

## 2020-21 Safeguarding Adults and Children Annual Report

### 1.0 Background / Introduction

- 1.1 The annual report summarises safeguarding work undertaken across the Trust and demonstrates to the Trust Board and external agencies how ELFT discharges its statutory duties and responsibilities in relation to Section 11 of the Children Act 2004 and the Care Act 2014.

The report outlines safeguarding activity across the Trust and highlights the achievements, challenges and priorities during the year. This is in accordance with the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (NHSEI, 2019). The framework provides an assurance that service users and their families are effectively protected.

All safeguarding work across the Trust is underpinned by our Trust values:



Staff are supported to work in partnership, and to respond proportionately and appropriately to safeguarding concerns for children, young people and adults at risk who access services across ELFT in accordance with their statutory responsibilities:

- 1.2 The Trust operates from the following Boroughs:

- Tower Hamlets
- City of London
- Hackney
- Newham
- Richmond
- Luton
- Bedford Borough
- Central Bedfordshire

- 1.3 The Trust employs 6939 permanent staff. The mixed demographic profile of the trust results in a range of adult and children safeguarding issues that require an individual response based on local partnership arrangements.

## **2.0 Governance and Accountability arrangements**

- 2.1 The Chief Nurse is the Executive Director for safeguarding who provides leadership in overseeing and steering safeguarding arrangements. The Director of Nursing has strategic responsibility for the safeguarding children and adult functions supported by the Associate Directors for Safeguarding Adults and Children.
- 2.2 The Chief Nurse and Director of Nursing have delegated responsibilities for safeguarding leadership, ensuring that the Trust safeguarding strategy is aligned to local safeguarding children partnership and safeguarding adult board priorities.
- 2.3 The Associate Directors of Safeguarding and Domestic Abuse (Adults and Children) provide operational leadership and co-ordination for the corporate safeguarding teams.
- 2.4 Named professionals for safeguarding are allocated to each borough, though provide corporate cover across the service (Appendix 1 and 2).

## **3.0 Quality Assurance**

- 3.1 All health providers are required to have effective arrangements in place to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators and their commissioners that these are working (Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework. NHSEI, 2019).

This includes:

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable children as appropriate.
- A suite of safeguarding policies and procedures that support local multi-agency safeguarding procedures.
- Effective training of all staff commensurate with their role and in accordance with the intercollegiate competences for Safeguarding children and adults.
- Effective supervision arrangements for staff working with children / families or adults at risk of abuse or neglect.
- Effective arrangements for engaging and working in partnership with other agencies.
- Developing and promoting a learning culture to ensure continuous improvement.
- Identification of named safeguarding professionals.

- Developing an organisational culture where all staff are aware of their personal responsibilities for safeguarding and information sharing.

#### **4.0 Assurance Framework**

- 4.1 The Trust has an internal assurance process. This includes a bi - monthly Safeguarding Committee which reports to the Quality Committee. The safeguarding committee has a performance and quality assurance role and monitors the annual work plan. (Appendix 3)
- 4.2 Each directorate has a lead manager representative at the safeguarding committee to ensure that safeguarding priorities are embedded at an operational level and feeds back to their local quality assurance group. Each service directorate considers safeguarding children and adults regularly at their Directorate Management Team meetings.
- 4.3 In recognition of the safeguarding complexities in relation to social care delegated responsibilities, Luton and Bedfordshire hold an internal monthly Safeguarding Assurance Group, to monitor activity across safeguarding adults and children. The group is attended by senior managers from CAMHS, Adult Mental Health and Addictions services as well as the safeguarding children and adults named professionals.

#### **5.0 Partnership working**

- 5.1 The new arrangements of Local Safeguarding Children Partnerships replacing Local Safeguarding Children Boards are now embedded within each area.
- 5.2 The Trust is committed to working in collaboration with all partners seeking to protect adults and children at risk from harm caused by abuse or neglect, regardless of their circumstances. As part of these arrangements the Trust is represented at seven Safeguarding Adult Boards and Safeguarding Children Partnerships covering the local authority areas where ELFT has a presence. The local safeguarding partnerships look at areas of concern for their local populations. Our services work in partnership to address these identified areas. These partnerships also have an assurance function that ELFT reports into.
- 5.3 Operational Directors or their representatives supported by the Associate Directors for Safeguarding attend the local Adult / Children Safeguarding Partnership meetings and contribute to the strategic development and objective setting with regard to local accountability and assurance. Any actions and deliverables are reported at the Trust's Safeguarding Committee.
- 5.4 The Associate Directors and Safeguarding Named Professionals are proactive on the local Safeguarding Partnership subgroups ensuring the Trust is linked in at all levels to multiagency developments and assurance. Named Professionals contribute to multi-agency and single agency audits in their local boroughs of operation.

5.5 There have been safeguarding adult reviews, child safeguarding practice reviews, domestic homicide reviews, learning disabilities mortality reviews, channel panel, PREVENT/CONTEST boards and serious incidents which the safeguarding team has been representing in the reporting year.

## **6.0 COVID-19 arrangements**

6.1 The safeguarding team implemented their business continuity plan at the start of the pandemic onwards to ensure that safeguarding remained a core function of the trust despite restrictions caused by the pandemic. Each business continuity plan has been reviewed and updated throughout the year accordingly.

6.2 The safeguarding children and adults teams continue to run a duty system of named professionals, operational 0900-1700hrs Monday to Friday. This ensures that staff from across the trust have access to a named professional for safeguarding children and adults for any advice and support should there be any absence of direct cover for a locality.

6.3 Government advice and Trust policy has been adhered to throughout the pandemic and relevant Trust policies were updated to address the Covid-19 pandemic.

6.4 The safeguarding team started sending out additional guidance to staff managing safeguarding cases.

6.5 The team also developed Domestic Abuse leaflets and cascaded this to staff to raise awareness and signposting.

6.6 The safeguarding team also arranged for the Domestic Abuse responder course in response to the Covid-19 pandemic because of the increase of Domestic Abuse cases.

6.7 When offering advice the Named Professionals provided guidance around virtual assessments and what to look out for when doing face to face visits.

6.8 The audit arrangements continued during the pandemic and the safeguarding team raised staff awareness about the new forms of online abuse and scams targeted towards children, adults and the elderly population.

6.9 All safeguarding meetings were arranged online and it helped to achieve better attendance and participation of staff and service users.


- 6.10 Safeguarding children/adult supervision has continued to be delivered via virtual platforms across the service enabling the safeguarding team to maintain good working relationships with staff in each Borough. The change from face to face to virtual delivery has not impacted on staff attendance and feedback received into the quality of supervision has been positive.
- 6.11 The safeguarding team have engaged with wider partnership teams to ensure that key updates between services are shared and emerging risks caused by the situation are identified and responded to.
- 6.12 All face to face safeguarding training has been cancelled since the start of the pandemic and replaced with virtual and online training.
- 6.13 In the early stages of the pandemic it was hoped that this would be a short lived pause and that face to face would be able to recommence without a long delay. When it became apparent that this was not the case work began on implementing a new training package, working in collaboration with the training and development department to identify a digital solution and in training the team to facilitate virtual teaching. Licenses were procured for the safeguarding teams to facilitate this using zoom pro.
- 6.14 All Safeguarding training moved to virtual sessions. This new training process has been well accepted by the entire staff group and the attendance at training is good. The feedback received from staff remains positive.

## **7.0 Safeguarding Training Compliance**

- 7.1 The Trust has a Safeguarding Children's Training Strategy and Training Needs Analysis in place which is based on the Intercollegiate Document, Safeguarding Children and Young People: Roles and Competencies for Health Care Staff. Fourth edition (2019) and Adult Safeguarding: Roles and Competencies for Health care Staff. First edition: August 2018. The strategy outlines the levels of training staff require to be compliant and frequency of training.
- 7.2 The training plan incorporates safeguarding children, adults, domestic abuse and PREVENTS training. The aim of high quality training is to improve practice and service provision.
- 7.3 Following the publication of the Safeguarding Adult Intercollegiate document 2018 the number of staff requiring level 3 trained has increased significantly. Staff is required to be fully compliant by 2021.
- 7.4 The updated Intercollegiate Document for children had a significant impact on the safeguarding level 3 training compliance especially for the adult mental

health workforce, with 1125 members of staff being re-mapped to receive level 3 safeguarding training from the 3<sup>rd</sup> February 2020. The pandemic has impacted gains in the training trajectory planned to account for this.

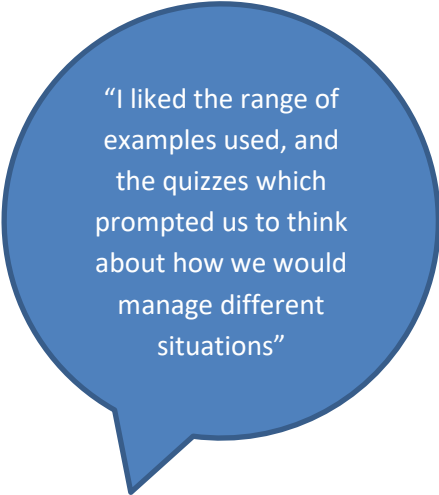
- 7.5 Training provision was increased to mitigate for this. However, due to restrictions caused by the pandemic, was not able to be delivered as planned.
- 7.6 Level 1 and level 2 safeguarding children and adult training is completed via an online package. A reduction in numbers from last year is attributed to staff shielding or working from home having difficulties accessing online content. The training and development department have been proactive in supporting members of staff to overcome these issues.
- 7.7 The trusts level 3 Adult Safeguarding training significantly improved since the last reporting period from 56% to 67%. The compliance for level 3 safeguarding children has decreased slightly from 67% to 60% in the same period. It has been recognised that the Trust is not set to meet trajectory of compliance, and the safeguarding children team are working with operational teams using QI methodology to improve uptake
- 7.8 The Trust compliance with WRAP (Workshop to Raise Awareness of Prevent) training has decreased slightly from 91% to 89%. This may perhaps be due to the Covid-19 pandemic where staff was busy and overworked along with high rates of sickness that could have potentially caused the training numbers to drop. This is being addressed with services.
- 7.9 The safeguarding adults boards and safeguarding children partnerships also provide multi-agency training and ELFT staff are encouraged to access this training. There was a pause in delivery from some partnerships due to the pandemic, but most are now delivering a program of virtual training. A QI project has been started looking into ways the uptake of the training offer can be increased.
- 7.10 The feedback from the training delivered has been highly positive. This has included:



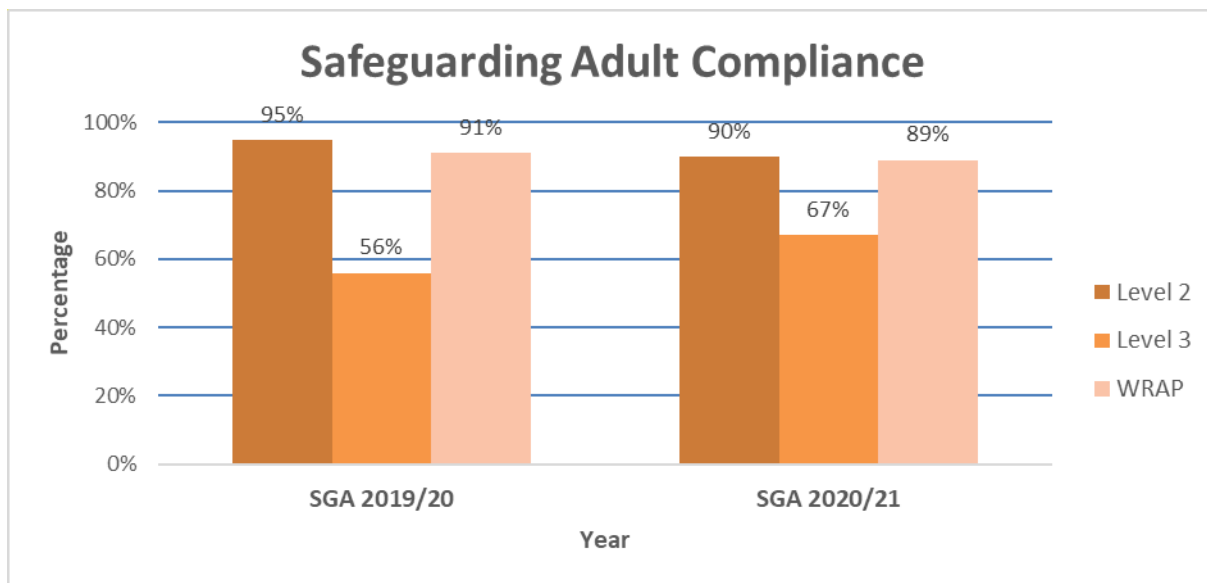
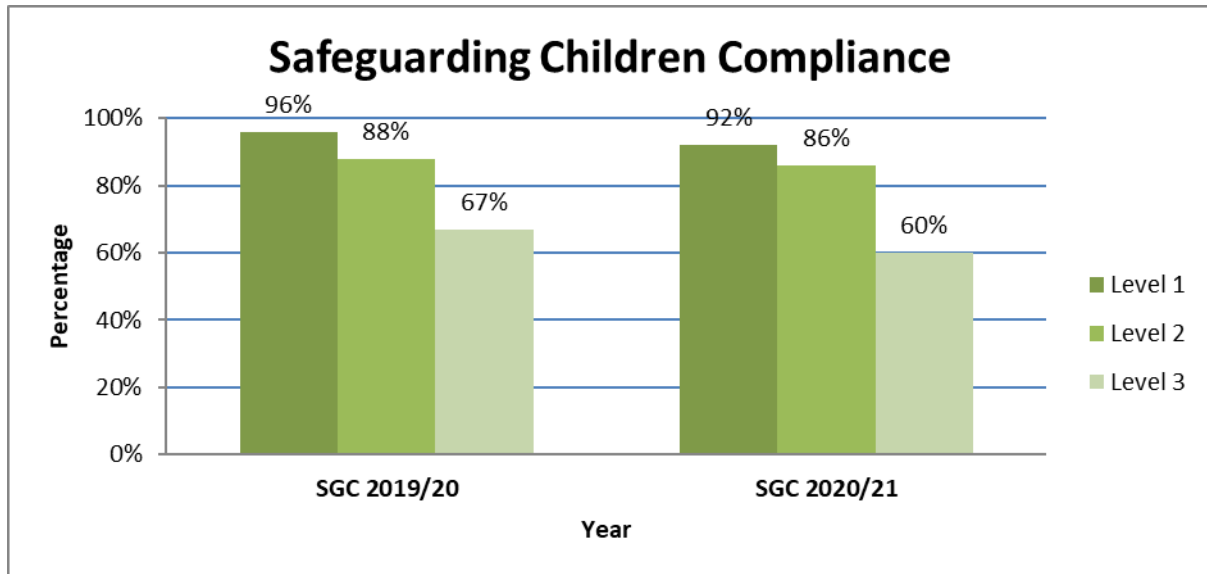
“Understanding how my adult service user’s presentation might impact children around them”



“Very clear info and appropriate level of detail, good mix of media - videos and text, presenters very warm and relatable! Sensitive discussion of dilemmas and ethical



“I liked the range of examples used, and the quizzes which prompted us to think about how we would manage different situations”



## 8.0 Safeguarding Supervision

8.1 Safeguarding children supervision is provided in line with the safeguarding children supervision policy. Effective supervision should provide opportunities for learning and discussion, provide protected time to think, explain and understand safeguarding concerns, help practitioners cope with the emotional demands of the job and help workers identify unknown issues or offer a new angle on complex issues. The quality and effectiveness of safeguarding children supervision is audited and monitored by the Trust Safeguarding Committee, as is representation across the services.

- 8.2 Safeguarding supervision for staff working within adult services is not a mandatory requirement. However the Named Professionals offer safeguarding supervision to adult facing staff on a regular basis which is well received by the staff members. The adult professionals received an increased number of requests for safeguarding supervision due to a number of staff working from home and needing advice when carrying out assessments and interventions.
- 8.3 The safeguarding team facilitates a number joint safeguarding supervision sessions to relevant services wherein the named professional for children and adults will provide joint safeguarding supervision to staff members. This provides staff an objective perspective to help them “think family” and to recognise the impact that parental and family behaviours have on children and young people and vulnerable adults.
- 8.4 Regular supervision sessions are held by named professionals for safeguarding and a record of the minutes of meetings and an action plan are provided to the staff.
- 8.5 The safeguarding team provides group, one to one and ad-hoc safeguarding supervision including telephone advice to staff across the Trust to ensure effective support and guidance is available to staff appropriate to their roles. Data collection tools have been developed to provide a broader picture of safeguarding themes discussed at supervision. A full year’s data should be available for the 2021-22 report.

## **9.0 PREVENT Duty**

- 9.1 PREVENT forms part of the Counter terrorism and Security Act, 2015 and is concerned with preventing children and vulnerable adults becoming radicalised and drawn into terrorism. NHS Trust is required to train staff to have knowledge of PREVENT and radicalisation and to spot the vulnerabilities that may lead to a person to becoming radicalised.
- 9.2 The purpose of PREVENT is for staff to identify and report concerns where they believe children, young people or adults may be vulnerable to radicalisation or exploiting others for the purposes of radicalisation.
- 9.3 The trust submits a quarterly return to the Regional Prevent Co-Coordinator and NHS England. The data submitted monitors the key elements of the prevent duties and responsibilities which include:
- Identification of PREVENT Leads- Strategic and Operational
  - Delivery of training
  - Levels of referrals made via the Channel process
  - Representation and engagement with local and regional PREVENT leads.
- 9.4 All staff are required to complete basic prevent training. Staff mapped at level 3 Safeguarding Adult and Children training are required to complete WRAP training.



- 9.5 The staff have achieved 89% compliance with WRAP training and 88% compliance with the Basic Prevent training against an expected target of 85%.
- 9.6 In total the trust responded to 219 PREVENT related concerns in 2020-21. This ranges from general enquiries to request by Channel Panel from assessments of people's mental health.
- 9.7 Luton and Bedford received the highest number of PREVENT related general enquiries followed by Tower Hamlets.
- 9.8 Luton also received the highest number of requests for assessments followed by Newham for individual cases when a case was open to Channel Panel.
- 9.9 The trusts Safeguarding team and operational teams attend Channel Panel meeting every month and contributes to the discussions for the panel to make informed decision on cases.
- 9.10 The Associate Director for Adult Safeguarding and Operational Directors attend the PREVENT and CONTEST boards to update them of the work done by the trust and provide inputs to their work plan.

## **10.0 Domestic Abuse**

- 10.1 The cross-government definition of domestic violence and abuse is:  
Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are ,or have been ,intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but not limited to:

- Psychological
- Physical
- Sexual
- Financial
- Emotional

This definition includes honour-based abuse, female genital mutilation and forced marriage, and is clear that victims are not confined to one gender, religion or ethnic group.

- 10.2 The Trust's "Think Family" approach ensures there is a shared vision for an integrated safeguarding approach to improve outcomes for adults, children and families at risk.
- 10.3 There continues to be Trust representation at the local Multi Agency Risk Assessment Conference meetings (MARAC).
- 10.4 The trust safeguarding team has developed and rolled out a number of Domestic Abuse training sessions for the staff to raise awareness and to ensure

early identification of domestic abuse among patients and staff members.

- 10.5 The safeguarding team has also included Domestic Abuse awareness in the new online Level 3 module to which all qualified staff members are mapped.
- 10.6 The trust has also implemented the Domestic Abuse and Harmful practices policy and established a domestic abuse steering group. There has been increased communications and awareness in response to increased prevalence of domestic abuse during the COVID-19 lockdown. The policy was further updated during the Covid- 19 pandemic to include staff members who are victims of domestic abuse.
- 10.7 The trust “Domestic Abuse Steering” group meets monthly to plan and identify areas of work that needs strengthening within the organisation to appropriately respond to concerns of domestic abuse. The meeting is chaired by the Director of Safeguarding and has representatives from various services within the trust and survivors of domestic abuse.
- 10.8 The trust has also provided staff with bespoke Domestic Abuse training is several directorates, to support staff in identifying and addressing the concerns appropriately.

#### **11.0 Safeguarding Adults Learning Reviews (SAR)**

- 11.1 With the implementation of the Care Act 2014 there is a statutory requirement under section 44 to undertake Safeguarding Adult Review (SAR).  
A SAR is about:

- learning lessons for the future
- making sure that Safeguarding Adults Boards get the full picture of what went wrong
- improving the practice of all organisations involved

- 11.2 A SAR is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place.

- 11.3 The purpose of a SAR is not to apportion blame. It is to promote effective learning and improvement to prevent future deaths or serious harm occurring again.

- 11.4 A SAR is commissioned when there is reasonable cause for concern about how SAB members or other agencies providing services, worked together to safeguard an adult if:
- The adult has died, and SAB knows or suspects that the death resulted from abuse or neglect.
  - Whether or not it knew about or suspected the abuse or neglect before the adult died

- The adult is still alive and SAB knows or suspects that the adult has experienced serious abuse or neglect

11.5 The Named Professionals and the Associate Director are members of the SAR sub-group and contributes to the reviews.

11.6 A SAR guidance and protocol has been developed for the trust staff to raise awareness about the SAR process.

11.7 The learnings from the SAR's are incorporated in the Level 3 training and disseminated to staff through away days, in safeguarding supervision and safeguarding newsletters.

11.8 During 2020-21 ELFT was involved in the following SAR's and Learning reviews:

Directorates	Ongoing	Completed	Agreed
Tower Hamlets	3	4	0
Newham	1	1	0
City and Hackney	0	1	0
Luton	1(Thematic review)	3	0
Bedford and Central Bedfordshire	1	1	1

\*Bedford and Central Bedfordshire are joint Safeguarding Boards.

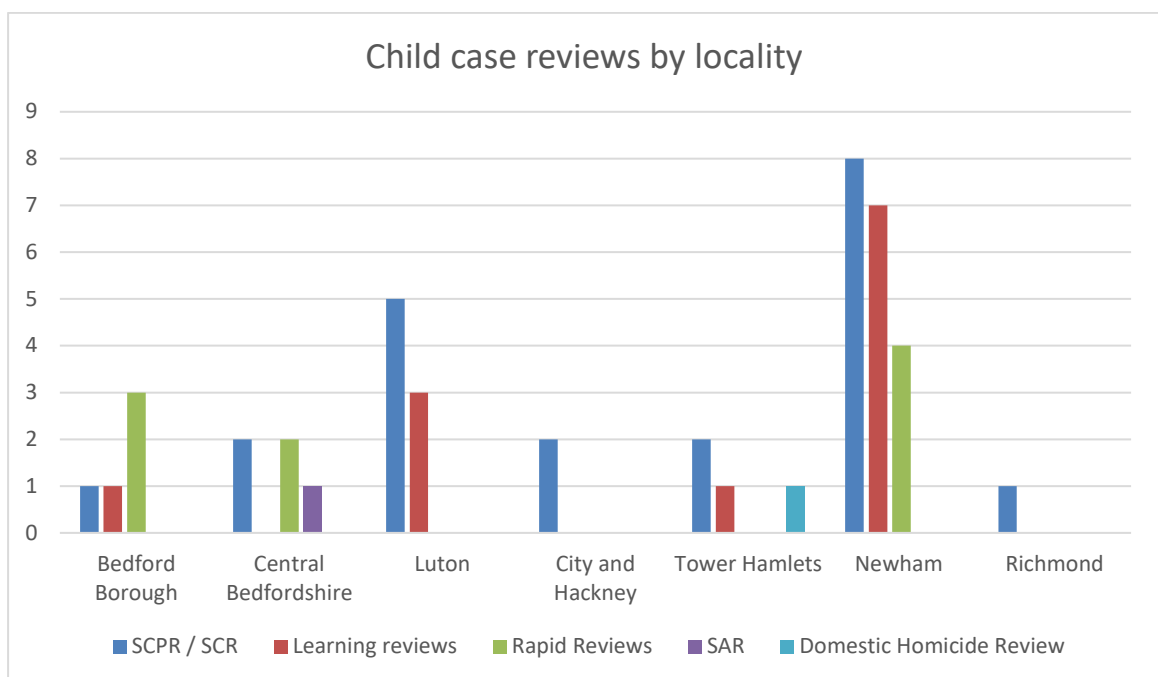
## 12.0 Child Safeguarding Practice Reviews

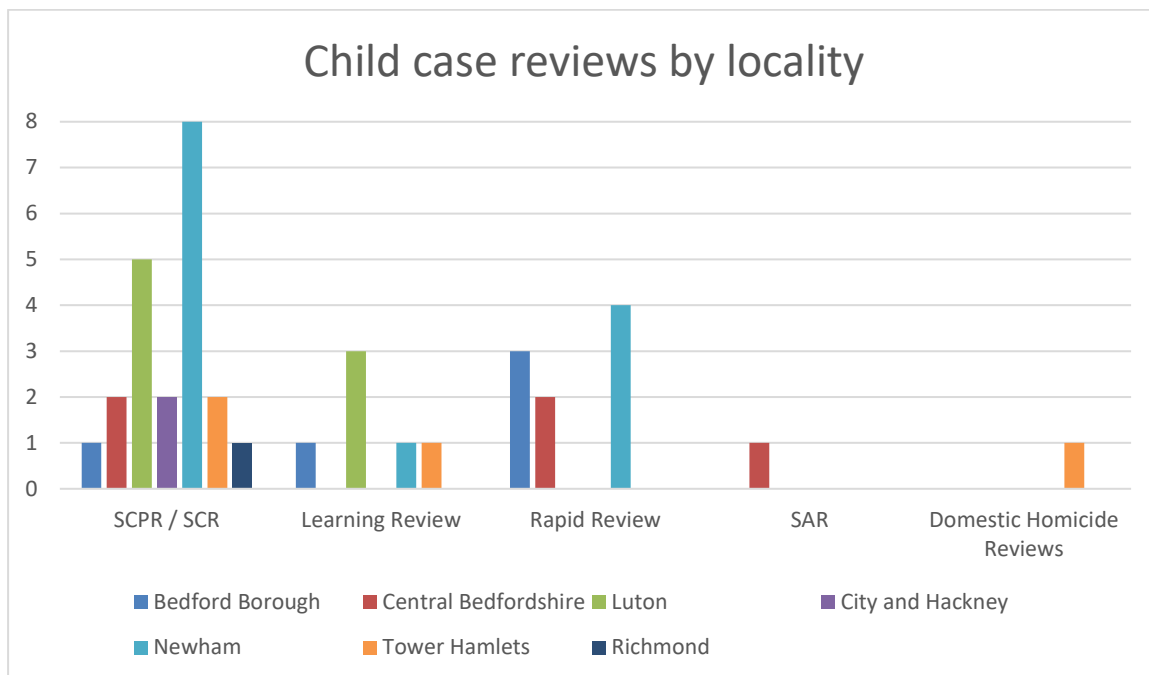
12.1 Due to the changes to partnership arrangements and the case review process, during 2020-21 worked with partners on child safeguarding practice reviews and serious case reviews. Statutory guidance into transitioning arrangements make clear that all serious case reviews needed to be completed and published by 29 September 2020.

12.2 A child safeguarding practice review takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons that can help prevent similar incidents from happening in the future. The new arrangements categorise reviews into those at which there is learning to be disseminated at a national level, and learning which is more suitable to a local area.

12.3 ELFT is represented by a member of the safeguarding team on each of the Local Safeguarding Children Partnership's case review sub-groups to ensure appropriate involvement by the Trust. Trust staff will participate in the reviews through providing information relevant to the case.

- 12.4 Over the past year the safeguarding team has participated in 19 serious case reviews / child safeguarding practice reviews for children known to ELFT services, which is in double last year's figures. The safeguarding team also contributed to 6 learning & thematic reviews, one safeguarding adult review and one domestic homicide review.
- 12.5 A rapid review meeting is held in all cases in order to gather facts about the case, ensure the immediate safety of any children involved, consider potential for any safeguarding improvements and decide on next steps. As well as participating in the rapid review process for the above cases, the safeguarding team were involved in 9 further rapid reviews in which it was identified that the threshold for further steps are not met, that sufficient learning had been gained from the rapid review process or that any learning identified is being actioned by the partnership already.
- 12.6 The distribution of serious incidents across the localities is represented in the below graphs. The majority of the cases in Newham are related to serious youth violence and concerns of sexual exploitation within the children looked after cohort.





12.7 The Safeguarding Committee receives updates on all safeguarding practice reviews and learning reviews and action plans are monitored at this meeting. The final reports are published by the respective local Safeguarding Children Partnerships or NSPPC and are available on their websites once complete.

12.8 Priorities across the safeguarding children partnerships include:

- Neglect
- Domestic abuse
- Mental and emotional health and wellbeing of children and families
- Contextual safeguarding
- Sexual and criminal exploitation
- Internet safety
- Health and wellbeing of safeguarding workforce
- Getting the basics right
- The appetite to learn

### 13.0 The Learning Disabilities Mortality Review

13.1 Following the ‘Confidential Inquiry into premature deaths of people with Learning disabilities’ (CIPOLD), NHS England launched the Learning Disabilities Mortality Review (LeDeR) Programme in conjunction with Bristol University. Subsequent to the publication of the NHS Long Term Plan, the LeDeR programme will continue, with the intention of embedding reviews of deaths of people who have learning disabilities into everyday practice.

- 13.2 Key findings from the third annual review paper issued in May 2019 included the following information related to death in those with a learning disability:
- Likely to be underrepresented in notifications of death if from a BAME group;
  - Concerns had been raised about circumstances of death in 11% of cases;
  - Women with learning disabilities died 27 years earlier and men 23 years earlier than the general population;
  - There is evidence of bias in the care of people with learning disabilities
- 13.3 The Trust now has a standard pathway to report any death of a person who has a learning disability, and LeDeR notifications are made through the Assurance Team from a Datix report. The deaths are discussed within the monthly Learning from Deaths meeting, and work is moving forward to establish a repository for completed reviews within Datix, and then a process for sharing the learning, not only for Learning Disability Services but also all services within the Trust. The trust safeguarding team and the LD services attends and contributes to the LeDeR reviews and shares the learnings across the trust
- 13.4 The Covid 19 crisis has again highlighted the vulnerability of the learning disabled service users as higher death rate was reported among this group of service users - based on CQC statistics, there is reported to be 134% increase deaths of people who have a learning disability from the same period last year.
- 13.5 Within the organisation, this has been reflected with knowledge of 31 COVID19 related deaths across Learning Disability Services of current and former users of services. Of those who have sadly died, a high percentage had physical health co-morbidities including diabetes, kidney failure and epilepsy. Across both North East London and Bedfordshire and Luton, LeDeR reviews have already started to identify learning from these deaths, which include increased working with Primary Care to establish multi-disciplinary teams across CQC registered homes for people who have a learning disability, and also revised plans to support Annual Health Checks. Services are also working with Public Health England to review shielding lists, discuss with the 111 service about recognising Learning Disability as a specific vulnerability, and agreeing testing regimes across provider.
- 13.6 The learnings from the LeDeR review is shared on a quarterly basis with the safeguarding team and this information is incorporated into the safeguarding trainings and supervision.

## **14.0 Domestic Homicide Review**

- 14.1 A Domestic Homicide Review (DHR) is a locally conducted multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- a person to whom he or she was related, or with whom he or she was or had been in an intimate personal relationship; or,
- a member of the same household as himself or herself.

14.2 DHRs were introduced by section 9 of the Domestic Violence, Crime and Victims Act 2004 (DVCA 2004) and came into force on April 13, 2011.

14.3 During 2020-21 there were 4 DHR's commissioned by the Community Safety Partnerships in the Local Authority areas that ELFT operates. ELFT safeguarding team represented the trust in those DHR's and contributed to the reviews.

14.4 The safeguarding team have incorporated the learning from the completed DHR's in the level 3 safeguarding training and Safeguarding Newsletter.

## **15.0 Complaints**

15.1 All complaints are reviewed at entry by the trust complaints team and the safeguarding team is forwarded any complaint where safeguarding concerns are identified.

15.2 The staff screening the complaints has received safeguarding training and understands what constitutes abuse when screening complaints.

15.3 During 2020-21 the trust received 8 complaints related directly to adult safeguarding.

15.4 The safeguarding adults team advised the complaints team to report the concern to the local authority by raising a safeguarding concern.

15.5 In the same period the trust received 1 complaint related to child safeguarding. This was managed in line with the safeguarding allegations policy.

## **16.0 Workforce**

16.1 Statutory guidance requires the Trust to have robust arrangements for safe recruitment practices including identity and DBS checks for all new and existing every three years. At the end of the financial year the percentage of staff with a valid Disclosure and Barring Scheme (DBS) check was 99.5%.

## **17.0 Safeguarding Adults Incident Reporting Data**

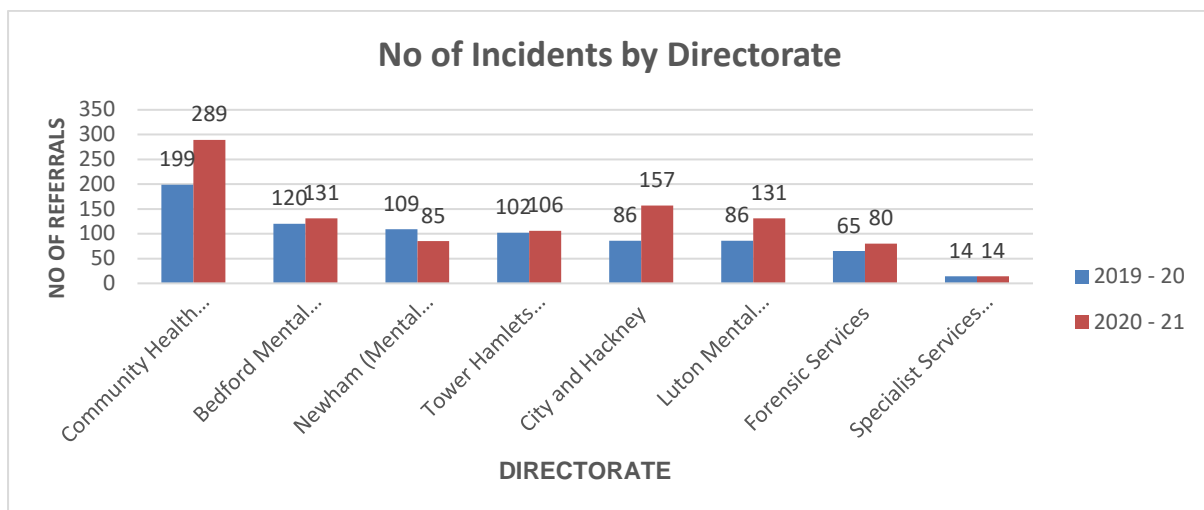
- 17.1 All patient safety incidents are reported on the Datix incident reporting system and are monitored, assessed and screened for cases where abuse or neglect or poor care are indicated. This process supports staff in their decision making to consider and identify safeguarding concerns. The information gathered from Datix incident reporting is monitored by the Safeguarding Team and Directorates to ensure appropriate safeguards are in place.
- 17.2 There were 993 incidents raised by the trust staff in 2020 -21 compared to 843 in 2019-20 and 537 in 2018-19. In the last three years the trust has seen an increase in the number of incidents being raised by staff and this could be due to increased awareness of Safeguarding issues.
- 17.3 Community Health Services raised the highest number of incidents followed by City and Hackney Services. Mental health services in Luton and Bedfordshire raised the third highest number of incidents in 2020-21.
- 17.4 In areas where low reporting of incidents have been identified, the safeguarding team are doing targeted safeguarding awareness work.
- 17.5 An increase uptake of safeguarding adults training has directly contributed to the increase in reporting. The other contributory factors include multi-agency working, bespoke training and supervision.
- 17.6 The highest reported category of abuse was Neglect and Acts of Omissions followed by financial and Domestic Abuse which is reflective of the local and National picture.
- 17.7 The trust has a delegated responsibility to manage Section 42 enquiries. The delegated section 75 commissioning arrangements vary in each directorate of the trust.
- 17.8 A Section 42 enquiry is instigated by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves from the risk of abuse or neglect because of their care and support needs.
- 17.9 Luton, Bedford, Central Bedfordshire and Hackney have delegated responsibility to undertake section 42 enquiries for service users over the age of 18 years known to the trust who have care and support needs due to their mental and physical health issues.



17.10 The volume of section 42 enquiries complete by the trust reflects the national picture with Neglect and Acts of Omission followed by financial abuse and Domestic abuse.

17.11 In all the concluded enquiries a risk was identified and a plan put in place to mitigate the risk.

**17.12 DATIX reported incidents (2020-21)**



**18.0 Safeguarding Children Incident Reporting Data**

18.1 During the year a total of 1376 ticked one or more of the safeguarding children fields, an increase of 47% on 2019-20. The data is shown in Table 1.

18.2 There has been an increase in all fields apart from self harm. The increase could be attributed to a wider understanding of child safeguarding themes as disseminated in safeguarding training as well as increased staff confidence to report incidents.

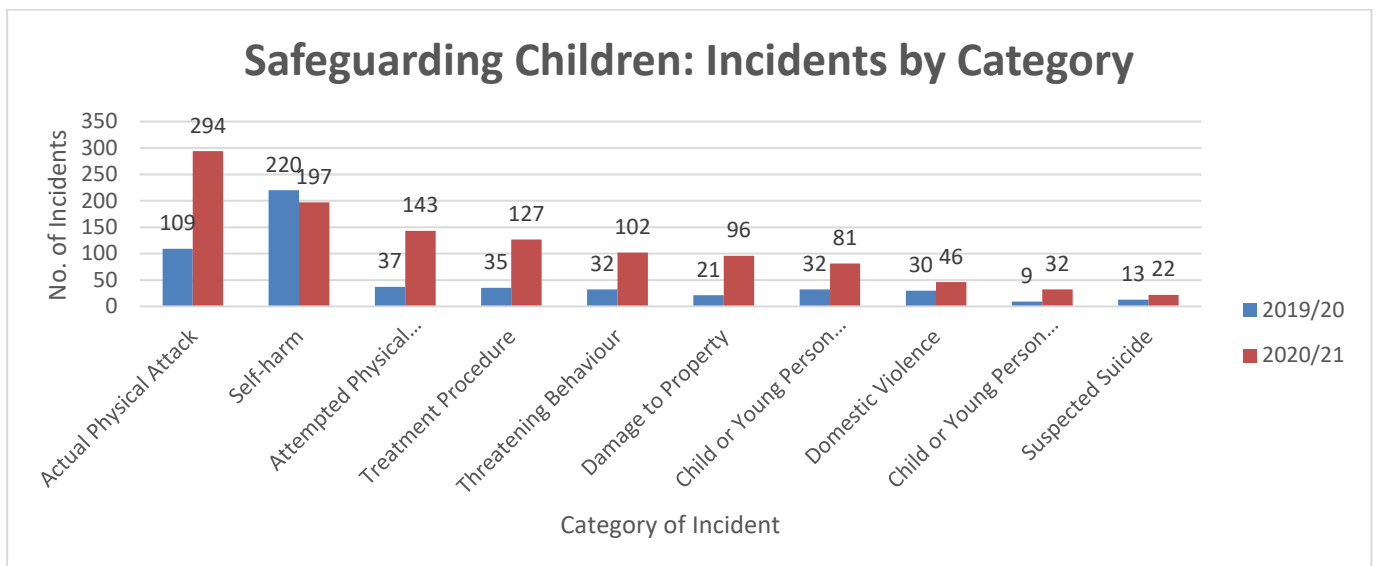
18.3 The vast majority of these (73%) are reported by the Coborn unit, who reported 1004 incidents during this period. This is on line with the highly complex cases receiving treatment there.

18.4 The safeguarding team have been working in collaboration with the risk team who are undertaking thematic review into the increase in incidents seen at the Coborn. It is thought the increase is largely attributed to the complexities and

challenges brought about by the pandemic, including delays in discharge due to lack of suitable places.

18.5 Of the 1376 incidents which showed that a child could have been affected 175 were made with the primary category of children at risk. This figure is a 59% increase on last year. This increase again can again be attributed to the increase in complex cases being managed within the Coborn unit. The remaining 1201 incidents are incidents which had safeguarding children implications, though the primary concern did not directly relate to safeguarding children. These include adults at risk of abuse, neglect or exploitation, care and treatment, and violence and aggression.

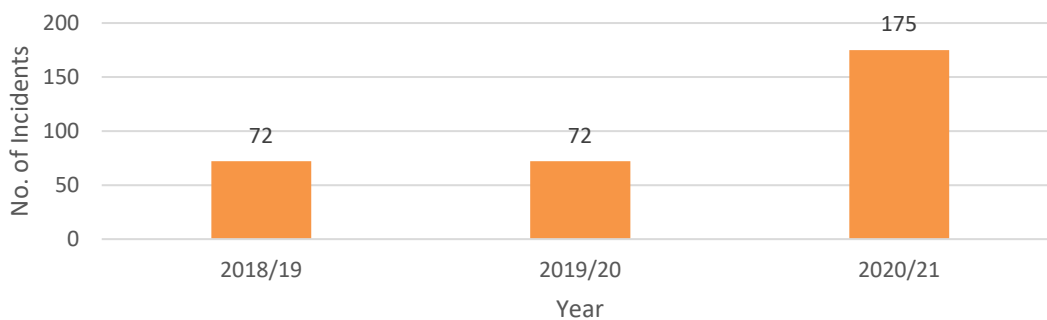
18.6 During the 2020-21 reporting period it was noted that there was an error in the reporting services system which provides data for social care referrals, in which cumulative data was being provided on a rolling basis. This issue has now been resolved and can account for the reduction in comparable referrals made in the 2019-20 period. It is not possible to gain a more accurate picture of the 2019-20 referrals using current systems, however there has been a 26% increase on social care referrals made during the 2018-19 period. This likely can be attributed towards increased staff knowledge of reporting procedures and accurate recording of referrals, as well as the related safeguarding children concerns brought about by the pandemic.



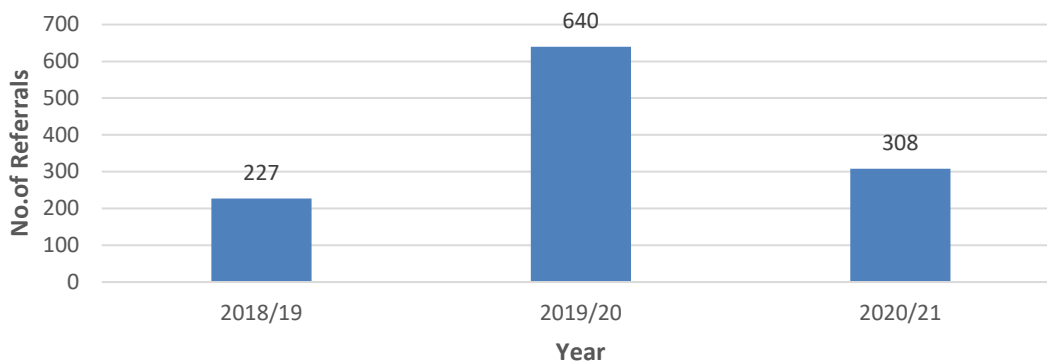
### Incidents with potential impact on child



### Children At Risk



### No of CSC Referrals (RiO Record only)



## 19.0 Looked After Children

- 19.1 The Looked After Children (LAC) health team is responsible for assessing and ensuring that the health needs of all the looked after children and young people from Newham are met, whether they live in the Borough or they have been placed out of area. In addition, the team is also responsible for assessing the health needs of children from other authorities who are placed in Newham when requested to do so.
- 19.2 A child will cease being “Looked After” when they are adopted, return home or reach the age of 18 years. Social care responsibilities for Care Leavers over the age of 21 has now changed under the recently published Children and Social Work Act (2017), which enables care leavers to request support up to the age of 25, regardless of whether or not they are in education.
- 19.3 Looked After Children (LAC) often enter the care system with a worse level of health than their peers, in part due to the combined effects of the impact of poverty, poor parenting, abuse and neglect. These young people often enter care from chaotic home situations and/or through the criminal justice system.
- 19.4 The total number of children looked after by Newham as of March 2021, was 385, a decrease of 6% from 2019-20 (source: Azeus reporting LBN). Of these children, 31% continue to live in Newham; this is a 9% decrease from last year and 58% live outside of the Borough (5% increase) (11% shown as ‘restricted’ on the LBN report and therefore not included in the figures). For those living outside of the Borough, care is provided by the host Local Authority and health provider.
- 19.5 During the 2020-21 reporting period:
- 110 children entered into care (13% were unaccompanied asylum seeking children (UASC))
  - 119 children left care
  - 41% of children and young people are female
  - 61% of these children and young people are male
  - Of UASC cohort, 14% are male and 1% are female
- 19.6 77.6% of initial health assessments (IHAs) were completed in the 20 working days’ timeframe. This is a 7% decrease from the last financial year. The expected national average per annual % of IHAs completed is 88%. Named Nurse for looked after children to analyse the raw data and to investigate the reasons why the information is shown to be falling below the national average and to address these, though is thought to relate to children not being brought to appointments and several breaches at the latter end of the reporting period. All breaches of the statutory 20 working day rule and any ‘did not attends’ are noted and reported to the CCG on a weekly basis.
- 19.7 Under 5yr Review Health Assessments

Under 2yrs are reviewed by the Community Paediatricians and age 2-5yr by the Specialist Nurses. For the purpose of this report they are calculated as a whole.

87% of under 5's Review Health Assessments (RHA) were completed in the set time frame, an increase of 2% from 2019-2020.

#### 19.8 5yr- 18yr Review Health Assessments

80% of over 5's were completed in the set time frame. This is an increase of 1% from last year. There is still room for improvement as the national average is 88%. The Named Nurse for looked after children to analyse the raw data and to investigate the reasons why the information is shown to be falling below the national average and to address these. All breaches of the statutory time frames and any 'was not bought' are noted and reported to the CCG on a weekly basis.

#### 19.9 LAC Governance and reporting arrangements

- The LAC health and safeguarding teams attend commissioner-provider meetings with Newham CCG at the Newham Joint Health Sub Group, every 2 months
- The Named Nurse for LAC attends Newham Corporate Parenting Board and participates in the Corporate Parenting Board Operational Group. Health updates are presented when required
- The Named Nurse for LAC attends the Clinical Governance meeting for Specialist Children's and Young Peoples Services (SCYPS) every month
- KPI data is reported monthly to the CCG
- The clinical team undertakes quarterly essential audits in record keeping and infection control
- The Named Nurse for LAC attends the Safeguarding Children Committee, every 2 months and reports progress and challenges at the committee
- There is a joint LAC and LBN meeting every 6 weeks where the data is discussed

2021-2022 Safeguarding Annual Plan (based on the Trust Safeguarding Strategy 2019-2022)

No 1	Improved population health outcomes	Action required	Lead	Timescale	Evidence/ progress	Rag rating
1	Provide a comprehensive training programme designed to meet the outcome set out in children and adult intercollegiate documents and to meet Trust training targets.	<ul style="list-style-type: none"> <li>• Training dates to be delivered to meet the trajectory caused by re-mapping of staff and covid-19 crisis.</li> <li>• Adult and children team to identify areas for joint refresher training focusing on case studies</li> <li>• Use case studies, SCR and SAR and different interactive methods of learning</li> <li>• Capture accurate training data</li> <li>• Ensure infrastructure supports virtual delivery of training</li> <li>• Online form to capture refresher training to be developed</li> </ul>	<p>Associate Directors Safeguarding Children and Adults</p> <p>Corporate Safeguarding Team</p> <p>Workforce and Learning Development</p>	Sep 2021	<p>Increase in staff compliance in all levels of safeguarding training to 85%</p> <p>Training audit</p> <p>Training compliance reports</p>	A

No 2	Improved experience of care	Action required	Lead	Timescale	Evidence/ progress	Rag rating
2 a	Safeguarding is an everyday business across the organisation evidenced in all areas of the Trust's activities and business.	<ul style="list-style-type: none"> <li>Ensure that there is representation at the safeguarding committee from a range of directorates and professions</li> <li>All areas are compliant with safeguarding training</li> <li>Themes and trends raised during contact with safeguarding team to be analysed and discussed in Trust SG committee</li> </ul>	<p>Chief Nurse and Borough Directors</p> <p>Associate Directors for Safeguarding</p>	Sep 2021	<p>Audit cycle</p> <p>Safeguarding datasets</p> <p>Safeguarding training remains an action outstanding, otherwise all other actions have been met</p>	
2b	Ensure staff understand that safeguarding is everybody's responsibility	<ul style="list-style-type: none"> <li>Details in all Job Descriptions</li> <li>Review Appraisal documents to see if safeguarding features as a competence</li> <li>Analyse the number and appropriateness of contacts made to the safeguarding team</li> </ul>	<p>Human Resources</p> <p>Directorates HR business partners</p> <p>Associate Directors for safeguarding / Corporate Safeguarding</p>	Sep 2021	<p>Audit cycle</p> <p>Safeguarding datasets</p>	

2c	Ensure patients are protected by organisational policies and Processes that are underpinned by safeguarding principles i.e. good practice	<ul style="list-style-type: none"> <li>• HR policies are up to date regarding safeguarding and voicing concerns</li> <li>• Ensure that Safeguarding policies are up to date</li> <li>• Ensure that the Mental Capacity Act and the DOLs framework is incorporated into Safeguarding training practice and intervention</li> </ul>	<p>Chief Nurse and Director of Nursing</p> <p>Associate Directors Safeguarding Children and Adults and Lead Nurse for Mental Health Law and Mental Capacity Act (MCA)</p>	Sep 2021	<p>Policies are updated in accordance with National and Regional guidance.</p> <p>Policy tracker</p>	
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2d	Ensure that staff receive appropriate support and training to be able to deliver high standards of Safeguarding practice and intervention	<ul style="list-style-type: none"> <li>• Safeguarding Team to work in collaboration with the lead Mental Health Act nurse and MCA and DOLs advisor</li> <li>• Themes and trends regarding access to safeguarding supervision to be analysed and discussed in Trust SG committee</li> <li>• Develop opportunities for themed learning lessons events across directorates so the learning is shared across Community Health , Learning Disabilities and Mental Health services</li> </ul>	<p>Named Professionals for Safeguarding and directorate Safeguarding leads</p> <p>Associate Directors for safeguarding</p>	Sep 2021	<p>Safeguarding datasets</p> <p>Audit cycle</p> <p>Thematic case review dissemination</p>	
<b>No 3</b>	<b>Improved Staff experience</b>	<b>Action required</b>	<b>Lead</b>	<b>Timescale</b>	<b>Evidence/ progress</b>	<b>Rag rating</b>

3	To ensure that staff are empowered to speak up and act when they see or suspect safeguarding issues by ensuring that they receive appropriate levels of training based on national and local guidelines.	<ul style="list-style-type: none"> <li>• Undertake incident review of SGA and SGC on the DATIX system</li> <li>• Incidents shared and analysed at Trust SG committee meeting.</li> <li>• Monitor quality of referrals to social care</li> </ul>	<p>Safeguarding Team Data Analyst</p> <p>Associate Directors for safeguarding</p> <p>Corporate Safeguarding Team / Service Directors</p>	Sep 2021	<p>Safeguarding datasets</p> <p>Audit cycle</p> <p>Performance reports</p>	
<b>No 4</b>	<b>Improved Value</b>	<b>Action required</b>	<b>Lead</b>	<b>Timescale</b>	<b>Evidence/ progress</b>	<b>Rag rating</b>

4a	To work in partnership with other agencies leading on health so that co-operation in a transparent and productive way progresses safeguarding	<ul style="list-style-type: none"> <li>• Attendance at multi-agency meetings</li> <li>• Joint working in relation to inspections and working together</li> <li>• Promote joint learning lessons events regarding SCPRs and SARs</li> <li>• Share learning and evidence from SCPRs and SAR in relation to partnership working</li> </ul>	<p>Corporate Safeguarding Team and Service Directors</p> <p>Chief Nurse</p> <p>Service Directors</p> <p>Corporate Safeguarding Team</p>	Sep 2021	<p>Attendance at partnership meetings</p> <p>Joint audits</p> <p>Thematic case review dissemination</p>	
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4b	To develop a dataset of information to monitor safeguarding activities and ensure that the organisation has sufficient capacity in meeting their statutory requirements.	<ul style="list-style-type: none"> <li>• Quarterly reports to be developed and presented at Trust SG committee to include themes and trends</li> <li>• CCG Dashboard to be further developed</li> <li>• Risk register to be maintained and presented at Trust SG committee</li> <li>• Multiple trust system and reporting issues to be resolved</li> </ul>	<p>Associate Directors of Safeguarding</p> <p>Associate Directors of Safeguarding / Safeguarding Team Data Analyst</p>	Sep 2021	<p>Audit cycle</p> <p>Safeguarding datasets</p>	
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4c	To promote a "Think Family" approach to safeguarding'	<ul style="list-style-type: none"> <li>• Themes and trends regarding access to safeguarding team to be analysed and discussed in Trust SG committee</li> <li>• Develop joined up training for areas of training /supervision where a think family approach is appropriate, such as domestic abuse and Prevent             <ul style="list-style-type: none"> <li>• Develop clinical assessment by exploring risk to all adult and children family / household members</li> <li>• Develop transition arrangements from children to adult services where safeguarding concerns are identified</li> <li>• Joint quarterly associate director meetings with borough directors</li> </ul> </li> </ul>	<p>Corporate Safeguarding Team</p> <p>Named Drs for safeguarding, Borough directors, Associate directors for safeguarding children.</p>	Sep 2021	<p>Safeguarding datasets</p> <p>Audit cycle</p> <p>Work continues on developing transitional arrangements from children to adult services where safeguarding concerns have been identified, otherwise all other actions have been met</p>	
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No 5	Improved Partnership working	Action required	Lead	Timescale	Evidence/ progress	Rag rating
5a	To ensure that there is clear accountability and transparency in delivering safeguarding priorities by building an effective governance assurance framework.	<ul style="list-style-type: none"> <li>• Pro-active well attended safeguarding committees fulfilling terms of reference</li> <li>• Measure the quality of work and compliance against regulatory standards</li> <li>• Quarterly upward reports to Quality Assurance Committee</li> </ul>	Director of Nursing	Sep 2021	Audit programme	
5b	Respond to both internal partnerships multi-agency requirements OfSTED, Inspections, CQC and Joint Targeted Area Inspections (JTAI)	<ul style="list-style-type: none"> <li>• Contribute and assist with partnership requirements for SAB and LSCPs</li> <li>• Ensure robust safeguarding processes are in place for CQC requirements and inspection</li> </ul>	Chief Nurse / Director of Nursing  Associate Directors for Safeguarding Children and Adults	Sep 2021	Funding arrangements agreed  Safeguarding datasets	
No 6	Aim	Action required	Lead	Timescale	Evidence/ progress	Rag rating

6	Single and multi-agency audits	<ul style="list-style-type: none"> <li>• All audits and reports are collated in calendar and reviewed to establish gaps and repeat as appropriate.</li> <li>• Audit cycle to be reinvigorated</li> <li>• Reports are reviewed and any actions implemented</li> </ul>	Corporate Safeguarding Team and Service Directors	Sep 2021	Audit cycle	
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## 20.0 Key Achievements for Safeguarding

20.1 The following are the key achievements of the safeguarding adults team in 2020-21:

- Successfully moved to delivering Level 3 Adult Safeguarding training virtually.
- Ensuring a safeguarding presence across all services, which include supporting staff through the safeguarding process.
- The Safeguarding team responded quickly in order to support the trust response to the COVID crisis through being flexible to meet the challenges of COVID as well as maintaining an effective Safeguarding service.
- Responding to findings from the safeguarding reviews and incorporating the learnings into practice.
- In response to the Covid-19 pandemic added a process for staff who are victims of Domestic Abuse to the Domestic Abuse and Harmful Practices Policy
- Established the Domestic Abuse Steering group which meets monthly.
- Held Safeguarding Adults week and will continue to hold awareness weeks in the future.
- Developed Audit Protocol for Safeguarding which will help us analyse and understand the safeguarding themes, risks and gaps within the services.
- Undertook audits of safeguarding and non-safeguarding cases to understand the staffs understanding and awareness of safeguarding.
- Participated in multi-agency audits which helped us to understand areas of practice improvement and development.
- Implemented safeguarding newsletter, posters and leaflets to promote awareness of safeguarding issues.
- The Corporate safeguarding team attended and participated in board and sub-group meetings.
- We have continued to build on our partnerships with other external agencies and strengthened working relations with our colleagues from Social care.

20.2 Key achievements - Children

- Embedding a new approach to safeguarding children training and supervision
- Ensuring all ELFT staff have had uninterrupted access to safeguarding advice and support throughout the pandemic
- Improved data collection systems to identify safeguarding themes and demographic data of the safeguarding cohort
- Close partnership working demonstrated in participation of multi-agency audits, case reviews, information sharing agreements and escalation of concerns
- Increased accuracy of key performance data
- Furthered access to multiple record keeping systems across the trust
- Positive feedback regarding the quality of safeguarding children supervision.



- Joint working alongside the safeguarding adult team within the Domestic Abuse steering group to promote the Think Family approach.

## **21.0 Key Priorities for Adult Safeguarding 2021-22**

- Supporting staff with new ways of learning during the Covid-19 crisis to ensure that staff continues to remain compliant and the trust is able to achieve 90% compliance with Level 3 training.
- Working across the various directorates of the trusts which have different policies and procedures and also managing the expectations of the Safeguarding Boards and CCG's.
- Formalising the Section 42 reporting process to enable the trust to be aware of the ongoing enquiries, the risks, the themes and gaps in service.
- The safeguarding team will ensure that transition is robust between each team at the point of transition from child to adult services is a time of particular risk for vulnerable young people.
- To embed and improve access to a sustainable adult safeguarding supervision.
- Continue to provide awareness and training of Modern Day Slavery, Self-Neglect and Hoarding, FGM.
- Implementation of SAR/DHR/SPR/LeDeR learnings in the trust level 3 training and bespoke training.
- Domestic abuse and violence will continue to have high priority within the work of the safeguarding teams key priorities. Safeguarding team to support other teams to embed and support Domestic Abuse screening in all the assessments completed by the trust staff.
- To put a system in place to receive service user feedback to understand service users experience of the safeguarding process.
- To monitor and evaluate how the learnings from SARs and DHRs has been embedded into frontline practice.

## **22.0 Key Priorities for Children Safeguarding 2021-22**

- To meet the training trajectory for safeguarding children level 3 training bought about by the changes to the intercollegiate guidance.
- Ensure any challenges associated with future peaks of Covid can be mitigated
- To work towards unifying safeguarding reporting data across several systems
- To maintain visibility at partnership meetings
- To ensure that the Trust 'Think Family' ethos and professional curiosity is embedded into everyday practice
- Continue to embed organisational learning through mandatory training, from serious incidents and adult/child reviews
- Making safeguarding personal and the demonstrating the voice of the child has been considered.
- Ensuring all mapped services are supported to receive safeguarding children supervision.

## **23.0 Key Priorities for "Think Family Approach"**

- Corporate Safeguarding Adults and Children team to jointly work to ensure that the transitioning from child to adulthood are supported and safeguarded from abuse, exploitation and neglect.
- Corporate Safeguarding Adults and Children team to ensure that learnings from Safeguarding Adults Reviews, Child Safeguarding Practice Reviews, Domestic Homicide Reviews are delivered to staff through joined supervision, team away days and safeguarding development days.
- Corporate Safeguarding Adults and Children team to develop new resources where common themes like Domestic Abuse. PREVENT, Homelessness, Self-Neglect, Female Genital Mutilation and Fabricated and Induced Illness.
- Corporate Safeguarding Adults and Children team to deliver joint Safeguarding supervision where possible to ensure that shared learning is delivered jointly.
- Corporate Safeguarding Adults and Children team also to deliver joint training where common themes are identified to embed the Think Family approach.
- Corporate Safeguarding Adults and Children team to Champion named Professionals in areas to shared learning where they could lead on an area of interest and take the lead in developing resources.

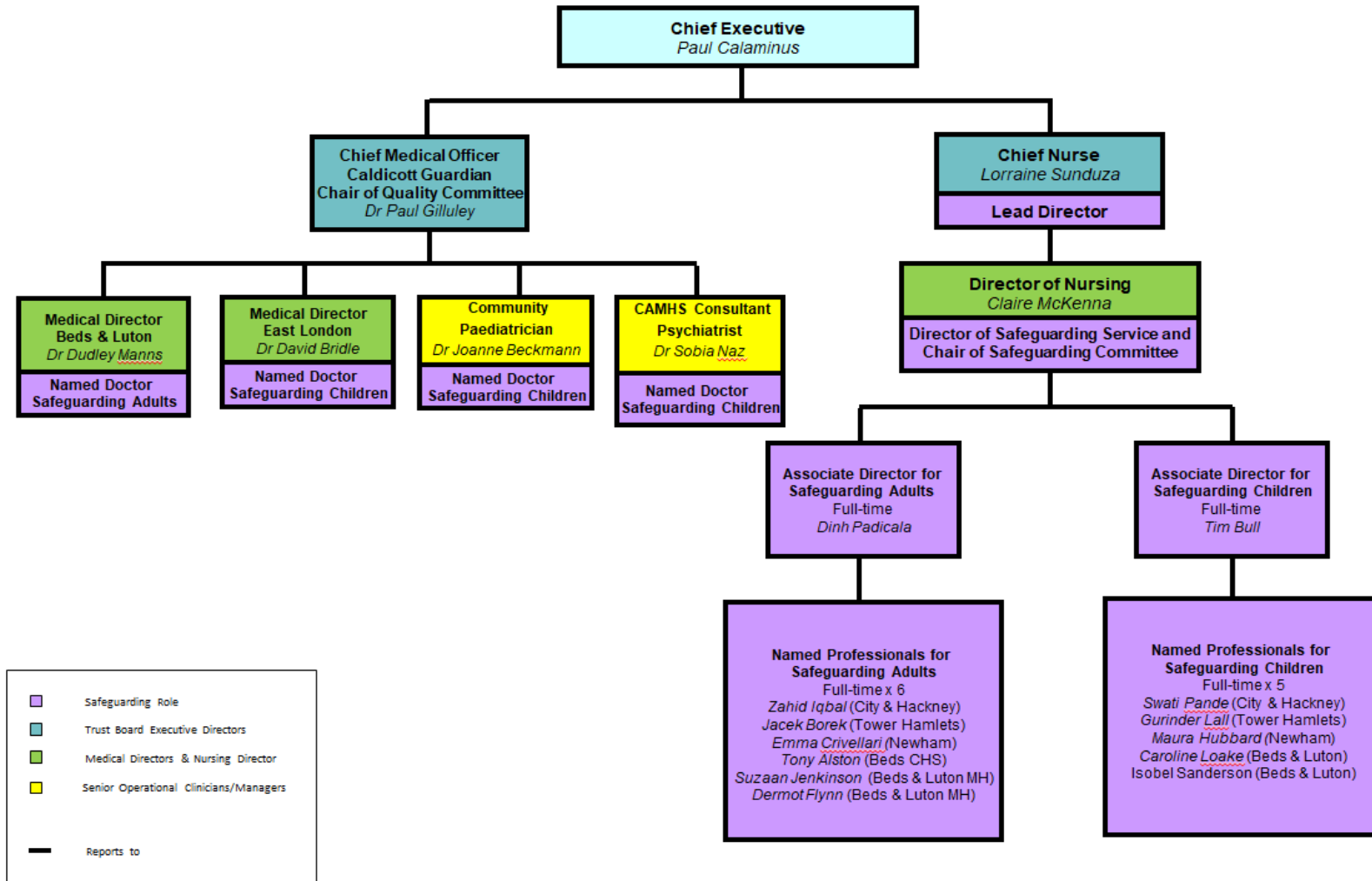
#### **24.0 Safeguarding Work Plan**

- 24.1 During 2020-21, the safeguarding team made progress with the safeguarding strategic objectives and work plan underpinned by the Trust's core values.
- 24.2 The work plan has achieved some of its objectives. Areas such as training and improving accuracy of data require ongoing oversight and development and are incorporated in our plans for 2021-22.
- 24.3 The achievements of the work plan has been highlighted in the achievements section 20.1 and 20.2
- 24.4 A new work plan for the next 4 years has been developed which incorporates some of the ongoing work of the existing work plan and will be reviewed by the Safeguarding Committee on a bi-monthly basis.
- 24.5 The work plan will ensure the Trust drives forward the safeguarding agenda across the organisation (Appendix-4).

#### **Appendix list**

- 1. Appendix 1 - Organisational Chart for Safeguarding**
- 2. Appendix 2 - Assurance Structure**

### ORGANISATIONAL CHART FOR SAFEGUARDING



## Appendix 2

### Assurance Structure

