are in current discussions with the Local Authority to try to establish a more streamlined reporting system where the team can be alerted and copied into any referrals made by staff at the Trust. This would then reduce the human error of not reporting to the Trust's safeguarding team. Therefore, it should be considered that the numbers of referrals raised by NGH cannot be taken as wholly accurate.

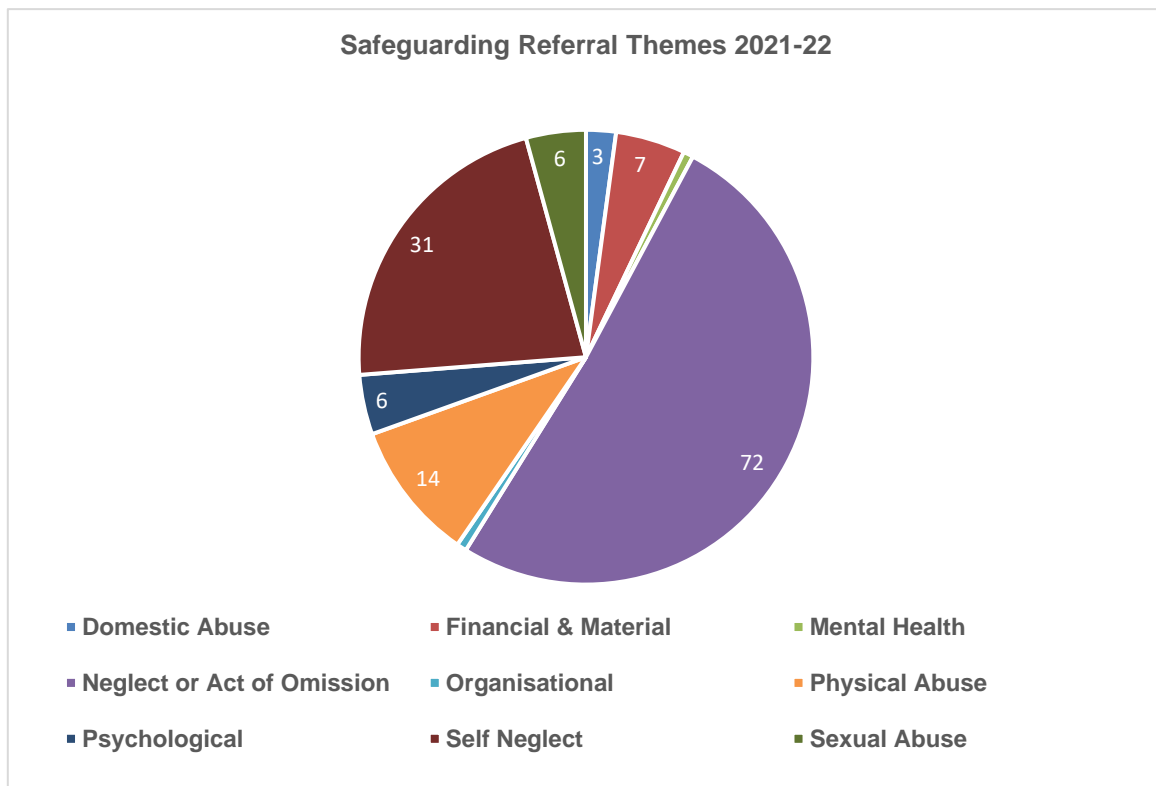
Within the reporting time frame, 129 referrals were received whereby Northampton General Hospital was named as the source of risk resulting in meeting the threshold of a Section 42 enquiry. This is a 16% decrease on the previous year of 153 safeguarding referrals raised against the organisation, and is likely to be due to COVID 19 where there were less people visiting the hospital.

The chart below shows the number of safeguarding referrals made against the Trust and the comparison to the previous year 2020 to 2021.



The chart below highlights the themes of referrals made by the Trust during this reporting period.

Neglect and/or act of omission has been the highest level of safeguarding adult concern, accounting for 51% of all referrals. Neglect and/or acts of omissions is the highest reported category in terms of both referrals made by against the Trust.



The themes of the allegations raised about the Trust predominantly refer to discharge arrangements. This includes lack of communication to the family or care provider regarding discharge, care not being reinstated prior to discharge and patients who return to hospital within a short amount of time following discharge resulting in a failed discharge.

Also, during the latter part of the reporting period, there was an increase in the reporting of patient's acquiring pressure tissue damage. The Named Nurse has consequently met with the tissue viability nursing team to discuss areas of concern, learning and changes that need to be implemented. Action plans have been initiated by ward areas following the completion of Section 42 enquiries to educate staff regarding the categorisation of pressure tissue damage, documentation and staff to escalate any pressure tissue concerns to the TVN team through a referral identifying the correct process and channels.

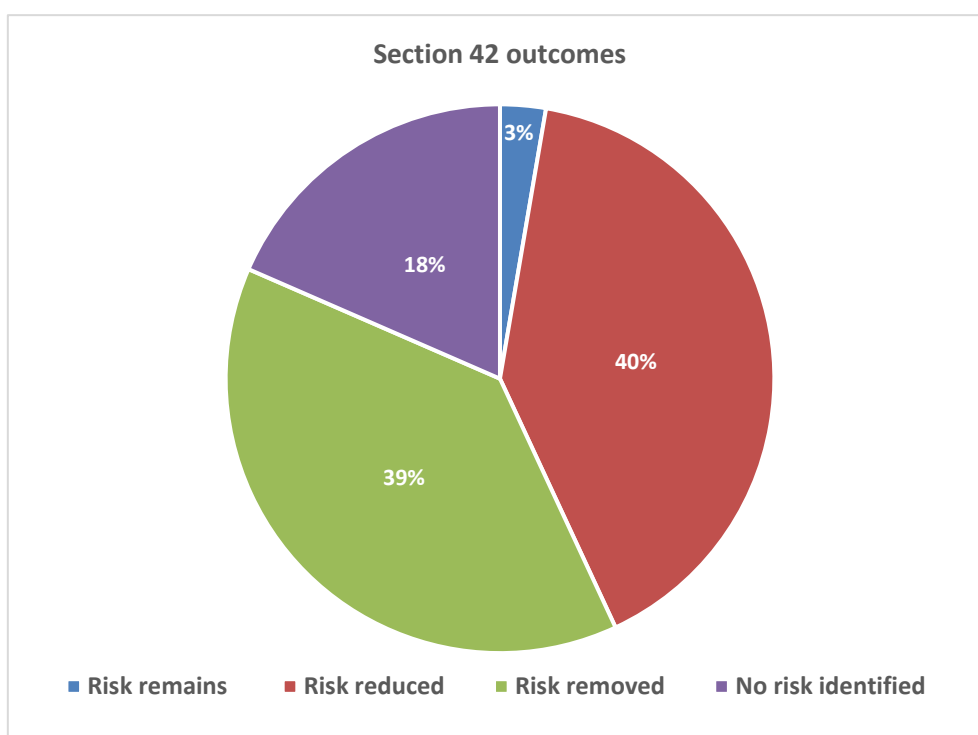
There are currently 3 outstanding Section 42 enquiries for this reporting period. This includes one serious investigation (SI) that is an ongoing investigation and 2 enquiries that require completion. Furthermore, there are an additional 12 reports that have been sent to West Northamptonshire Council and the outcome of the enquiry is still pending.

114 Section 42 enquires were returned to the local authority and the outcomes agreed within the reporting period.

The agreed outcomes of the Section 42 enquiries are as follows;

Outcome	Amount
Risk Remains	3
Risk removed	44
Risk Reduced	46
No Risk Identified	21

The chart below shows that a risk remained in 3% off all enquires. 18% of all enquiries concluded that no risk was identified.



In addition, in 96% of concluded Section 42 enquiries where a risk was identified, the outcome was that the risk was reduced or removed. This is significantly higher than the average in England of 89% (SAC, 2021).

A Section 42 standard operational procedure (SOP) has been produced to provide guidance on the process of a Section 42 Safeguarding Adults Referrals raised against the Trust. The SOP will ensure that all staff are aware of the process, their roles and responsibilities for completing a Section 42 enquiry and the support available to them from the safeguarding team. The SOP also includes a new escalation process and flowchart whereby outstanding reports will be escalated up to senior members of the Nursing Team and is included in this communication for sign off.

Following agreement and publication of the SOP, it is anticipated that all Section 42 enquiries will be completed within the prescribed timeframe of 28 working days.

The outcome of the Section 42 enquiry is then shared with the ward Sister and Matron following closure from the local authority. A database has been commenced by the safeguarding team with any actions and learning identified from the enquiry.

Safeguarding Adult Reviews

During this reporting period one Safeguarding Adult Review referral was made and information provided to Leicestershire & Rutland Safeguarding Adults Board as the patient was a Leicestershire resident, Northampton Safeguarding Adult Board has directed the case to this area. The concerns are regarding the discharge process from Northampton General Hospital and the communication from hospital to the care home regarding pressure sores. There are concerns regarding the development of the pressure sores whilst an inpatient at NGH. The concerns were also made by the family of the patient via a complaint and a referral for a Structured Judgement Review has been accepted to allow for an internal investigation of the concerns raised. Leicestershire and Rutland Safeguarding Adults Board have chosen to use the report as the investigation.

The Safeguarding team continue to implement the agreed actions within the action plan following the SAR publication SAR019, The Safeguarding Review for Jonathan. This includes the initiation and participation within Adult Risk Management (ARM) meetings, engaging with partner agencies regarding homeless prevention and to ensure that discharge processes are improved for patients who are experiencing homelessness. The full report can be accessed at:

<https://www.northamptonshiresab.org.uk/Documents/SAR019%20-%20Overview%20Report%20-%2002.03.21%20-%20Final%20v3.pdf>

Training

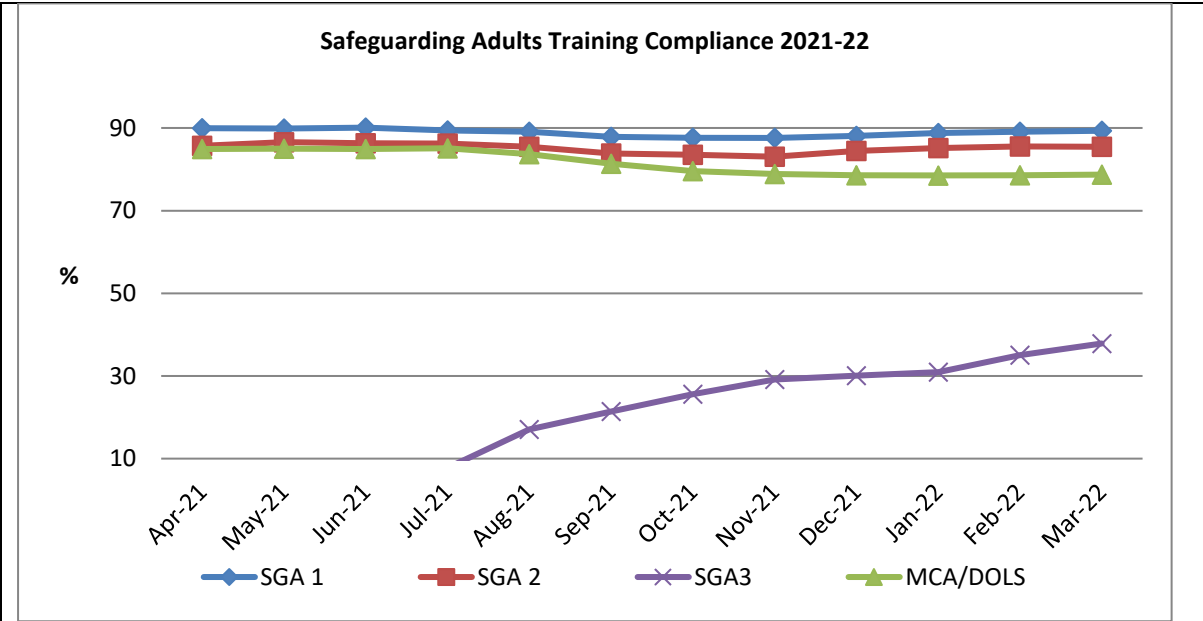
The safeguarding teams remain committed to training and educating staff to ensure they are aware of their roles and responsibilities to reporting any safeguarding concerns and the consequences of not reporting or sharing information.

The team are passionate about providing training that is meaningful and one that empowers staff to give them the knowledge and skills to understand their roles and responsibilities of safeguarding.

Within the reporting period, face to face training was reintroduced for a short period. However, with the increase of COVID-19 and the social distancing measures in place the decision was made to present face-to-face training virtually via Microsoft Teams. This therefore allowed a higher number of staff to attend the training due to there being no restrictions on numbers able to attend the session. Moreover, it was predicted that this would then also allow the compliance to increase and meet the target faster.

A range of alternative training programmes have been offered to encourage training compliance. This includes e-learning, workbooks, and reflective accounts. This also meets a range of learning styles for staff members.

The chart below highlights the safeguarding adult training compliance over the year of 2021/22



Safeguarding adults level 1 training has continued to remain above the expected compliance level. However, safeguarding adult level 2 marginally dropped just under compliance for four months during the reporting period.

The intercollegiate document published in 2018 states that all registered health care staff who engage in assessing, planning, intervening and evaluating the needs of adults when there are safeguarding concerns all need to be level 3 trained.

Therefore, level 3 safeguarding adults training was initially rolled out in August 2021. At present, due to the training analysis undertaken at the end of 2020, there are 613 staff identified as requiring level 3 training within the organisation.

Level 3 safeguarding adults training was initially presented face-to-face, however, as previously mentioned this was then changed to virtual training via Microsoft Teams. The current Level 3 safeguarding adults training day is an eight-hour day and consists mainly of external speakers who are experts in their own right. The current package includes specialists from domestic violence, the Local Authority, PREVENT, modern day slavery and fire and rescue service which includes hoarding as a self-neglect element of safeguarding.

The initial training trajectory indicates that the target of 85% compliance would be achieved by 31st March 2023. However, with the current numbers attending continuing to increase it is predicted that compliance will be met a lot quicker than initially expected.

Training Trajectory 2022 to 2023

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Staff trained	257	32	32	32	32	32	32	32	32	32	32	32

The feedback gained from attendees has been extremely positive and well received by staff. Staff are asked to provide feedback regarding subjects that they would find beneficial to their role.

Modern day slavery was the highest requested subject for a number of months and therefore a session is now within the day.

In addition, the safeguarding adults team deliver personalised training sessions for the Health Care Assistant induction, International Nurses induction and the Band 6 development day.

Mental Capacity Act

The safeguarding team continues to undertake audits regarding the compliance and application of the MCA in practice, which has then been presented to the SAG. The audit also forms part of the Trust quality schedule, which reports to the CCG.

The audit results over this reporting period continue to be consistent with previous years and have highlighted that the application of the principles of the Mental Capacity Act when making undertaking assessments are not always clear. Also record keeping and information sharing in relation to assessments and best interest's decisions was variable.

An MCA steering group has subsequently been established. This includes members from the safeguarding team, patient safety, specialist nurses, occupational and physiotherapy and a representative from Kettering General Hospital (KGH) safeguarding team.

The Mental Health and Mental Capacity Act Lead Practitioner has continued to deliver the bespoke training package established in response to a comprehensive investigation which highlighted poor application of the MCA. This is offered to all staff on a monthly basis.

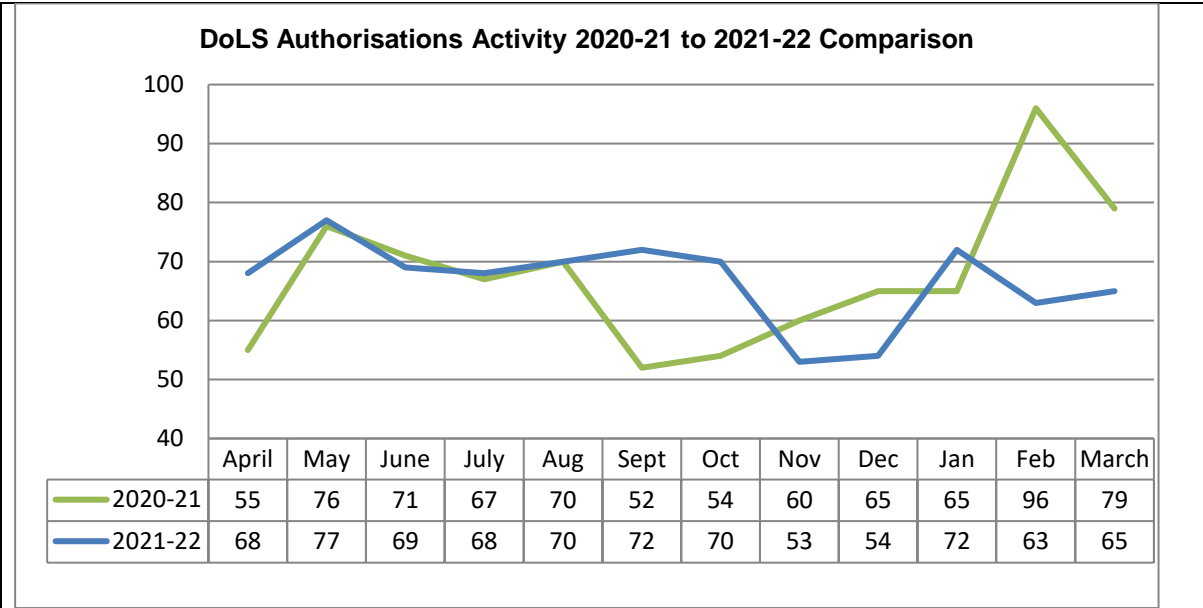
An Independent Mental Capacity Advocate (IMCA) supports people when they are assessed to lack capacity to make a best interest decision and they do not have family or friends appropriate to consult about the decision. During the reporting period the Trust made 16 referrals for an IMCA compared to 12 in 2020/21. There is a request from the Safeguarding Adult Board to consider referring more patients for an IMCA.

The Liberty Protection Safeguards (LPS) and Deprivation of Liberty Safeguards (DoLS)

The Liberty Protection Safeguards (LPS) will supersede the Deprivation of Liberty Safeguards (DoLS) in the near future. A consultation on LPS guidance has been issued and a response has been given by the safeguarding adults leads and Associate Director for Safeguarding. Once the consultation is published, it will be embedded into the trust practice.

The changes include the management of the process and Northampton General Hospital will manage the whole process instead of reporting to the Local Authority. This is expected to have an impact on staff's time and will also have resource implications. Work for this will be in conjunction with the safeguarding adult leads and the Mental Health and Mental Capacity Lead Practitioner who works within the safeguarding team. The safeguarding team will continue to attend LPS steering groups to ensure there is consistent implementation across the county and health partnerships.

Deprivation of Liberty Safeguards applications in the Trust have seen a slight decrease in 2021/22. There were 802 DoLS applications in the Trust during the reporting period against 809 in 2020/21. The below chart shows the applications made and the comparison of the two reporting periods.



The Trust continues to request Best Interest Assessments from the Local Authority under the legislative framework. Only one best interest assessment was carried out in February 2022.

Prevent

Prevent forms part of the Counter Terrorism and Security Act, 2015 and is concerned with preventing children and vulnerable adults becoming radicalised into terrorism. NHS Trusts are required to train staff to have knowledge of Prevent and radicalisation and to spot the vulnerabilities that may lead to a person becoming radicalised. The purpose of Prevent is for staff to identify and report concerns where they believe young people or adults may be vulnerable to radicalisation or exploiting others for the purposes of radicalisation. The Named Nurse for Safeguarding Adults is the Prevent lead for the Trust.

The Named Nurse will make referrals and attends the Local Authority Channel panel when appropriate. This multi-agency panel discusses the risk posed by vulnerable people who are referred for multi-agency support.

All NHS Trusts and Foundations Trust are required to submit Prevent data to NHS England and NHS Improvement. This is submitted on a quarterly basis. All staff members are required to receive basic awareness Prevent training and the Trust has achieved 86% compliance.

The Named Nurse for safeguarding adults receives information gathering requests for completion. This is the sharing of information held by NGH regarding the risk that an individual may pose for discussion at the Channel Panel. 56 information gathering requests were completed during the reporting period.

Colleagues from the Special Branch, Counter Terrorism Policing deliver a session to staff at safeguarding adults' level 3 training. This has consistently been the most valued session of the day captured on the feedback.

Modern Slavery

Modern slavery is a complex but largely hidden crime. In England and Wales, modern slavery is used as an umbrella term that covers several different forms of exploitation which can include human trafficking, labour exploitation, criminal exploitation, sexual exploitation, and domestic servitude.

Modern slavery is incorporated within the safeguarding children and adult mandatory training from levels 1 -3, which applies to all staff employed by the Trust.

Due to the increase in modern day slavery and the current associated risks of human trafficking and exploitation related with the war in Ukraine, Northamptonshire Police are now delivering a one hour session to staff at safeguarding adults level 3 training. This has been greatly received from staff.

Maternity Safeguarding

During 2021 to 2022 the maternity safeguarding service has seen immense challenges and changes. At the beginning of the year, we were still in COVID, the Named Midwife went on maternity leave and due to unforeseen circumstances, the interim role was not in place until March 2022. There were also several changes to the Head of Safeguarding position and a gap.

The new Associate Director of Safeguarding did not come into post until February 2022. As well as these challenges there have been staffing issues in maternity more widely which has impacted on the ability of staff to undertake their roles as cover has been provided specifically with safeguarding external meetings in order for NGH to complete its statutory role.

The annual report for midwifery is therefore completed with the senior staff who were not in post at the time.

The data for the referrals can be seen in Appendix 1. There is an increase in the complexity of the safeguarding referrals.

During the reporting period there was a gap for the unborn tracking meetings, however they have been reinstated and continue to take place on a monthly basis with the local authority and health visitors. The meetings are proving are very beneficial in discussing safeguarding concerns with the local authority early and putting plans in place

Maternity Supervision

Safeguarding supervision remains a priority within the Maternity Safeguarding Team, however due to staff covering statutory safeguarding meetings. The number of people being supervised at any one time is reduced.

In addition, Midwives are offered adhoc supervision by the Maternity Safeguarding Team daily. The Maternity Safeguarding Team also receive a significant number of calls daily whereby support, and advice is given.

Training Update

A new safeguarding training strategy has been signed off by the Safeguarding Assurance Group, and the Quality Group who have agreed for the safeguarding children to be 3 yearly

in line with national guidance and KGH strategy. This will make staff at NGH Level 3 children's safeguarding compliant. There is one final discussion required at the weekly executives meeting, before the figures can be updated.

Female Genital Mutilation (FGM)

NGH continue to identify women with FGM during their booking consultation. The Named Midwife reviews the records for these women when the booking report is received to ensure that the Midwife has completed the FGM risk assessment form and paediatric liaison form or MASH referral, depending on the level of risk identified, and NGH is compliant with their duty for reporting.

Did Not Attend (DNA) Guideline

The Named Midwife and Clinical Effectiveness and Audit team made significant amendments to the DNA Guideline during 2021.

In brief, the following changes have been made for all women;

- Alert to be placed onto the woman's electronic records to signify to all professionals that the lady has DNA (did Not Attend) an appointment,
- Paediatric liaison form to be circulated to professionals supporting the woman to notify them when the woman does not attend 2 or more appointments,
- A home visit to be completed within 72 hours of third DNA appointment.

The following changes have been made for women with safeguarding concerns who DNA appointments.

- MDT or Adult Risk Management (ARM) meeting to be held for women with known safeguarding concerns
- distribution of safeguarding alerts for women with safeguarding concerns, including neighbouring hospitals and ambulance alert
- If termination of pregnancy (TOP) is suspected, written confirmation should be received from BPAS prior to the pregnancy being closed on Maternity Medway

Baby Abduction Policy / Exercise

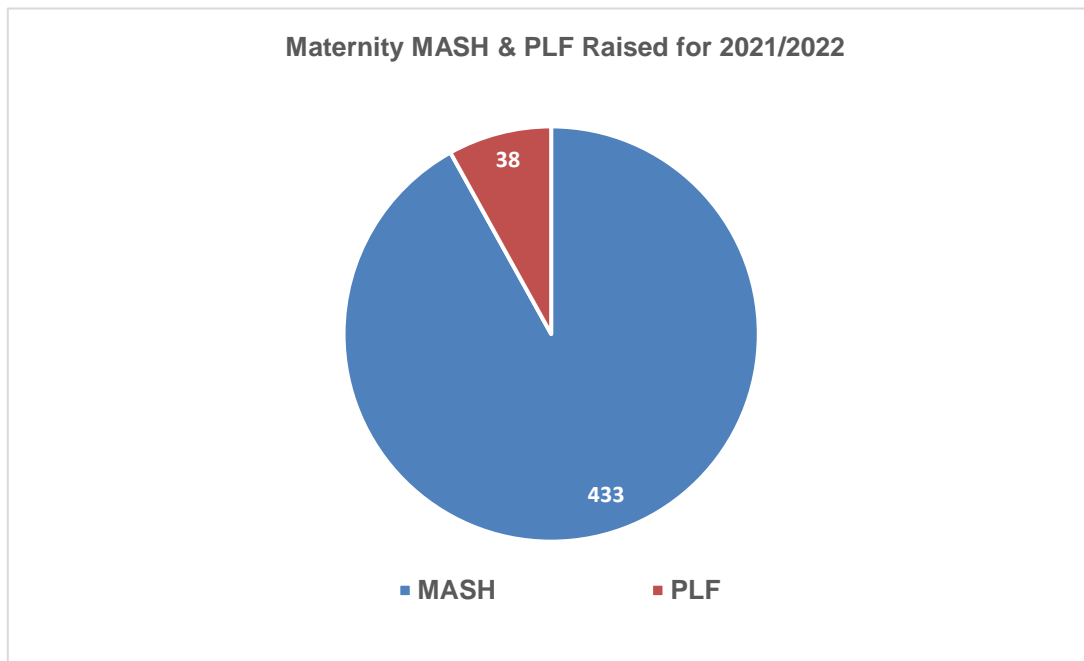
There was also a Baby Abduction Exercise completed during this reporting period. This included The Named Midwife for Safeguarding completing a face-to-face child abduction drill exercise with several midwifery professionals over two days (from 28/7/21-29/7/21). During this time, 31 professionals completed the exercise which included staff working day and night shifts.

The Named Midwife discussed the following acronym to help raise awareness of actions required, should a baby abduction or attempted abduction take place at NGH.

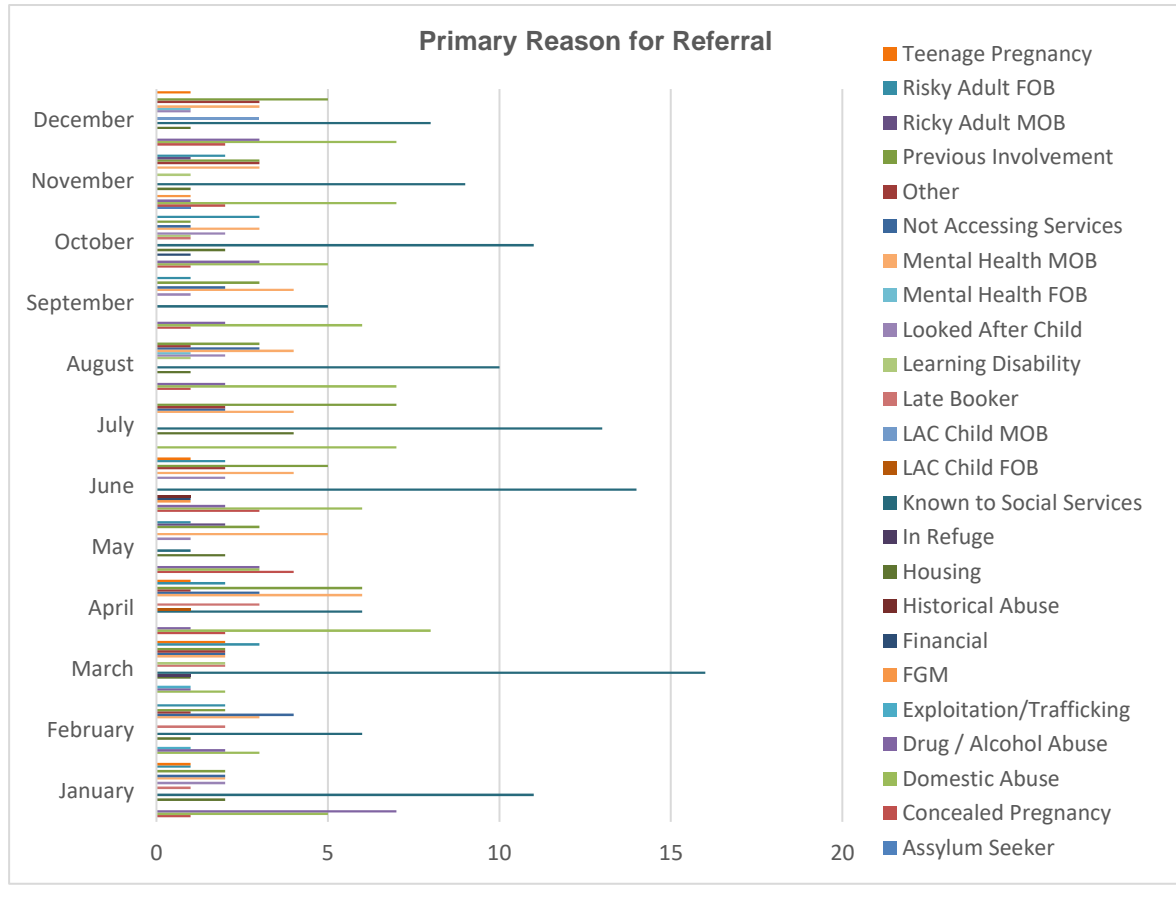
In addition, all maternity staff were sent out a 5-minute presentation devised by the Named Midwife which talked through the abduction/ attempted abduction of baby or child policy at NGH (PO-1117).

Activity

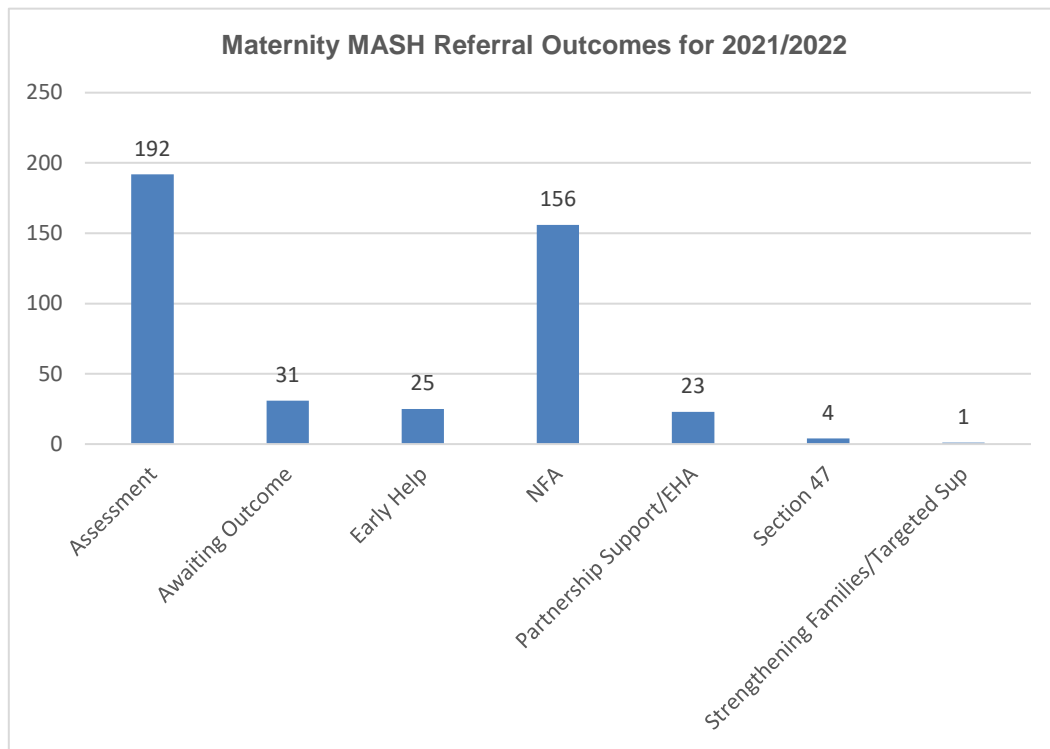
The chart below highlights the numbers of MASH & Paediatric Liaison Forms (PLFs) Referrals raised for the period of 2021-22



The chart below shows the primary reason for referrals made



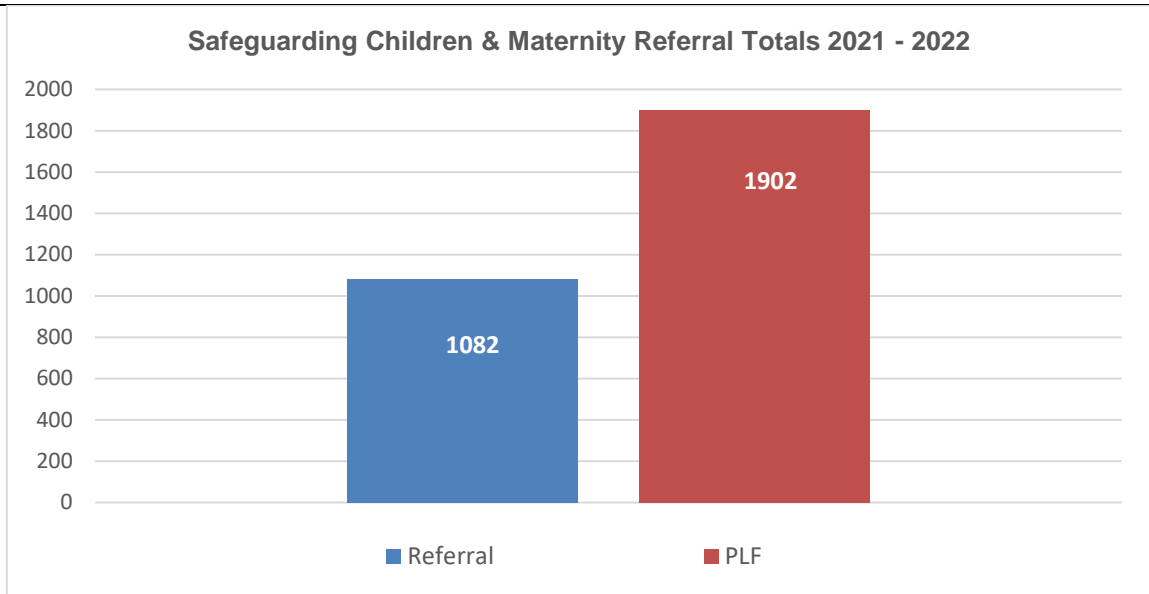
The chart below highlights the Maternity MASH Referral Outcomes for 2021-22



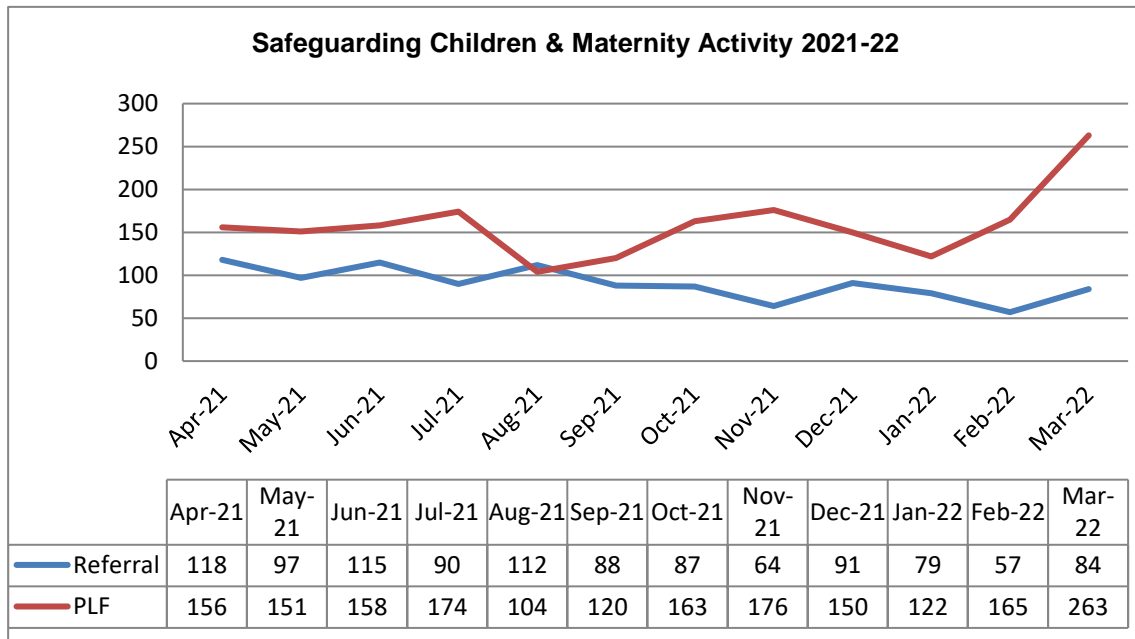
Safeguarding Children

As previously outlined there have been challenges in terms of staffing and COVID during this annual report. For the children's safeguarding area there was a vacant named nurse for safeguarding children position for a significant period of time and there is a gap for the paediatric liaison nurse position due to maternity leave. This has meant that the service has been more reactive during this year responding to the safeguarding cases arising and fulfilling NGH's statutory responsibility for safeguarding.

There have been a total of 1082 Multi-Agency Safeguarding Hub (MASH) referrals during 2021/2022 some 438 more than the previous year of 644. This is considered to be attributable to a significant increase in ED attendances and admissions of children and young people due to relaxation in covid measures.

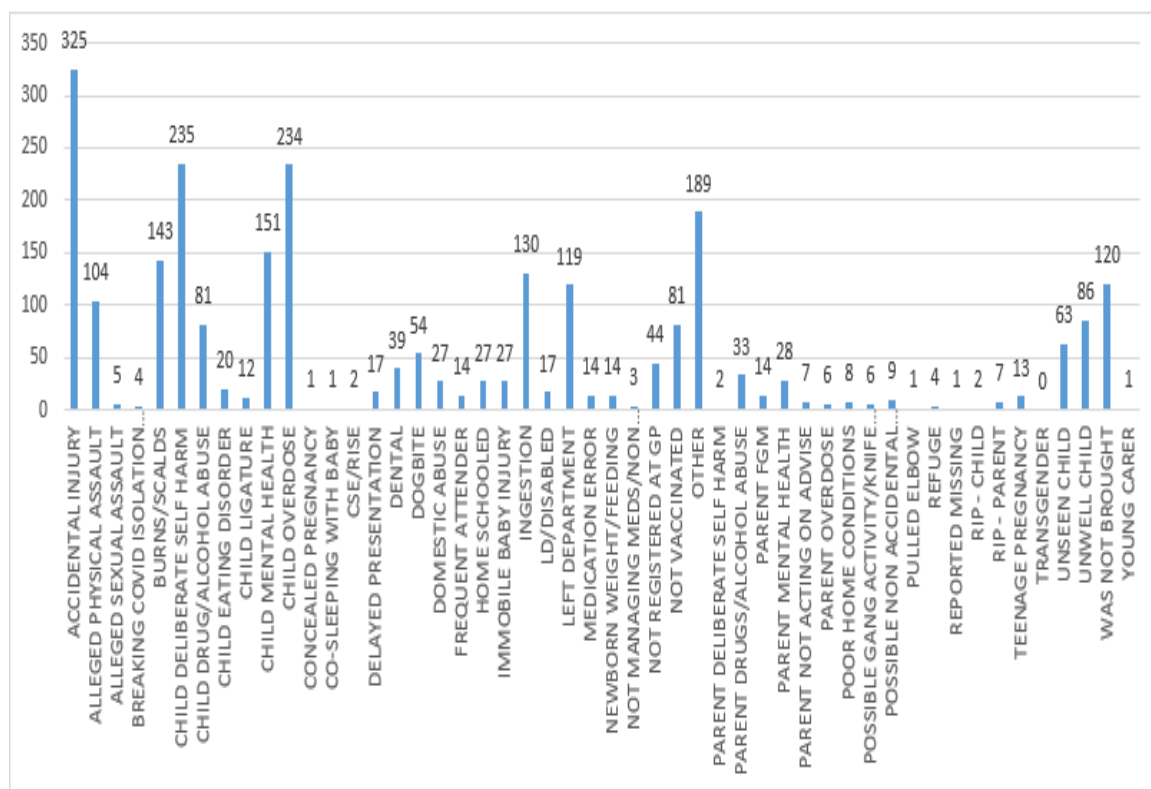


The chart below presents the safeguarding activity across the reporting period



There were 1902 paediatric liaison forms (PLF's) completed which shows a significant increase of 1211 more than the previous year of 691 potentially due to the relaxation in the covid isolation measures. This evidence good practice in terms of timely information sharing and liaison with external health colleagues i.e. GP's, health visitors, school nurses, LAC CAMHS. Although there has been a delay in sending the PLF's during the staffing shortage periods.

The bar chart below presents the primary reason for MASH Referrals and Paediatric Liaison Forms by the Trust. However, there will often be multiple concerns or reasons for statutory intervention.



The graph evidences the deterioration in the mental wellbeing of children and young people presenting to hospital with deliberate self-harm, child mental health concerns, including suicidal ideation, and child overdose. The combination of these presentations account for 26.9% of the MASH/PLFs raised by the Trust during the reporting period 2021/2022, over one quarter of the total referrals.

The demand upon existing services and agencies following an escalation in referrals presents challenges due to finite resources which has resulted in some prolonged hospital admissions whilst mental health and specialist inpatient beds are sought both locally and nationally. Work is also underway to support children who are self-harming and have suicidal ideation.

The 325 attendances for accidental injury informs future audit to see if there is any correlation between preventable accidents and the reduction in key public health messages with the revision of Health Visiting service

Paediatric Liaison Nurse (PLN)

The Paediatric Liaison Nurse (PLN) is the vital link between the Trust, community health services and social care colleagues ensuring pertinent and timely safeguarding information about children aged 0-19 years is shared and exchanged with the professionals.

The role of the PLN ensures that the ED child attendance lists are scrutinised on a daily basis to ensure MASH referrals and PLF's are raised appropriately mitigating risk whilst ensuring the Trust's statutory responsibilities are discharged in promote the safety and welfare of children.

Designated Officer (LADO)

The Designated Officer (formerly known as the Local Authority Designated Officer or LADO) at Northamptonshire County Council is informed by the Trust of all cases in which it is alleged that a person who works with children has behaved in a way that has harmed or may have harmed a child or behaved in a way that indicated they may pose a risk to children. There has been one reported case to the Designated Officer in the reporting period.

Child Safeguarding Practice Reviews (CSPR's)

The CSPR's for this annual report include Child Bb who appeared to be a healthy baby, born to a teenager with engagement from the FNP. Child Bb did not wake at the usual time on the morning of the incident and mother allowed the baby to sleep. She then checked the baby around lunchtime to find the baby lifeless. Child Bb had been sleeping in a Moses Basket and appears to have died of natural causes.

The Safeguarding Midwifery team were proactively involved in the CSPR for Child Bi who sadly died in November 2021. This CSPR is ongoing