Imperial College Healthcare NHS Trust

TRUST STANDING COMMITTEE

Paper title:	**Safeguarding Annual Review 2023-24**
Agenda item	
Lead Executive Director:	**Janice Sigsworth, Chief Nurse**
Author:	**Nicci Wotton, Consultant Nurse Safeguarding** **Anne Middleton, Deputy Chief Nurse, Empowerment and Inclusion**
Purpose:	**For information and approval**
Meeting date:	**2 July 2024**

1. Executive Summary

1.1. The Chief Nurse has executive leadership for safeguarding, learning disability and autism at ICHT and is represented by the deputy chief nurse and by the head of safeguarding at adult safeguarding boards and child partnership and forum meetings. This portfolio also includes prevention of terrorism (Prevent), mental capacity and child sexual exploitation.

1.2. Safeguarding children and maternity referrals overall increased during 2023/24 with 1985 (increase of 20%). Child safeguarding referrals continue to steadily increase with key themes including neglect of children; exploitation and assaults of children (gangs and sexual); serious youth violence; domestic abuse and alcohol/drug use in families (particularly in pregnancy). Themes are monitored and shared with partner agencies to inform learning and interventions. A total of 59 child protection medicals have been carried out in the Trust. Under eighteen-year-old trauma calls to the emergency department have decreased over the year however serious youth violence for over eighteen year olds who have children or siblings have increased. Key threats include knives, machetes, guns, sexual violence, kidnapping, acid attack and multiple punches by multiple assailants.

1.3. In maternity, from a total of 10,711 bookings, 17% (n=1781) were identified as tier 3 (highest vulnerability) and discussed at interagency meetings. This represent an increase of 64% compared to 2022/23. Birth plans were put in place for these women to ensure all clinical staff were aware of the risks. Increases in domestic abuse, drug and alcohol misuse and mental health issues are the causes of this increase.

1.4. Safeguarding adult referrals have increased by 32% (n=1095) during the year. This is an average of 91 cases/month. Themes relate to physical abuse, neglect and self-neglect. A safeguarding adult review (SAR) led by Gloucester adult safeguarding board found no specific actions for ICHT; key themes concerned communication processes involving information sharing between organisations (Gloucester to ICHT). A safeguarding adult review published by Hammersmith and Fulham (H&F) also did not highlight any issues for the Trust but focused on mental capacity assessments and general discharge planning. There were 103 deprivation of liberty (DoLS) applications, which is a decrease of 52 compared to last year.

1.5. **Domestic Abuse (DA)**

There have been 597 DA stand-alone referrals for Multi-Agency Risk Assessment Conferences (MARACs) and Independent Domestic Violence Advisors (IDVAs) this year. This is an increase compared to the previous year.

The Trust has signed up for the NHS sexual safety charter in collaboration with key partners across the healthcare system. Signatories to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this. It is expected that signatories will implement all ten commitments by July 2024. The charter also covers potential domestic abuse for staff cases. The people and organisational development team are taking responsibility for developing an action plan for this charter.

1.6. **Learning disability and autism(LD/A)**

In line with the Equality Act 2010, the LD/A team supports personalising care for LD/A patients and their carers prior to, after and during attendances at the hospital. Support is given equally to people in unscheduled care settings, day appointments or as in-patients. Numbers for these patients are increasing with a total of 1771 identified as having potential vulnerability this year. This represents an increase of 26% compared to last year as a result of training and education.

1.7. **Training information**

The key performance indicator for all training is set by the Integrated Care Board and is 90%. Current performance at ICHT is as follows:

Adult Level 1 = 92%	Children Level 1 = 92%
Adult Level 2 = 92%	Children Level 2 = 91%
Mental Capacity = 92%	Children Level 3 = 92.6%

Learning disability and autism = 69%

It should be noted that both adult and child safeguarding training includes Prevent (prevention of terrorism and identification of radicalisation) training and the principles of recognising domestic abuse.

The LD/A training was launched in August 2023. We are confident that with a continued focus, compliance rates will reach the 90% threshold within the next three months.

Some staff require a higher Level 3 adult safeguarding training. In advance of detailed national guidance on identifying exactly who these staff are, we have commenced training for those we have identified internally. We are working closely with divisions to identify those that need to be trained whilst we await further national guidance.

1.8. **Partnership working**

Partnership working across the sector and beyond continues to be strong and collaborative. Trust safeguarding representatives attend the safeguarding board/forums sub-groups and also multi-agency operational meetings, strategy and discharge planning meetings etc. There are good systems in place to share information on risks to protect our patients across the care system.

1.9. **Key achievements**

- The increase in referrals across the whole of the safeguarding agenda represents significant progress in recognising risk in our patients. Compliance with all training is generally good. There has been good inter-agency partnership working through the case practice review groups and quality review groups where practice is checked and challenged across the sector.
- Work continues in partnership with the charity Redthread, who support young people where violence is involved with education, support and first aid talks delivered by members of the safeguarding team.

- The Trust's Women's Network, in collaboration with the safeguarding team, have finalised an action plan to achieve the Domestic Abuse White Ribbon accreditation. The White Ribbon Campaign (WRC) is a global movement of men and boys working to end male violence against women and girls. This will be launched in collaboration with the NHS sexual safety charter.
- An easy-read leaflet for LD/A patients has been developed to highlight the risks of accidental fire hazards from medications such as emollients.
- A '16 days of activism' event was held during November and December to improve awareness of gender-based violence. Other awareness campaigns continued throughout the year and covered aspects such as private fostering, advocacy, discriminatory abuse and sexual abuse.
- Imperial has led work across the acute trusts in the sector to develop electronic safeguarding referrals. This has greatly improved the process and ensures consistent information.
- Through focused training and education, formal mental capacity assessments are now documented where a DoLS order is in place. Mental capacity assessment training is now available to all staff.
- A number of internal and external audits have been completed by the safeguarding team to gain assurance around practice and standards.

1.10. **Key challenges**

- The increased activity and complexity across all areas of safeguarding continues to pose some pressures on the teams. This is constantly reviewed to ensure risks are managed and staffing is optimal to manage increasing case loads.
- Whilst mental capacity training compliance is good audit and practice checks suggest that application is not always optimal – there will be a continued focus on training and education to improve this and a further audit of practise during 2024/25
- In addition to the virtual LD/A training, we are awaiting details of the face to face training requirements the higher level tier 2 training from the integrated care board. Achieving compliancy is a focus for 2024/25.
- Some staff require a higher level 3 adult safeguarding training. We are awaiting detailed guidance on identifying exactly who these staff are and are currently working closely with divisions to ensure compliance before the guidance is finalised
- In a large complex organisation, maintaining training requirements to meet the key performance indicators will require continued focus and work along with a revised training policy
- We are working with the medical photography department to ensure that we are providing an optimal service across the Trust for all safeguarding requirements and a project group has been tasked to collate a NWL clinical photography solution that will encompass the safeguarding elements required.
- The requirement for audit in safeguarding is often high and frequently involves multi-agency work. A robust audit plan that provides good statistical evidence will be developed to support oversight and maintenance of standards.
- Currently the independent domestic violence advisors in the emergency and sexual health departments are funded by charity monies. Going forward we will need to consider how to fund these posts permanently.

2. Approval process

2.1. This report was discussed at EMB Quality Group (EMBQ) on 17 June 2024 and Executive Management Board (EMB) on 25 June 2024.

3. Recommendation(s)

3.1. The Trust Standing Committee is asked to note the report.

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Main Report

Introduction

The Trust has a responsibility to safeguard children, young people and adults in its care. This requirement is laid out in legislation that includes: The Children Act (1989), the Children Act 2 (2004), the Mental Capacity Act (2005), the Care Act (2014) and Health and Social Care Act (2022). This responsibility is also made clear in CQC Regulation 13: Safeguarding service users from abuse and improper treatment. The NHS Safeguarding Contract is annually updated on 31 March and specifies certain conditions that providers need to abide by and Imperial is compliant in all areas.

1. Definitions

1.1 Safeguarding children

- A child is an individual under the age of 18 years.
- The Children Act (1989, 2004) states that the welfare of the child is paramount and that all practitioners are required to protect children, prevent the impairment of health and development, and ensure they are provided with safe and effective care in order to fulfil their potential and to keep safe from harm.

1.2 Safeguarding Adults

- An adult is an individual aged 18 years or over.
- Appendix 1 gives the definition of vulnerable adults/adults who have care and support needs and are at risk according to the Care Act 2014.

2. Purpose

2.1. This paper presents the annual report for safeguarding children and adults for the period April 2023 to March 2024 in line with 'Working Together to Safeguard Children' 2023, Safeguarding accountability and assurance framework (2022), the Children Act 2004 and the Care Act 2014. This includes those with learning disabilities and autism (inpatient, outpatient and unborn).

2.2. This report represents the requirement for Trust Boards to produce an annual report with assurance that safeguarding arrangements are robust and are working. The Trust Board received the last annual safeguarding report in the quarter four 2023 safeguarding report.

3. Background

3.1 The safeguarding executive lead during this period was Janice Sigsworth, Chief Nurse. The safeguarding team is led by the deputy chief nurse for empowerment and inclusion and the consultant nurse for safeguarding. A structure chart is included in Appendix 2.The teams work together to provide a family based service across the Trust and in partnership with external agencies.

3.2 Safeguarding is a complex area of practice. The potential patient group is wide-ranging and includes inpatients, outpatients and unborns as well as their wider families and others living within and external to family homes. Abuse and neglect can happen in any context and takes many forms, some of which may not always be obvious. It is therefore important that the Trust has strong systems and processes to identify safeguarding issues and to take action to prevent harm.

3.3 The safeguarding team covers six domains, children, maternity, adults, domestic abuse, modern slavery exploitation, learning disability and autism.

3.4 Overall safeguarding case work has increased in all domains (Fig 1) over the last four years. Increased awareness and understanding of risk is the main contribution to this along with changes in the population demographics associated with asylum seekers; increased violence; financial instability; increasing unscheduled care attendances where there are vulnerabilities and support needs; mental capacity issues associated with increasing mental health issues in our patients and alcohol misuse and self-neglect. The activity work includes cases that have required referrals and also those that are information shared with external agencies and meetings that have occurred for safety planning.

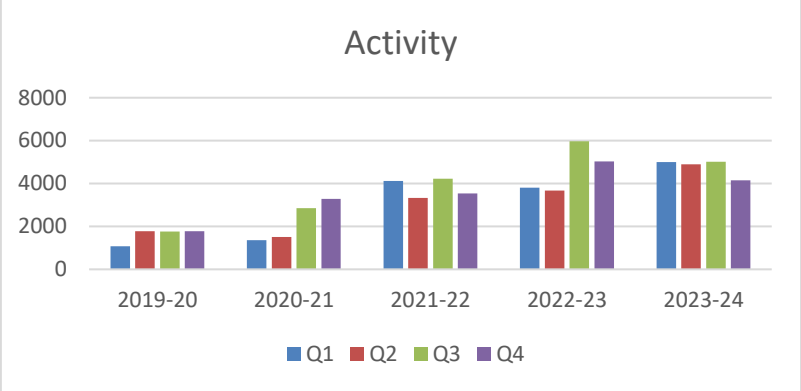


Figure 1: Overall safeguarding activity (Adult, child, maternity) for 2023/24

4. Safeguarding system data

Children activity

4.1 Children's Safeguarding activity is divided into three main areas:

- Consultation activity
- Safeguarding Liaison
- Child protection medicals

4.2 Safeguarding referrals for children have increased by 20% during 2023/24 with a total of 1985 referrals, averaging 165/month. The most common themes are neglect of children; exploitation and assaults of children (gangs and sexual); serious youth violence along with effects of domestic abuse and alcohol/drug use in families (especially in pregnancy). Families/children not waiting to be seen in unscheduled care has also increased.

4.3 There have been 33,085 unscheduled care attendances for under 18s. This included 193 under 18 trauma cases. All unscheduled under 18 attendances are reviewed by the team to exclude any safeguarding issues and also to liaise out to community staff (school nurses and health visitors) in regard to certain health conditions and accidents.

4.4 Whilst around 8% of trauma victims are under 18 and include those involved in serious youth violence (stabbings, machete attacks and shootings), any trauma in a family setting can have a negative effect on children in that family/household. An additional 2365 adult trauma cases were reviewed during the year. We have seen an increase of older siblings and (mainly) fathers who are involved in gang violence and violence related injuries or substance misuse related injuries. In all cases there has been liaison with relevant external agencies.

4.5 The Trust liaises closely with the charity Redthread to tackle the causes of youth violence and gang-related crime through education and teaching along with first-aid advice and support to the young victims of the violence.

4.6 A total of 59 child protection medicals have taken place in the Trust to support investigations of possible abuse. This is a similar number to previous years.

Maternity activity

4.7 Maternity pregnancy bookings increased by 5% (n=10,711) this year. A total of 17% (n=1781) of all bookings were identified as having a tier 3 vulnerability (Appendix 3) at some point of their pregnancy. This is an increase of 64% compared to last year. Key themes included related to late transfer of care of mothers with safeguarding issues; women who had not booked in prior to delivery; women with mental health and substance misuse issues; issues around fathers with gang connections; criminality; substance misuse and mental health issues. The additional workload will form part of a review of services in 2024/25.

4.8 There were 11 infants removed at birth from mothers, which is consistent with previous years.

4.9 Delayed discharge due to social care needs have occurred for a small number of mothers and infants. These families stayed on the maternity ward until suitable housing was found.

Safeguarding Adult activity

4.10 Safeguarding activity is divided into five main areas:

- Safeguarding consultation activity;
- Safeguarding referrals including Prevent, modern slavery and harmful practices;
- Section 42 (Care Act 2004) enquiries and/or investigations of safeguarding concerns for the Trusts or other agencies including Safeguarding Adult Reviews (SARS) and Offensive Weapon Homicide reviews;
- Deprivation of Liberty Safeguards (DoLS) applications for the Trust. This is where it is deemed in someone's best interest to deprive them of their liberty to keep them safe if they lack capacity to manage this themselves. This process is managed by the site teams and the Mental Health Law Office at CNWL NHS Foundation Trust. DoLS have to be authorised by the Local Authority;
- Court of protection applications to decide on care needs and living arrangements where there is dispute between the Trust and others.

4.11 The main themes of the consultations related to financial abuse, physical, neglect and self-neglect. The team provide support to clinical staff where there are complex safeguarding issues. Through training and supervisions, we encourage staff to think whether domestic abuse, modern slavery exploitation or a harmful practice is occurring as many service users do not realise they are being abused, controlled or exploited.

4.12 There have been 1095 safeguarding adult referrals, an increase of 351, which is 32% higher than 2023-24. This is an average of 91 per month. Many of the adult cases now are very complex with different strands regarding the safeguarding concerns. We have produced a flow chart for staff to help them ascertain when it is appropriate to make a referral.

4.13 The Trust received 48 Section 42 requests over the year that related to various adult concerns but mainly organisational abuse/omission of care. Four were directed at Imperial but these had already been investigated as either local learning or serious incidents so actions had taken place already, which were shared with the local authority.

4.14 There were 103 DoLS applications made during the year, a decrease of 52 (33%) from the previous year (Fig 2). There has been a focus this year on mental capacity training to support clinical areas in ensuring assessments are undertaken and capacity is documented to support the applications process.

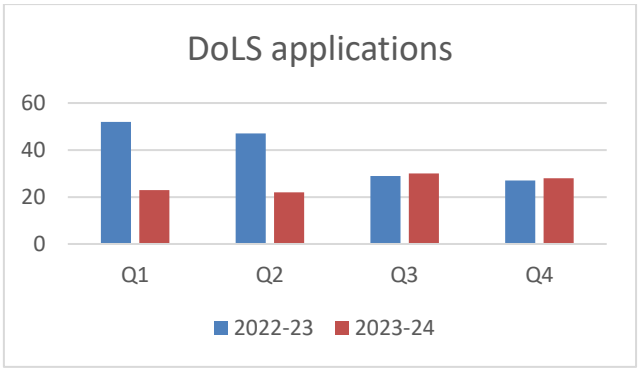


Figure 2 DoLS applications

Domestic Abuse

4.15 Domestic abuse referrals to support services have been at a higher level during the last year than previously with a total of 715 cases. (Fig 3) Last year's increase in quarter two coincided in an increase of attendances to unscheduled care. Patients disclosing to staff is increasing consistently and aligns with increased awareness and training around domestic abuse for the staff. These figures also include staff who are victim/survivors or perpetrators of domestic abuse.

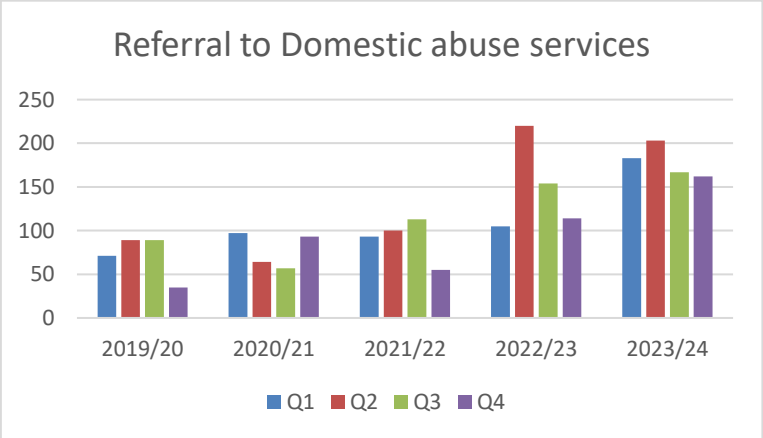


Figure 3 Referrals to Domestic Abuse Services

The Trust has signed up for the NHS sexual safety charter in collaboration with key partners across the healthcare system which commits to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this. The People and Organisational Development team are taking responsibility for developing and action plan for this charter.

The Trust works with a number of charities who provide support services in domestic abuse cases. There are currently three independent domestic violence advisors funded by a charity working in our emergency departments and in sexual health. Going forward we will consider how to fund these roles permanently.

Modern Slavery

4.16 Modern slavery exploitation (MSE) the umbrella term for forced labour, people smuggling/trafficking, domestic servitude, sex exploitation, (adult and child), debt bondage, county lines, organ harvesting, forced labour, criminal exploitation and child marriages (which

can also be a harmful practice). There were 82 safeguarding referrals in this category during the year, which is a consistent number with previous years.

4.17 Harmful practices (HP) include Female Genital Mutilation (FGM), so-called honour-based violence (HBV), breast ironing, forced feeding, child marriages, scarification, tribal marking and virginity testing. ICHT is an active member of the community HP operational group and provides any relevant data. There have been seventy-one cases reported in his category during the year and an additional 943 women coded as having had FGM. These figures are consistent with previous years.

4.18 There have been no court of protection applications this year and this is consistent with previous years. In general, these are always low in number.

Learning disability and Autism

4.19 We are responding to increasing LD/A patient referrals (inpatient and outpatient) by ensuring reasonable adjustments are in place prior to hospital attendance where possible. Numbers for these patients are increasing. Underlying this increase is higher rates of diagnosis and better awareness as a result of training and education. We have two members of the team that cover this area and give advice and support to staff and patients.

4.20 We had 1141 inpatient hospital episodes of care in 2023-24 where patients with learning disabilities and autism were known to the hospital team. This is a decrease of 16% compared to last year.

4.21 Despite an increase of the overall numbers of patients referred, the death in hospital numbers of identified LD/A patients remain very similar at 26 for 2023/24 compared to 24 for 2022/23. All Learning disabilities deaths are subject to a LD/A Learning from deaths (LeDeR) external review.

4.22 Reasonable adjustments: In line with the Equality Act 2010, the LD/A team supports personalising care for LD/A patients and their carers prior to, after and during attendances at the hospital. Support is given equally to people in unscheduled care settings, day appointments or as in-patients.

5. Partnership working to improve outcomes for children and adults

5.1 The consultant nurse for safeguarding represents the chief nurse on various safeguarding boards/forums for North West London, namely the boroughs of Kensington and Chelsea (RBKC), Westminster and Hammersmith and Fulham (H&F). RBKC & Westminster work jointly on the safeguarding agenda (bi-borough), H&F function independently.

Safeguarding Meetings

Kensington & Chelsea/Westminster Local Safeguarding Children Partnership (LSCP)	Hammersmith & Fulham Local Safeguarding Children forum (LSCF)	Kensington & Chelsea/Westminster Safeguarding Adults Executive Board (SAEB)	Hammersmith & Fulham Safeguarding Adults Board (SAB)	Tri-borough learning and development sub-group
H&F Quality assurance group (adults)	H&F Quality, performance and challenge group (children)	H&F (Safeguarding adults review) SAR champions champion group	H&F partnership meeting (children)	Multi Agency risk assessment conference (MARAC) x 5
Children and young people operational group (VAWG)	VAWG(Violence against women & girls) Strategic Board	VAWG Risk and Review	NWL ICS VAWG Health	Modern slavery exploitation operational group
Bi-borough developing best practice and effective outcomes group (adults)	Bi-Borough Case practice review groups x 4 (2 each of adults and children)	Best Practice and Performance subgroup bi-borough		
Mental Capacity Act (MCA) Regional meetings	Harmful practices operational group	Safeguarding adults health leads meeting		

The Consultant nurse for safeguarding chairs the Bi-borough children's case practice review meeting and also facilitates the pan London band 7 safeguarding network.

5.2 The safeguarding team attended a total of 62 Multi-Agency Risk Assessment Conferences (MARACs) in the year to share relevant information in high risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors. The primary focus of the MARAC is to safeguard the adult victim (over 16 years old). The MARAC will also make links with other agencies to safeguard children/adults and manage the behaviour of the perpetrator. Information is recorded on the electronic patient record to inform practitioners involved with patients when they attend the Trust.

5.3 Prevent forms part of the Counter Terrorism and Security Act 2015. It is concerned with preventing children and vulnerable adults becoming radicalised into terrorism. Staff are trained in the principles of recognition through safeguarding training. We have made two referrals during this year associated with Prevent.

6. Allegations against people in positions of Trust

6.1 When allegations concerning members of staff are made they are managed by the consultant nurse for safeguarding and the named professionals alongside the Local Authority Designated officer (LADO) or Local authority Safeguarding adult manager (SAM) depending on the content of the allegation. Concerns raised may be professional and/or personal.

The Allegations against People in Positions of Trust is a nationally agreed framework that sets out the process for responding to allegations and concerns against people working with adults with care and support needs.

6.2 A new policy is being developed at the Trust to support this framework, which will be launched in collaboration with the sexual safety charter action plan.

6.3 From April 2023 to March 2024 there were twenty-one safeguarding cases involving members of ICHT staff, including our third-party contractors and bank staff members. One common theme was alleged sexual assaults by staff on adult patients but after thorough investigation there was no evidence to support the allegations and the police closed the cases. Consideration is always given to referral to external regulatory bodies.

7. Case reviews

7.1 The Trust is an active participant in the four local adult and children safeguarding case review sub-groups that are part of Safeguarding Adult Boards (SABs) and Local Safeguarding Children Partnership/Forum (LSCP/Fs).

7.2 Reviews vary in their scope and may on occasion require the preparation of press statements. Identified learning from reviews is put into immediate action and, where necessary, staff attend learning practitioner reviews.

7.3 **Child Safeguarding Practice Reviews** (CSPR) are commissioned by the Local safeguarding partnership/forum when a child or young person dies or experiences serious harm or injuries and there is interagency learning. Learning would be disseminated through learning events; learning summaries and lessons are included on safeguarding training. There have been no reviews within this year that have involved the Trust.

7.4 **Rapid reviews** of children can occur to either notify the serious incident panel of a particular case or of an observed trend. During 2023/24 there were two rapid reviews that proceeded to practice review panels. In one, neglect was a feature in the death of a child. In the second

case a child who was also a victim of gang youth violence and extra familial harm and was murdered. There were no actions for the trust in the first case, in the second assurance around the quality of referrals to social care was provided. In addition a historic case from 2019 was reopened following the child's death in 2003. ICHT was discharged from that panel as no learning was required for the trust.

7.5 **Safeguarding adult reviews** is a multi-agency process that considers whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented. The process identifies learning that enables the partnership to improve services and prevent abuse and neglect in the future. A person would need to have care and support needs for a review to take place.

7.6 There have been four reviews during the last year. Two of these are still in progress:

1) A Safeguarding adult serious case review (SAR) that involved an Imperial patient was published by Gloucester Safeguarding Adults' Board. Elements of this case were declared internally by ICHT as a serious incident as the patient left our Emergency Department and took their own life. Key findings of the review flagged that there are improvements to be made in the way in which organisations arrange and deliver services to people with multiple diagnosis. It highlighted serious gaps in resources for people with mental health difficulties, especially whilst in crisis, which results in significant risks to their safety. Professionals had to work within systems which were under resourced and with communications systems which did not facilitate information sharing in crisis (Gloucester to London). The case review focussed on Gloucester practitioners with no deliverable actions identified for ICHT.
2) Hammersmith and Fulham published a review concerning the home invasion and murder of a gentleman. Learning for ICHT included accurate documentation of mental capacity assessments and discharge planning for complex patients.
3) ICHT requested that Brent authority conduct a review in relation to abuse a woman received from her son. This process has just commenced.
4) Hammersmith and Fulham have just commenced a review into a young man with complex health needs, including LD/A and an attempt at suicide.

7.7 Domestic homicide reviews (DHRs) or death associated with domestic abuse is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from domestic abuse. The trust participate on DHR panels across the borough and bring any learning back to the organisation. Currently the Trust is participating on four panels, none of which have been yet completed. Key themes include suicide, murder and parricide (Child killing a parent).

7.8 Offensive weapon homicide reviews are being trialled by Brent local authority. The Trust is participating in a scoping exercise to inform how these will function.

8. Training

8.1 The Key Performance Indicator (KPI) for safeguarding training is locally agreed by the NWL Integrated Care Board. This is set at 90%.

8.2 In general, compliance at levels 1, 2 and 4 are satisfactory. Level 3 safeguarding children training has reached the required threshold of 90%. It should be noted that Prevent training is included in all adult and child safeguarding training as well as standalone eLearning sessions.

8.3 The table below shows compliance levels as at 31 March 2022, 2023 and 2024.

Type	Compliance level % March 2022	Compliance level % March 2023	Compliance level % March 2024
Safeguarding adults level 1	89	92 ↑	92 =
Safeguarding adults level 2	88	90 ↑	92 ↑
Safeguarding children level 1	91	92 ↑	92 =
Safeguarding children level 2	86	90 ↑	91↑
Safeguarding children level 3	62	82 ↑	92 ↑
Safeguarding children/adult level 4	100	100 =	100 =
Oliver McGowan LD/A training	N/A	N/A	69

8.4 Oliver McGowan (learning disability and autism) training is being rolled out across the Trust. We are confident that this will meet the 90% threshold within the next three months. Bespoke training is also available from the LD/A team. Various mental capacity training is available through our online and virtual learning package.

9. Audit

9.1 The Safeguarding team completed the Safeguarding Adult Partnership Audit Tool (SAPAT) for the bi-borough as well as for Hammersmith & Fulham and participated in learning events to look at and review priorities for both safeguarding adult boards. The SAPAT reviewed achievements and challenges; the embedding of the strategy to make safeguarding personal; Covid recovery; and Learning from Safeguarding Adult Case Reviews (SARS). Feedback to Imperial was very favourable with no identified gaps.

9.2 Section 11 of the Children Act 2004 places a duty on key people and bodies to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. This includes conducting self-assessment Section 11 audits to monitor the effectiveness of such arrangements. The audit includes six main headings:

- Leadership and accountability
- Policies and procedures
- Recruitment and selection
- Staff induction ,training and development
- Information sharing, communication and confidentiality
- Tailoring services for children and young people

Feedback to ICHT at the challenge event following the audit was very favourable and praised the organisation for innovation. Areas to focus on included:

- More accurate documentation of a child's words
- Better feedback form staff following training to assess learning

These areas for improvement will be a focus going forward through training and education for child safeguarding.

9.3 The safeguarding team have completed a number of internal audits during the year, with generally good results, which are reviewed at the safeguarding board. Going forward a more comprehensive plan that includes numerators, denominators and outcome measures will be developed to support oversight of practice standards across the board; to support case reviews and to comply with multiagency requests.

9.4 An external audit was carried out to review processes and controls around safeguarding adults in the Trust and provided 'significant assurance with minor improvement opportunities' in line with management's expectations. It concluded that this is driven by strong oversight by the Safeguarding Committee and Executive Management Board Quality (EMBQ), due to periodic and standardised reporting and robust policies in place to oversee safeguarding procedure.

9.5 All actions identified from any audits will be included in the annual work plan. Progress with actions will be monitored via the safeguarding committee and in quarterly reports to the Executive.

10. Policy

10.1 All Trust policies relating to safeguarding of adults and children and learning disability and autism are up-to-date. A minor amendment was made to the Domestic Abuse Policy, which is currently being ratified. The Chaperoning Policy has been updated and ratified. A new policy covering allegations against People in Positions of Trust has been developed and is being reviewed by People & OD to ensure it aligns with all people policies. A policy to support all safeguarding training requirements will be developed.

11. Key Achievements

- The increase in referrals across the whole of the safeguarding agenda represents significant progress in recognising risk in our patients. Compliance with all training is generally good. There has been good inter-agency partnership working through the case practice review groups and quality practice and challenge sub-groups.
- Work continues in partnership with the charity Redthread, who support young people where violence is involved. First aid talks are delivered to young people in by members of the safeguarding team as soon as clinically indicated and at weekends.
- The Trust's Women's Network in collaboration with the safeguarding team have finalised an action plan to achieve the Domestic Abuse White Ribbon accreditation. The White Ribbon Campaign (WRC) is a global movement of men and boys working to end male violence against women and girls. This will be launched in collaboration with the NHS sexual safety charter.
- An easy read leaflet for LD/A patients has been developed to highlight the risks of accidental fire hazards from medications such as emollients.
- A '16 days of activism' event was held during November and December to improve awareness of gender-based violence. Other awareness campaigns continued throughout the year and covered aspects such as private fostering, advocacy, discriminatory abuse and sexual abuse.
- Imperial has led work across the acute trusts in the sector to develop electronic safeguarding referrals. This has greatly improved the process and ensures consistent information.
- Through focused training and education, formal mental capacity assessments are now documented where a DoLS order is in place. Mental capacity assessment training is now available to all staff.
- A number of internal and external audits have been completed by the safeguarding team to gain assurance around practice and standards.

12. Key Challenges

- The increased activity and complexity across all areas of safeguarding continues to pose some pressures on the teams. This is constantly reviewed to ensure risks are managed and staffing is optimal to manage increasing case loads
- Whilst mental capacity training compliance is good audit and practice checks suggest that application is not always optimal – there will be a continued focus on training and education to improve this
- In addition to the virtual LD/A training, we are awaiting details of the face to face training requirements for higher level tier 2 training from the Integrated Care Board. Achieving compliancy is a focus for 2024/25.

- Some staff require a higher level 3 adult safeguarding training. We are awaiting detailed guidance on identifying exactly who these staff are and are currently working closely with divisions to ensure compliance before the guidance is finalised
- In a large complex organisation, maintaining training requirements to meet the key performance indicators will require continued focus and work.
- We are working with the medical photography department to ensure that we are providing an optimal service across the Trust for all safeguarding requirements and a project group has been tasked to collate a NWL clinical photography solution that will encompass the safeguarding elements required.
- The requirement for audit in safeguarding is often high and frequently involves multi-agency work. A robust audit plan that provides good statistical evidence will be developed to support oversight and maintenance of standards.
- Currently the independent domestic violence advisors in the emergency and sexual health departments are funded by charity monies. Going forward we will need to consider how to fund these posts permanently.

13. Conclusion

13.1 The Safeguarding Team continues to meet the requirements set out in section 11 of the Children Act 2004 and the Care Act 2014. In addition, the team have responded to increasing numbers LD/A patients. A review of staffing levels across the whole of safeguarding will take place to ensure we can continue to meet our legislative requirements.

13.2 Significant multiagency joint working, including a number of charities, has demonstrated the Trust's commitment to work together to improve the identification of concerns, and to protect children and vulnerable adults within the Trust.

13.3 The work across the Trust and partnerships would not be possible without the commitment of our front-line staff and the safeguarding team who demonstrate extraordinary professionalism, curiosity, challenge and commitment to safeguarding our patients.

14. Recommendations

14.1 The Trust Standing Committee is asked to note this report.

Appendices

Appendix 1: Definitions of Adult Safeguarding
Appendix 2: Safeguarding team structure
Appendix 3: Tiering system for high vulnerability

Appendix 1

The Care Act 2014 statutory guidance defines adult safeguarding as:

‘Protecting an adult’s right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult’s wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.**'**

Practitioners must act when it has **‘**reasonable cause to suspect that an adult in its local authority area, regardless of whether the person ordinarily lives there:

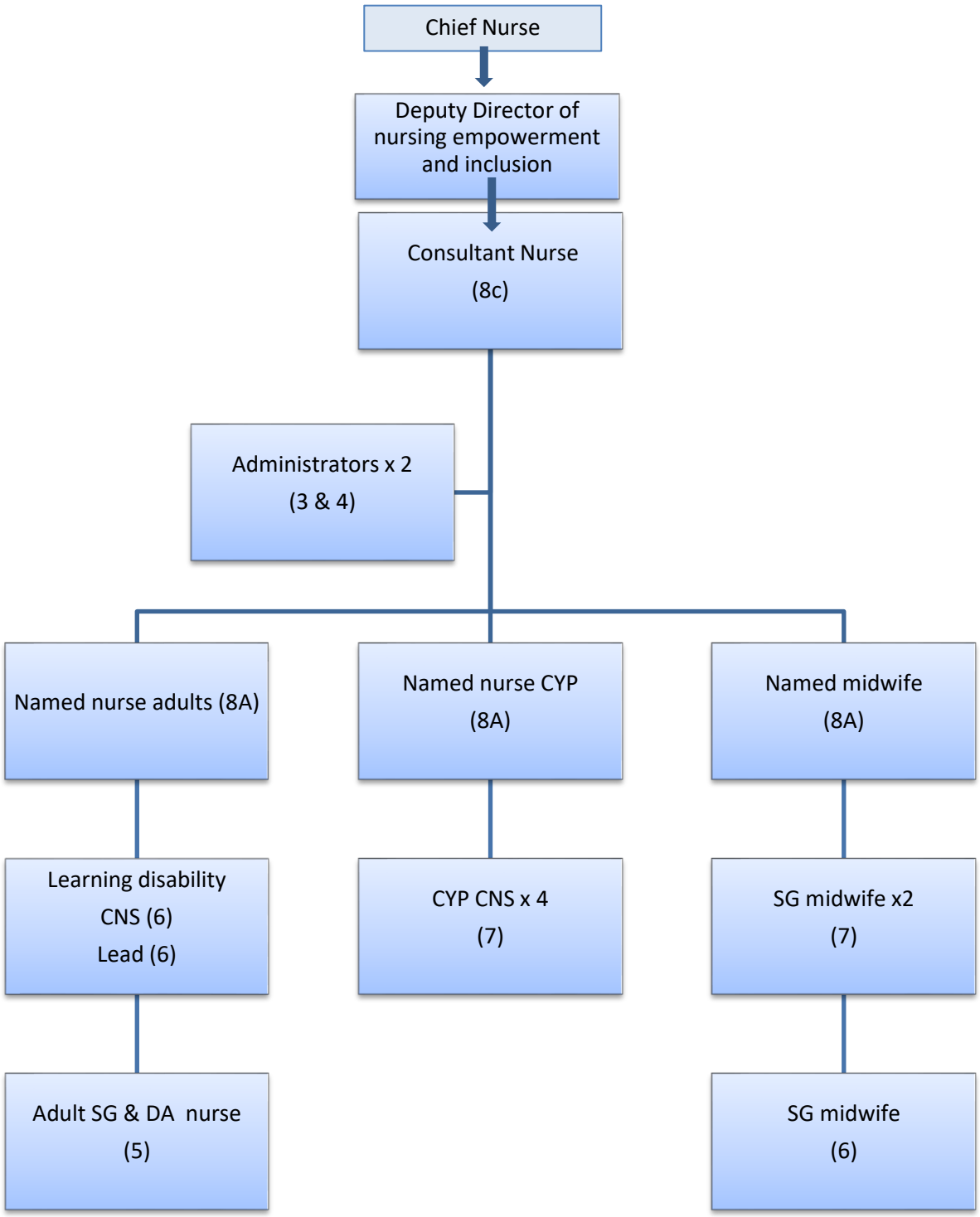
- has needs for care and support (whether or not the local council is meeting any of those needs);
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.**’**

Safeguarding is for people who have care and support needs because of issues such as dementia, learning disability, mental ill-health or substance abuse that may make them more vulnerable to abuse or neglect.

(Care Act 2014, section 42)

Appendix 2

Safeguarding teams Organisational chart



Appendix 3

Tiering System for maternity cases

The tiering system is categorised into Tier 1- Low, Tier 2- Medium and Tier 3 - High Risk. The criteria can be adapted according to professional judgement.

Tier 3
Under 15 at point of referral* Younger age may increase level of concern
Currently a LAC or LAC within last 3 years*
Referred to social care in this pregnancy (by any agency)*
Previous involvement with social care – children with CP or CIN plans*
Previous child(ren) removed by care order*
Child(ren) currently on CIN plan*
Child(ren) currently on CP plans*
Currently in prison/on probation*
Previous prison sentence (in context)*
Previous probation (in context)*
Homeless, sleeping rough*
Significant housing issues likely to result in homelessness or homeless but with current place to stay – but no recourse to public funds.
Physical/learning disability likely to significantly impact on parenting ability with little/no support*
History of overdose or suicide attempt within the last 2 years, or longer, but contributing factors have not resolved*
Current substance misuse (opiates) - heroin, methadone etc. or inhalants (aerosols), crack cocaine, class A drug, alcohol - use on-going in pregnancy*
Substance misuse (any substance, including alcohol) used as a coping strategy (e.g. for DV, mental health issues), or requiring use of support services*
History of significant substance misuse, but not currently using (opiates) - heroin, methadone etc. or inhalants (aerosols), crack cocaine, alcohol*
Current domestic abuse, or previous domestic abuse with same partner*
Previous domestic abuse but still in potential high risk contact with perp e.g. child contact*
History of domestic abuse with father of unborn baby (regardless of contact)*
History of significant MH concerns, including bipolar disorder, personality disorder, schizophrenia, eating disorder, self-harming, OCD **unstable/currently requiring treatment***
Significant deterioration in MH (antenatal or postnatal)*
History of psychosis/psychotic episodes*
Previous inpatient MH care for significant MH concerns (in context) including previous section under MH act*
History of abuse as a child – impacting/likely to impact ability to parent without support*
History of abuse as a child – perpetrator likely to/will have access to child(ren)*
History of sexual assault/rape – currently impacting on life/ability to parent e.g. PTSD, perpetrator poses a current risk etc.*
FGM – child(ren) have had/at risk of FGM*
FGM – woman herself is under 18*
Woman involved with gang/gang-related activity*
Woman victim of CSE or CSE suspected*
Woman has been trafficked/suspected trafficking*
Unbooked/No antenatal care – e.g. presents in labour/late pregnancy with no valid explanation for missing care.
Partner currently in prison/on probation (in context)
Partner/other household member has significant MH concerns e.g. bipolar, schizophrenia, psychosis, requiring MH input.
Partner/other household member currently using heroin, other opiates, crack cocaine, inhalants etc.
Partner currently using other class A drugs on a regular basis.
Booking >30 weeks with no valid explanation