Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Safeguarding Annual Report

2015-2016

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April 2016

Contents

Introduction

The purpose of this report is to provide assurance regarding arrangements within the Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBHFT) to safeguard and protect children and adults. The report provides an overview of activity relating to safeguarding children and adults setting out key risks and issues, and some examples of good practice and developments over the year 2015/2016. It should be noted that this report does not provide information about children in care /looked after children as this is within a separate report.

Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to creating high-quality health and social care. The people most in need of protection are children, young people and adults whose circumstances make them vulnerable/at risk. Safeguarding issues affect all patient groups across all specialities and services Trust wide and this report reflects this.

Section 1 An overview of safeguarding arrangements at DBHFT

The Director of Nursing, Midwifery and Quality is the trust Executive Lead for Safeguarding. The Head of Safeguarding leads and manages the corporate safeguarding team which includes

- Safeguarding adults - Lead Professional and Specialist Nurse
- Safeguarding Children – Named Nurse and Specialist Nurse
- Lead Nurse – Child Death Rapid Response
- Administration staff

In addition within the Child and Family Care group are:-

- A Named Doctor and Midwife, Safeguarding Children
- Designated Doctor for Safeguarding Children
- Designated Doctor Looked after Children
- Designated Paediatrician for Child Deaths

The Head of Safeguarding has overall responsibility in assuring that the Trust meets its safeguarding responsibilities working in partnership with Local Safeguarding Boards and its partner agencies.

The Trust has a Strategic Safeguarding People Board which oversees the safeguarding arrangements in the trust. Its purpose is to:-

- Provide leadership and strategic direction for maintaining, developing and implementing safe and reliable safeguarding systems and processes within the Trust.

- Provide the Trust Executive Group and the Board of Directors with assurance of the Trusts compliance with statutory regulations, obligations and standards in relation to safeguarding.

- To receive feedback and assurance from the Clinical Care Groups

The Strategic Safeguarding People Board is chaired by the Director of Nursing, Midwifery and Quality. As well as safeguarding professionals the membership includes Care Groups Head of Midwifery, Head of Therapy and Heads of Nursing so that each Care Group has a representative that provides assurance to the board. In addition, each Clinical Care Group has its own internal safeguarding arrangements.

Strategic Safeguarding People Board (SSPB)

Meeting attendance

Meeting	**Total number attending**	**Total apologies**	**Comment**
June 2016	15	8	1 governor attended
September 2016	14	7	
December 2016	20	7	2 governors attended
March 2016	Postponed to April 2016 due to venue unavailability		

Care group attendance - review September 2014 to December 2015

Care group	**Head of Nursing /Midwifery/Therapy or a care group representative at meeting**
MSK and Fraility	6/6
Child and Family	6/6
Outpatients and Diagnostics	5/6
Emergency Care	4/6
Surgical	5/6
Special Surgery	4/6

Section 2 Risks, issues, governance and assurance

Risks and issues

The Trust has a Safeguarding Risk Register which is reviewed at the Strategic Safeguarding People Board. It is expected that each Care Group has its own risk register and safeguarding is reflected in this as relevant to the Care Group and its services. A summary quarterly report (a condensed version of the safeguarding quarterly report), is provided to the Board of Directors via the Clinical Governance Oversight Committee giving the position with safeguarding activities within the Trust.

The current corporate risk items at the end of quarter 4 are:-

- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (Dols) - the risk relates to lack of evidence to demonstrate that the MCA is fully embedded in practice and that the trust is applying for DOLS whenever the clinical situation warrants this.

- Domestic Abuse – this relates to not fully meeting NICE guidance (2014) and the need to increase focus in the Trust on raising awareness and responding to Domestic Abuse.

- Child Death – this risk relate to the service arrangements to meet the service specification due to a vacant Child Death Paediatrician post (interim cover in place)

- Vacancies in the Safeguarding team- by quarter 4 the corporate safeguarding team will have two vacant posts - Specialist Nurse for Safeguarding Children and Safeguarding Secretary.

Assurance and compliance

Safeguarding declaration

In March 2015 the trust completed its safeguarding contract declaration. This is RAG (Red, Amber, Green) rated. There were no areas of Red, but a number of Amber (partial compliance) and actions and current position are identified as shown below.

Policy and procedures

To review and update trust safeguarding children and adults policies- Completed

To put in place a trust clinical / professional supervision policy – awaiting completion – in draft.

To put in place a trust advocacy policy. Established that a separate advocacy policy is not needed. To reflect advocacy in the revised Complaints Policy and included as a consideration in the process for policies.

Governance

Review capacity of safeguarding adult's team and options. Some work undertaken. Further review of corporate safeguarding team taking place 2016.

Head of Safeguarding and Complaints Manager to review complaints and PALS feedback and develop more formal process and expand to capture user feedback. To put in systems for analysis. Care groups also need to ensure they have a system in respect of safeguarding issues. Work undertaken by Head of Safeguarding and Patient Experience Team (complaints manager). Information sent out to care groups.

Further work to be done in relation to MCA audit and compliance. Improvements made- work continues re MCA/Dols.

Multi-agency working

Awareness of management of complaints or concerns about abuse needs to be raised in care groups, particularly in respect of timeliness and reporting safeguarding concerns in parallel with other investigations. Work undertake to raise awareness.

Recruitment and employment

Recruitment policies to be revised and updated - completed

Volunteer's policy to be published. The volunteer's policy is awaiting completion – in draft.

Training

Safeguarding Strategy to be completed - completed.

Volunteers to be nominated for safeguarding training- nominations taking place.

Care Quality Commission (CQC) Inspections

Trust wide inspection

In April 2015, the Trust underwent a Care Quality Commission (CQC) Inspection of its services clinical services at Doncaster Royal Infirmary, Bassetlaw District General Hospital, Retford Hospital and Montagu Hospital. The inspection was part of the CQC's scheduled inspection programme. As part of this inspection the key question 'are services safe' was asked.

Overall the Trust was judged as "requires improvement".

The CQC made positive comments in their reports about safeguarding arrangements and staff awareness of safeguarding and what to do if they have a concern, the safeguarding newsletter, policies and processes in place and supervision arrangements.

In relation to safeguarding the CQC concluded the following in their overall report:

- There was a mixed picture regarding safeguarding across the Trust
- The Trust's central reporting systems were weak and reported number of staff who had received training was low. However, locally held training records indicated more staff had received training.
- Staff were aware of their responsibilities in regard of safeguarding.
- Although there were safeguarding structures in place there was no formal Named Nurse in place from summer 2014 to March 2015.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (Dols) were captured within the question 'Are services effective'? The CQC found that most staff were aware of the MCA and DoLs, however there was a low level of DoLs applications. An issue was identified in relation to do not attempt cardio-pulmonary resuscitation (DNACPR) forms – some were not completed correctly. MCA assessments were not linked to DNACPR decisions.

The CQC report identified that the Trust must "Ensure that staff receive Mandatory training including adult and child safeguarding training". A range of other improvement areas were also identified related to safeguarding training, MCA/DoLs- training and implementation in practice and revision of the Trust Domestic Abuse policy. An action plan is being taken forward.

Nottinghamshire CQC Inspection, Child Protection and Looked After Children

A CQC Inspection took place in September 2015 in Nottinghamshire and this included services at Bassetlaw Hospital. The final report has been published and an action plan is being developed with DBHFT actions for the Emergency Department, Children's Services, and the safeguarding team.

The trust Named Nurse, Bassetlaw CCG Designated Nurse and Head of Safeguarding undertook assurance visits to the Emergency Departments at DRI and BDGH in January/February 2016 to look at action items arising from the CQC inspections for Child Protection and Looked after Children (including the CQC Child Protection and Looked After Children inspection in Doncaster in September 2014. A number of areas were identified for follow up actions.

Monitoring of compliance

The contract declaration, Savile actions and Safeguarding Self-assessment Audit Tool (DSCB/DSAB) all monitor compliance against a range of items. There are action plans in place.

Savile Enquiry

Monitor wrote to all Trusts in 2015 to ask them to review their current practice against the recommendations in the national "lessons learned' report, which drew on the findings from all published investigations into Jimmy Saville, television personality and celebrity. Actions were in four key areas: - volunteers, recruitment, social media activities and celebrities. All DBHFT actions are now completed except production of a volunteer policy/strategy (this is in draft).

Safeguarding Self-Assessment Audit Tool – Doncaster

In 2015 work has taken place between the Doncaster Safeguarding Adults Board (DSAB) and Doncaster Safeguarding Children's Board (DSCB) to develop a Safeguarding Self-Assessment Audit Tool incorporating Section 11 for children and a self-assessment tool for adults. The Check and Challenge process for DBHFT with the Doncaster Safeguarding Children and Adult Board members' panel took place in October 2015. There was positive feedback for DBHFT with some areas to follow up.

Section 3 Performance and activity

Contacts and enquires

The safeguarding team deal with a range of enquiries and calls for advice and support. These can range from a brief query with advice given to responding to complex issues, complaints and incidents. The Head of Safeguarding started monitoring this activity in quarter 2 and from quarter 3 has been looking at the source of the enquiry and themes.

	Total	Safeguarding adults	Safeguarding children	Contacts relating to Bassetlaw		Contacts relating to Doncaster		Contacts – nonspecific/unknown/other	
				C	A	C	A	C	A
April 2015	48	21	27	2	6	15	13	10	0
May	52	36	16	0	1	11	17	5	18
June	56	37	19	4	3	10	26	5	8
July	46	23	43	11 +2 Retford	3	23	17 + 2 MMH	7	1

August	33	17	16	16	0	11 +1 MMH	11 +1 MMH	4	5
September	65	37	28	4	5	19	23 +4 MMH	5	5
October	67	39	28	3	4	19	28 +2 MMH	6	5
November	51	27	24	5	1	15 +1 MMH	18 +1 MMH	3	7
December	55	24	31	3	5	19 +1 MMH	8 +5 MMH	8	6
January 2016	60	36	24	4	3	16 +2 MMH	25 + 1 MMH	2	7
February	59	33	26	2	0	20	32	4	1
March	55	30	25	1	4	19 + 1 MMH	23	4	3
There were a total of 647 telephone contacts									

C= children A = adults

It should be noted that whilst some calls were brief and straightforward many were complex and resulted in a number of actions. Some calls relate to both children and adults.

The key areas the contacts related to were:

Children

DNA's, missing child, neglect, safeguarding processes, records/information sharing, CSE/sexual abuse, self-harm, complaints, referral, bullying , transition services, carer issues, different types of abuse, child protection medicals, overdoses, IT issues, carer issue – adult with children/child of adult patient, overdoses, 16+ on adult wards, social worker's requesting notes reviews, domestic abuse, medication issues, drug misuse, pressure ulcer, vulnerable adults, dementia and impact on children, consent, possible non accidental injuries, records requests, historical CSE, parenting, self-harm, queries re policy, absconding issue, query re child protection medical, post natal depression, parental behaviour.

Adults

Self-neglect, neglect, discharge, financial abuse, domestic abuse, safeguarding referrals and investigations, learning disabilities, mental health issues, sexual abuse allegations, complaints, aggressive behaviour/behavioural issues, best interests, substance misuse, pressure ulcers, falls, restraint, MCA, DoLs, family conflict, drug misuse, discharge, updates on referrals/cases, social care issues, information requests, power of attorney, CSE, access

to notes, follow up of referral, allegations, discharge issues , self-harm, restraint, training query, issue re family/carers.

Safeguarding adults performance

During quarter 3 an issue was raised by the Doncaster Safeguarding Adults Board (DSAB) Performance Sub Group in relation to the timescales associated with the referral, strategy, investigation and over 70 days performance indicators which were comparatively worse when compared with previous year's data. The data relates to all stages of the process across all agencies.

DBHFT was formally requested to attend the Performance Sub Group and present the group with the relevant assurance or rationale behind the data so that the sub group could assure the Board in relation to safeguarding vulnerable adults. DBHFT were also asked to feedback on any actions being taken to improve the performance in relation to the data.

A number of actions have been taken to improve DBHFT internal systems and processes. The use of a whiteboard to provide a visual display to the safeguarding adults team of current cases. This provides a quick reference at a glance.a number of improvements Computerised tracking system already in place to this to provide more detailed tracking of cases and where they are in the process.

Safeguarding adult's referrals

<u>Safeguarding referrals about other services and individuals (e.g. care home, relative)</u>

This information was introduced into the quarterly report from quarter 2.

Quarter	**Number of referrals Doncaster/Bassetlaw**	**Category of abuse**
Q2	**6 BDGH** **DRI 14** **1 Lincolnshire**	Neglect 10 Physical 6 Financial 1 Self-neglect 1 Sexual 1 Emotional /physical 1 Physical/ financial 1
Q3	**18 DRI** **12 BDGH**	Emotional 1 Neglect 16 Physical 5 Financial 3 Domestic abuse 3 Self-neglect 1 Sexual 1
Q4	**DRI 26**	Neglect 17 Physical 9

	BDGH 6 **Rotherham 2**	Domestic abuse 2 Self Neglect 2 Financial 3 Emotional 1

Safeguarding referrals about DBHFT

This information was introduced into the quarterly report from quarter 2.

Month	Doncaster/Bassetlaw	Source of referral	Practice area	Category of abuse
Quarter 2	0 BDGH 6 DRI	5 external 1 DBHFT	Mallard x2 A&E x2 AMU x2	Neglect 4 Physical 1 Financial 1
Quarter 3	2 BDGH 10DRI	BDGH x2 OSAT x9 Ward 27 x1	A4 B5 Ward 24 Ward 3 A&E Kingfisher AMU Stirling A & E Ward 25 AMU Stirling Ward	Emotional 1 Physical 3 Neglect 8
Quarter 4	0 BDGH 7 DRI	OSAT (6) DRI (1)	ED AMU Renal 27 25 Pharmacy	Neglect 6 Neglect (dispensing error)1

OSAT= Operational Safeguarding Adults Team at Doncaster Local Authority

All of Quarter 4 were closed at alert, or did not meet the safeguarding threshold.There were also 4 referrals not meeting the safeguarding adults threshold that were in respect of discharge planning issues.

Child Protection referrals

This information was new to the quarter 3 report. The safeguarding children team review all child protection/safeguarding referrals as each copy is received and staff are contacted to feedback on areas for improvement and good practice.

Quarter 3

Referrals	Number	Staff designation	Domestic Abuse related	Parental Drug/Alcohol/Mental Health	Child Drug/Alcohol/Mental Health
Total	91	Nursing 80 Medical 9 Other 2	16	21	27
Doncaster	51	Nursing 41 Medical 8 Other 2	11	8	14
Bassetlaw	40	Nursing 39 Medical 1 Other 0	5	13	13

Quarter 4

Referrals	Number	Staff designation	Domestic Abuse related	Parental Drug/Alcohol/ Mental Health	Child Drug/Alcohol/ Mental Health	Other
Total	106	Nursing 86 Medical 17 Other 3	9	19	45	33
Doncaster	73	Nursing 53 Medical 17 Other 3	7	10	32	24
Bassetlaw	33	Nursing 33 Medical 0 Other 0	2	9	13	9

Corporate safeguarding team activities.

Key priorities in 2015 -16 for the corporate safeguarding team included "getting the 'safeguarding' message across to all staff" and "Visibility and accessibility of the safeguarding team". A range of activities have taken place to meet these objectives including:-.

- Trust safeguarding leaflet – updated and being distributed at training
- The team have attended departmental meetings to promote the safeguarding service and answer any questions.
- Screen saver with a safeguarding message about training

- Head of Safeguarding undertook the NHS Clinical Safeguarding Children Leadership Programme and as part of this undertook a project on raising the profile of safeguarding from ward to board. She was one of a small number of course participants who were asked to attend and showcase a poster presentation from their projects at the NHS England 3rd Annual Safeguarding Conference held in London in October 2015.
- Report to Board of Directors – quarterly report to Clinical Governance Overview Committee
- Safeguarding newsletter published and distributed trust wide every 2 months
- Team members attended preceptorship sessions during the year for newly qualified nurses.
- Audit timetable developed including face to face audits undertaken by safeguarding team members.
- Safeguarding Adults Team delivering Deprivation of Liberty /MCA workshops.
- Safeguarding Children Team delivering drop in sessions to the Emergency Departments
- Safeguarding Strategy published onto intranet and distributed August 2015.
- Range of items in staff bulletin DBH Buzz on training, profiles of the Safeguarding Adults Team and Safeguarding Children Team and a range of safeguarding activities and information.
- In September 2015 members of the Safeguarding Team attended the Trust's annual members meeting to display information about safeguarding and speak to members of the public and trust staff.

Newsletter

The first edition of a new Safeguarding Newsletter was distributed in November 2014. In 2015/16 newsletters were distributed in February, March, May, July, September, October and December 2015 and in February 2016. Topics included:

- Update on Care Act
- MCA/DoLs
- Child Sexual Exploitation (CSE)
- Learning Lessons
- Early Help
- Safeguarding Self-Assessment
- Inspections & Reviews
- Child Protection Information Sharing (CPIS)
- Safeguarding Supervision
- Prevent
- Domestic Abuse
- Professional duty to report FGM
- MCA/DoLS Lunchtime lecture & workshops
- Mental Health Act Training
- Midwifery actions in relation to Domestic abuse
- DSCB Multi-agency training
- Feedback from a Case Conference
- A week in the life of the Safeguarding Adult Team
- Safeguarding Question Time
- Safeguarding Training
- Annual Reports
- Private Fostering
- Paediatric Liaison Pathway Workshop

The Safeguarding Team continue to receive very positive feedback on the newsletter.

Emergency Department (ED) Drop-in Sessions

From July to September 2015, the Safeguarding Children Team piloted safeguarding drop-in sessions weekly in DRI and BDGH ED's and ad hoc in the Minor Injuries Unit at MMH. These have continued every week at BDGH ED and there has been very positive feedback about the support and advice offered. A revised plan is being put into place from April 2016 to implement a new plan for the ED drop in sessions at DRI.

Section 4 Policies and procedures

During 2015/16 a number of policies related to safeguarding were reviewed and updated. The safeguarding professionals also contribute to the writing and review of a range of other trust wide policies. At the end of 2015/16, the Trust is compliant with the following safeguarding policies:-

Safeguarding Policy	Comments/Actions
Safeguarding and Promoting the Welfare of Children Policy PAT/PS 10	Updated in 2015/16 to reflect a number for national and local changes
Safeguarding Supervision Policy PAT/PS 13	Up to date policy in place
Safeguarding Adults Policy PAT/PS 8	Updated in 2015/16 to reflect a number for national and local changes
Domestic Abuse Policy PAT/PS 12	Updated in 2015/16 to include specific reference to NICE Guidance 2014
Mental Capacity Act and Deprivation of Liberty Policy PAT/PA 19	Updated in light of the changes from Cheshire West Supreme court ruling.
Restrictive Practice Policy: Clinical holding, restraint and restriction PAT/PS 15	Revised in 2015 .Updated in 2016 to respond to national patient safety alert.
Prevent Policy CORP/RISK 25	The Trust Prevent Policy has been revised to reflect changes in training.
Female Genital Mutilation: Identification Reporting and Management PAT/T64	A new policy was developed to support the national Mandatory data collection and was then updated to reflect changes in this.

Section 5 Safeguarding Supervision

Safeguarding Supervision Policy

The Trust's Safeguarding Supervision Policy sets out the plan to provide professional and emotional support to staff working to safeguard children and adults, to promote good practice and support effective decision making. The Policy describes the arrangements for individual and group supervision with the safeguarding professionals providing individual supervision to supervisors who through a cascade model implement this in their clinical areas. Whilst safeguarding supervision originally focussed on safeguarding children, safeguarding adults supervision is now included within the Trusts arrangements and policy.

Safeguarding Supervision Training for Supervisors

Those practitioners providing supervision should be trained in safeguarding supervision skills and possess up to date knowledge of the legislation, policy and research relevant to safeguarding and promoting the welfare of adults and children. The Trust previously commissioned a series of 3 day Safeguarding Supervision training courses from an external trainer. However, this person retired and following a decision at the Strategic Safeguarding People Board (SSPB) in December 2014 an internal safeguarding supervision course was developed and has been delivered as shown in the table below. It is expected that those attending the training will take forward supervision in their area as per the trust policy.

Supervision Training for supervisors

Date of Course	**Total attendance**	**Did not attend /cancelled**
27th and 28th July 2015	**10** 8 ED Staff 2 Children's Nurses	1 cancellation
7th and 8th October 2015	**10** 3 Midwives 2 Children's Nurses 3 ED Nurses 1 Adults Nurse (Ward 16).	2 = 1 GUM Nurse 1 Adults Nurse (Musculo skeletal and Frailty Care Group).
1st and 2nd February 2016	**6** 3 Children's Nurses 1 ED Consultant 1 ED Registrar 1 Adults Nurse (Ward 25)	5= 2 ED Nurses 1 Adults Nurse(ward 18) 1 Midwife 1 Therapist (Dietetics) 1 Cancellation (1 Adults Nurse-Musculo skeletal and Frailty Care Group).

Examples of comments from training evaluations

- The course made me more aware of how supervision should be delivered. I will try to discuss supervisee issues, rather than telling them what is happening in safeguarding.

- Good mix of listening and participation- time went really quickly. I gained insight into the structure and approach that safeguarding supervision should ideally take and adaptions I can make within my work setting. Lots of positive aspects to the process.

- Fantastic 2 days but would include more Adult Nursing content. Really enjoyed it. Safeguarding someone is not a bad thing as I initially felt. The intent behind an act or omission doesn't deviate from the need to put safeguarding in place.

- I would like a bit more on the theory of adult learning and conducting an interview re- poor performance/ giving feedback. I learned where to find information I need in day to day practice, what supervision actually is and feel more confident about delivering it.

- The course was interactive and interesting, would have found it useful if we had pre-course reading. It would have been better to have a more structured (trainer guided) supervision practice session. I learned of the need for regular supervision sessions, to allocate time for sessions and to encourage other people to be involved.

- Gained confidence in providing safeguarding supervision. Safeguarding referral is not negative but about prioritising the patient

The training programme is now being reviewed and revised to ensure it focuses on key messages and information to support individuals to implement a plan in their areas and the most effective use is made of the trainers and participant's time.

Section 6 Safeguarding Training

A key priority for the corporate safeguarding team in 2015/16 was delivery of the trust training programme and demonstration of improvements in practice.

The Trust took a new approach to delivering Safeguarding training in 2015. This was to ensure the Trust meets its obligations in respect of safeguarding training and the best use is made of resources. Our safeguarding training from February 2015 has included Safeguarding Adults, Safeguarding Children, Domestic Abuse, Mental Capacity Act and Deprivation of Liberty, Prevent, Child Sexual Exploitation and Female Genital Mutilation

All new staff now receive a safeguarding leaflet as part of induction. The leaflet was revised to make sure it reflects the range of key safeguarding topics. Following this staff book on to safeguarding training. All staff undertake either a 2 hour awareness session appropriate for non-clinical staff i.e. those who do not have direct patient contact /care delivery or a full day training appropriate for clinical staff i.e. – those who do have direct patient contact /care delivery - nurses, doctors, midwives, therapists, health care assistants.

Staff working directly with children need to undertake level 3 training (Working Together). This must be accessed externally from the multi-agency programmes run by the Doncaster Safeguarding Children Board (DSCB) or Nottinghamshire Safeguarding Children Board (NSCB).Advice and information can be sought from the safeguarding children team.

Our safeguarding training has been adapted in response to comments made by delegates where appropriate for example adding in activities, adapting presentations , incorporating additional videos/ films and trying to encourage audience participation and interaction.

Training has been updated in line with government recommendations and legislation for example on FGM, CSE & Prevent.

The Training has been quality assured by local safeguarding boards – more formally by Nottinghamshire with the presentation of a certificate.

Training attendance

	Full day		2 hour session	
Month	**Number held**	**Number of staff attended**	**Number held**	**Number of staff attended**
April 2015	1	135	3	78
May	1	116	2	9
June	2	160	2	6
July	2	189	5	129
August	2	194	0	-
September	2	143	5	127
October	2	119	3	89
November	3	232	2	36
December	1	113	5	93
January 2016	2	130	3	63
February	1	35	1	10 1 session cancelled due to low numbers booking
March	1	81	2	26 2 sessions cancelled by the Education Dept. as inadvertently not released for booking on OLM
Total	**20**	**1647**	**33**	**676**

In total 2323 staff have attended the new training programme in 2015/16. From February 2015, the start of the new programme, to the end of the 2015-16 financial year a total of 2660 staff have attended the training.

Some comments from the evaluation forms from Quarter 4 full day training

Quiz very useful at end as useful revision of important messages.
More awareness of how to make referrals.
Interesting use of U-Tube DVD clips – found very helpful.
Refer to safeguarding for a discussion even if only a slight concern.
Learnt about FGM/CSE – greater understanding.
General awareness of safeguarding issues – knowing who to contact if you see any risk factors.
To be more aware on admitting patients as to their mental capacity about making decisions on their care.
More knowledge of DoLS – investigate how it impacts on our service in practice

Clarified the MCA process so good for me.
The massive amount of issues that safeguarding covers.
Excellent study day – knowledgeable lecturers and very relevant
Found Prevent talk interesting – realising people target vulnerable people.
How to refer in Doncaster as I come from a different Trust and it was completely different.
Being new to the NHS and the Trust the training opened my eyes to areas I hadn't really considered before, so all areas were enlightening.
Good training day – very interesting – thank you.
Be aware of children and how affected in Domestic Abuse case.
Feel happy to contact the safeguarding team knowing someone is there with advice.
Never heard of FGM before today.
Domestic abuse session was insightful and I now know how to contact people regarding this service.
It was very good to put a face to a name
Well presented – knowledge of presenters excellent
Personally a full day works well – very useful day – informative.
This is the first time I have had joint safeguarding training – found it better – also liked different speakers with more in-depth knowledge.
Like the examples – stories being used to make better practice and to highlight what goes on locally.
This training day was prepared excellently as it has tackled all areas of safeguarding vulnerable adults and children. The only thing to improve is the involvement or actual participation like in group activities.
The day was packed with very good content – we really do need all of it. The speakers were knowledgeable and clearly know about their specialist subject. They imparted this clearly and logically to the delegates.
Learnt several signs I would not have considered previously.
That safeguarding is a complex and emotive issue, documentation that is informative and accurate is essential.
Terrorism information was interesting. Learnt how to deal with disclosures, help available, how to refer.
MCA – I now understand this more clearly
I found the day to be really interesting – informative. Speaker's delivery was excellent and pitched at a level to keep my interest – I wouldn't change anything.

Other work has also taken place related to training. This includes:-

- The Head of Safeguarding has undertaken a review of safeguarding training and e-learning options. She has met with the E-learning lead in the Education Department to discuss e-learning packages. A plan will be developed to offer e-learning as an option to the face to face safeguarding training programme.
- Standardisation has taken place of safeguarding induction training for junior doctors across Doncaster and Bassetlaw.
- The Named Nurse and Head of Paediatric Nursing have done some work to negotiate a multi-agency training programme for level 3 safeguarding children updates to be hosted by DRI in conjunction with the Doncaster Safeguarding Children Board (DSCB)

but open to all DBHFT staff and other relevant agencies. This will commence in April 2016 and meets recommendations following the recent Nott's CQC inspection.

- The Trust has developed a new electronic Statutory and Essential Training book as part of its new policy. This will be completed on induction. The Safeguarding Team have developed a comprehensive safeguarding section for this.

Section 7 Audit activity

The corporate safeguarding team participate in a range of multi-agency audits and undertake single agency internal audits. Some examples are given below.

Multi-agency Section 47 Multi-agency audit - Doncaster

A Section 47 is initiated to decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm. A multiagency S47 audit was commissioned by the Doncaster Safeguarding Children's Board. The aim of the audit was to review how well the different agencies worked together. The audit was undertaken utilising an agreed methodology and professionals from all agencies participated. The audit tool included the referral process and strategy meetings/discussions, assessment and outcome for the child. Throughout the audit all participants focussed on "the needs of the child". All participants shared information in relation to their own agency/organisation. A final report and action plan have been produced.

Internal audit of Referrals to Children's Social Care

Trust staff are expected to confirm in writing all telephone child protection referrals. One of the Specialist Safeguarding Children Nurses completed an audit of completed multi-agency child protection referral forms in order to identify any common issues or problems and examine the quality of the completed forms.

Two months in 2015, July and August, were identified and all referral forms received by the safeguarding children team were included in the audit. The total number of referral forms received was 76. These included 27 forms within Bassetlaw and 49 within Doncaster. The 27 Bassetlaw forms were all completed in Accident & Emergency (A&E). Of the 49 forms completed in Doncaster, 43 were completed in the Emergency Department (ED). Others were completed in GU Medicine, Fracture Clinic and Dental Department.

The findings were generally positive and the majority of the referral forms included in the audit were appropriately completed. However approximately half of the forms required follow-up relating to documentation of the details of the social worker spoken to. Another reason for follow-up identified was inappropriate referral to children's social care, i.e. more appropriate for Health Visitor liaison in Doncaster and Bassetlaw or Doncaster Project 3

(support service for children and young people attending following misuse of drugs or alcohol).

The audit showed that Staff Nurses make all the child protection referrals in A&E at BDGH and the majority of referrals in ED DRI. It is not known if this procedural or coincidental but all grades of staff have a responsibility to make child protection referrals where they have concerns.

It has been identified on individual referral forms that staff do not obtain the social worker's name when referring overnight and messages are left. This was compounded in Bassetlaw due to the referral form, used at the time of the audit, asking staff to document social work team rather than name of social worker. The safeguarding children team are of developing a single child protection referral form, appropriate for an acute service, for use across all sites within the Trust. The use of this new form should help to address the above issues once in place.

Section 8 Incidents, reviews and learning

DBHFT safeguarding professionals and staff have contributed to a number of safeguarding reviews during 2015/16. Examples are given below.

A single agency Health Lessons Learned Review relating to a child death took place in Bassetlaw. This LLR was completed using the 'Welsh' model. There was input from Midwifery Services and Children's Services. A practitioner event (facilitated by the Designated Nurse and Doctor) was held. The final report included recommendations relating to interagency and inter-professional working. A midwifery liaison group was developed in Bassetlaw following this and Midwives have been identified to attend training in relation to disguised compliance.

In Doncaster a Lesson Learned Review took place in relation to an incident involving two young people in a residential child care unit. There was limited DBHFT involvement in relation to A&E attendances. The Head of Safeguarding was on the multi-agency Review panel. This review was undertaken using the SCIE methodology. This report was submitted to the Doncaster Safeguarding Children Board and wider action and learning will be taken forward by the Sub Groups.

Two multi-agency reviews in Doncaster took place relating to two child deaths. In one review the focus was on discharge planning and the other partnership working. Areas of good practice and for further improvement work were identified.

In Nottinghamshire there have been two serious case reviews relating to a husband and wife carried out using a Significant Learning Incident Process. The Lead Professional for Safeguarding Adults prepared written review reports on each case. No specific recommendations were made in the independent overview report relating to DBHFT. The A&E Matron participated in a practitioner event and she fed back that she was very impressed with the process and how well managed it was. The overview author had fed back that the reports submitted from organisations were very good.

Section 9 Specific safeguarding topics and activities

Domestic abuse

Over the last year, the Head of Safeguarding has attended the Domestic Abuse Chief Officer's group in Doncaster. Links are now being developed with Domestic Abuse work in Bassetlaw through liaison with the Domestic Violence Co-ordinator for Bassetlaw, Newark & Sherwood Community Safety Partnership.

Health Domestic Abuse Caseworker – Doncaster

Last year Doncaster Council received funding from the Police and Crime Commissioner to recruit a number of Domestic Abuse Caseworkers to enhance the current service. A full time Caseworker was allocated to DBHFT based within the Safeguarding Adult Team to promote work on raising awareness and responding to Domestic Abuse.

The Health Domestic Abuse Caseworker (DAC) started in post in August 2015. Following induction she undertook a baseline audit to assess staff awareness of Domestic Abuse. The results were variable as expected. This audit is being repeated at intervals to assess whether staff awareness is increasing as a result of both the safeguarding training and the case worker post.

The DAC has worked to raise awareness of Domestic Abuse and the Service through for example:-

- visiting wards and departments at DRI
- domestic Abuse Awareness Display in November 2015
- items in the trust safeguarding newsletter
- developing a programme of regular visits to the Emergency Department at DRI to offer advice and support and to help implement the referral process.
- delivered awareness sessions at team meetings
- meeting staff at the trust safeguarding training day
- delivering a session in the A&E mandatory training programme

As a result of working with the Domestic Abuse Caseworker Midwifery have re-introduced the 'blue sticker' process in maternity. Posters have been placed in all clinical area's which

advise women that if they would like to speak to someone in private regarding potential domestic abuse or violence then they can place a blue sticker on their urine pot or notes/growth chart and staff will ensure they are given the opportunity to speak to a member of staff alone during their attendance/stay.

Referrals to the DAC August 2015- March 2016

Month	Number of hospital referrals	Received from
August 2015	3	GUM, Dermatology, Midwifery
September	2	A&E
October	3	A&E
November	4	DCC, Midwifery, GUM, A&E
December	5	A&Ex2, self-referral, Midwifery, Speech and Language Therapy
January 2016	5	A&E x2 GUM x2, Rehab MMH
February	4	A&E , GUM, Speech and Language Therapy ,Children's ward
March	2	A&E, via safeguarding team

Female Genital Mutilation (FGM)

FGM Cases 2015/16

	New cases	
	Doncaster	Bassetlaw
April 2015	1	0
May 2015	3	0
June 2015	4	0
July 2015	4	0
August 2015	0	0
September 2015	2	0
October 2015	2	0
November 2015	2	0
December 2015	2	0
January 2016	0	0
February 2016	1	0
March 2016	0	0
Total	21	0

Two cases were reported from Genito Urinary Medicine and the remainder from midwifery services.

The Trust Policy on FGM has been updated to reflect changes in Data Collection and the new mandatory reporting for healthcare professionals of under 18 year old cases. An information section on FGM has been put within our safeguarding section on the intranet.

The Named Doctor and Named Nurse are emphasising the need to report FGM and the roles and responsibilities of the clinicians, through the internal Level 3 Safeguarding Course run by the Named Doctor . The Designated Doctor has cascaded information to all the consultant paediatricians and has done a presentation in one of the child protection medical peer review meetings. She also delivered a teaching on FGM to Bassetlaw GPs in February 2016.

Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoIs)

As a result of the Supreme Court ruling in May 2014 and the introduction of the acid test, an increase of the amount of requests was anticipated but this had not been seen at DBHFT. A snapshot "audit" which was discussed at the March 2015 SSPB meeting highlighting a significant under requesting of Deprivation of Liberty Safeguards.

Following on from the audit the safeguarding team developed and piloted DoLs workshops. Scenarios are used in the workshop to generate discussions about recognising if deprivation is evident. The workshop provides an opportunity to go through the process of completing DoLs forms and an exemplar form is circulated. Any questions or queries about the process can also be discussed. This model of workshops continues to be offered to all care groups/relevant clinical areas delivered by the safeguarding team.

<u>DoLs /MCA Workshops 2015/16</u>

Month	**Area/service /team booking workshop**	**Numbers attending**	**Comments**
April 2015	Ward 16	15	
May	Stirling Ward	14	
June	Ward 25	0	Cancelled by ward
July	A4	13	
September	Emergency Care Group sisters (BDGH) Band 6 development Day	15 6	
November	Mallard Ward 16	3 9	
December	Mallard x2	0	2 workshops cancelled by the Ward.
January 2016	Palliative Care Team	6	
February	Surgical Care Groups Heads	15	

<u>Audit</u>

In July 2015 the Lead Professional for Safeguarding Adults and Specialist Nurse for Safeguarding Adults carried out an audit to measure staff awareness in relation to the Mental Capacity Act 2005 and assess documentation in the clinical records in respect of the trusts compliance around Deprivation of Liberty safeguards. The findings demonstrated some improvement in understanding of MCA but there continued to be variable responses.

In relation to DoLs awareness appears to be increasing resulting in an increase of referrals although there still remain a number of patients on the wards where it cannot be evidenced that this appropriate safeguard is always being considered.

The audit was repeated in January 2016 and suggests that staff have an increased awareness of the Mental Capacity Act, although staff in in all areas would benefit from further activities to embed this.

At the December SSPB the Lead Professional for Safeguarding adults delivered a presentation to the group on the Law Commission Consultation on Dols. There was a discussion about the proposed changes.

DoLs applications

During 2013/2014 the trust made 7 requests for authorisation and in 2014/2015 there were 14 requests. The numbers since April 2015 are shown below.

Quarters (2015/2016)	Number of Applications	Doncaster	Bassetlaw
Quarter 1	13	9	4
Quarter 2	13	10	3
Quarter 3	18	15	3
Quarter 4	20	17	3
Total of 64 Dols application in 2015/16			

Training

Training on MCA and DoLS continues to be delivered within the new trust training programme.

A "Friday Lunchtime Lecture" took place on 11th December 2015 .The title was, "Are your patients free to leave? Deprivation of Liberty Safeguarding in acute hospitals" and this was delivered by solicitor John Glendenning. 70 staff, primarily medical staff, attended the session at DRI and 15 at BDGH.

John Glendenning has also delivered some MCA/Dols workshops in early 2016 funded by Doncaster CCG. A total of 44 clinical staff attended these workshops. Two further sessions will be run during May 2016.

Child Protection Information Sharing (CP-IS) programme

The Child Protection – Information Sharing (CP-IS) project is an NHS England sponsored work programme dedicated to developing an information sharing solution that will deliver a higher level of protection to children who visit NHS unscheduled care settings such as accident and emergency wards and walk-in clinics. It proposes to do so by connecting local authorities' child protection social care IT systems with those used by staff in NHS unscheduled care settings. The information sharing focuses on three specific categories of child only:

- Those with a Child Protection Plan
- Those classed as *Looked After* by the local authority
- Any unborn child that has a Child Protection Plan

Care settings that will use CP-IS include

- Accident and emergency departments
- Paediatric wards
- Maternity wards

Information continues to be has been shared across the Trust about CP-IS in the safeguarding newsletters and with key individuals. An IT Lead has been identified to support the Trust work on CP-IS and to liaise with local authority partners. A number of meetings have taken place with Care Groups and leads have been identified

Doncaster Children Services Trust (DCST) have a project group and DBHFT staff have attended meetings of this group. DCST have prepared information for their Social Care Staff and looked at arrangements for implementation in their services. Work is taking place to establish the IT arrangements so that implementation can move forward.

A CP-IS group is in place in Nottinghamshire. A Project Lead post has recently been funded to support implementation across Nottinghamshire.

Mental Health Act

A Care Quality Commission (CQC) visit to the Trust took place in in February 2013 to monitor how the Mental Health Act was used and how the trust manages patients with mental health issues. The Mental Health Act Commissioner who carried out the visit reported a number of key findings and following the visits an action plan was developed to include:-

- Agree a draft Memorandum of Understanding and a Scheme of Delegation with RDaSH to formalise the relationship and set out roles and responsibilities to administer the processes.

- Agree and implement a training programme for the Clinical Site Management Team in the use of the Mental Health Act.

In addition a number of actions were then identified including the need for a trust protocol, further training and awareness raising as well as a process to monitor, review and learn from incidents.

A quarterly meeting with RDaSH Mental Health Services representatives now takes place and includes a review of data and any issues and provides a forum for support and learning. This meeting includes a CSM representative, safeguarding representative and the Heads of Nursing /Midwifery/Therapy or their deputies.

PREVENT

Prevent is about taking a taking a multi-agency approach to share information and support vulnerable individuals. The national *Prevent* Strategy aims to stop people becoming terrorists or supporting terrorism.

The trust has in place:-

- an executive lead for *Prevent* –Director of Nursing, Midwifery and Quality
- an Operational *Prevent* Lead –Head of Safeguarding, who provides representation at local and regional Prevent groups.
- a *Prevent* Policy - aimed at supporting staff in the event that they have any concerns in relation to the radicalisation of a vulnerable person and guidance that includes an escalation process for both within and external to the Trust. The trust Prevent Policy has recently been updated.
- a training programme. The trust safeguarding training from February 2015 includes Prevent as a specific session in the full day training and a brief awareness in the 2 hour session.

Section 10 Partnership working

A priority in 2015-16 was to strengthen relationships within health and with partner agencies.

The corporate safeguarding team and trust's safeguarding professionals provide input to a range of safeguarding meetings and forums, including safeguarding boards sub groups and Task & Finish Groups and specific work streams, for example participation in safeguarding audits and lessoned learned reviews.

DSAB Peer Review/Challenge and strategic planning day

This review took place in November 2015. Members of the Safeguarding Team participated in the review process. A final report was discussed at a Board time out in February 2016 and

a plan prepared to address areas identified for development/improvement. The Head of Safeguarding attended this as the DSAB Board Member.

DSCB Challenge Meeting

Doncaster Safeguarding Children Board's (DSCB) local Learning and Improvement Framework covers a full range of single, multi-agency and thematic audits, case reviews and quality assurance processes which aim to drive improvements to safeguard and promote the welfare of children in Doncaster.

As part of the approach to quality assurance and challenge partners around data and performance thematic performance challenge meetings are taking place to gain further evidence from partner agencies, which will involve a "deep dive" looking at quantitative and qualitative data, engagement with service users and front line staff.

The DSCB Performance Challenge meeting for Children's Mental Wellbeing in February 2016 was attended by the Matron for Children's Services, Emergency Department Lead Paediatric Nurse and Head of Safeguarding. Following this there is a DSCB multi-agency audit taking place in which DBHFT staff will participate.

Safeguarding Board attendance

DBHFT is a partner member of the following boards:-

- Doncaster Safeguarding Children Board (DSCB)
- Doncaster Safeguarding Adults partnership Board (DSAPB)
- Nottinghamshire Safeguarding Children Board(NSCB)
- Nottinghamshire Safeguarding Adults Board (NSAB)

The Trust's board members are:

- DSCB and DSAPB- Head of Safeguarding
- NSCB and NSAB- Deputy Director of Nursing and Midwifery

	DSCB		DSAB		NSCB		NSAB	
	Meetings held	**Meetings attended**	**Meetings held**	**Meetings attended**	**Meetings held**	**Meetings attended**	**Meetings held**	**Meetings attended**
Quarter 1	1	1	1	1	1	1	1	0
Quarter 2	1	1	1	0	1	1	1	1
Quarter 3	1	1	1	1	1	1	1	1
Quarter 4	1	1	1	1	1	1	1	1
Totals	4	4	4	3	4	4	4	3

Section 11 Care groups- safeguarding activities

A range of safeguarding activities have taken place over the last year within in the Care Groups. A few examples are given below.

MSK and Frailty Care Group

- Group of Sister's have been identified to undertake safeguarding supervision training and to carry out Safeguarding Adults supervision in their clinical areas.
- A Rapid Tranquillisation Group has been established by Dr Rod Kersh. He is planning a webinar to help promote this and the group is growing.
- Dementia champions group meet monthly and this is open to all trust staff to share and improve learning.
- A dementia education lead has been recruited for 18 months fixed term contract through funding from Health Education England. She will help develop a tier 2 education package.
- Tier 1 dementia awareness video has had over 1000 hits on You Tube and is being shown at Statutory and Essential Training days.
- A business case for an enhanced care team was approved. This will be a pilot for 4 bands 2's who will be trained to provide 1:1 supervision to frail vulnerable patients.

Specialty Care group

- Work has taken place to develop a safeguarding risk log and action plan which goes to the care group governance meeting, where safeguarding is a regular agenda item.
- The Head of Nursing lead a piece of work to undertake a Training Needs Analysis to get a baseline of staff safeguarding training and to develop a plan for staff to undertake safeguarding training accessing the trust training programme .
- The Head of Nursing is also using the Ward Quality Assurance Toolkit and governance processes to address a number of safeguarding actions.

Pharmacy and Diagnostic Care Group

The Matron in the Pharmacy and Diagnostic Care Group facilitated a multidisciplinary training day for care group staff in December 2015 .The day included learning and development relating caring for the vulnerable and older person, particularly for groups of staff who are not providing ward based care.

Child and Family Care Group

Safeguarding related activities include:-

- The introduction of a Care Group Safeguarding Group to respond to safeguarding in the care group and provide assurance and feedback to the SSPB
- The adaptation of the Children's Integrated Pathways of Care (IPOC) document to ensure community services are informed if children are not registered with a GP
- The adaptation of the Children's IPOC to assist the implementation of the new CP-IS process
- Working with the Named Nurse to look at the different opportunities for level 3 safeguarding training for staff

<u>Bassetlaw CCG Assurance visits</u>

These assurance visits on the Bassetlaw site, led by the Nurse Consultant, Safeguarding look at quality and safeguarding. This year visits took place to SCBU and Midwifery. A number of areas of good practice were identified. An identified issue around communication between midwifery and SCBU staff when a baby is transferred has resulted in a pilot document being devised. The pilot of a transfer information document from Maternity to Neonates to ensure safeguarding and other important issues/communications are shared has been developed specifically with regards to information sharing around safeguarding and child in need issues .

Emergency Care Group – Emergency Departments

- From January 2016 the Emergency Departments (ED) are hosting Safeguarding Supervision sessions twice a month. Staff are booked onto these and these hours are accommodated in their off duty. A power point presentation has been developed to support these sessions. These sessions are hosted by one of the Band 7 Safeguarding Supervisors working in ED on a rota basis so they all facilitate 2 sessions per year. These sessions are minuted and minutes shared amongst services (anonymised).
- All Band 7's are now safeguarding supervisors and as well as hosting the pre-booked sessions will also deliver ad hoc support as required in the department following difficult cases / referrals.

- The Doncaster Domestic Abuse Caseworker and Lead Nurse Child Death Rapid Response continue to deliver sessions on the ED essential to role training on a monthly basis which all staff will attend over a 12 month period.

- The Clinical Educators represent ED at many meetings and forums- Clinical Governance, The Health and Social Care Meeting, Paediatric Critical Care Network and the Paediatric Trust forum. They incorporate best practice and lessons learned into training.

- The trust Safeguarding newsletters are shared for dissemination at supervision sessions.

Maternity Services

Safeguarding related activities include:-

- Very positive feedback from the Bassetlaw CCG deep dive safeguarding quality assurance inspection at Bassetlaw hospital.
- The pregnancy liaison meeting was nominated for a new innovation award in the trust's annual awards ceremony. It came in the top 3 and was recognised for improving communication between maternity and social care and improving multi-agency working within safeguarding.
- The Named Midwife been approached by 2 other trusts (Rotherham and Barnsley) who have now heard about the pregnancy liaison meetings to request information and learning as they would like to introduce the process in their areas.

<u>Pregnancy Liaison Meeting</u>

For midwifery the implementation in 2014 and continuing development of the Pregnancy Liaison Meeting has improved communication between midwifery and social care. It also means that cases can be discussed between the professionals attending the meeting and agreements made whether individual cases meet the threshold for social care involvement or early help services. This has also reduced the number of calls to the referral and response team in social care which they have welcomed.

In 2015 there has been a slight change to the pregnancy liaison meeting in Doncaster. Most of the time was taken up by doing background checks on new pregnancies where social care had been involved at some point. There is now a separate meeting with social care to do background checks only so that at the meeting those present can concentrate on discussing cases that may meet the threshold for referral as was the original plan. This is making the service more effective.

Doncaster

Pregnancy Liaison Meetings

Month	Number of cases discussed
April 2015	6
May	9
June	8
July	6
August	11
September	10
October	Meeting not held
November	18
December	14
January	16
February	17
March 2016	19

Background check meetings

Month	Number of cases discussed
April 2015	9
May	2 meetings (27 and 8 cases)
June	No meeting held
July	31
August	20
September	14
October	No meeting held
November	14
December	16
January	24

February	2 meetings held (30 and 20 cases)
March 2016	2 meetings held (23 and 26 cases)

Bassetlaw

Due to smaller numbers of cases the background checks are done and the cases discussed within the one pregnancy liaison meeting at Bassetlaw. All cases are sent to the Named Midwife who submits them to the MASH manager 10 days before the meeting and she brings any information for sharing. The meeting is held when there are cases to discuss.

Month	**Number of cases discussed**
July 2015 (First meeting)	6
August	No meeting
September	7
October	8
November	4
December	No meeting
January	12
February	No meeting
March	11

Child Death Rapid Response

A detailed update on the child death rapid response work is provided in Appendix 1 by the Lead Nurse for Child Death, Rapid Response.

During this quarter a risk in relation to this service was identified. This risk relates to the service arrangements to meet the service specification due to a vacant Child Death Paediatrician post. The Child and Family Care Group have advertised for a Community Paediatrician post to undertake this role. An arrangement has been put in place to maintain the Rapid Response rota cover with an interim cover.

Appendix 1 Child Death Rapid Response Annual Report

This report provides an overview of activity relating to the Child Death/ Rapid Response work, setting out any key risks and issues, good practice and developments April 2015 - March 2016.

1. Child Deaths 1.4.2015- 31.3.16

Expected Deaths	Q 1	Q 2	Q 3	Q4	Unexpected Deaths	Q1	Q2	Q3	Q4
Doncaster	9	4	1	3	Doncaster	2	4	2	1
Bassetlaw	0	1	1	3	Bassetlaw	0	1	1	1
Out of Area	0	0	0	0	Out of Area	1	0	0	0

2. Ongoing Child Death Caseload at 31.3.2016

Doncaster – Number of on-going Cases at 31.3.2016	Number of cases sent to Doncaster CDOP from 1.4.2015-31.3.2016	Total awaiting review that died during 2012/2013	Total cases awaiting review that died during 2013/2014	Total cases awaiting review that died during 2014/2015	Total cases awaiting review that died during 2015/2016
26	23	1	1	4	20
Bassetlaw – Number of on-going Cases at 31.3.2015	**Number of cases sent to the Nottinghamshire CDOP from 1.4.2014-31.3.2015**	**Total awaiting review that died during 2012/2013**	**Total cases awaiting review that died during 2013/2014**	**Total cases awaiting review that died during 2014/2015**	**Total cases awaiting review that died during 2015/2016**
10	5	0	0	3	7

3. Service Delivery

- During the first 3 quarters of the reporting period, there were 2 identified Designated Paediatricians providing the lead roles of the Rapid Response service within Doncaster and Bassetlaw, supported by an identified Lead Nurse and a Safeguarding Secretary for the Rapid Response service. However, since 31st December 2016 there has been a vacant Designated Paediatrician post for Child Deaths within Doncaster. During March 2016, the Bassetlaw Designated Paediatrician agreed to provide cover across Doncaster for a 3 month period from 1st April 2016 until 30th June 2016, whilst recruitment plans are implemented.

- There is a 1:6 rota in place, currently supported by 1 Consultant paediatrician and 5 Rapid Response Nurses. The service is provided from 9am- 5pm Monday to Sunday. All staff contributing to the Rapid Response rota has attended appropriate training in order to undertake the role. During quarter 1 of the reporting period, there was 1 occasion where due to availability; 1 day rota cover was not maintained. This issue was recorded on the Trust's risk management system Datix as an adverse incident and the Rapid Response Contingency plan was implemented. There were no

child deaths on this date. An action was taken to reduce this occurring again by ensuring more effective and timely distribution of rotas.

- The Lead Nurse completed a review of the Rapid Response service against the Service Specification, for discussions with the Child and Family Care Group. However the resignation of the Doncaster Designated Paediatrician for Child Death and the vacant post meant that recommendations within the review were not progressed. The Lead Nurse recommends this work is revisited in order to develop a long term plan for the service.

- During the first 3 quarters of this review period, the Trust Rapid Response team maintained representation to the Doncaster and Nottinghamshire Child Death Overview Panels. During quarter 4, attendance in Doncaster could not be maintained due to the vacant Designated Paediatrician post and this resulted in cases not being able to be discussed. .

- The Designated Paediatricians and Lead Nurse for the Rapid Response have established regular feedback with the local Nottinghamshire Child Death Peer Support group network and development groups during the review period.

- The Lead Nurse for the Rapid Response has produced quarterly and annual reports as an appendix to the Safeguarding reports to NHS Doncaster Clinical Commissioning group, which are shared directly with the NHS Bassetlaw Clinical Commissioning Group.

Following negotiation with lead professionals of the NSCB and DSCB Child Death Functions during quarter 4, it was agreed that all future reports will include the additional detail below relating to performance.

Unexpected Deaths in Doncaster	**Response in 24 hours Yes or No**	**If timescale for response not met- explanation**	**Home Visit Yes or No**	**If no home visit- provide explanation**	**Date the Initial Discussion meeting is held**
Qtr 1 2015/16 DC 2015 05 A DC 2015 05 C	Yes Yes	NA NA	Yes No	 Not required. Child died in SCH and cause of death was medical.	07.05.15 21.05.15
Qtr 2 2015/16 DC 2015 07 A DC 2015 08 A *DC 2015 08 B	Yes Yes Yes	NA NA NA	Yes Yes Yes	NA NA NA	15.07.15 04.08.15 19.08.15
Qtr 3 2015/16 DC 2015 11 A DC 2015 12 A	Yes Yes	NA NA	No No	Road Traffic Accident Child died in hospital	12.11.15 07.12.15
Qtr 4 2015/16 DC 2016 01 B	Yes	NA	No	Child died in hospital	13.01.16

Unexpected Deaths in Bassetlaw	Response in 24 hours Yes or No	If timescale for response not met- explanation	Home Visit Yes or No	If no home visit- provide explanation	Date the Initial Discussion meeting is held
Qtr 1 2015/16	0	NA	NA	NA	NA
Qtr 2 2015/16 U5(15-16)	Yes	NA	No	Baby died in hospital following birth (30 wks+1 day gestation)	29.09.15
Qtr 3 2015/16 U8(15-16)	Yes	NA	No	Child died in hospital	30.10.15
Qtr 4 2015/16 U12(15-16)	Yes	NA	No	Child died in hospital	07.03.16

* This death was not notified to the RRT until 17.08.15 (2 days following death). Rapid Response was therefore in timescale from the time of notification. The Locum Consultant Paediatrician carried out the Home Visit.

4. Child Death Team achievements and activities during the review period

- The team developed and implemented SUDIC (Sudden Unexpected Death in Infancy and Childhood) boxes within the 2 Emergency Departments within the Trust, which contain relevant guidance, information and documents required by staff when a child dies unexpectedly and presents to the Emergency Department.

- The Rapid Response team developed and implemented a system to ensure all Trust Staff involved with child deaths are made aware of support systems within the Trust. All Emergency Department staff now receive information regarding support and the Child Death Functions in a written format following their input with individual cases.

- A bereavement support mapping exercise was completed with regard to the Doncaster area which identified what support individual disciplines offer families and staff. This work is currently being repeated within Bassetlaw.

- The Designated Paediatrician is working with relevant professionals within the Trust in order to secure agreement of the Emergency Department Medical Protocol in line with requests from the Doncaster and Nottinghamshire Coroners.

- The Rapid Response team have established systems to ensure that relevant information and learning from the Children and Families' Care Group Mortality meetings is incorporated into the Rapid Response process.

- The Lead Nurse contributed to work with the DSCB (Doncaster Safeguarding Children Board) relating to the revision of the Rapid Response/Child Death procedures.

- The Rapid Response team developed systems which enable the tracking of and identification of the status of all on-going child death cases across Doncaster and Bassetlaw. This has enabled on-going monitoring of action completion and /or auditing of the timescales of the child death process. Audit reports relating to aspects of the Rapid Response service, in line with national practice standards are now produced on a six monthly basis. The first audit completed during quarter 4 identified learning with regard to information gathering when children dies out of area and guidance has been produced in order to improve practice.

- The Rapid Response team now hold regular team meetings in order to share information, good practice and learning.

5. Training

The lead Nurse for the Rapid Response developed an annual training plan which outlines arrangements for delivering training regarding the Child Death Review and Rapid Response Team functions. Professional groups that regularly contribute to the child death rapid response process were prioritised and a commitment made to ensure contribution to multi-agency / multi-disciplinary training within Doncaster and Bassetlaw.

Training Delivered	Date	Number of Participants	Staff Group
Child Death Functions and Rapid Response Process training.	10.04.115	12	Emergency Department
Child Death Functions and Rapid Response Process training.	17.04.15	6	Emergency Department
Child Death Functions and Rapid Response Process training.	18.05.15	18	Referral & Response (Doncaster Social Care)
Child Death Functions and Rapid Response Process training.	12.06.15	33	Consultants, Associate Specialists, Staff Grades, Junior doctors and other staff
Child Death Functions and Rapid Response Process training.	17.06.15	10	Emergency Department
Child Death Functions and Rapid Response Process training.	25.06.15	8	Emergency Department Doncaster
Child Death Functions and Rapid Response Process Training. Specific focus upon modifiable factors and learning from child deaths.	26.06.15	12	Training with Dr Al Kabir for Paediatrics
Child Death Functions and Rapid Response Process training.	15.07.15	18	Emergency Department
Child Death Functions and Rapid Response Process training.	13.08.15	11	Emergency Department
Child Death Functions and Rapid Response Process training.	27.08.15	4	Bassetlaw Hospital Staff
Child Death Functions and Rapid Response Process training.	22.09.15	11	Emergency Department Nurses
Child Death Functions and Rapid Response Process training.	22.09.15	3	Emergency Department Medical Staff
Child Death Functions and Rapid Response Process training.	10.11.15	8	South Yorkshire Police – Traffic Division

Child Death Functions and Rapid Response Process training.	07.03.16	10	DSCB Multi Agency Training
	Total Trained	**164**	

The annual training plan will be reviewed during quarter 1 2016- 2017.

Additional to the above training delivered on a face to face basis, the Lead Nurse distributed an Educational Brief relating to the Child Death Functions to the Child and Family Care Group.

6. Incidents, learning, actions and developments.

Incident Occurred	Learning Identified	Actions and developments
Quarter 1	Incident related to an occasion where due to unforeseen circumstances the Rapid Response professionals could not provide cover for 1 day.	This led to the development and implementation of a contingency plan.
Quarter 2	A complaint to the Trust determined that a formal agreement is not in place with Sheffield Hospital regarding the distribution of memory boxes.	Following liaison with the Sheffield Children's Hospital child bereavement team, a temporary plan is in place. Work is on-going to establish robust systems for the management and distribution of memory boxes within both Doncaster and Bassetlaw. This work includes a plan to develop child "bereavement packs" for families.
Quarter 2	There was an incident relating to the delayed reporting of a child death to the Rapid Response team within the Trust.	This led to the development of an escalation plan for use when a Rapid Response person does not respond to a call and the development of strategies to raise staff awareness and knowledge of the Child Death Functions within the Emergency Departments of the Trust.
Quarter 2	Two unexpected child deaths occurred abroad.	This identified learning relating to the pathway for Rapid Response team information gathering.
Quarter 3	No new Incidents	-
Quarter 4	Incident relates to a delay in sharing information with other agencies in a timely way following the death of a child and parental perceptions regarding a lack of support from the Trust post the child's death.	Plan in Place 1. Incident is subject to an internal review. 2. Work on-going with Children and Families' Care group to; • Introduce SUDIC boxes within the children's ward environments, ensuring all relevant information for staff and patients is readily accessible in the event of unexpected child deaths. • Drop- in Educative sessions to be trialled for a period of 4 months. • Policy to be updated when new guidance is developed. • Work with Hospital Chaplain to ensure arrangements re- memory boxes and any bereavement packages are included within SUDIC boxes.

7. Dissemination of Local and National Learning from the Child Death Review Panel (CDOP) process.

In order to disseminate national and local learning from child deaths, information has been incorporated into the Trust Safeguarding Newsletter and Rapid Response training events.

Where learning is specific to an identified single agency area- this is managed on an individual basis, including the development of action plans with relevant practice area or service managers.

Where learning relates to external agencies, the Lead Nurse liaises with relevant managers and where appropriate, learning is taken forward by the Local Safeguarding Children Board.

8. Issues/ Risks

There is a temporary plan in place to cover the work of the Vacant Designated Paediatrician for Child Deaths within Doncaster.

Currently 5 Doncaster cases are awaiting approval and can then be presented to CDOP and 13 cases require further work. All other cases are not currently ready to progress.

9. Team Priorities for the Period 1st April 2016- 31st March 2017.

1.To work with the Designated Paediatrician providing temporary cover for the Doncaster area to prepare cases for Doncaster Safeguarding Children Board Child Death Overview Panel (CDOP) in order to reduce backlog of cases.

2. Develop and implement SUDIC boxes within the children's ward environments, ensuring all relevant information for staff and patients is readily accessible in the event of unexpected child deaths.

3. Work with Hospital Chaplain to ensure arrangements re- memory boxes and any bereavement packages are included within SUDIC boxes

4. Provide drop- in Educative sessions for a period of 4 months within the Children and Families' Care Group and evaluate effectiveness.

5. Child Death Policy to be updated when new internal guidance for ward staff is developed.

6. Designated Paediatrician to secure agreement and implement the Child Death Medical Protocol.

7. To develop and implement at 2016/2017 Rapid Response Training Plan

8. To provide 6 monthly Rapid Response performance audits to the Doncaster and Nottinghamshire Child Death Overview Panels.