Here
Annual Safeguarding Report

SAFEGUARDING ANNUAL REPORT

1 January - 31 December 2016

and

SAFEGUARDING ACTION PLAN

For 2017

Purpose:

The purpose of this report is to provide assurance to HERE board that the services for which it is accountable are operating responding appropriately and within best practice guidelines with regards to the safeguarding of vulnerable adult and children.

Authors:

Peter Ley, Wellbeing Operational Manager (Safeguarding Manager)

Jon Ota, Assistant Director (CQC Registered Manager)

Naomi Eades-Cornall (Quality Coach)

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Registered offices at Fourth Floor, 177 Preston Road, Brighton, BN1 6AG

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1   Introduction and Purpose

The following report and action plan for HERE has been submitted by the Safeguarding Manager.

The purpose of this report is to provide assurance to HERE board that the services for which it is accountable are operating responding appropriately and within best practice guidelines with regards to the safeguarding of vulnerable adult and children.

Colleagues in all parts of the organisation and within every service may have to respond to a situation where a vulnerable adult or child is subject to potential abuse or neglect. It is the Board's responsibility to assure itself that the culture, systems and processes are in place to enable colleagues to act it the best interest of the child and are well supported in doing so.

2   Current Approach to Safeguarding

HERE uses the following mechanisms to identify and deal with any issues that may arise, as they arise.

2.1   Policies and Procedures

Responding to safeguarding concerns is likely to be an infrequent occurrence for most colleagues in HERE services. These policies not only articulate role responsibilities, but provide guidance to colleagues should a situation arise. All colleagues are made aware of the Policy during their induction to the organisation. It is therefore important to ensure the organisations policies and procedures are up to date, to reflect best practice, incorporate legislative changes and the developments in the local health economies we work in. To this end the Safeguarding Manager and CQC Registered Manager review the policy on an annual basis. The annually reviewed Safeguarding policies accompany this report and require Board ratification.

Following sign-off, these will be cascaded to all Colleagues and clinicians to ensure they are aware. These documents are reviewed on an annual basis or earlier if legislation changes and the documents require amendments.

2.2   Training

People's awareness of who is considered a vulnerable person, what constitutes abuse, what to look out for, what colleague's responsibilities are and how to respond in a safeguarding situation is important.

All colleagues, whether employed or on contract are required to undertake statutory and mandatory training. Safeguarding training is provided by an e-learning on-line package. This training package has been nationally assessed as complying with guidelines and is regularly reviewed and updated by the training provider.

At the start of a clinician's employment or contract a Governance Assurance form is completed by the relevant services Clinical Director and evidence of statutory and mandatory training already undertaken is gathered. The training policy dictates that at the time of new recruitment or contract start, evidence of training having been undertaken must not be more than 12 months old. This applies to all Clinical personnel, regardless of their employment/contract status.

All new non–clinical personnel are required to complete training within their first three months. HERE safeguarding training requirements are as follows:

Safeguarding Child Training

People who should carry out Safeguarding Children and Young People (SGC) training Level 1, Level 2a and Level 3	The Safeguarding Manager, every three years Clinical personnel that see children
People who should carry out Safeguarding Children and Young People (SGC) training Level 1 and Level 2a	All clinical personnel – both employed and on contract, every three years
People who should carry out Safeguarding Children and Young People (SGC) training Level 1	All non-clinical personnel – both employed and on contract every three years

Safeguarding Vulnerable Adults Training

People who should carry out Safeguarding Adults- Level 1	All colleagues, both employed or on contracts with HERE - every three years
People who should carry out Safeguarding Adults training – Level 1 and Level 2	All clinical personnel, both employed and on contracts with HERE – every three years

Once evidence of training has been received, HR populates the HERE Training Matrix with the data. The Training Matrix has the ability to monitor expiry of training. The Individual Training Report pulls the data from the Training Matrix and is used by Line Managers or Responsible individuals in self managing teams to monitor Colleagues levels of training.

Training data is monitored on a monthly basis by middle management to ensure we are working towards our target of 85% of all colleagues trained at any one time. Current training coverage is shown below:

Current percentages of Colleagues who have undertaken safeguarding training is as follows:

Safeguarding Children – Safeguarding Manager	100%
Safeguarding Children – Clinicians	94%
Safeguarding Children – Non clinicians	84%
Safeguarding Vulnerable Adults – Safeguarding Manager	100%
Safeguarding Vulnerable Adults – Clinicians	92%
Safeguarding Vulnerable Adults – Non clinicians	87%

ACTION REQUIRED

Clinician safeguarding levels are above the agreed target of 85%, however to increase this percentage service leads will continue to ensure that staff/colleagues in their service area complete training on time. Particular attention will be given to ensure new members of staff complete mandatory training as part of their induction. Non-Clinician levels are 1% below target for safeguarding children, service leads will review to ensure training is completed.

2.3   Support and advice to colleagues - Safeguarding Log

Should a colleague have a situation they need support and advice on beyond their service lead, the safeguarding manager, CQC registered Manager or within Wellbeing the Wellbeing Safeguarding lead is available to provide this. Safeguarding experts within the CCG, SPFT or SCT are available to these colleagues should they be required. The Safeguarding Manager keeps a log of all safeguarding queries received. The purpose of this log is to enable the organisation to better understand the types of situations colleagues encounter, spread learning and identify gaps in learning. For the period 1 January to 31 December 2016 there have been 5 Safeguarding incidents and complaints logged.

2.4   Incidents and Complaints

HERE has an Incident Policy, which includes Major Incidents and a Complaints Policy. All clinicians use these as directed by their Service Level Agreement (SLA) or employment contract. This makes it clear that the HERE policy should be employed rather than any policy of the site where they may be delivering the service. These policies are regularly reviewed to ensure they stay compliant with relevant legislation.

The Complaints and Incidents policies lay out timescales for issues reported to be addressed. Priority is placed on ensuring patient safety and correcting any system errors.

All new incidents and complaints are reviewed regularly in team briefings. Incidents and Complaints remain open until all learning has been actioned and if appropriate, shared across the organisation and with the Patient Safety Group. The Patient Safety Group review Incidents and Complaints with shared learning on a weekly basis to identify themes for shared learning and possible system improvements. All risks are closed via the appropriate Clinical Quality Group which meets on a monthly or bi-monthly basis. If incidents or complaints identify risks that we are unable to mitigate entirely, they are added to the Appropriate Risk Log. Each service provides the Board with an annual report which includes all Incidents and Complaints. The report details volumes, services, grades and themes etc.

2.4.1   Audit of Incidents and Complaints

The annual audit of incidents and complaints for the following services identified the following types of safeguarding incidents or complaints for the period 1 January – 31 December 2016.

Service	No. of Safeguarding Incidents and Complaints for the period	Details of incident or complaint
MSK	1	A female patient was seen in a hip clinic with a 7 week history of hip pain. Gave no history of trauma, an MRI showed bilateral

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		iliac blade fractures with some healing. The clinician was concerned as this was an unusual injury and may be non-accidental. The patient had significant mental health issues and is a vulnerable adult. The GP was informed and had a discussion with the clinical director of the secure unit where the patient was staying. This was reported to the social care direct safeguarding team. The patient access administrator was informed and alerted the mental health team.
Wellbeing	2	A GP reported to the service that a patient had made allegations of misconduct against a member of staff in the service. The service was notified that a patient had been charged for violence towards a family member, patient was not open to Wellbeing at that time so no action required.
Memory Assessment Service	0	N/A
CPAMS	0	N/A
Croydon Gateway Service	0	N/A
Human Resources	0	N/A
Primary Care Collaboration	2	**(A)** A Proactive Care GP raised this significant event after sending a safeguarding referral on 30/06/16. A previous SG referral for the same patient had been sent (02/06/16) but wasn't actioned. Attempts to contact the patient ahead of making the referral were unsuccessful. An email received on 11th July indicted the referral had been dealt with and a follow up call would be beneficial. The Head of SG received an email on 18th July to say the patient had received a visit from a social worker and an action

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		plan had been put into place. The patient had not been put at any risk in the time this was being investigated.
		Email from Head of SG (20/7/17) indicated the following findings:-
		Email inbox used by the team is liable to create further risk of such an incident occurring, as safeguarding concerns are not flagged up separately within it. Thus causing the situation of them getting lost amongst other email traffic.
		In order to prevent a reoccurrence it has been agreed that no further emails are to be placed in the email inbox, and the inbox will be deleted. Any concerns, or other information, which is to be triaged by the team will be (a) opened directly by a named worker or (b) remain in the main duty inbox where they will be monitored as part of established procedures.
		(B) - A Proactive Care GP, raised this significant event following a visit to a proactive care patient on 12/07/16.
		Previous concerns regarding the alleged misuse of prescription drugs had been raised. Concerns have been raised with the Safeguarding team and were logged with other relevant organisations.
		It was found that the patient was not at any potential risk however it was important that the patient not be made aware of this concern as it would affect the outcome.
		This matter was referred on and from the evidence we have it does not appear we know the final outcome.

		The CCG were also informed.
Diabetes	0	N/A
Community Eyes	0	N/A
Workflow	0	N/A

2.5 Audits

An annual audit of the safeguarding alerts and incidents identified that:

- Logging of safeguarding incidents on the database is happening but these incidents are hard to identify retrospectively.

ACTION REQUIRED:

- The organisation is in the process of moving over to a new Incident and Complaints database called Datix. As part of the design process Datix will be asked to include a prefix that allows us to identify Incidents or Complaints linked to Safeguarding. We will ask that access is restricted to nominated individuals for Safeguarding Incidents and Complaints meaning sensitive data will only be visible to nominated individuals.

3 Key Findings and Recommendations

3.1 Review of actions for previous period 1 June - 31 December 2015

Objective	Update
Ensure a minimum of 85% compliance of required safeguarding training at any one time	Non Clinical staff Safeguarding children remains outstanding by 1%. All other areas are compliant
Pay particular attention to ensuring new members of staff complete mandatory training as part of their induction.	The organisation are developing a new on boarding process, training will continue to be included in the induction process.
Publish this report on the HERE website.	This was complete for 2015, following the Boards approval this report will be updated on the website.
All staff colleagues to be made aware, via Middles, of the Safeguarding Manager role and advice available	This role needs continual promotion.
All safeguarding incidents to be logged with the prefix [Safeguarding]. Incident log to be reviewed to include a drop down for 'Safeguarding'	This will be taken forward via the project to introduce 'DATIX' as the reporting system

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3.2   Findings and Recommendations from this report

The annual review of safeguarding arrangements in the organisation has found that there appears to be some confusion around what a Safeguarding Incident and Complaint is and the difference between these and actual Safeguarding alerts. As there is currently no way of flagging a Safeguarding Incident or Complaint on the current Access database, to gather this information we rely on service member's recalling Incidents and Complaints from the previous year. Short of this we would need to review a full years' worth of incidents and complaints to identify those linked to Safeguarding. This process needs reviewing, however the organisation are in the process of transferring to Datix which should resolve the issue as Safeguarding can be added as a prefix meaning an annual audit can be done easily to identify across the organisation Incidents and Complaints linked to Safeguarding.

The board is asked to approve this report and agree the actions proposed. Once approved by the board, this report will be published on the HERE website.