Report To:	Risk & Clinical Governance Executive Committee
Date of Meeting:	July 2012
Title of Report:	Safeguarding Annual Report
Status:	For discussion
Board Sponsor:	Paul Keedwell: Director of Operations and Nursing
Author:	Penny Rogers; Head of Safeguarding
Appendices:	1 – Safeguarding Children Performance Activity data 2 – Safeguarding Adults Performance Activity data 3 – MCA & DoLS (pan essex) Report

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1.1 Purpose of Report

The purpose of this report is to inform and update the Board of the current status in meeting the requirements of safeguarding children and safeguarding adults.

1.2. Summary of Key Issues for Discussion

The presentation will cover the following key issues.

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- Training
- Serious Case Reviews
- Safeguarding Children
- Safeguarding Adults
- MCA
- DoLS
- Clinical Governance
- Objectives for 2012 - 2013

1.3. Recommendations (Note, Approve, Discuss etc)

The Board is asked to discuss this report and to note the key Safeguarding risks and achievements and of the Safeguarding Team during this financial year. These include:

- Despite offering a significant volume of training opportunities for staff during 2011 – 2012, the Safeguarding Team is not confident that 80% of all clinical staff have completed their Safeguarding Training at level 3 in Safeguarding Children or Safeguarding Adults[1]

- Ensuring no service user in NEPFT is unlawfully deprived of their liberty - NEPFT completed more DoLS applications (101) than any other NHS Trust in EoE during 2011 - 2012.

- Ensuring that where there are doubts regarding a service user's capacity, robust assessments are completed. NEPFT completed more MCA2 assessments than any other NHS Trust in Essex during 2011 – 2012

- Ensuring proactive response to Safeguarding Concerns for both children and adults (with a consequent increase in the volume of Safeguarding Adults referrals, from 291 to 365 new SETSAF investigations)

- Working proactively on a multi-agency perspective leading to successful new initiatives regarding:
  - Missing Person's Protocol (which has saved Essex Police in excess of £250k since implementation in November 2011)

[1] A detailed report on training compliance was requested from Workforce Development at the beginning of May, but has not yet been received. All data from the Safeguarding Training database was uploaded onto OLM in October 2011, some errors appear to have occurred however and a reconciliation exercise is currently being completed

- Prevent
- HBA.FGM and FM

- The success of the small safeguarding team in generating income (£260k) during 2011 – 2012. This income is however non-recurring due to changes in legislation.

1.4. Care Quality Commission Outcomes (which apply)

This paper relates to outcome 7 - Safeguarding people who use services from abuse.

1.5. Legal / Regulatory Implications (NHSLA / Value for Money Conclusions etc)

It is a legal requirement to ensure that children are safeguarded as outlined in HM Government Department for Children, Schools and Families' "Working Together to Safeguard Children" (March 2010) and the Care Quality Commission essential standards of quality and safety.

1.6. NHS Constitution

This report demonstrates compliance with the following principle; 3. The NHS aspires to the highest standards of excellence and professionalism.

1.7. Risk (Threats or opportunities link to risk on vb register etc)

- A failure to comply with the legal requirements of safeguarding children could risk the Trust's registration with the Care Quality Commission.
- Changes in Primary Care and Social Care over the course of 2012 will need to be monitored closely in order to see a strong co-ordinated multiagency approach to child protection is continued
- The Safeguarding Team generated in excess of £260,000 during 2011 – 2012. Sources of income will cease following changes in the Health & Social Care Act, which result in the LA becoming the Supervisory Body for Deprivation of Liberty Safeguards for Health.

1.8. Resources Implications (Financial / staffing)

There is a cost associated with releasing staff for training.

1.9. Equality and Diversity

No issues identified.

1.10. Communication

The Local Safeguarding Children's Board (LSCB) will be informed that the Safeguarding Children's Annual Report has been submitted to Management Board

and to Trust Board. This report will be made public at Trust Board. A public declaration of safeguarding children compliance should be made available on our website.

1.11. References to previous reports

- Safeguarding Report 2010-2011
- CQC Standard 7

2. Introduction:

The report reflects the Trust's responsibilities to provide structures and mechanisms for safeguarding and promoting the welfare of children and adults by ensuring that appropriate specialist advice and support are available to trust staff.

In line with Government Policy as detailed in the document "Working Together to Safeguard Children"(March 2010) the trust must ensure that there is "board level focus on the needs of children and that safeguarding children is an integral part of their governance systems."

The last year has been a period of significant change and development for Safeguarding within the trust including:-

- The Intercollegiate Document (October 2010) required a review of the safeguarding children training arrangements for the trust and an associated review of the safeguarding adults training.
- The Munro Report has raised the profile and the challenges for Safeguarding locally and nationally.
- The appointment of a new Named Dr for Safeguarding Children – Dr Lionel Bailly.
- Restructuring of the Essex Safeguarding Children Board
- The creation of the Safeguarding Children Clinical Network (established, June 2011, Director appointed, October 2011)
- Greater integration of Safeguarding with trust governance structures.
- Management of the DoLS Contract on behalf of the North Essex PCT Cluster.
- New domains of responsibility for Safeguarding – eg Prevent; HBA,FM & FGM, and Domestic Homicide Reviews.

2.1 The Safeguarding Team:

The Trust Executive Board lead for Safeguarding is the Director of Operations and Nursing. During 2011 – 2012, the Safeguarding team comprised:

- Head of Safeguarding (seconded 45 hours per month to ECC) (c.0.73 wte for NEPFT)
- Clinical Specialist; Safeguarding Adults (working 0.2 wte as an AMHP)
- Clinical Specialist; Safeguarding Adults (working 0.2 wte as an AMHP)
- Clinical Specialist; Safeguarding Children (1 wte)
- Safeguarding Administrator (0.8 wte) (of which 37.5% of time is spent solely administering safeguarding training)
- DoLS Administrator (0.5 wte, temporary position)

In effect, during 2011 – 2012, the total safeguarding resource for NEPFT was **3.33 wte clinicians plus 1.1 wte administrative support.**

- **Named Dr: Safeguarding Adults – Dr Flechtner**
- **Named Dr: Safeguarding Children – Dr Bailly (appointed November 2011)**

2.2 Safeguarding Team funding:

During 2011 – 2012, the safeguarding team produced an income in excess of £260K (through the DoLS and ECC contracts); whilst much of this is set against staffing costs, it is a considerable income for such a small team. These sources of income will cease completely by April 2013, as the Health and Social Care Act has transferred responsibility for DoLS to LA who is not seeking to commission this service externally.

3. The Safeguarding Group

The Safeguarding Group meets bi-monthly and is currently chaired by the Director for Operations and Nursing and reports to the Trust Board through the Risk and Clinical Governance Executive Board. Each Clinical Board has an Operational Lead for Safeguarding on the Safeguarding Group and in addition the Trust Professional lead for Psychological Services is a member of the Group. Other members of the group include leads for HR, MEC and the Named Dr's for Safeguarding.

The Safeguarding Group monitors progress against the safeguarding work through the Action Plan which outlines the Trusts Strategy in relation to safeguarding children and vulnerable adults, and the legislative domains on MCA and DoLS. The action plan is supported by more detailed plans as required for key areas of work and captures progress around partnership working, primary care and performance management.

4. Education, Training and Supervision

Following the publication of the revised Intercollegiate Document on Safeguarding Children training in September 2010 the levels of training and methods of training delivery were reviewed by the Safeguarding Team.

During 2011-2012 a comprehensive review of the existing training model has been undertaken. This has included reviewing how training is delivered in other mental health providers and reviewing numerous e-learning packages.

It was apparent that the existing model of training delivery was unsustainable, there were insufficient resources within the Safeguarding Team to deliver the training to all registered and non-registered clinicians (resulting in delays in accessing training places) and senior managers struggled to release staff to attend the face-to-face training.

A new training model comprising a combination of e-learning and face-to-face training has been developed and approved. This model of training commenced in April 2012. The new model of training (commencing April 2012) will ensure that during a full financial year, the Safeguarding team offer **1,860 places per annum.**

During 2011 – 2012, the Safeguarding Team offered **1,149** places on Safeguarding courses for face to face training (52 days). Despite robust training administration and booking systems, with staff required to confirm their attendance on a course 10 days prior to attending, **24% of staff who booked and confirmed their intention to attend a Safeguarding Course failed to attend on the day**. Each non-attendance is followed-up by contact with the respective line-manager. Whilst many staff have valid reasons, the predominant reason provided for non-attendance was a staffing issue in a ward or team which prevented them from being released on the day; their non-attendance being supported by their line manager.

Training	Level	No. of Courses offered	No of Places offered	No of Places booked	No who attended	No & % who booked but did not attend on day
Safeguarding Children	3	11 (2 days)	512	439	346	93 (18%)
Safeguarding Adults	3	11 (2 days)	477	480	357	123 (25.6%)
Safeguarding Children	4	4	80	36	29	6 (20%)
Combined Refresher	3	4	80	70	50	20 (28.5%)
TOTAL		30 (52 days)	1149	1025	782	**242 (24%)**

- 671 staff completed their level I e-learning on OLM in Safeguarding Children during the financial year
- 220 staff completed their level I e-learning on OLM in Safeguarding Adults during the financial year,- this training only became mandatory in April 2012.

Administration of safeguarding training is managed solely by the safeguarding team and is not supported by Workforce Development. The costs of administering each course are considerable, and take approximately 0.3 wte of the band 5 administrator (who is employed for 0.8 wte).

All new staff can access the Level 1 Safeguarding training (both Children and Adults) at Trust Induction; This has been delivered face-to-face within the Trust Induction programme since the Autumn, 2011.

4.1 External Education and Training

Trust staff continue to access multi agency training and learning events led by the ESCB. Trust staff also contribute to a number of these trainings including the Impact of parental mental health, the management of alcohol and substance misuse, MCA and DoLS training events.

The Essex Safeguarding Boards organised a joint conference in November 2010 on Sexual Abuse. No Conference was held during 2011 - 2012.

Essex Social Care organised a one-day workshop on Hidden Harm which was well attended by staff from CAMHS, AMHS and the Substance Misuse Teams.

4.2 Training completed by individual members of the Safeguarding Team

During 2011-2012, the members of the Safeguarding Team have maintained their own knowledge and practice through a range of training (in addition to mandatory CPD requirements). This has included:

- National Leadership Programme (BME) – Tendayi Musundire
- Peer Reviewer Training – Penny Rogers
- Attendance at a number of specialist courses on the interfaces between MCA/DoLS/MHA
- Prevent full training – Tendayi Musundire / Carolyn Smith
- HBA/FM/FGM – Elaine Irwin / Penny Rogers

4.3 Safeguarding Clinics

Safeguarding Clinics do not provide formal opportunities for learning but offer staff opportunities for informal learning, consultation and advice either as individuals or as small groups.

During 2011 – 2012, Safeguarding Clinics have been established across NEPFT within clinical teams. Safeguarding Clinics are led by a member of the Safeguarding Team and provide clinicians with opportunities for reflective supervision, to discuss complex cases or safeguarding investigations, access consultation, or to update their training and knowledge of Safeguarding. Clinics have evolved differing structures across NEPFT according to the varying requirements of specific clinical teams. Safeguarding Clinics are currently held in the following clinical areas:

- Substance Misuse Teams (CDAT & Changes) – monthly
- EIP Teams (West & Central) – monthly
- Rainbow Mother & Baby Unit – monthly (currently weekly)
- Longview – weekly
- CAMHS (West) – monthly
- CAMHS (Maldon) – monthly
- CAMHS (Braintree) – monthly
- CAMHS(Clacton) - monthly
- CMHT (Latton Bush) – monthly
- Kingwood/Landermere – monthly (alternating venue)
- Kitwood – monthly
- Crystal Centre – monthly

Requests have been received to establish further Safeguarding Clinics during 2012-2013, including requests from

- Carers Team
- Veterans Team

Due to limited capacity in the Safeguarding Team it is not possible to respond positively to all requests for a Safeguarding Clinic. Safeguarding Clinics are open to all registered and non-registered clinicians.

5. Newsletters:

During 2011–2012, the quarterly Trust Safeguarding Newsletters – one for Safeguarding Children and a second for Safeguarding Adults have continued to be published to be well received. These newsletters have been published on I-Connect and distributed to all team managers and Safeguarding Champions and Safeguarding Group members via email. The Newsletters provide valuable sources of information for all staff and seek to ensure that Safeguarding remains in the forefront of clinicians thinking at all times. The newsletters are been published in:

- June
- September
- December
- March

Feedback has been positive both internally and externally with mental health Commissioners, other agencies and NHS Trusts requesting copies of the Newsletter. In January 2012, the first article written by a service user about their personal experience of Safeguarding was published. It is hoped that this will be the first of a series of articles by service users.

In January 2012, it was agreed to combine the newsletters into a single edition – Safeguarding News and reduce the size of the contents. This initiative commenced in March 2012.

6. Prevent:

The current threat level to the UK from international terrorism is severe. The most significant international terrorism threat to the UK remains violent extremism associated with and influenced by Al Qa'ida. The Prevent strategy, launched in 2007, seeks to stop people becoming terrorists or supporting terrorism. It is the preventative strand of the government's counter-terrorism strategy, CONTEST. It was reviewed in 2011 and the review confirmed a number of key issues:

- Prevent will remain an integral part of the government's counter-terrorism strategy, CONTEST.
- Prevent will address all forms of terrorism, including the extreme right wing.
- However, it is clear that Prevent work must be targeted against those forms of terrorism that pose the greatest risk to our national security. Currently, the greatest threat comes from Al Qa'ida, its affiliates and like-minded groups.

- Prevent will tackle non-violent extremism where it creates an environment conducive to terrorism and popularises ideas that are espoused by terrorist groups.
- Prevent will make a clearer distinction between our counter-terrorist work and our integration strategy. Prevent depends on the success of that strategy. But the two cannot be confused or merged together. Failure to appreciate the distinction risks securitising integration and reducing the chances of our success.
- The new Prevent must do much better in evaluating and monitoring progress against a common set of objectives.

The Department of Health requires all NHS Trusts to have an identified lead and to implement a Prevent Protocol. In NEPFT the Board lead for Prevent is Paul Keedwell (Director of Operations & Nursing) and the Safeguarding Team are leading on the drafting and implementation of a Prevent Protocol. Training for many senior managers has already occurred and a Task and Finish group is drafting a Protocol.

In practice, PREVENT is about sharing information on a "need to know" basis with named colleagues in Essex police who may have received intelligence about an individual and may need to establish if an individual is possibly mentally ill and in receipt of services from NEPFT—in which context risk may be significantly lower than if the individual is unknown to services, isolated and more prone to potential grooming by radicals. Prevent is not about criminalising an individual but it may involve breaching an individual's confidentiality in the public interest.

During 2011 – 2012:

1) Two members of the Safeguarding Team have completed their full Prevent Training and are authorised to deliver full health WRAP Prevent Training to other staff.
2) All members of the Safeguarding Team have received some training in Prevent.
3) Workshops on Prevent have been held with senior staff from across NEPFT and with the Criminal Justice Mental Health Teams. Further workshops are planned during 2012 – 2013.
4) Staff awareness raising has commenced, and Prevent has been included in the Safeguarding Adults Training for all staff completing this training since July 2011.
5) Safeguarding Newsletter (SA; Dec 2011) has included information on the Prevent Agenda and invited interested or concerned staff to become involved in the Task & Finish group working on the protocol.
6) A draft Prevent Protocol has been written in close collaboration with Essex Police, this is due for ratification by the Risk and Clinical Governance Executive Committee in July 2012.

7) Essex Safeguarding Adults Board and Essex Safeguarding Children Board have proposed that the NEPFT/Essex Police Prevent Protocol should be adopted by ESAB/ESCB and subsequently be implemented across all agencies in Essex.
8) Links to the EoE Prevent Newsletter have been hosted on the Safeguarding Pages on i-Connect
9) NEPFT has responded proactively to requests from Essex Police under the Prevent agenda.

7. Honour Based Abuse; Forced Marriage and Female Genital Mutilation

7.1 Honour Based Abuse

Honour Based Abuse is an international term used by many cultures for justification of abuse and violence. It is a crime or incident committed in order to protect or defend the family or community 'honour'. Honour based abuse will often go hand in hand with forced marriages, although this is not always the case. Honour crimes and forced marriages are already covered by the law, and can involve a range of criminal offences.

7.2 Female Genital Mutilation

This is a collective term used for procedures, such as female circumcision, which include the partial or total removal of the external female genital organs, or injury to the female genital organs for a cultural or non-therapeutic reason.

7.3 Forced Marriage

A forced marriage is when one or both parties do not consent to the marriage, and people are forced into marriage against their will. There could be both physical and emotional abuse used to coerce you into the marriage.

Forced marriage is an abuse of human rights.

This is not the same as an arranged marriage, where you have a choice as to whether to accept the arrangement or not. The tradition of arranged marriages has operated successfully within many communities and countries for a very long time.

Awareness of the prevalence of HBA, FM and FGM has increased significantly in Essex during 2011-2012 and the necessity for multi-agency guidance has been acknowledged by both ESAB and ESCB, with the establishment of a joint board Task & Finish Group to develop and agree joint guidance. The Head of Safeguarding is vice-Chair of this Task & Finish Group which is led by Essex Police (Inspector Burston).

Direct experience of this agenda has occurred within NEPFT during 2011-2012 with the admission of a young woman who was the subject of a Forced Marriage Protection order and required police protection whilst she was admitted.

8. Missing Persons Protocol:

During 2010-2011, the Safeguarding team reported on the successful development of the multi-agency missing children and young people protocol.

During 2011-2012, NEPFT has worked closely with Essex Police and colleagues in SEPT to develop a multi-agency Missing Persons Protocol which has been approved by ESAB.

The protocol seeks to ensure that where individuals do go missing, there is a jointly agreed risk assessment which enables police resources to be effectively targeted at high risk cases that planning for missing occurs for all adults as a routine part of care on admission and that this "planning for missing" is regularly reviewed.

In addition all service user's are requested to consent to the provision of a digital photograph being added to their medical records which can be shared with Police in the event that they go missing. Service user's with capacity may refuse to provide consent.

The protocol was launched at the end of November at the Linden Centre in Chelmsford and attracted support from NPIA (National Policing Improvement Agency) as it is the first multi-agency protocol of its type in the UK. The protocol has since been implemented across all NEPFT in-patient units.

Since its implementation, the Protocol has proven extremely successful. Essex Police estimate that it has saved them in excess of £250,000 since its implementation. The success of this protocol is not solely financial; it has made a significant improvement to relationships between mental health professionals working in in-patient units with local Police Teams and improved understanding of the respective roles and responsibilities of each agency. In addition it has ensured that where a service user does go missing, there is a shared understanding of risk and high levels of resources can be promptly allocated by Essex Police.

It is hoped that during 2012 we will see the protocol adopted by all care homes and by all hospital units caring for people with learning disabilities or mental health problems in Essex.

9. Serious Case Reviews (SCR) and Independent Management Reports (IMR)

Serious Case Reviews (SCR) are a statutory requirement, led by the ESCB or ESAB. They are undertaken following the death or serious injury to a child or adult where abuse or neglect are thought to be a factor, and there are issues about the way a service or services have worked together (Chapter 8 Working Together to Safeguard Children 2010).

The prime purpose of a Serious Case Review (SCR) is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children. The trust has contributed to a number of SCR's and provided Individual Management Reports (IMR) to these and other incidents. The Action Plans from the SCR's are closely monitored and assured and the trust has responded to these action plans in a timely manner.

The Trust is fully compliant with all recommendations from recent SCR and IMR reports. was able to report a fully compliant RAG report to ESCB in March 2012. The recent trust IMR for the Beatrice SCR was reviewed by Ofsted in December 2011 and given a grade of Good stating that "the review critically examines the practice and management of the case within the trust….recommendations arising are pertinent to the critical analysis….the action plan is good and includes measurable outcomes and accountabilities." The learning from this SCR led to the trust increasing the level of training in safeguarding delivered to staff within CAMHS and EIP to level IV and in the development of Safeguarding Clinics. Over 80% of CAMHS staff have now completed their level IV Safeguarding Training.

A failure to comply with the legal requirements of safeguarding could risk the Trust's registration with the Care Quality Commission. Changes in Primary Care and social care over the course of 2012 will need to be monitored closely in order to see a strong co-ordinated multiagency approach to child protection is continued.

10 Allegations of abuse by staff

There have been several investigations during this financial year regarding inappropriate relationships between staff and service users of a sexual nature. It is an offence under the Sex Offences Act (2003) for a staff member to knowingly commence a sexual relationship with a service user – this constitutes a breach of a position of trust

Despite appropriate boundaries between staff and service users being addressed in the Safeguarding Training and in the Sexual Wellbeing Policy there continues to be a necessity to improve awareness of the inappropriateness of such relationships. It is recommended that a statement advising all staff that to knowingly commence a sexual relationship with a service user is a criminal offence is included in all contracts of employment.

In addition, some safeguarding investigations of abuse in Care Homes have found that staff were working as carers (holding additional employment to their substantive position within NEPFT). It is recommended that managers remind staff of their contracts of employment and obligations to report if they are subject to an investigation led by another employer.

11. Trust Objectives (2011 – 2012):

Objective	Outcomes	Actions	Time frames	Summary of Progress to August 2011.
1. To highlight the DCSF document 'Working Together to Safeguard Children.'	Increase awareness and knowledge.	• Include in induction. • Include in Level 3 training. • Highlight in Safeguarding Newsletter & on intranet.	From Oct 2011 From Nov 2011 October 2010	**Integrated into all levels of training.**
2. Increase uptake of Level 3 training and refresher courses.	Wider knowledge across the organisation	• Local Safeguard leads to highlight. • Highlight on trust intranet • Highlight in Safeguarding Newsletter.	• From Oct 2011 • Discussion at all Safeguarding Group meetings • All editions make reference to training	**Improved uptake of level III training**
3. Improve knowledge of Serious Case Review (SCR) process.	Wider knowledge and greater confidence.	• Include SCR process in all training. • Encourage local leads to use trust Safeguarding Team for consultation and advice.	Ongoing	**SCR process included in 3 and 4 training.**
4. Review current delivery of Safeguarding Training and Introduce e-learning packages for Safeguarding children.	Improved knowledge for all staff.	• E-learning packs explored at Level 1 and level II and implemented .	Ongoing	**All Safeguarding Training undertaken for past 3 years is now recorded on ESR** **All staff can access and complete Safeguarding Training to level II through e-learning on OLM**

5. Contribute to Serious Incidents	Integrate Safeguarding into reviewing and learning from serious incidents.	Link with the trust MEC team . Provide advice and consultation to investigations	Ongoing.	**MEC are members of the Trust safeguarding group. Joined up process established for SI/SCR cases**
6. Develop Trust-wide Safeguarding Clinics	Improve access to consultation and advice re Safeguarding Concerns	Ensure staff had access to consultation and supervision re safeguarding concerns	Ongoing	**Safeguarding Clinics established pan the Trust**
7 Work with Social Care to develop forums for resolving complex cases	Improve and resolve concerns and disputes between agencies in individual complex cases	Ensure Staff can raise concerns about responses to complex cases direct with Social Care	Ongoing.	**Complexity Forum (ECC / NEPFT) has been established. This group is not fully embedded in the work of NEPFT**

12. Safeguarding Children

12.1 Introduction

This section of the report provides an overview of children's safeguarding, outlining both the national and local positions and an update on the current work programmes.

12.2 Safeguarding Children Legislation

The Children Act (1989) provides the legislative framework for the protection of children and is supported by statutory and supplementary guidance in Working Together to Safeguard Children (March 2010). A further revision of Working Together is underway following the completion of the Munro Review (May 2011). The statutory inquiry into the death of Victoria Climbié in 2003 and the first Joint Chief Inspectors Report on Safeguarding Children (2002) highlighted the lack of priority status given to children's safeguarding. The Governments response to these findings resulted in the Every Child Matters programme and the Children Act 2004

An important consequence from the above resulted in a duty on key agencies to make arrangements to safeguard and promote the welfare of children

12.3 The National Picture:

The publication of the Serious Case Review (SCR) in November 2008 following the death of Peter Connolly in Haringey and the subsequent political and media interest has seen a marked increase in safeguarding activity across the country.

In Essex in 2009 inspections of our Safeguarding and Looked after Children Services brought a sharper local focus on the work required to ensure that these services for children improved, building on our strengths and ensuring that areas of weakness were addressed through a partnership approach. A recent re-inspection' of Local Authority safeguarding services occurred in and its positive outcome is highlighted further in the report.

12.4 The Essex Picture:

There are approximately 329,100 children and young people within Essex. 41,000 children live in poverty in Essex, predominantly in Tendring, Harlow and Basildon. Tendring is the most deprived district in Essex and the 103rd most deprived district in the UK. The number of referrals to social care of children per 10,000 of the population is lower overall than the England average and the number of children subject to a child protection plan (per 10,000 of the population) is also lower. There are approximately 600 children subject to a Child Protection Plan at any one time in Essex. There are approximately 1,300 children and young people who are 'Looked after' (LAC) by the Local Authority. Overall the LAC numbers have remained relatively static, but there has been a 30% 'churn' in the children moving in and out of care. The numbers above give a brief indication of the level of safeguarding need across Essex.

12.5 Children subject to a Child Protection Plan:

A Child Protection Plan is put in place following a multi-agency Child Protection Conference led by the Local Authority. In most cases there will be one or more health professionals working in partnership with the child, family and partner agencies to ensure that the child's needs are being addressed through the plan.

The number of children subject to a plan changes on a daily basis, but there has been a steady increase in this number over the past year both nationally and locally. This is thought to be due to the national profile on safeguarding following the death of Peter Connolly and the requirement following the 2009 OfSTED Inspection in Essex that Social Care referral thresholds be reduced.

The current figure of approximately 600 children subject to a plan brings Essex in toline with their statistical neighbours in regards of where that figure is expected to be. Work is underway within Children and Young Peoples Social Care (CYPSC) and partner agencies to ensure that thresholds for children being subject to a child protection plan are appropriate and preventative and early intervention work is in place. Examples of this are the work to increase the use of the Common Assessment Framework (CAF) and the Early Start approach being progressed within Health Visiting and early years teams.

12.6 Essex Safeguarding Children Board (ESCB)

Safeguarding and promoting the welfare of children requires effective co-ordination in every local area, this is the primary function of the Local Safeguarding Children Board (LSCB). The ESCB is the key statutory mechanism for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children in that locality, and for ensuring the effectiveness of what they do.

During 2011 – 2012, the Chief Executive was a member of the ESCB with representation on the Board. The Safeguarding Team are key contributors to the work of the LSCB and there is attendance by the team on each sub group:

- Policies and Practice
- Health Executive Sub-committee

12.6.1 Working with the Local Safeguarding Children Board

During the past financial year there has been a restructuring of the ESCB.

During 2011 – 2012, NEPFT played an active role in the wider Safeguarding Economy - NEPFT regularly attends the:

- Health Local Operational Groups (with Named Nurses from PCT's and Acute Trusts) (Elaine Irwin / local Safeguarding Group leads);
- Essex Health Safeguarding Children Strategic Network (Penny Rogers)

- Essex Safeguarding Children Board (Andrew Geldard).
- ESCB SET Guidance Review Group. (Penny Rogers)
- Childrens Trust Board – (Toni Scales)
- ESCB/ESAB Joint Task & Finish Sub-Committee-HBA/FM/FGM (Penny Rogers)

2011 – 2012 saw some significant changes in the wider Safeguarding Children economy with the restructuring of the ESCB, creation of a new health Executive Forum and the establishment of a Safeguarding Children Clinical Network – a commissioning support group.

As a result of these changes, whilst NEPFT retains the right to a seat on the ESCB NEPFT will be represented from April 2012 by Sheila Bremner (Chief Executive, North Essex PCT Cluster). Representation at the Health Executive Forum (a subcommittee of the ESCB) is exclusive to Directors / Board Leads and thus representation from NEPFT at the Health Executive Forum will be the Board lead for Safeguarding the Director of Operations and Nursing (Paul Keedwell). The NEPFT Head of Safeguarding will continue to attend the ESCB Policies Subgroup.

12.7 The Safeguarding Children Clinical Network:

The Safeguarding Children Clinical Network (SCCN) was established in June 2011 and a Director (Hussein Khatib) appointed in October 2011. Contact between NEPFT and the SCCN has been minimal during this financial year and the relationship between the Safeguarding Children Clinical Network and NEPFT is still being explored. The SCCN comprises over 32 funded posts and will function as a Commissioning Support Group.

13. Safeguarding Adults:

Adult safeguarding, unlike children's safeguarding does not have a specific legislative framework however since 'No Secrets' (2000) and the Human Rights Act (1998) were published there have been significant legal and policy changes relating to adult health and social care in particular:

- Disability Discrimination Act (2005)
- Mental Capacity Act (2005)
- Safeguarding Vulnerable Adults Group Act (2006)
- Mental Health Act (1983)(2007)
- Deprivation of Liberty Safeguards (2009)
- Equality Act 2010

The most significant pieces of legalisation in the area of Safeguarding Adults are the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DOLS) 2009. The Mental Capacity Act provides a framework to empower and protect people who may lack capacity to make personal decisions. The DOLS provides a legal framework to ensure that adults who lack capacity in care homes and hospitals are protected from unlawful deprivation of their liberty.

13.1 The National Picture

The sections below outline some of the key changes surrounding adult safeguarding which continues to progress at a rapid pace. Almost daily news reports outline concerns regarding the care of vulnerable adults many of these reports are in relation to health care. This area will continue to require strict attention from the Trust. It is rightly argued by many that until we address the quality of care for vulnerable adult's we will fail consistently in the area of safeguarding.

13.2 Law Commission report on Adult Social Care

The Law Commission report on Adult Social Care 2011 recommended that local authority social services have the lead responsibility for adult safeguarding. This includes having a statutory duty to investigate adult protection cases or cause an investigation to be made by other agencies, in individual cases. The report recommends changing the terminology from "vulnerable adult" to "adult at risk". This may have implications in the future in how we define and identify adults at risk. The Essex Safeguarding Adults Board (ESAB) is reviewing the Law Commission Report further.

The report requires the local authority to establish Local Safeguarding Adults Boards with representatives from the local authority, NHS and police and the board will be responsible for commissioning serious case reviews. Essex has already established a safeguarding board.

13.3 Domestic Homicide Reviews

Domestic Homicide Reviews (DHR's) Community Safety Partnerships are responsible for leading these multi-agency reviews into the death of a person aged over 16 from violence, abuse or neglect by a related person or member of the household. The process aims to identify lessons for services to prevent domestic homicides. Two Essex cases have been considered for DHR's with both these cases involving service users from NEPFT. IMR reports were submitted for both DHR's.

Domestic homicide Reviews were established on a statutory basis under s9 of the Domestic Violence, Crime & Victims Act 2004 and came in to effect from April 2011. It creates an expectation for local areas to undertake a multi-agency review following domestic abuse homicide to make sure lessons are learned and to identify what needs to change in order to reduce the risk of such tragedies happening again in the future. The Statutory guidance is available on iConnect or from www.homeoffice.gov.uk.

To support professionals taking part in Domestic Homicide Reviews, the Home Office has produced an on-line training pack available at www.homeoffice.gov.uk. This training has been completed by the Head of Safeguarding during 2011.

During 2011 – 2012, two domestic homicide reviews were undertaken. One followed the sad death of a mother and her two year old daughter in Braintree and a second in Clacton where a mother was found dead in a hotel having met her former husband there. NEPFT provided IMR reports in response to both these DHR's.

13.4 **Department of Health Safeguarding Adults Guidance**

In response to the No Secrets (2000) review in 2010 the Department of health issued a number of key documents:

"Safeguarding Adults: The Role of Health Service Practitioners (2011)"

This document reinforces the role of front line clinical staff in working with vulnerable adults

"Safeguarding Adults: The Role of Health Services Managers and their Boards (2011)"

This document serves as a reminder for health service managers and their boards in recognising that they have a statutory duty to safeguarding adults in their care particularly those who are less able to take care of themselves form neglect or abuse.

"Safeguarding Adults: The Role of NHS Commissioners (2011)"

This document highlights commissioner's responsibility for commissioning high quality care for patients in their area.

The documents establish 6 principles for safeguarding adults:

Principle 1 – Empowerment - Presumption of person led decisions and consent
Principle 2 – Protection -Support and representation for those in greatest need
Principle 3 – Prevention- Prevention of harm and abuse is a primary objective
Principle 4 – Proportionality – Proportionality and least intrusive response appropriate to the risk presented
Principle 5 – Partnerships - Local solutions through services working with communities
Principle 6 – Accountability - Accountability and transparency in delivering Safeguarding

13.5 Winterbourne View

A BBC Panorama programme in 2011 revealed appalling abuse in Winterbourne View, a private hospital for people with learning disabilities. As a result of this the Care Quality Commission (CQC) closed the facility and conducted reviews of all Castlebeck facilities. In Essex all out of area placements commissioned by the NHS have been reviewed and their safety assured. Assurance about patient safety has been given to the Essex Safeguarding Partnership Board. Further work will be undertaken in 2011-12 and beyond to ensure preventive safeguarding systems are in place.

13.6 The North Essex Picture

Increased training and awareness around adults at risk of abuse has led to an increase in referrals into the safeguarding process. Work is underway within the ESAB to understand the local picture around safeguarding referrals and incident's within both a regional and national context.

The adult safeguarding field nationally is moving towards an empowerment approach to safeguarding adults where risk is balanced with personal choice. This has been made explicit in the Safeguarding Adults documents from the Department of Health. The approach is summed up by The Right Honourable Lord Justice (Sir James) Munby "what good is it to make someone safe if it merely makes them miserable?"

13.7 The Essex Safeguarding Adults Board (ESAB)

Vulnerable adults can be abused in many different ways and effective safeguarding can only be achieved through partnership working and public engagement. Adult safeguarding is co-ordinated by the Essex Safeguarding Adults Board (ESAB). This board is jointly funded by police, health and adult social care.

During 2011 – 2012, NEPFT played an active role in the wider Safeguarding economy - NEPFT regularly attends the:

- ESAB Safeguarding Adults Management Committee (SAMC) (Penny Rogers)
- ESAB SCR Subcommittee (Penny Rogers)
- Essex Health Safeguarding Adults Strategic Network (Penny Rogers)
- Essex Safeguarding Adults Board (Paul Keedwell – attendance is delegated to Penny Rogers).
- SET MCA LIN (Chair, Penny Rogers)
- SET Best Practice Group (Chair, Penny Rogers)

Significant outputs from these groups this year include:

- The revision of policies and procedures including thresholds for referral and investigation
- Establishing a system for contesting safeguarding decisions
- A policy on safeguarding and unauthorised DoLS
- Development of a "balanced scorecard" to measure safeguarding outcomes
- A community engagement event
- Revised multi-agency safeguarding training packages

14. Mental Capacity Act (MCA)

The Mental Capacity Act is the legal framework for people who lack capacity to make decisions for themselves or who have capacity and want to make preparations for the future. NHS Leeds is working with primary and secondary care providers to ensure that capacity assessments are undertaken and recorded, that due process is followed when an individual is assessed as lacking capacity.

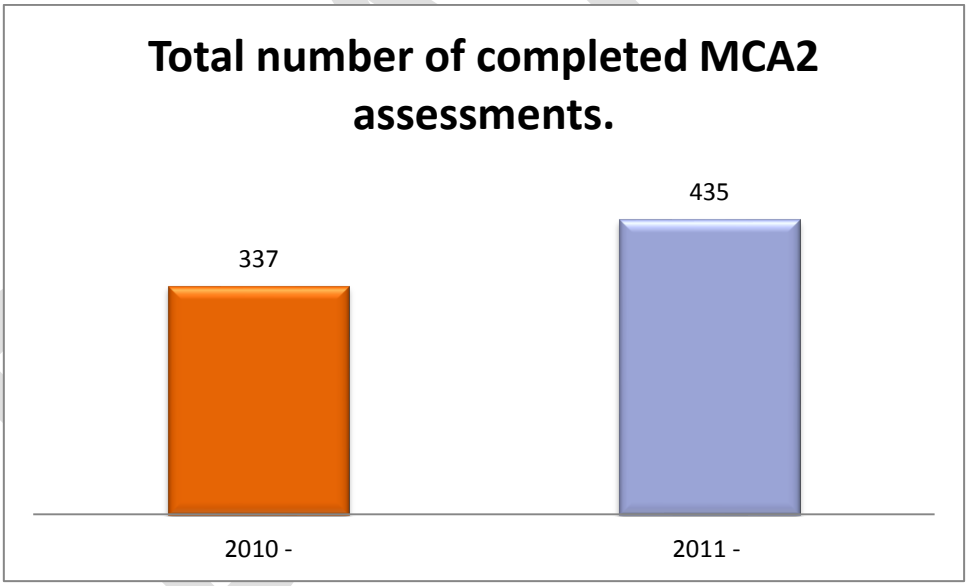
The North Essex PCT's (in common with all PCT's in England and Wales) receive specific funding from the Department of Health for the implementation of the MCA. The monies from the DH are for the provision of the MCA including DoLS, and the North Essex Cluster of PCT's spends this budget on its DoLS Contract with NEPFT

The MCA also makes provision for people to plan for their future healthcare and financial decisions through the appointment of Lasting Power of Attorney. Advance Decisions enable people, while still capable, to refuse specified medical treatment for a time in the future when they may lack capacity to consent to or refuse that treatment. NEPFT, through the delivery of training to and collaborative work with the ESAB has increased the professional and public awareness of these advanced planning directives.

Independent Mental Capacity Advocates (IMCAs) provide support and representation for a person who lacks capacity to make specific decisions. IMCA activity has decreased in this financial year.

NEPFT has continued to lead the health economy in Essex regarding the implementation of the Mental Capacity Act, completing more MCA2 assessments (435) than any other NHS Trust during 2011 – 2012 and three times as many as SEPT (431:130).

Whilst NEPFT can be confident of the implementation of the MCA, there remain some areas of potential risk. No MCA2 assessments have been completed by CAMHS clinicians in the community teams (the MCA is applicable from the age of 16), although MCA2 assessments have been completed by staff at Longview.



NEPFT only made **20 referrals for IMCA's** during this financial year. On occasion there have been challenges to clinicians from IMCA's regarding the outcome of capacity assessments and whilst such disputes have been resolved, there has been a growing reluctance from some clinicians to refer for an IMCA Service. A new IMCA provider has been appointed by the Local Authority (the Head of Safeguarding was actively involved in this process) and it is hoped that the new provider will proactively provide training regarding the IMCA role during 2012-2013.

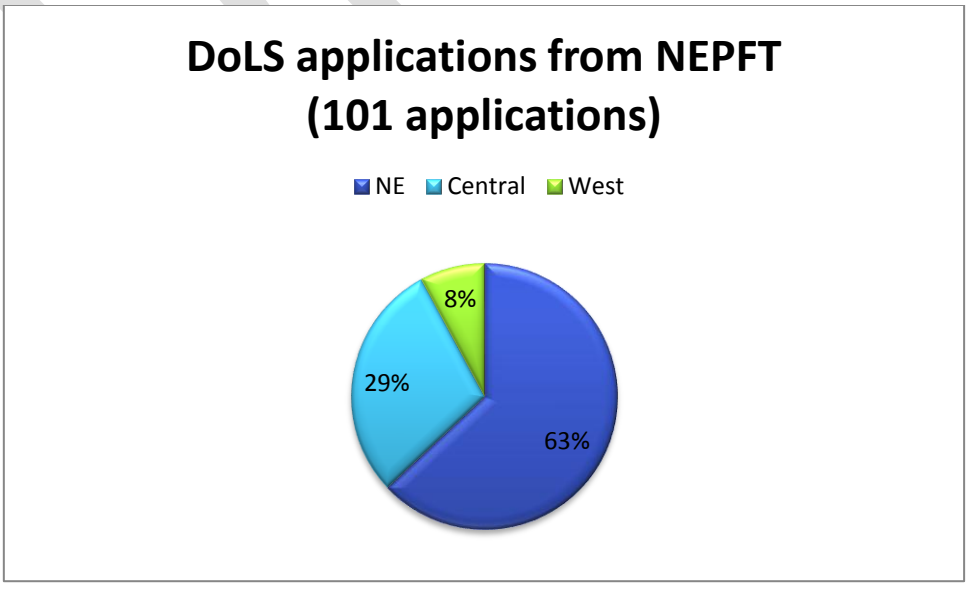
15. Deprivation of Liberty Safeguards

NEPFT is commissioned by the North Essex PCT's in their capacity as supervisory bodies for hospitals to provide a DoLS Service. Hospitals are required to seek authorisation from a Supervisory Body (North Essex PCT's) where a patient may be deprived of their liberty. The PCT has a duty to commission relevant assessments and to ensure that proper process has been followed. In care homes the local authority acts as the Supervisory body.

DoLS applications are administrated through the Safeguarding Team who additionally provide training and consultation / advice to all staff across health in North Essex

The national picture of the number of DoLS applications shows an extremely varied picture with health applications being significantly higher than other areas in the East of England. **208 DoLS applications** were made to the Safeguarding team on behalf of North Essex NHS - these accounted for **41% of all health applications in the East of England and 46% of all applications in Essex.** This is a positive reflection on the guidance and training delivered across the North Essex Health economy during 2011 – 2012 by the NEPFT Safeguarding Team

101 DoLS applications were made on behalf of service user's in mental health hospital beds in NEPFT. 80 of these applications were from NE, 37 Central and just 10 for service user's in West, of whom 6 were on Brian Roycroft. This suggests that knowledge of DoLS is uneven across the Trust despite similar levels of training having occurred in each domain. Not all DoLS applications are authorised, 68% of DoLS applications are authorised, suggesting that most DoLS applications are appropriate. Where a DoLS is not authorised and the service user is in a mental health hospital bed there has frequently been a recommendation that assessment is required under the MHA which has resulted in detention under s.2 or s3. (MHA, 1983). Only 11 applications were from AMHS, the remainder being from OAMH



In addition to delivering the DoLS Service on behalf of the North Essex PCT Cluster, NEPFT participates actively in:

- Southend, Essex and Thurrock MCA LIN (Chair: NEPFT Head of Safeguarding)
- Southend, Essex and Thurrock Best Practice Forum (Chair: NEPFT Head of Safeguarding)
- EoE MCA RIN (Head of Safeguarding)

Analysis of health data in North Essex reveals that over 10% of DoLS applications made in health are declined (on the grounds of eligibility) but do result in a successful application for detention under the MHA. These inappropriate applications are most frequently of a female older adult who has been admitted to a OAMH ward and who has dementia. The service user will lack capacity to consent to admission / treatment and is not free to leave the ward as they would be at risk, should they leave the ward. Whilst such an individual may appear to be superficially compliant and may not be physically attempting to leave a ward, they may be objecting to a component of their treatment – (eg refusing medication), and thus are objecting to treatment. As their status is that of a mental health patient and they are objecting, they are ineligible for DoLS but may be eligible to be detained under the MHA.

DoLS pose significant legal, financial and reputational risks to Supervisory Bodies. The changes agreed in the Health & Social Care Act can be summarised as transferring the function of Supervisory Body from Health to LA's from April 2013. This is a transfer of risk from the NHS to the Local Authority The Local Authority has no intentions of commissioning a DoLS service externally; and thus NEPFT will no longer be commissioned to provide a DoLS service on behalf of the North Essex PCT Cluster.

Aside from the transfer of risk from the NHS to the Local Authority, the risks can be summarised as including:

- Potential breaches in human rights by not undertaking as many DOLS applications and authorisations as necessary, therefore leaving people unprotected.
- Supervisory Bodies ending up with expensive court cases because families and others challenge the absence of authorisations or the quality of the assessments.
- DoLS in hospital beds are a new role for the LA and may result in local authorities authorising and challenging assessments within NHS environments.
- ECC has a limited number of experienced Best Interest Assessors, but none of this small team are jointly qualified as AMHP's. DoLS applications in mental health hospital beds are highly complex and there is potential risk for NEPFT after April 2013 if the BIA's appointed by the Local Authority to complete assessments are not dually qualified.

- The above risks are compounded by what local authorities may regard as inadequate funding arrangements.

A detailed report on MCA and DoLS activity is provided in Appendix 3.

16. Clinical Governance

16.1 Clinical Governance: Safeguarding Children

The Safeguarding group meets two monthly to discuss trust and national issues and review and ratify procedures and protocols.

Performance Activity Reports are prepared for the Safeguarding Group and for each Area Clinical Board. Representatives from the Safeguarding Group attend Clinical Boards to present the findings and lessons from Serious and Complex cases. Key findings are additionally published in Safeguarding Newsletters. Performance Activity figures are currently shared with Area Clinical Boards regarding:

- Number of Safeguarding Children Referrals made to Social Care (by team and type of abuse)
- Number of Child Protection Conferences (attendance requested / attended; by team)[2]

The priority for the coming year is to ensure that the trust develops robust arrangements to ensure that information is obtained and readily accessible regarding the details of:

- The number of service user's with dependent children living in the same household.
- The number of service user's (or families) who are currently subject to a Child Protection Plan or a Child in Need Plan
- The number of Looked-After Children being seen in CAMHS
- Outcomes of referrals to Social Care - % accepted and % refused

The Safeguarding Team is working proactively with Remedy to ensure that the NCIS will be able to provide routine reports regarding the above and additionally identify those families referred to the MARAC and those service user's where clinicians have failed to record a genogram.

The current system for clinical governance is unsafe and depends on clinicians copying referrals made to Social Care to the Safeguarding Team. The implementation of the NCIS (expected April 2013) will remedy this. In addition, the present system does not accurately reflect the complexity and high risk of many of the service user's – some of whom live in families where:

- Parent is a victim of domestic abuse and referred to MARAC and has a SETSAF
- Children are subject to child protection plans and/or child in need plans
- Grandmother (living in the same household) is subject to a SETSAF

[2] Appendix 1 contains the details.

- Children, parent and grandmother have differing sirnames, are all known to NEPFT and receiving services from differing teams, but clinicians have not joined the information gained in separate assessments and interventions together.

The NEPFT Head of Safeguarding is leading a joint ESCB/ESAB Task and Finish Group "Think Families" to develop multi-agency risk assessment tools to facilitate identification of such families. The Head of Safeguarding is chairing the ESCB Health Executive Forum "Think Family" group

It is hoped that Remedy will enable NEPFT to provide more detailed and robust Quality Accounts regarding Safeguarding which will additionally provide the ESCB with assurance and detail regarding the numbers of dependent children and any Safeguarding concerns that have been identified.

S.11 Audit:

ESCB require all agencies to complete a s.11 audit of their practice and to submit this report to the Essex Safeguarding Children Board (on a three yearly basis). NEPFT completed its s11 audit for submission to the ESCB in March 2011 and was independently evaluated in July 2011 as being fully compliant with all requirements – the first agency in Essex to achieve this status.

In the past year there has been a greater integration of Safeguarding within the trust governance structures. It is recommended that the Head of Safeguarding should be a member of the Serious Incidents Governance Group to ensure that Safeguarding is embedded in all reviews of serious incidents and the development of action plans and trustwide learning.

The trust Safeguarding Children policy has been reviewed and amended and will be presented to the trust Risk and Clinical Governance Executive Committee in July 2012.

The Munro Review highlights the importance of local approaches and responses to child protection and a move away from generic, nationally prescribed approaches. The report recognises the importance of named and designated safeguarding health professionals and recommends that Government should engage with the Royal Colleges to explore the impact of health reorganisation on partnership arrangements. Most importantly for the trust, the report acknowledges the role of adult services in child protection and the impacts of parental factors. The report also highlights the importance of early interventions and includes the need for interventions with adolescents as well as early years.

16.2 Clinical Governance: Safeguarding Adults.

The Safeguarding group meets two monthly to discuss trust and national issues and review and ratify procedures and protocols. The number of SETSAF investigations led by NEPFT staff has continued to rise, with **365** new investigations being commenced and led by NEPFT staff during 2011-2012. The impact of this on teams

is considerable; investigations are complex, time-consuming and require clinicians to liaise with other agencies and put into place comprehensive Safeguarding Adults protection plans.

Performance Activity Reports are prepared for the Safeguarding Group and for each Area Clinical Board. Representatives from the Safeguarding Group attend Clinical Boards to present the findings and lessons from Serious and Complex cases. Key findings are additionally published in Safeguarding Newsletters. Performance Activity figures are currently shared with Area Clinical Boards regarding:

- Number of SETSAF (Safeguarding Adults Investigations) commenced Care (by team and type of abuse)
- Number of SETSAF (Safeguarding Adults Investigations completed (by team)
- Number of referrals to the MARACs (by team)

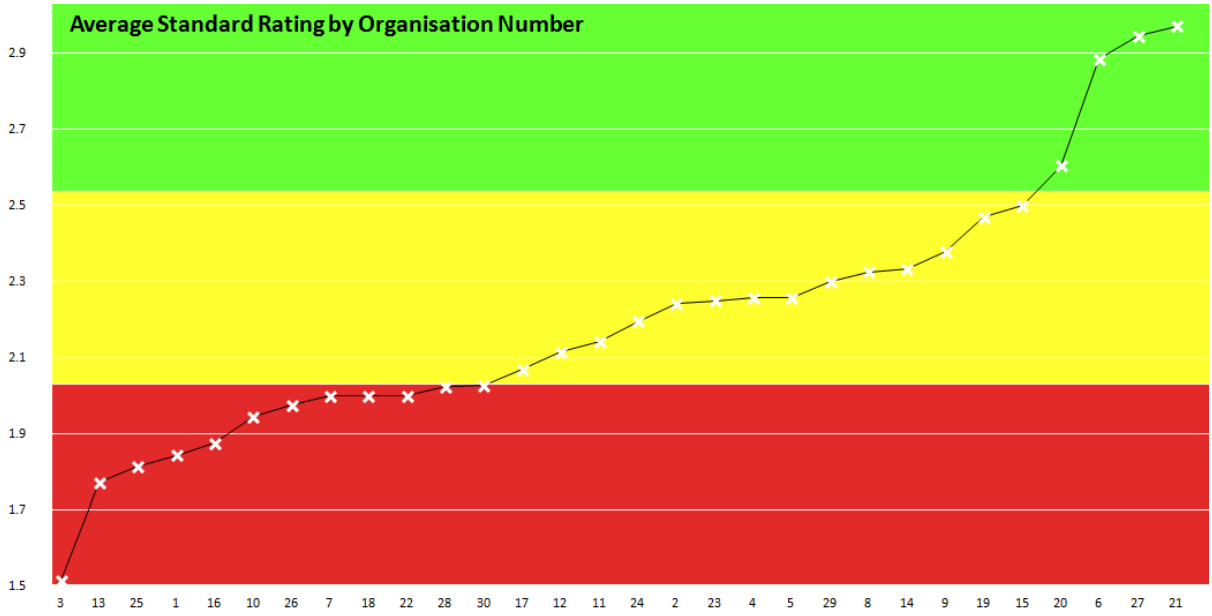
The priority for the coming year is to ensure that the trust develops robust arrangements to ensure that information is obtained and readily accessible regarding the details of:

- Care homes subject to investigations
- The number of service user's (or families) who are currently subject to a SETSAF investigation or Safeguarding Adults Plan

This is now a key aspect of the trust's Quality Accounts for the Department of Health and will provide the ESAB with assurance and detail regarding the numbers of dependent children and any Safeguarding concerns that have been identified. The Head of Safeguarding is chairing the ESAB "Think Family" group.

ESAB requires all agencies to complete an annual audit of their practice and to submit this report to the Essex Safeguarding Adults Board. NEPFT completed its audit for submission to the ESAB in July 2011 and was evaluated as being fully compliant with all requirements. Of the 30 differing agencies completing the audit on July 2011, only 2 agencies were judged as having slightly improved performance compared with NEPFT.

NEPFT is organisation 6 in the table below. We exceeded requirements for all but one criteria within the audit; NEPFT could not provide assurance to ESAB was regarding CRB compliance for all staff having contact with service users



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The trust Safeguarding Adults policy has been reviewed and amended and will be presented to the trust Risk and Clinical Governance Executive Committee in July 2012.

17. Objectives for 2012 – 2013:

Objective	Outcomes	Actions	Time frames
1. Increase uptake of Level 3 training and refresher courses.	Wider knowledge across the organisation; increased compliance with CQC requirements	• Local Safeguarding leads & Area Directors to highlight. • Highlight on trust intranet • Highlight in Safeguarding Newsletter.	Ongoing
2. To work with Remedy to ensure NCIS is fit for purpose and able	Comprehensive Safeguarding Children Data available to Clinical Boards &	• Engagement with Remedy Team	Ongoing

to report relevant Safeguarding Data including genograms	Commissioners		
3. Safeguarding Clinics	To develop meaningful reporting system Improved awareness & engagement with Safeguarding Increase volume of appropriate referrals to Social Care	• Monitoring and reporting attendance at Safeguarding Board • Safeguarding Clinics provided into Veterans Team and Carers team	Ongoing
4. Improve knowledge of Serious Case Review (SCR) process.	SCR process included in level 3 and 4 training. Wider knowledge and greater confidence.	• Include SCR process in all training. • Encourage local leads to use trust Safeguarding Team for consultation and advice.	Ongoing
5. Contribute to Serious Incidents	MEC are members of the Trust safeguarding group. Joined up process established for SI/SCR cases Integrate Safeguarding into reviewing and learning from serious incidents.	• Link with the trust MEC team • Provide advice and consultation to investigations	Ongoing.
6 Work with HR to ensure greater compliance re enhanced CRB	Improved compliance with Enhanced CRB requirements	• Include reporting on enhanced CRB compliance at Safeguarding Group	To be developed
7 To continue to improve awareness of Safeguarding throughout NEPFT	Improved engagement in SC Conferences and increase volume of appropriate referrals to ECC	• Safeguarding Newletter published quarterly • Improved web pages for Safeguarding • Safeguarding	Ongoing

		Forum for Champions to meet twice per annum	
8 To review the SC Policy and procedures and include Prevent, HBA, FM and FGM in more detail in revised procedures	Reviewed and Revised Policy Staff able to access training on Prevent, HBA, FM and FGM through level III training and signposting.	•	Ongoing – to be complete by September 2012
9 Complexity Forum	Robust and active complexity forum – greater awareness of referral pathway by all staff in NEPFT	•	Ongoing
10 Deprivation of Liberty Safeguards	To seek to ensure that the transition of Supervisory Body function from PCT's to the LA does not create risks for NEPFT	• Task and Finish Group re DoLS reprovision post April 2013 has been established • Guidance re allocation of s12 Dr's and BIA's to be approved by EoE MCA RIN	Ongoing
11 Safeguarding Champions	Ensure twice yearly forums are held for Champions to provide opportunities for trust-wide learning on range of topics	• Safeguardings Champions forum will be held on 29th June	Ongoing

18 Safeguarding in the Future

There is no doubt as we move towards the future that safeguarding will remain a key issue for health and service provision. The Safeguarding team will need to integrate into the new structures following the implementation of the Health and Social Care Act. In times of significant structural and organisational change the risks to patient safety can increase. NEPFT safeguarding team will continue to seek assurance that systems are in place that prevent abuse occurring and when it does occur it is identified and service user's are effectively protected. What will continue to be needed is advice, support, supervision, training and expert knowledge.

19 Conclusion

2011 has been a very busy year for the Safeguarding team. This has been the first full year of the team including a pan North Essex DoLS service in its remit. There have been important achievements including delivering significant amounts of training, both adults and children, increasing the number of DoLS applications and revising the safeguarding standards and assurance process.

The critical structural changes ahead for the NHS present fresh challenges to ensure that our service user's are protected from abuse and are empowered to make decisions about their healthcare. The safeguarding team are committed to and ready to face this challenge.

20 Recommendations

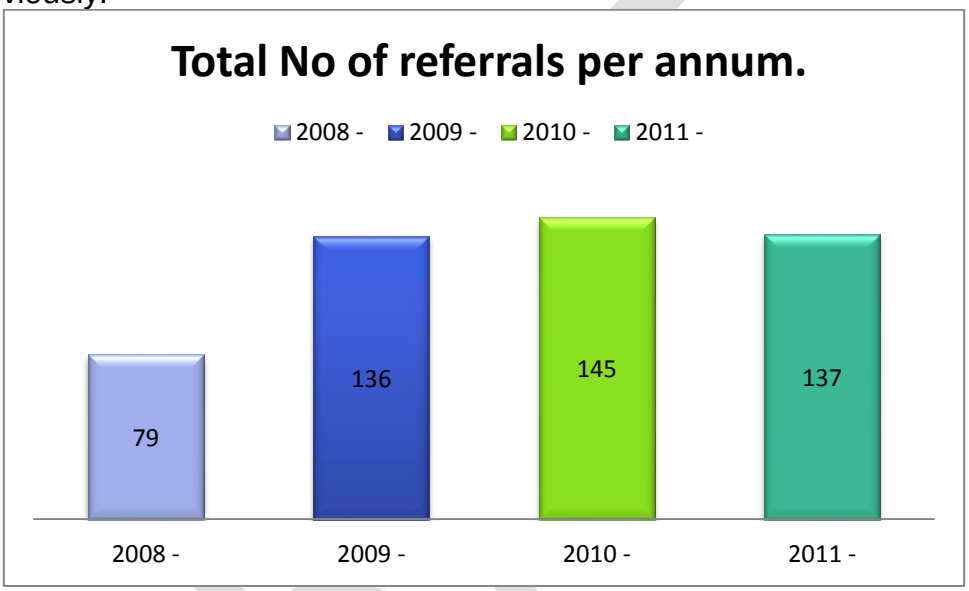
- That the Board receives this report and notes the successes and future key goals
- That the Board notes 24% of staff fail to attend training having booked and confirmed their attendance.
- That the Board receive future safeguarding updates as required

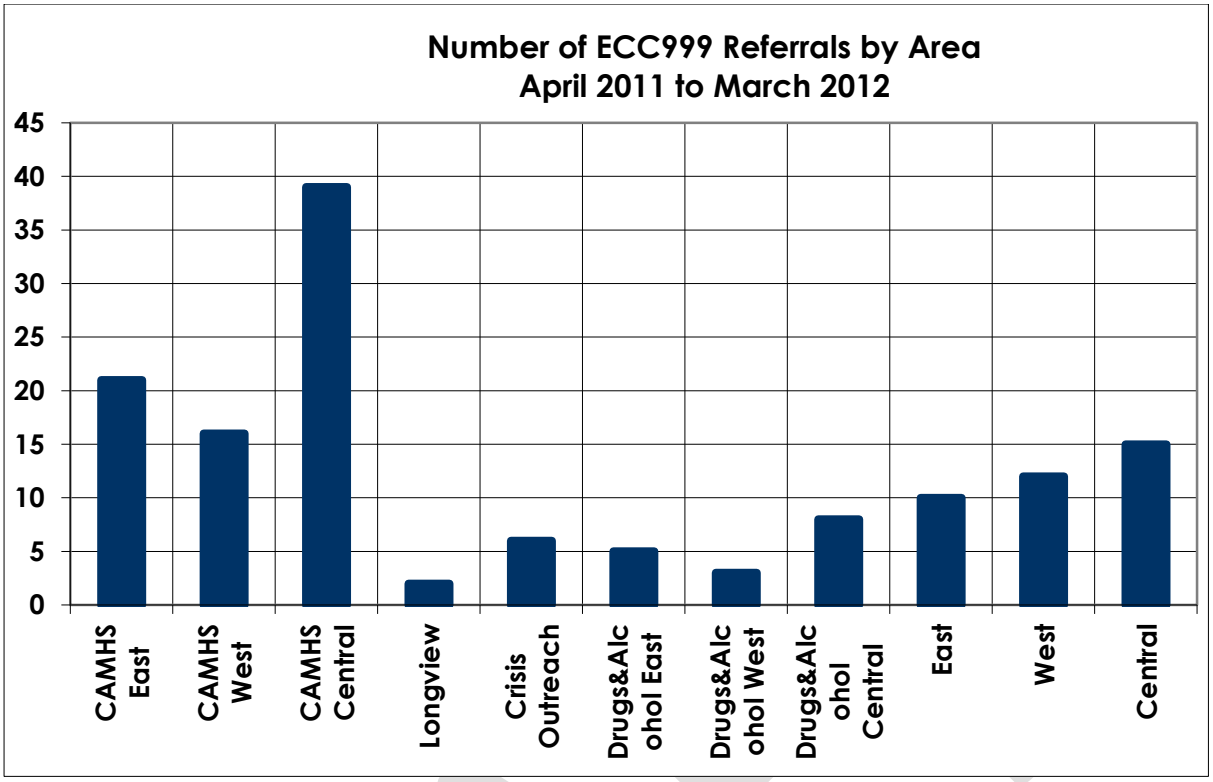
Appendix 1: Safeguarding Children Performance Activity:

For the purposes of the Annual Report, only headline information has been provided. More detailed information is provided to Clinical Boards.

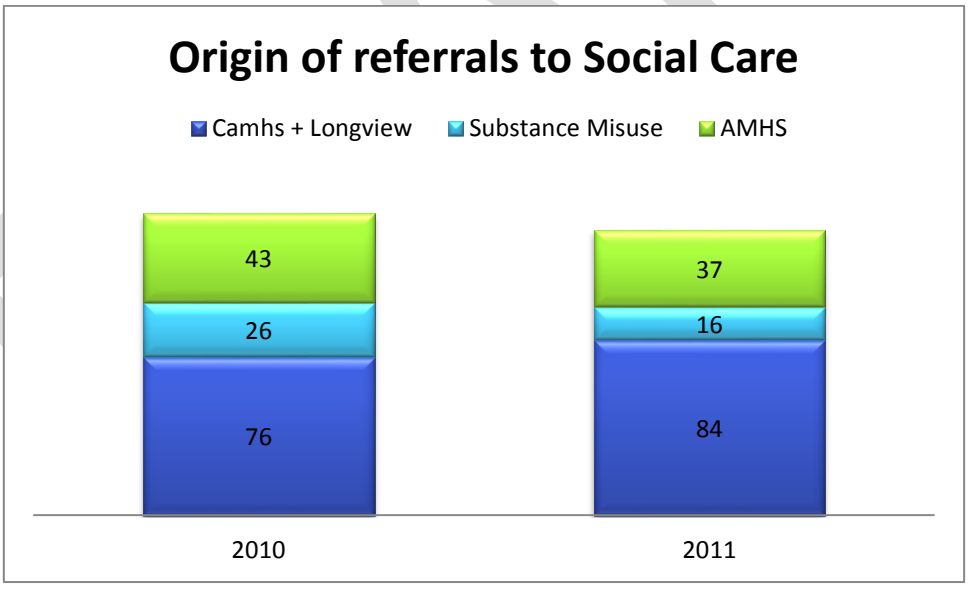
The volume of referrals made by NEPFT to Children's Social Care has decreased slightly during 2011– 2012 (from 145 - 137).

Clinicians routinely express disquiet and unease about the value in referring children to Social Care unless the risk is extreme or the child is under 5 years of age; the perception remains that many referrals are not accepted and that the thresholds for a referral being accepted (for investigation) within social care are significantly higher than previously.





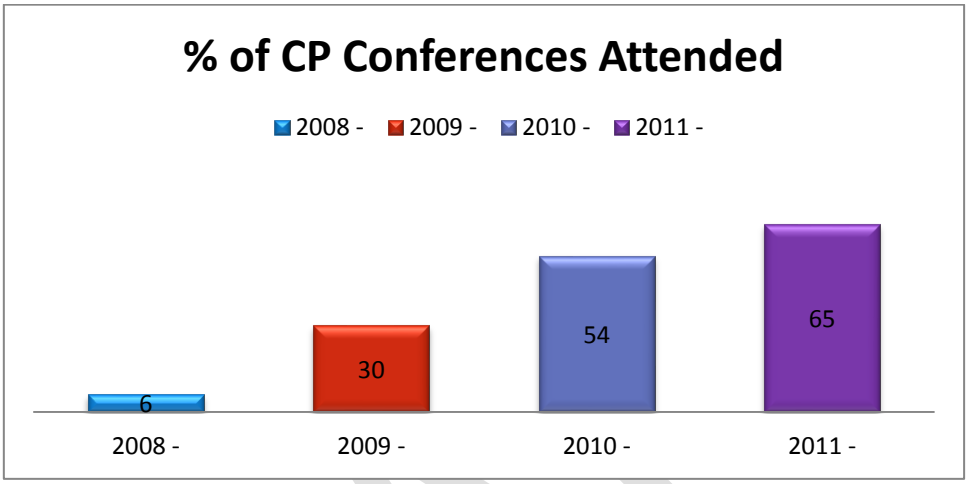
The origin of referrals:



Attendance at CP Conferences:

Attendance at CP Conferences has historically been very poor in NEPFT. Considerable work has been put into place to ensure that:

- Reporting on attendance is only recorded where a child or member of the same household is a service user of NEPFT.
- Immediate support is provided to clinicians required to attend CP Conferences
- In addition to recording attendance, reporting on the number of Reports provided to CP conferences is recorded.



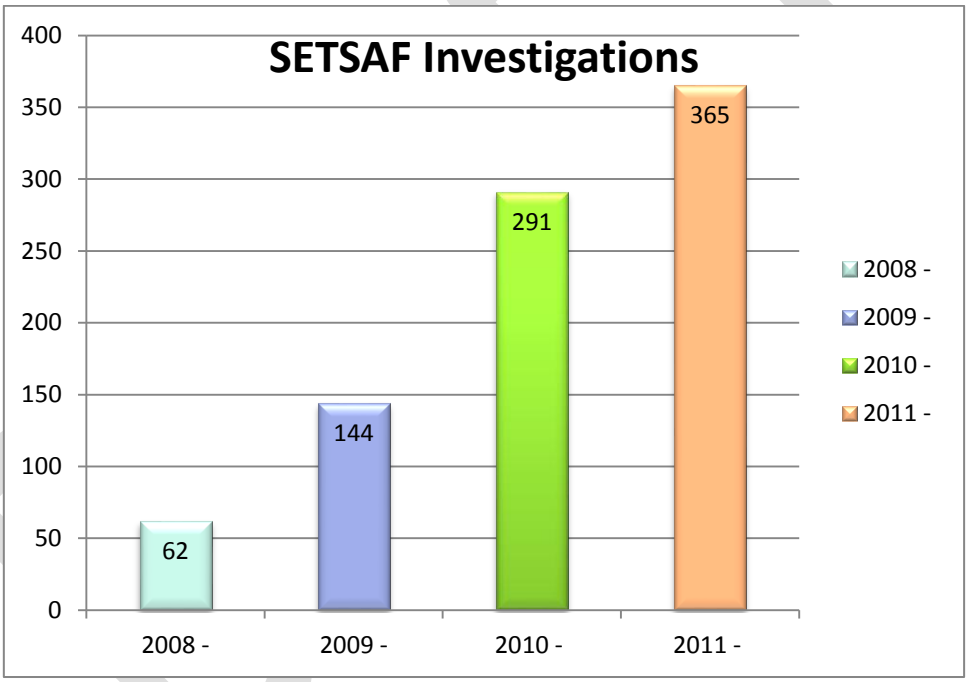
Attendance at CP Conferences continues to vary significantly between teams for example the CDAT team in West Essex attended over 95% of all CP Conferences they were invited to, whereas clinicians in AMHS West attended just 46% of the Conferences they were requested to attend.

Appendix 2: Safeguarding Adults Performance Activity:

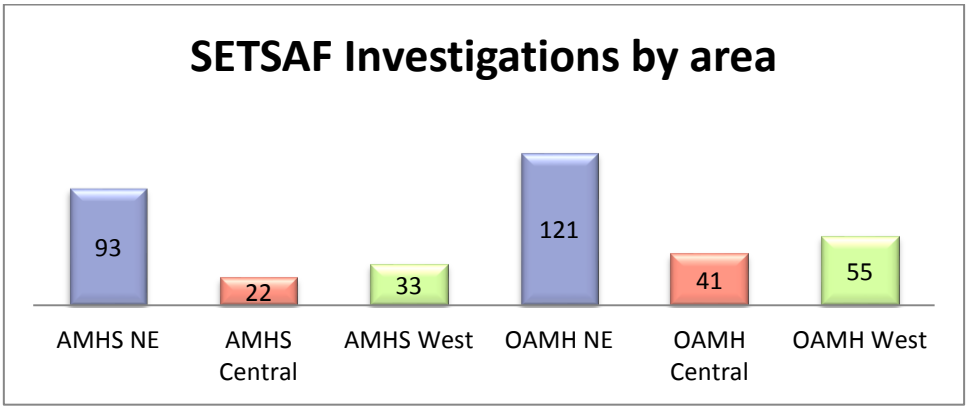
For the purposes of the Annual Report, only headline information has been provided. More detailed information is provided to Clinical Boards.

The volume of referrals made by NEPFT to Children's Social Care has increased during 2011– 2012 (from 291 - 365).

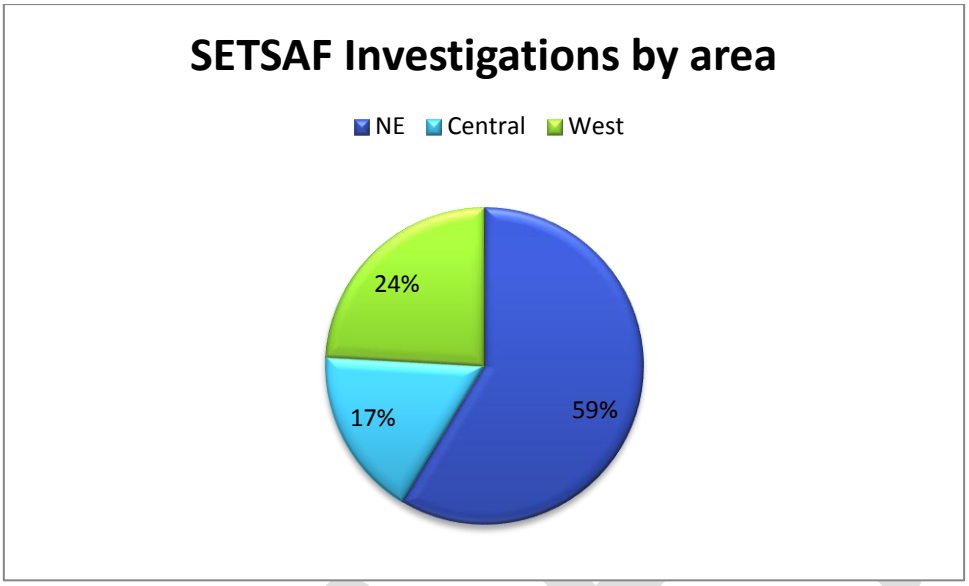
The increasing volume and complexity of SETSAF investigations and the resource implications cause both individual clinicians and team managers increasing concerns. In addition an increasing number of SETSAF investigations are inappropriately referred by ECC to NEPFT for investigation. This results in the Safeguarding Team and Operational leads for Safeguarding spending increasing amounts of time in negotiating with Essex County Council to ensure the appropriate Social Care team leads the investigation.



SETSAF Investigations by area:



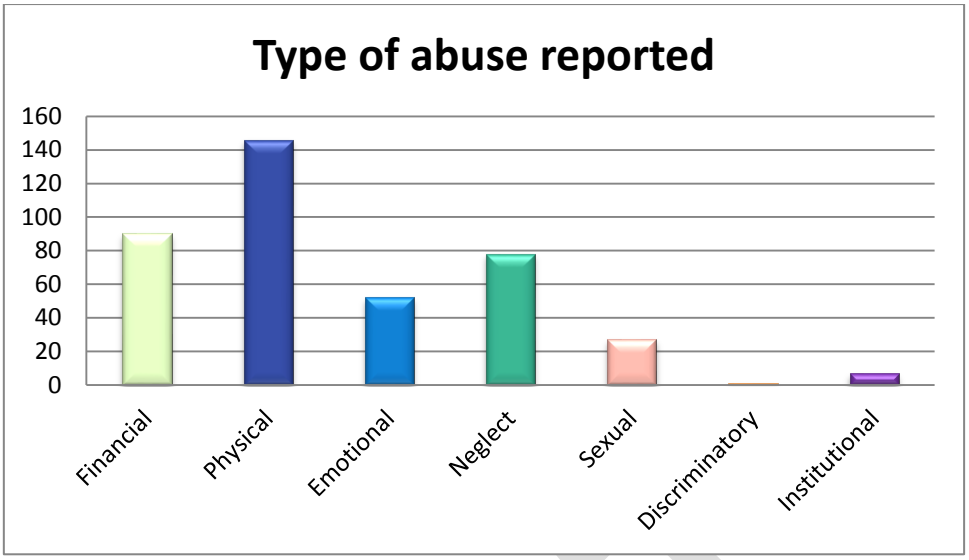
More detailed analysis reveals that 59% of all SETSAF investigations occur in North East area. Whilst there are a signifciant number of carehomes in North East which should have some impact on the data, there is an inconsistency between NEPFT data and ESAB data for the wider economy.



As in previous years, SETSAF activity continues to raise concerns about the safeguarding adults agenda within CAMHS, EIP and Substance Misuse teams as no SETSAF has been raised for a service user engaging with these Trust services.

Type of Abuse reported:

Some of the most complex investigations involve allegations of financial abuse, these are often very time-consuming to investigate requiring several assessments of capacity and liaison with banks and applications to the Court of Protection. NEPFT staff have led a number of investigations into sexual assaults, often jointly with colleagues from Essex Police, these investigations can have a significant impact on staff who may be particularly distressed to learn about the sexual assault of an older vulnerable adult.



Attendance at MARAC conferences:

A major new initiative in the Autumn of 2008 was the development of MARAC committees – multi-agency risk assessment committees primarily involved with families where there is a significantly high risk of domestic violence. NEPFT is actively involved in attending three monthly MARAC meetings (one in each PCT domain).

Appendix 3

MCA2 and DoLS Activity Analysis Report for ESAB

2011 – 2012

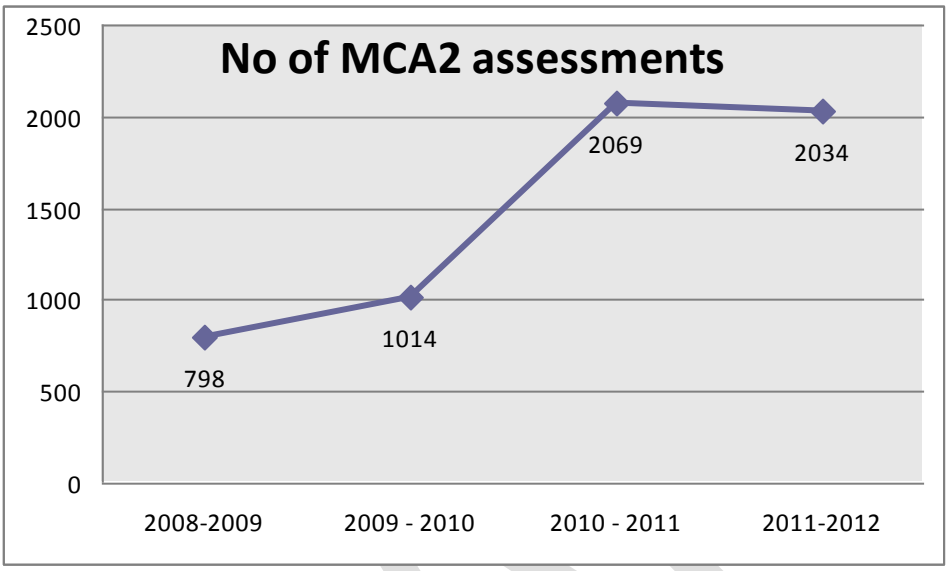
The SET MCA Policy and associated procedures were agreed in 2009. All NHS health agencies have confirmed to ESAB that they have formally adopted the SET MCA Policy with the exception of Southend Hospital. No amendments have been made to the SET MCA Policy and Procedures during this financial year, however a task and finish group has been established as a subcommittee of the MCA LIN and a revised policy and associated procedures will be ready for adoption in June 2012. This revised Policy will not be adopted by Southend, but will be shared by Essex and Thurrock.

This MCA Activity Report reports data surrounding MCA2 assessments in Essex since the legislation was enacted. Although some conclusions are drawn and recommendations made, this should in no way be viewed as a review of the MCA2 processes, procedures or policies of those involved. It is designed to be used as supporting documentation for project planning and benchmarking current performance.

Since 1st February 2010 all NHS Trusts and agencies in Essex have been responsible for quality monitoring their own MCA2 Assessments but are requested to record the figures monthly (using a pro-forma excel spread sheet) and forward the information to the Essex County Council Adult Safeguards Unit on a quarterly basis. As in previous years, not all agencies have responded to this request and thus there may be some activity in NHS Trusts that has not been available.

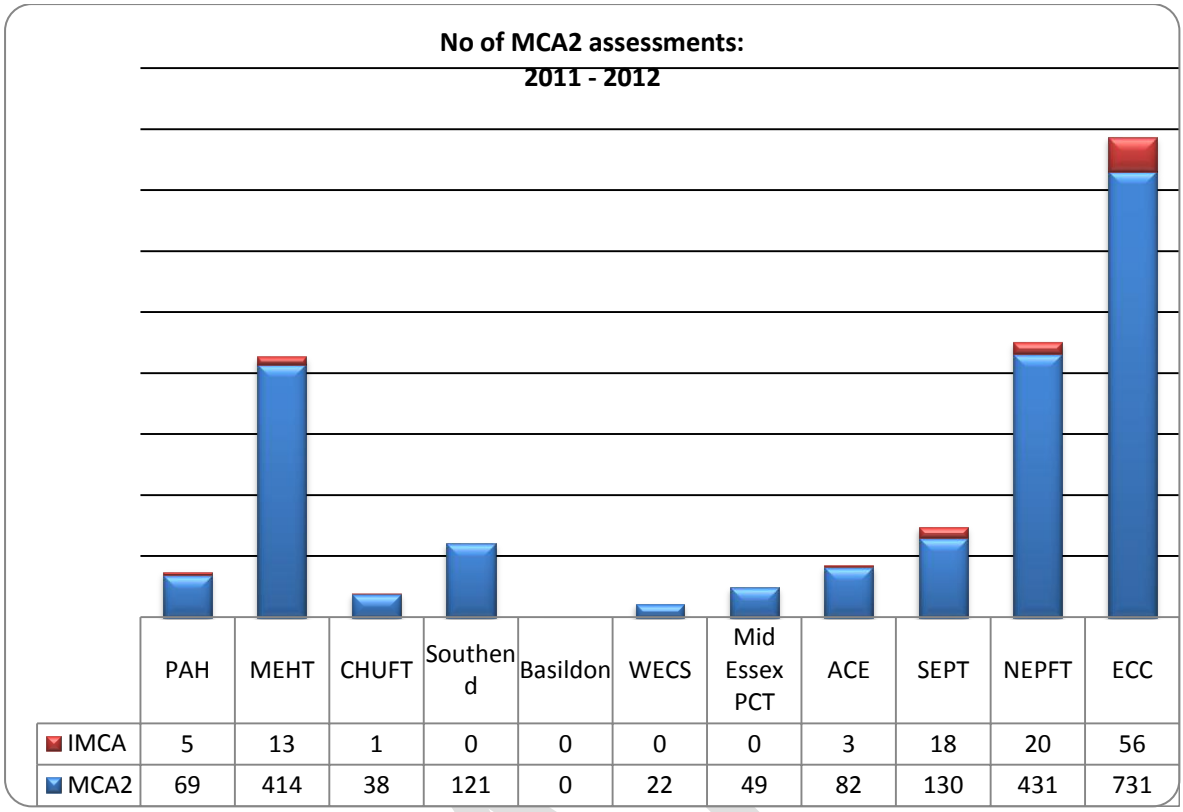
All IMCA requests are submitted through the Essex County Council Safeguarding Essex team - thus data detailing the volume of requests for an IMCA is accurate.

The total volume of MCA2 assessments for the financial year (2011 – 2012), is 2034. This results in a slight decrease in the volume of MCA2 activity across the whole of Essex. **This data may however be inaccurate as some agencies have failed to submit returns on time[3].**



Analysis of where MCA2 assessments are conducted reveals that there are significant differences between comparable NHS Trusts – NEPFT has completed 3 times as many assessments as SEPT (431:130). Mid Essex Hospital Trust has completed 414 assessments, compared with just 38 in CHUFT and 69 in PAH. Such differences raise concerns that not all service users who may lack capacity to consent to significant decisions (such as admission or treatment) are being offered an MCA2 assessment or having their statutory right to an IMCA supported.

[3] The following agencies have not submitted a return as this report is complied: Basildon NHS, WECS. Data re DoLS for South Essex is submitted to the MCA RIN and can be assumed to be accurate.



	PAH	MEHT	CHUFT	Southend	Basildon	WECS	Mid Essex PCT	ACE	SEPT	NEPFT	ECC
IMCA	5	13	1	0	0	0	0	3	18	20	56
MCA2	69	414	38	121	0	22	49	82	130	431	731

MEHT continues to complete significantly more MCA2 assessments than other Acute Hospital Trusts. Southend NHS – whilst stating that they are using the SET MCA Policy – have in practice developed alternative forms for recording MCA assessments which involve a single clinician. The data provided from Southend does not include information about any referrals for IMCAs and has not been provided on the excel spread-sheet therefore more detailed analysis of their MCA activity has not been possible within this report. It is probable that the use of an amended CONS4 within MEHT has led to an increase in the appropriate use of the MCA and as stated in previous reports, it is recommended that all Acute Hospital Trusts evaluate the MEHT CONS4 and consider its local adaption. The revised MCA Policy will propose the adoption of the MEHT CONS4 pan Essex.

Analysis of which groups of service user's receive MCA2 assessments reveals that there have been no significant changes in patterns of activity since the implementation of the legislation. In common with the findings from CQC and the NHS Information Centre; the majority of MCA2 assessments are completed on female elderly service users (over the age of 70) with diagnoses of dementia. The main decision being assessed is "change of accommodation" closely followed by "finances". Within NEPFT, there has been an increase in the volume of assessments regarding consent to admission – this is linked to clearer guidance on the Deprivation of Liberty Safeguards.

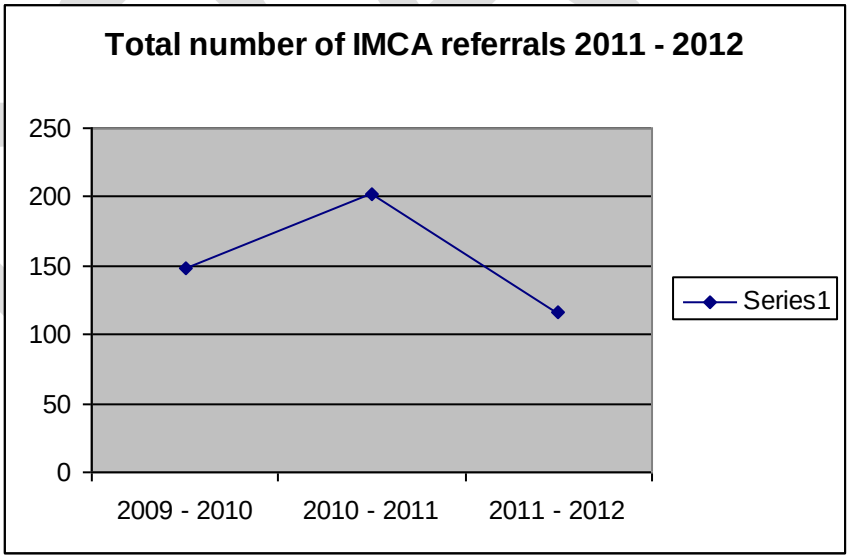
MCA IMCA activity:

The MCA provides a statutory duty for service users who lack capacity and are un-befriended to have access to an IMCA for certain specific decisions:

1. Change of accommodation
2. Serious Medical Treatment

In addition service users who are subject to safeguarding investigations (where their alleged perpetrator is friend or family) may have an IMCA and un-befriended service users subject to a care review may have an IMCA.

There has been a significant reduction in the number of referrals for IMCA's in this financial year. This is concerning, particularly given that the overall volume of MCA2 assessments has remained relatively steady. In 2012 – 2013, a new IMCA provider has been commissioned to provide a service pan-Essex (Voiceability) and it is hoped that with a new emphasis on training, volume of IMCA referrals will increase in 2012 – 2013.



On the positive side, 46% of all IMCA referrals during this financial year were made during q.4 (January – March 2012). This is encouraging and suggests that awareness is improving**.**

Deprivation of Liberty Safeguards:

CQC annual report: 2010-2011(published in April 2012) reported a number of key findings:

- 8,982 applications to deprive a person of their liberty were processed, of which 50 per cent were authorised.
- Many services have developed good practice on the use of the safeguards, especially in involving people and their families in the decision-making process, but some were confused as to when restraints or restrictions on a person amounted to a deprivation of liberty.
- Between a third and a quarter of care homes had not provided their staff with training on the safeguards, and in some cases only the manager had received training.
- Most hospitals had held some training, but the proportion of staff involved ranged between 20-100 per cent.
- There are big gaps in information which limit our ability to comment on the safeguards' overall effectiveness. To broaden our findings, we plan to work with stakeholders more to monitor the use of the safeguards.

As a consequence of CQC's findings, CQC are planning three ways to improve their approach to monitor the safeguards. CQC want to:

- embed the safeguards as a routine and major part of their inspectors' practice.
- improve their information on managing authorities' applications and authorisations for the safeguards.
- develop their ability to monitor the overall safeguards system and managing authorities.

CQC is placing an increasing emphasis on ensuring that all service user's rights and safeguarding (outcome 7) are appropriately implemented and this has been reflected in the focus of recent CQC inspections within Essex.

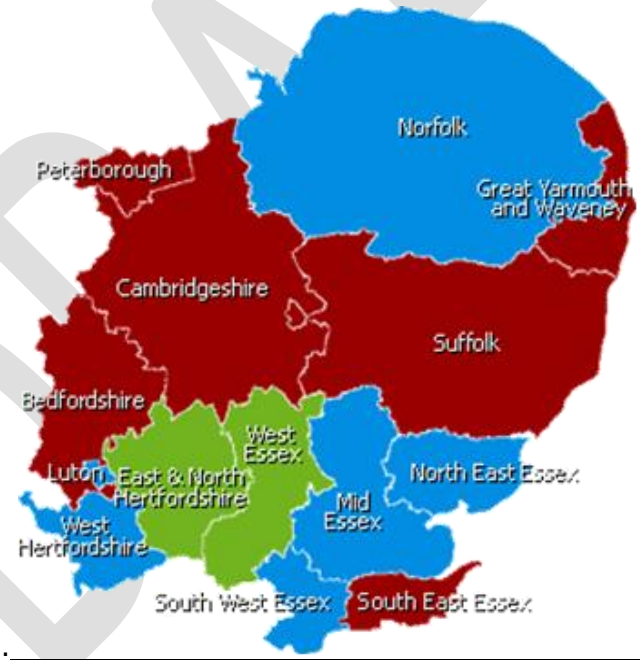
DoLS Data provided to the NHS Information Centre and the MCA RIN reveals significant differences in the level of applications across the Eastern Region both in

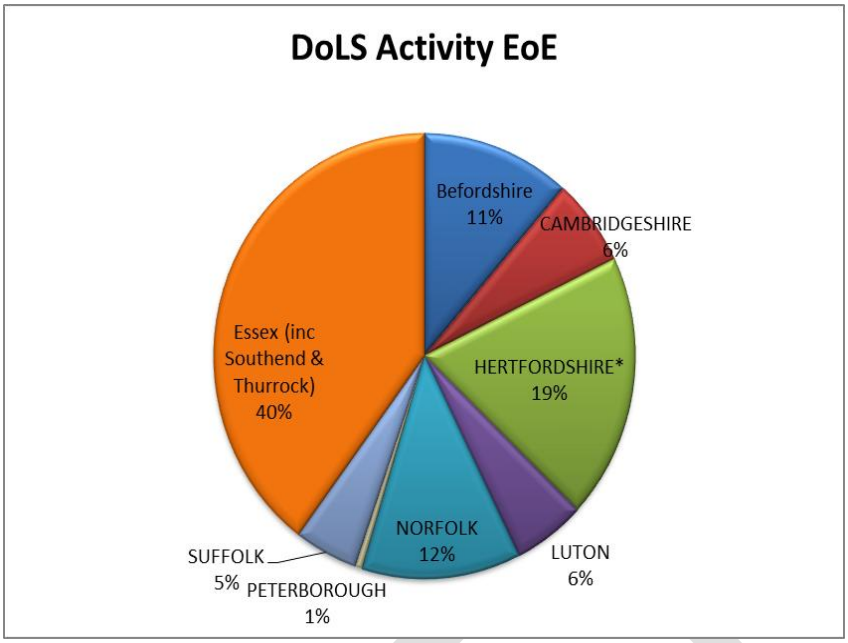
the Health and Social Care Economy. In total, **954** applications were made to Supervisory Bodies in the EoE, of which 512 (53%) applications were authorised.

The total volume of applications made by Health in Essex in 2011 – 2012 was 304, but the range of applications between PCT areas was 14 (South West Essex PCT) – 108 (Mid Essex PCT). North Essex made 207 applications compared with 97 applications in South Essex. In contrast, NHS Norfolk received 18 applications and NHS Suffolk received just 9 applications.

Data available from LA's shows similar variations; Essex County Council received 147 applications, whilst Suffolk received 29 and Cambridgeshire 16.

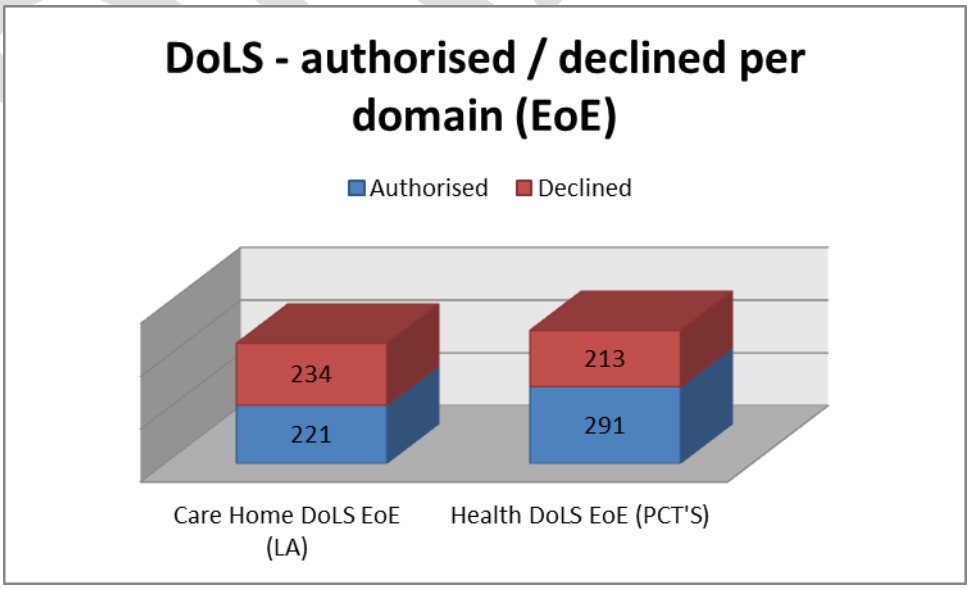
The volume of applications authorised varies across domains – 51% carehomes (LA's) and 42% hospital beds (PCT's)





DoLS activity in Essex shows some very concerning differences in levels of activity between north and south Essex NHS. North Essex NHS received 207 applications **(40% of all health DoLS activity in the East of England)** compared with 97 applications in South Essex NHS – the majority of which concerned service user's on OAMH wards within SEPT.

The overall pattern revealed is that 51% of DoLS applications from carehomes have been authorised, compared with only 42% of DoLS applications being authorised in health.

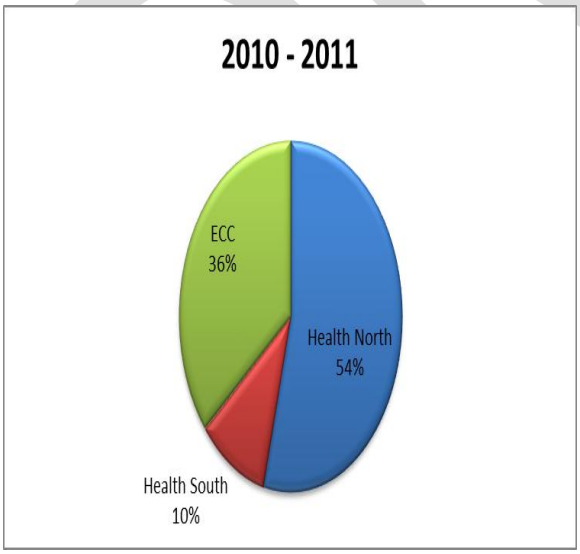


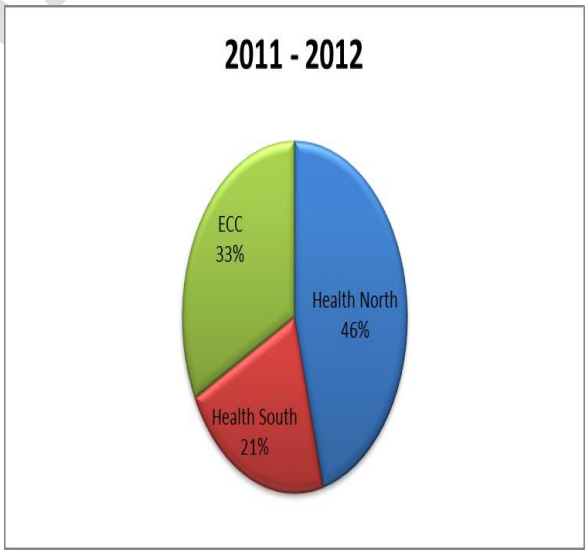
More detailed analysis of health data in North Essex reveals that over 10% of DoLS applications made in health are declined (on the grounds of eligibility) but do result in

a successful application for detention under the MHA. These inappropriate applications are most frequently of a female older adult who has been admitted to a OAMH ward and who has dementia. The service user will lack capacity to consent to admission / treatment and is not free to leave the ward as they would be at risk, should they leave the ward. Whilst such an individual may appear to be superficially compliant and may not be physically attempting to leave a ward, they may be objecting to a component of their treatment – (eg refusing medication), and thus are objecting to treatment. As their status is that of a mental health patient and they are objecting, they are ineligible for DoLS but may be eligible to be detained under the MHA.

The projected trend for 2012-2013 is in excess of 250 applications for North Essex Health. was generated by North Essex Health. It is of note that NHS North Essex has received 23 applications during April 2012 alone (giving a projected volume of over 275 assessments for 2012-2013)

The DH reported that it expected DoLS activity to be 4:1 LA's: PCT's. In Essex however the trend which began to develop in 2010-2011 has continued, with only 33% of DoLS completed during this financial year being for service user's in care homes in Essex. This is relevant as the financial sums made available by the DH to health and social care were on the basis of the formula 4:1; therefore ECC received a sum of £700K compared with a total health budget of approximately £300k.





There is no clear explanation as to the very significant difference in the volume of DoLS applications across the county, but factors which have improved the volume of appropriate referrals for DoLS from health include:

- Many NHS Trusts have ensured that training on MCA & DoLS is accessible through safeguarding clinics and mandatory training programmes
- Internal NHS Trust Policies on MCA, DoLS and Safeguarding
- Use of the CoNS4 (consent to admission / treatment) in NHS Trusts – the modified version used in MEHT appears to promote thinking about necessity to complete MCA2 assessments and results in a increased awareness of MCA *and* DoLS
- Local audit and reporting systems regarding the MCA in NHS Trusts
- Commissioning Arrangements for DoLS – for example NHS North Essex commission NEPFT to provide a DoLS service which includes

Significant differences emerging for older adult service user's with a mental disorder (frequently a dementia) who are admitted to a mental health hospital bed – dependent on their geographical location. Such service user's may be admitted informally (under s131 MHA or MCA) or assessed for detention under MHA or DoLS. It is *not* a choice about which legislation may be used; the MHA trumps the MCA & DoLS; it is only where MHA is not applicable that DoLS should be considered for the older adult with a mental disorder in a mental health hospital bed who is not free to come and go as they please.

NEPFT and SEPT were jointly proactive in jointly developing "Guidance for Psychiatric Hospitals" which has been adopted by the EoE MCA RIN. This guidance and associated training has led to a significant increase in awareness of the legal frameworks under which service user's are admitted and service user's rights (to come and go as they please, unless lawfully detained). It has led to an increase in referrals for both assessments under MHA and under DoLS from OAMH inpatients.

DoLS approval of professionals:

During 2011-2012, all BIA's used by NHS North Essex and ECC have completed and submitted portfolios for approval in accordance with the MCA RIN guidance. This ensures that practising BIA's evidence completion of a number of requirements (18 hours CPD, supervision, completion of a minimum of 3 DoLS assessments and submission of a portfolio of additional evidence). It has emerged during this financial year that not all Supervisory Bodies have accepted the standards recommended by

the MCA RIN for the re-approval of BIA's, with some Supervisory Bodies advising that they only require 12 hours of CPD per annum.

Since 2009, ECC has hosted an annual CPD training event for s12 Dr's on behalf of all Supervisory Bodies in SET. This event was very popular with s12 Dr's but costly for ECC to host. In 2011-2012, ECC made a decision not to host a CPD event for s12 Dr's, rather CPD training for s12 Dr's was organised through the MCA RIN, with two events held in Cambridge and Runwell. This has resulted in fewer s12 Dr's completing their required CPD competencies during this financial year.

NEPFT hosted a training event for s12 Dr's to become DoLS approved in November 2011, resulting in a further 25 psychiatrists from EoE gaining their DoLS approval. Some s12 Dr's attend such events not with a wish to practice but simply to improve their own knowledge of the field.

The cohort of s12 Dr's approved and willing to practice has in practice reduced across SET during this financial year. This poses a potential risk to Supervisory Bodies as the volume of DoLS activity increases. Completion of DoLS assessments within tight time-scales is often dependent on the good-will of a few s12 Dr's to accept assessments.

DoLS Training:

It is the responsibility of Supervisory Bodies in receipt of DH monies for the implementation of MCA and DoLS, to ensure that professionals are aware of the MCA and DoLS.

NHS North Essex have ensured that there are new commissioning standards for Safeguarding Adults which specifically include awareness of the MCA and DOLS. In NEPFT and MEHT all clinicians have access to robust training in these domains (451 staff in NEPFT attended a 1 day training on MCA and DoLS during the financial year) and it is believed that training in MCA and DoLS results in higher numbers of completed MCA and DoLS assessments and more appropriate safeguarding of clients. There are e-learning programmes available on OLM (used by many NHS Trusts in Essex) on MCA and DoLS. SCIE offers an extensive programme of excellent elearning programmes on MCA and DoLS.

A wide variety of training events and safeguarding clinics have been held within health across the county to improve awareness of this legislation.

MCA and DoLS Training in care homes is commissioned by Care Home Managers. It can be commissioned from the ECC DoLS team. In addition there are a number of private training providers also operating in SET.

ESAB is now offering training on MCA and DoLS to providers and ECC offers an e-learning programme on MCA and DoLS.

SCIE offers some excellent e-learning training programmes on MCA and DoLS.

DoLS: The Future:

The government has issued a Local Authority Social Services Letter LASSL(DH)(2011)1 regarding the consultation on the redistribution of PCT funding for DoLS

http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Localauthoritysocialservicesletters/DH_131558

The letter accompanies a document providing an analysis of the consultation for a number of issues, including the transfer of funding for DoLS assessments in hospitals from the NHS to local authorities.

In short, there are no shocks and the message is:

1. The supervisory body responsibility for DoLS in hospitals will transfer to local authorities in April 2013
2. PCTs will remain responsible for hospital authorisations during 2012/13 and will continue to receive NHS DoLS resources for that purpose.
3. DH accepts that there is some new work required to develop the hospital supervisory body role for local authorities and there is a small amount of new money being made available for one year for this purpose. (see paras 72 - 74)

Annex A of the document includes provisional DoLS allocations for local authorities for 2012/13.

The combined MCA & DoLS grants for the three Local Authorities (Southend, Essex & Thurrock) and the 5 PCT's in Essex is **£1,823,410.**

The NHS DoLS component (of this total budget of £1,823,410) which will be transferred to the LA Supervisory Bodies in April 2013 totals **£55,640**. The three LA have a new duty under the Health & Social Care Act (following completion of its passage in parliament) is to make assessments and authorisations of DoLS in hospitals. The funding transferred specifically includes:

- Assessing the nature and extent of liberty deprivations that are appropriate on a case by case basis
- Training those involved with respect to their responsibilities under the MCA (2005)

The MCA LIN advises that the sum of £55,640 is insufficient for the combined Local Authorities to implement DoLS, given that during 2011-2012, 304 DoLS applications

were completed in Southend, Essex & Thurrock by Health. Given that the s12 component of a DoLS assessment costs an average of £200 per application, then £60,800 would be required by LA's to complete the Dr's component alone.

The MCA LIN also notes that under the Health and Social Care Act the NHS retains significant responsibilities in respect of the MCA, thus it is unlikely that PCT/CCG's will agree to transfer the total sums allocated to health for implementation of the MCA & DoLS. If health merely transfers the sums recommended by the DH to LA's, they will receive just **£55,640.**

In advance of this duty transferring to Local Authorities in April 2013, the DH has made £1.35m available within the Learning Disability and Health Reform grant this year (2012-2013) to help Local Authorities, PCT's and Hospital Trusts work together to prepare for the transfer. This funding is in addition to the resources already allocated to PCT's in 2012/2013 for DoLS. The sums allocated to SET for this purpose total £41,988

- Essex - £33,608
- Southend – £4,596
- Thurrock - £3,784

A task and finish group comprising NHS DoLS leads together with LA DoLS Leads has been established consider how a future DoLS service should be constructed to best meet the needs of service user's in Essex. A questionnaire has been completed by all Supervisory Bodies and the information obtained has been evaluated. Proposals regarding the future management of DoLS are being constructed at the present time.

There remain risks in Essex to the human rights of people who lack capacity (unequal levels of applications from acute hospitals, lack of awareness of DoLS in some care homes). DoLS pose significant legal, financial and reputational risks to Supervisory Bodies. The changes agreed in the Health & Social Care Act can be summarised as transferring the function of Supervisory Body from Health to LA's; this is a transfer of risk from the NHS to the Local Authority.

Aside from the transfer of risk from the NHS to the Local Authority, the risks can be summarised as including:

- Potential breaches in human rights by not undertaking as many DOLS applications and authorisations as necessary, therefore leaving people unprotected.

- Supervisory Bodies ending up with expensive court cases because families and others challenge the absence of authorisations or the quality of the assessments.
- DoLS in hospital beds are a new role and may result in local authorities authorising and challenging assessments within NHS environments.
- The above risks are compounded by what local authorities may regard as inadequate funding arrangements.

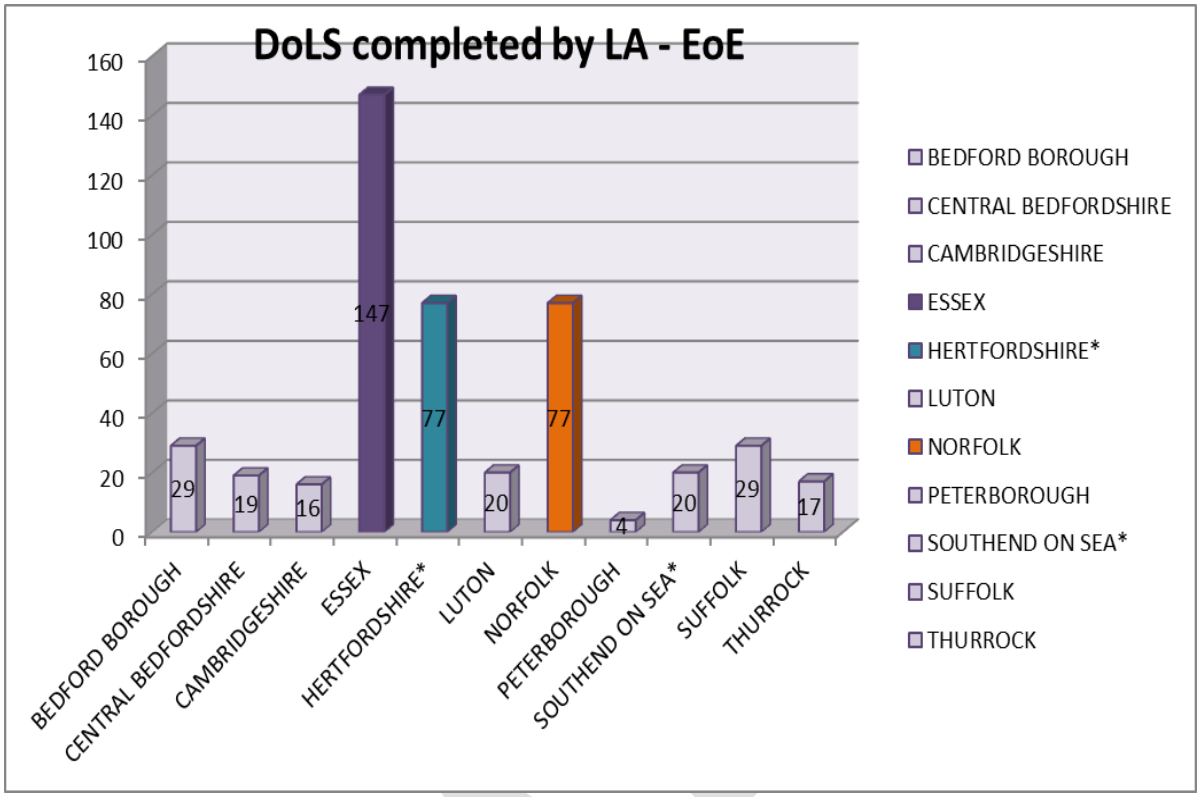
ESAB is asked to note:

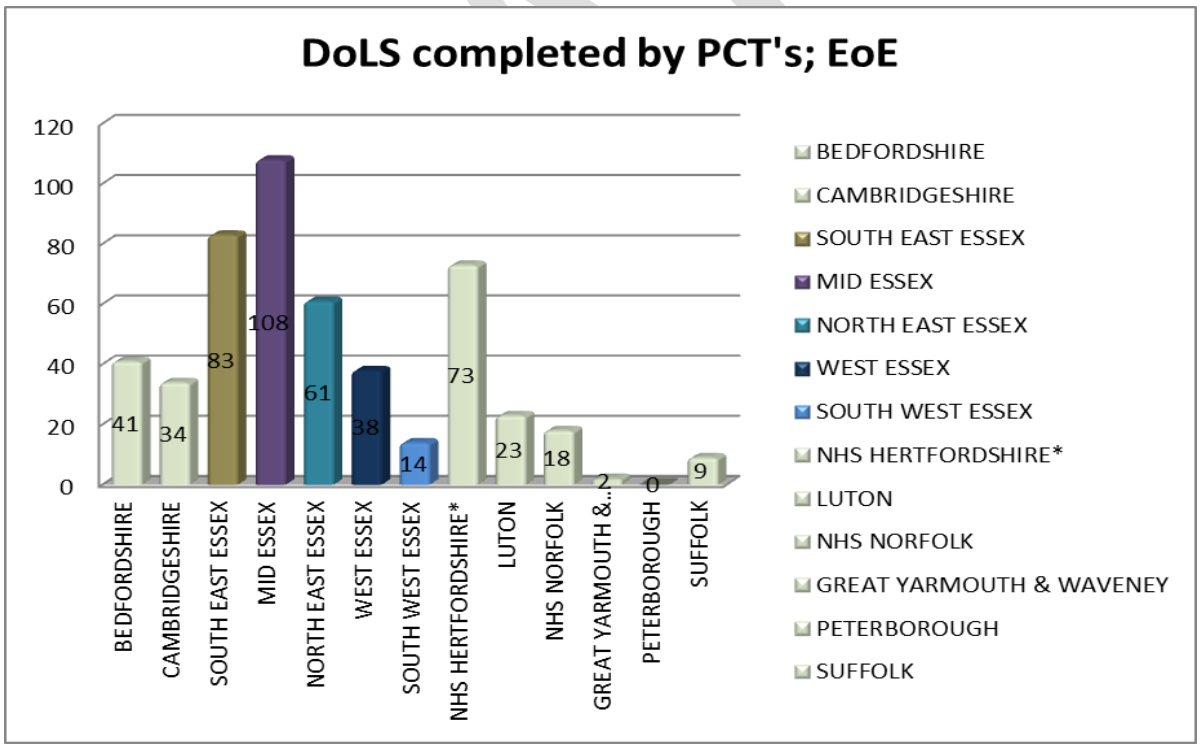
- The Health and Social Care Act transfers responsibilities for DoLS to LA, but only provides for limited monies to be transferred to the LA to fulfil these new statutory duties, Whilst a Task and Finish group has been established to explore this issue, there are a number of potential risks with this transition, particularly during this time of uncertainty.
- The number of approved BIA's and s12 Dr's in Essex is reducing and will be unable to cope with increased volume of referrals.
- The DH predicted that the volume of DoLS activity would be 4:1 (LA's completing 4 DoLS application for every single application submitted to Health). In contrast in Essex, only 33% of applications are managed by the Local Authority

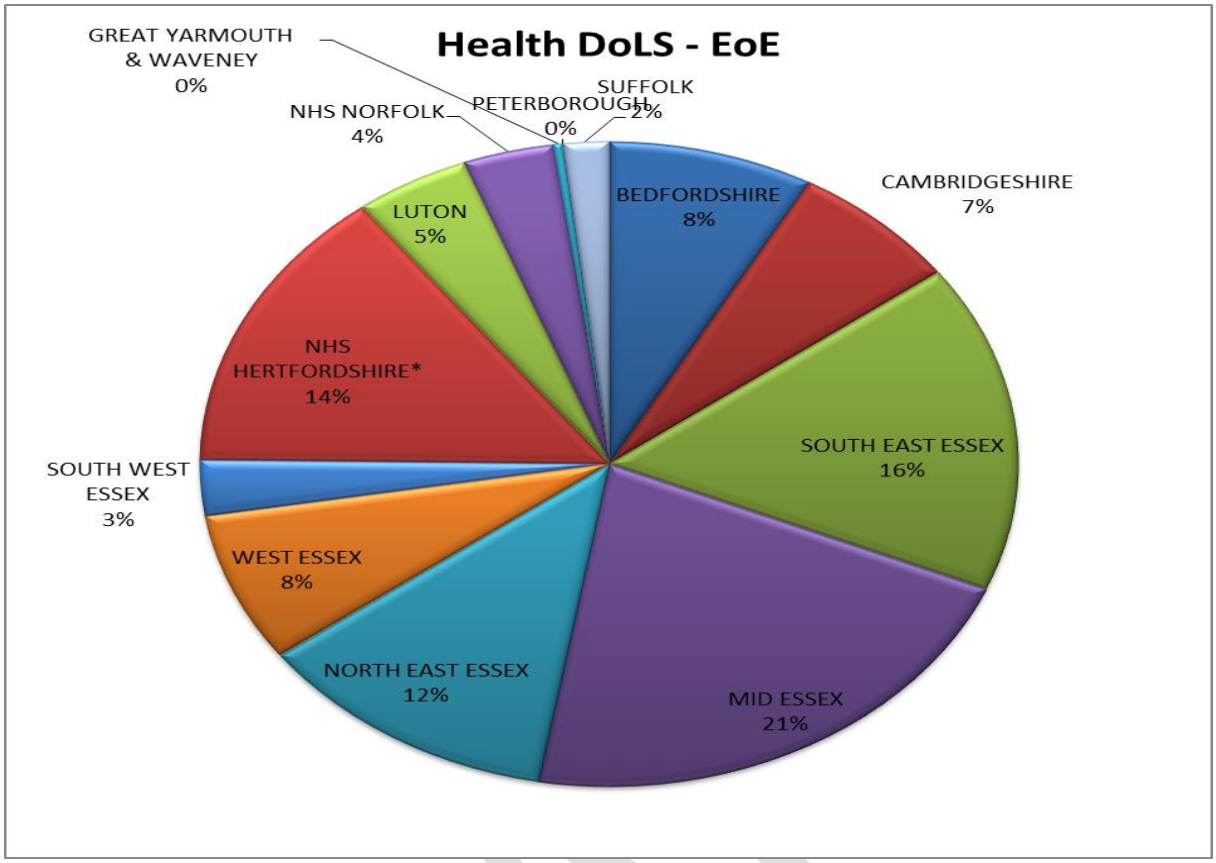
Recommendations:

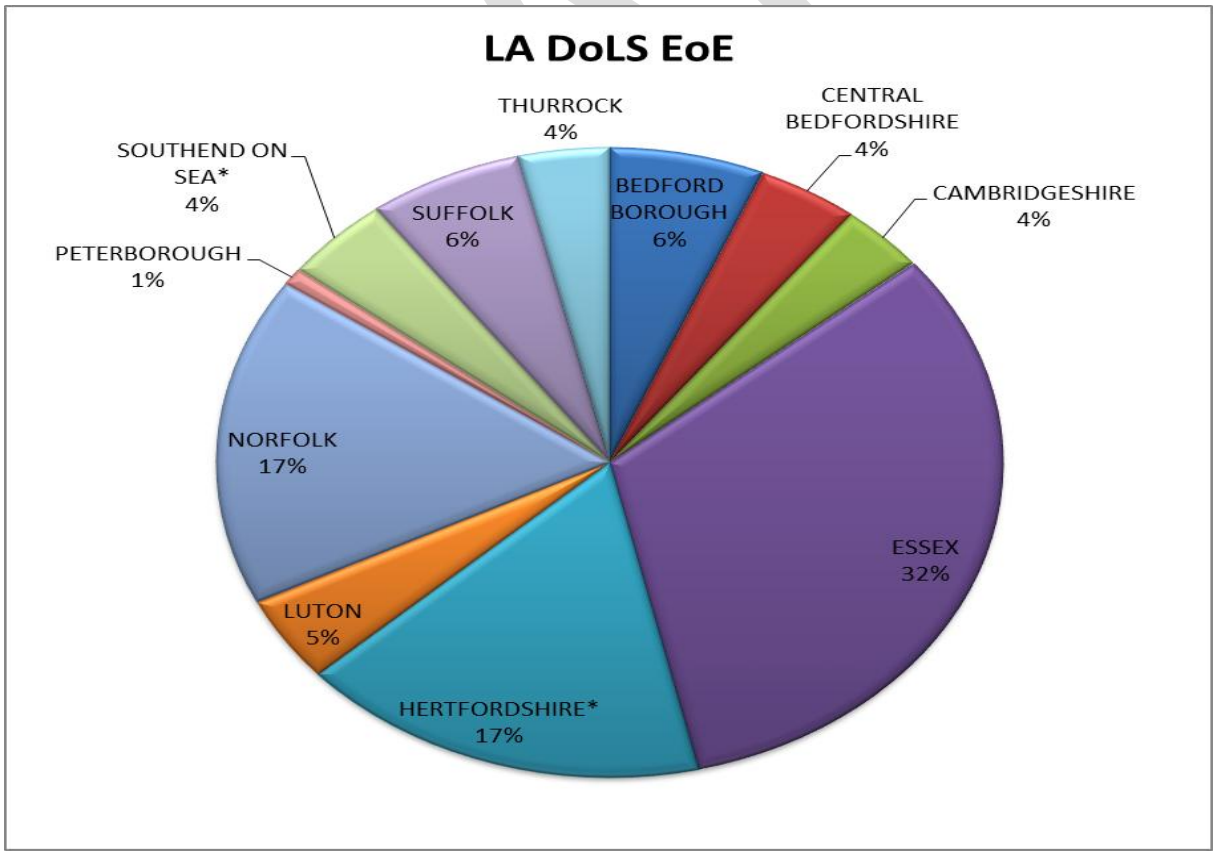
1. Organisations who have not responded to requests for MCA2 data should be contacted by the Chair of ESAB and requested to provide this data for the whole of this financial year; to enable meaningful analysis of MCA and DoLS activity across the whole economy. CEO's should be reminded that no patient-identifiable information (names) are being requested.
2. ESAB requests regular updates from the Task and Finish group regarding future provision of DoLS and creative options should be explored in resolving the challenges posed
3. Commissioners seek assurance that no adult in SET is being unlawfully deprived of their liberty from relevant provider organisations. In addition Commissioners are requested to include MCA and DoLS in Safeguarding Standards .

Penny Rogers
Head of Safeguarding,
NEPFT


DoLS completed by LA - EoE
160
140
120
100
80
60
40
20
0
29
19
16
147
77
20
77
4
20
29
17
BEDFORD BOROUGH
CENTRAL BEDFORDSHIRE
CAMBRIDGESHIRE
ESSEX
HERTFORDSHIRE*
LUTON
NORFOLK
PETERBOROUGH
SOUTHEND ON SEA*
SUFFOLK
THURROCK


DoLS completed by PCT's; EoE
120
100
80
60
40
20
0
41
34
83
108
61
38
14
73
23
18
2
0
9
BEDFORDSHIRE
CAMBRIDGESHIRE
SOUTH EAST ESSEX
MID ESSEX
NORTH EAST ESSEX
WEST ESSEX
SOUTH WEST ESSEX
NHS HERTFORDSHIRE*
LUTON
NHS NORFOLK
GREAT YARMOUTH &...
PETERBOROUGH
SUFFOLK


Health DoLS - EoE
GREAT YARMOUTH & WAVENEY 0%
NHS NORFOLK 4%
PETERBOROUGH 0%
SUFFOLK 2%
BEDFORDSHIRE 8%
CAMBRIDGESHIRE 7%
LUTON 5%
NHS HERTFORDSHIRE* 14%
SOUTH EAST ESSEX 16%
SOUTH WEST ESSEX 3%
WEST ESSEX 8%
NORTH EAST ESSEX 12%
MID ESSEX 21%


LA DoLS EoE
THURROCK 4%
CENTRAL BEDFORDSHIRE 4%
SOUTHEND ON SEA* 4%
BEDFORD BOROUGH 6%
CAMBRIDGESHIRE 4%
SUFFOLK 6%
PETERBOROUGH 1%
NORFOLK 17%
ESSEX 32%
LUTON 5%
HERTFORDSHIRE* 17%

References:


DoLS.pdf


DoLS outcome of consultation.pdf