

Safeguarding Annual Report 2019–2020

Trust Board	Item: 12
Date: 1 st December 2020	Enclosure: G
<p>Purpose of the Report: The purpose of this annual report is to inform members of the Trust Board of the Safeguarding activities within Kingston Hospital NHS Foundation Trust (KHFT) during the year 1st April 2019 to 31st March 2020, and priority areas for 2020/21.</p>	
<p>For: Information <input checked="" type="checkbox"/> Assurance <input checked="" type="checkbox"/> Discussion and input <input type="checkbox"/> Decision/approval <input checked="" type="checkbox"/></p>	
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Risk Implications – Link to Assurance Framework or Corporate Risk Register:	Compliance with statutory requirements for safeguarding children and adults
Legal / Regulatory / Reputation Implications:	Reputational, Regulatory - CQC Risk Profile Compliance with Care Act 2014.
<p>Link to Relevant CQC Domain: Safe <input checked="" type="checkbox"/> Effective <input checked="" type="checkbox"/> Caring <input checked="" type="checkbox"/> Responsive <input checked="" type="checkbox"/> Well Led <input checked="" type="checkbox"/></p>	
Link to Relevant Corporate Objective:	To comply with Care Quality Commission requirements to maintain license to practice
Document Previously Considered By:	Safeguarding Children Committee Patient Safety & Risk Management Committee Executive Management Committee
<p>Recommendations: The Trust Board is asked to:</p> <ul style="list-style-type: none"> • Note the annual report, the improvements made during 2019/20 and the priority areas for implementation during 2020/21 • Approve publication of the report as the Annual Safeguarding Declaration 	



Kingston Hospital
NHS Foundation Trust

Safeguarding Annual Report

April 2019 – March 2020

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Executive Summary

Kingston Hospital NHS Foundation Trust (KHFT) is committed to ensuring safeguarding is part of its core business and recognises that safeguarding children, young people and adults at risk is a shared responsibility with the need for effective joint working between partner agencies and professionals. This annual report outlines how the safeguarding service is performing and promoting best practice. The report provides an update on safeguarding progress during 2019/20 and identifies safeguarding key issues, risks and priorities for 2020/21.

The Safeguarding Adults and Children's Steering Groups are responsible for disseminating and monitoring information from Kingston Safeguarding Adults Board (KSAB) and Safeguarding Children's Partnership (KRSCP). In turn as a partner agency, the Trust provides challenge and scrutiny to both Boards as this is an essential part of working together to keep children, young people and adults who are at risk, safe.

The Safeguarding Adults and Children's Steering Groups are responsible for disseminating information to operational leads across the Trust ensuring that safeguarding is embedded into practice.

Kingston Safeguarding Adults Board rated the Safeguarding Adults Team as compliant in most areas assessed for the 2019/20 Safeguarding Adults at Risk Audit Tool.

Safeguarding training meets the national standards as identified in the Intercollegiate Guidance 2019 (Children) and the RCN Intercollegiate Guidance 2018 (Adults).

There have been one Safeguarding Adult Review (SAR) and one Learning Lessons Review (LLR) completed within this reporting period. There is one Safeguarding Adult Reviews (SAR) ongoing.

The London Multi Agency Safeguarding Adults Policy has been updated during this period. This policy has been approved for use in all NHS Organisations by NHS England. Use of this policy has been approved by the Trust and will ensure that it is acting in line with current legislation and guidance.

2019-20 has seen a continuation of the strengthening and improvement of the arrangements in place within the Trust to safeguard our most vulnerable patients. The safeguarding teams will continue to develop and embed a culture that puts safeguarding at the centre of care delivery throughout 2020/2021.

In June 2019, the CQC inspected the effectiveness of safeguarding arrangements within health for all children in Richmond upon Thames. Acute Hospital services provided by KHFT were reviewed as part of the process.

The Safeguarding Children's Team has been audited as part of the Trust internal audit programme with the rating of 'Significant Assurance'.

1. Introduction

- 1.1 This annual report reflects the arrangements to safeguard and promote the welfare of children, young people, and adults at risk within KHFT for the period of April 2019 to March 2020. In doing so, the Trust discharges part of its responsibility for Board-level assurance, scrutiny and challenge of safeguarding practice within the Trust, in line with the statutory requirements of section 11 Children Act (2004), Working Together to Safeguard Children (2018), the Mental Capacity Act 2005 and the Care Act 2014.
- 1.2 In addition to the requirements of the Children Act 2004, the Trust, as a registered provider with the Care Quality Commission (CQC), must have regard for the Regulations as established under the Health and Social Care Act (2008). In relation to Safeguarding, including but not limited to, Regulation 13 and Regulation 17, relating to protecting service users from abuse and good governance, respectively.
- 1.3 This report presents the integrated safeguarding portfolio and is arranged sequentially under safeguarding adults, safeguarding children and safeguarding within maternity services.

2 National

- 2.1 Safeguarding is a complex area of practice. The potential patient group is wide ranging from people able to self-care to those who are experiencing a short-term illness or a long-term disability. Abuse can happen in any context and takes many forms, some of which may not be obvious. It is therefore essential that the Trust continues to promote the importance of safeguarding for our patients and community.
- 2.2 Modern slavery, hoarding and Professional Curiosity have been priority work streams 2019/20 highlighted either by central government or by national publication. The safeguarding teams have ensured that their training programmes highlight these themes for frontline staff.

3 Local Context

KHFT is a key partner agency for safeguarding within the Borough of Kingston. This is achieved by:

- Membership of Kingston Safeguarding Adults Board (KSAB) and Kingston & Richmond Safeguarding Children's Partnership (KRSCP) and sub-groups of both Boards
- Multi-agency audit and multi-agency training with the KSAB and KRSCP.
- Active contribution to Safeguarding Adult Reviews (SAR's) and Serious Case Reviews (SCR's)
- Active contribution to Domestic Homicide Reviews (DHR's) with the associated Community Safety Partnership
- Active participation at complex safeguarding meetings
- Attendance and dissemination of information at the Multi-Agency Risk Assessment Conference (MARAC) when appropriate

- Commitment to attendance to support the Prevent agenda and the Channel panel in Kingston when requested
- Close liaison and dissemination of information with the Multi Agency Safeguarding Hub (MASH)

4 Safeguarding Governance

4.1 Named Safeguarding Roles

4.2 KHFT is accountable for ensuring that its own safeguarding structure and processes meet the required statutory requirements of the Children’s Act 2004, the Care Act 2014 and other statutory and national guidance. The safeguarding roles, duties, and responsibilities of all organisations in the National Health Service (NHS) including the Trust, are laid out in the NHS England ‘Accountability and Assurance Framework’ which was published in 2015.

4.3 The Trust is highly committed to safeguarding with a strong culture of safeguarding vulnerable individuals of any age that have contact with services – either as patients, visitors, or staff. Therefore, robust governance processes are in place to ensure that services delivered are keeping people of all ages safe.

4.4 The Trust is statutorily required to maintain certain posts and roles within the organisation in relation to safeguarding. These have been fulfilled throughout 2019/20.

4.5 The Director of Nursing & Quality is the Executive Lead for Safeguarding and represents the Trust at the Kingston Safeguarding Adult’s Board (KSAB) and Kingston & Richmond Safeguarding Children’s Partnership (KRSCP). When required the Named Nurses for Safeguarding Adults and Children deputise.

4.6 The Deputy Director of Nursing and the Director of Midwifery provide strategic direction for both adult and children’s safeguarding and support the Director of Nursing & Quality in the Executive role.

4.7 The Named Professionals provide the organisation with operational advice, support and input. The professionals are committed to supporting the workforce in understanding safeguarding, embedding it into ‘everyday business’ and improving outcomes.

4.8 The aims of the service are to:

- Provide visible and professional safeguarding leadership for all aspects of safeguarding adults, children, and young people to ensure that day to day advice, support and expertise is available to all staff in the Trust. This includes the responsibility of the implementation, maintenance, and development of effective and efficient systems for the detection, prevention, surveillance, investigation and control of harm and abuse.
- Facilitate safeguarding training sessions across the hospital to ensure that learning, skills set, and knowledge of staff is provided as per statutory and mandatory training requirements. This includes all matter of communication across the hospital to ensure that the local needs and risks of children, young people and adults are understood and dealt with to a degree by the frontline staff using lessons learnt from national and local case reviews, best practice and research. Ethical concerns, legislative processes and reporting processes are part of this training as per hospital staff’s roles and responsibilities.

- Contribute to the development of appropriate systems including audit, governance policies and procedures to ensure safe practice in relation to the delivery of an effective safeguarding service across the hospital.
- Provide guidance and advice to the Human Resources Department in staff investigations including disciplinary, related to vulnerable adults, children, and young adults.
- Work in partnership with key internal and external stakeholders to deliver a comprehensive, cohesive, safe, and effective safeguarding service for the hospital. This includes engagement with at risk patients, relatives, and advocates gaining feedback in order to ensure services and service improvements are patient centred and enhancing equality and parity of esteem.

4.9 The expected outcomes of the service are to:

- Facilitate the development of a confident, informed workforce in relation to their role and responsibility to children, young people and adult welfare and safeguarding matters
- Improve outcomes for children, young people, and adults
- Reduce risk to children, young people, adults, visitors, and staff

4.10 The Named Professional Team comprises of:

- WTE Named Nurse (Children)
- WTE Named Midwife
- WTE Named Nurse (Adults)
- WTE Named Doctor (Children)

4.11 The Named Nurse Adult is supported by a 0.8 WTE Safeguarding Practitioner, who provides advice, support and training to all staff within the Trust about the management of safeguarding and vulnerability issues. The Named Nurse, Safeguarding Children is supported by a 0.6 WTE Liaison Health Visitor who ensures that there is effective two-way communication and sharing of information between hospitals and community services which enables children and their families to receive appropriate care and support. The Safeguarding Children team administrator works with the Safeguarding Children's team and is essential for providing general assistance and support to the Children's team daily, including handling sensitive, emotive and confidential information.

5. The Child Safeguarding Committee and Adult Safeguarding Committee

5.1 The Child Safeguarding Committee and Adult Safeguarding Committee meet individually four times a year and jointly twice a year. Thus, each meets six times in total. These meetings are chaired by the Deputy Director of Nursing and the Director of Midwifery. They are attended by the senior clinical, governance and legal professionals with a direct responsibility for ensuring that the Trust is meeting its safeguarding responsibilities. They provide scrutiny, direction and leadership to the Trust on safeguarding activities.

6. Safeguarding Senior Ward Managers Group

- 6.1 The Safeguarding Senior Ward Managers Group (SSWMG) was established towards the end of this period to support the work of the Safeguarding Adults Steering Group. This group meets bi-monthly and membership consists of Matrons and Ward Managers. It is responsible for providing assurance that the safeguarding of adults at risk agenda is effectively implemented within the Trust.

7. Disclosure and Barring Service (DBS)

- 7.1 Disclosure and Barring Service (DBS) regulations are in place for the Trust. All new employees and volunteers are checked as part of the employment/volunteer process. Safer recruitment processes are followed, and the safeguarding team work closely with Human Resources when concerns are raised.

8. Safeguarding Incidents

- 8.1 Safeguarding incidents in the Trust are monitored by the safeguarding team daily. Alerts for safeguarding incidents are generated via Ulysses. The majority of incidents are managed at ward level by the Ward Manager however some are more complex. The Named Nurses are involved in providing safeguarding expertise when required. The incidents are analysed to detect trends and themes and to improve safeguarding within the Trust.

9. Quality Schedule

- 9.1 The Trust has agreed Key Performance Indicators with the CCG to ensure compliance with statutory safeguarding requirements. A quarterly Safeguarding Adults and Children's report is submitted to the CCG to demonstrate progress against the established Key Performance metrics.

10. Care Quality Commission

- 10.1 The Care Quality Commission (CQC) visited and inspected the Trust in May and June 2018 when the Trust received an 'Outstanding' rating. The inspection team found that there were good safeguarding systems, processes, and practices in place to keep people safe, and these were well communicated to staff. Staff understood how to protect patients from abuse and had training on how to recognise and report abuse, and they knew how to apply it in practice.
- 10.2 Documentation, training and staff understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards had improved since the previous inspection. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

11. Partnership Working

- 11.1 The Trust is committed to working with partners to improve outcomes for adults at risk, young people, and children. Part of that commitment takes the form of attendance at, and active participation in the KSAB and KRSCP.

11.2 The table below highlights the attendance of the safeguarding teams at the external Kingston Safeguarding Boards and subgroups (relevant subgroups in italics). Commitment to these subgroups is substantial, not only in terms of attendance, but also with active participation and contribution to work streams:

Meeting	Frequency	Role
Kingston Safeguarding Adults Board	Quarterly	Director of Nursing & Quality/Deputy Director of Nursing/Named Nurse Safeguarding Adults
Kingston Safeguarding Adults Communication Sub Group	Quarterly	Named Nurse for Safeguarding Adults
Kingston Safeguarding Adults Training Sub Group	Quarterly	Named Nurse for Safeguarding Adults
CCG South West London Health Leads Forum	Quarterly	Named Nurse for Safeguarding Adults
CCG South West London Health Leads MCA/LPS	Bi-Monthly	Named Nurse for Safeguarding Adults
Kingston & Richmond Safeguarding Children Partnership Learning Review Subgroup	Quarterly	Named Nurse for Safeguarding Children
Kingston & Richmond Safeguarding Children Partnership Quality and Innovation Subgroup	Quarterly	Named Nurse for Safeguarding Children
Kingston & Richmond Safeguarding Children Partnership Workforce Development Subgroup	Quarterly	Named Nurse for Safeguarding Children

11.3 There have been one Safeguarding Adult Review (SAR) and two Learning Lessons Review (LLR) completed within this reporting period. There is one on-going SAR. These reviews take place after an adult or a child dies or is seriously injured, and abuse or neglect is thought to be involved. The reviews look at lessons that can help prevent similar incidents from happening in the future.

11.4 Domestic Homicide Reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victim Act 2004. There has been no DHR's in which the Trust contributed to during 2019/20. All requests for information to potential DHRs have been completed within the requested time frame.

Safeguarding Adults

12. National Context

12.1 The Safeguarding Adults Collection (SAC) Annual Report 2018-19 published by NHS Digital in December 2019 presents information about adults at risk for whom safeguarding enquiries were opened during the reporting period 1 April 2018 to 31 March 2019. A safeguarding concern is where a local authority is notified about a risk of abuse, follows up the notification with information gathering, and if appropriate, instigates an investigation (enquiry) under the local safeguarding procedures. The report highlighted:

- There were 415,050 concerns of abuse raised during 2018-19, an increase of 5.2% on the previous year.
- The number of Section 42 enquiries that commenced during the year increased by 5.7% to 143,390 and involved 116,230 individuals. The number of other enquiries increased by 1.8% to 18,540 during the same period.
- Older people are much more likely to be the subject of a Section 42 safeguarding enquiry; one in every 43 adults aged 85 and above, compared to one in every 862 adults aged 18-64.
- The most common type of risk in Section 42 enquiries that concluded in the year was Neglect and Acts of Omission, which accounted for 31.4% of risks, and the most common location of the risk was the person's own home at 44.8%. In 89% of Section 42 enquiries a risk was identified, and action was taken.

13. Activity

13.1 There were 325 Safeguarding Adults referrals made by Trust staff during the reporting period. The referral rates to the Local Authority have increased slightly compared to the previous period 2018/19 when 311 referrals were made.

13.2 The majority of referrals were generated by the emergency and urgent care departments. These areas are often where initial assessments are undertaken prior to admission to the Trust in-patient wards.

13.3 The table below highlights the categories of referrals made by the Trust during this reporting period. Neglect or Act of Omission has been the highest level of safeguarding adult concern in terms of both referrals made by the Trust or against the Trust which is in line with the national findings of The Safeguarding Adults Collection (SAC) Annual Report 2018-19.

SAFEGUARDING REFERRALS	325
Neglect or Omission	149
Domestic Violence	26
Financial Abuse	15
Modern Slavery	1
Physical Abuse	42
Psychological Abuse	14
Self-neglect	70
Sexual Abuse	8

- 13.4 Safeguarding Adults investigations run on a 28-day timeline by the Local Authority. The Trust has contributed and completed within this timeframe for the majority of investigations. □
- 13.5 KHFT is committed to working with its community partners to improve the care provided to our patients both inside and outside the hospital. Previously the Hospital had re-established and embedded the Cause for Concern process to support this. The process has been designed so that community partners can formally raise issues of concern with KHFT. These are issues that have mostly occurred following an inpatient stay and are predominantly related to discharges but are not exclusive to this group. Previously many of these concerns were coming to the hospital via the Safeguarding route despite not meeting the threshold for a safeguarding concern. Therefore, by reinvigorating this process the Hospital is able to allocate its safeguarding resources appropriately whilst still ensuring all patient safety incidents are thoroughly addressed by the Patient Safety Team via the correct governance route.
- 13.6 During this period the Trust received 43 Cause for Concern referrals. A quarterly meeting is facilitated by the patient safety team and attended by the Named Safeguarding Adults and Children's Nurses, The CCG designated Safeguarding Leads, The Royal Borough of Kingston Safeguarding Adults Lead and Your Health Care (provider of Kingston Community Services).
- 13.7 Where safeguarding and Cause for Concern investigations have taken place, the outcomes have been shared with staff members via ward / department meetings to review and instigate processes/clinical practice to prevent similar incidents from occurring. For example, the clinical, discharge and transport teams have come together to review processes to ensure that there is appropriate contingency planning for the care of patients who are being transported on longer journeys on discharge.

14. Training

- 14.1 The safeguarding teams are committed to training and education which are fundamental to develop staff confidence and skills in relation to safeguarding. In recognition of the need for safeguarding adults training to be competency based the E Learning platform used by the Trust to deliver Level 1 and Level 2 Safeguarding Adults training facilitates the use of assessments to confirm that staff have achieved the required level of knowledge and understanding. The table below highlights the safeguarding adult statutory and mandatory training compliance over the year of 2019-20.

Safeguarding Adults	%
April 2019	68.21
May 2019	66.70
June 2019	67.42
July 2019	79.36
August 2019	84.62
September 2019	87.60
October 2019	87.39
November 2019	87.32
December 2019	86.58
January 2020	86.77
February 2020	85.78
March 2020	85.69
Average for 2019-20	81.12

Safeguarding Adults	%
Average for 2016-17	86.03
Average for 2017-18	82.29
Average for 2018-19	69.05

14.2. The Trust recognises that since the introduction of the new E Learning platform for the delivery of statutory and mandatory training, compliance rates for safeguarding adults training had dropped below the 85% target set by the Trust. Compliance rates are monitored by the Safeguarding Adults Steering Group and the Safeguarding Adults Senior Ward Managers Group and have improved this year. The below actions have been initiated by these groups to address the current compliance rates.

- Safeguarding Adults training compliance rates are raised at multiple internal meetings including the Senior Sisters Meeting and the Nursing and Midwifery Board Meeting to ensure it remains high on the agenda for all staff and line managers.

14.3 The Trust has now migrated onto the NHS Electronic Staff Record (ESR). This system allows staff to see, with a traffic light dashboard system their individual mandatory training compliance rate.

14.4 The Adult Safeguarding Specialist Nurse has continued to provide additional face to face training jointly with the Safeguarding Children's Named Nurse to all new members of staff as part of their Trust induction and as part of the new nurse and health care assistant induction programme. Additionally, ad hoc training is provided on request to all departments in the hospital when they run their department led study days for staff. The safeguarding team also ensure that managers and staff are made aware of external learning opportunities via the KSAB or NHS England particularly for Level 3.

15. Mental Capacity Act

15.1 The Mental Capacity Act (MCA) published in 2007, protects and empowers individuals who are unable to make all or some decisions for themselves. The MCA applies to everyone working in health and social care providing support, care, or treatment to people aged 16 and over who live in England and Wales.

15.2 Practical application of the MCA was identified as a specific training and support need as part of the feedback of the audits. Ward rounds are undertaken by the Safeguarding Adults Practitioner to provide hands on support to staff undertaking MCA assessments. The Safeguarding Adults MCA intranet page has been updated to provide practical support tools and guidance on using the MCA. The Safeguarding Adults Link Practitioners have been provided with updated training on the practical application of the MCA and now have the responsibility of disseminating these skills and knowledge to their colleagues throughout the Trust.

15.3 In partnership with the South West London Health Leads Forum a Mental Capacity Act audit has been implemented to provide an initial benchmark for work on supporting staff to meet their requirements under this legislation and the introduction of Liberty Protection Safeguards in October 2020.

16. Deprivation of Liberty Safeguards

- 16.1 The Trust submitted 142 DoLS applications for authorisation during this period. This is a decrease on the previous period (2018/19), when 178 applications were submitted.

DOLS applications 2019-2020	Number
April	14
May	13
June	19
July	10
August	10
September	16
October	8
November	8
December	8
January	14
February	12
March	10
Total DOLS applications 2019-2020	142
Withdrawn DOLS	115
Authorised	8
RIP	18
Active DOLS	1

- 16.2 Due to the high turnover of patients in an acute hospital environment the Trust has repeatedly seen low numbers of DoLS applications authorised. The local authorities surrounding the Trust have not managed to assign best interest assessors to patients in the time frame set by the current legislation. This has been recognised as an issue nationally and a new system, the Liberty Protection Safeguards, has been developed to address the issues around the practical applications of the DoLS.
- 16.3 The Government made their final response to the Law Commission review of the DoLS legislation in March 2018. Forty two out of forty-seven recommendations were accepted. These recommendations have now been approved and given royal assent. The Trust is participating in a SWL task group to established to identify the resource implications (financial, staffing and training) and practical steps required by the Trust to get ready for the roll out of the new system which requires that the majority of authorisations should now be approved internally by the Trust itself rather than referred out to the local authority.

17. Court of Protection

- 17.1 The Trust has made no applications to the Court of Protection during this period.

18. Prevent

- 18.1 Prevent forms part of the Counter Terrorism and Security Act, 2015 and is concerned with preventing children and vulnerable adults becoming radicalised into terrorism. NHS Trusts are required to train staff to have knowledge of Prevent and radicalisation and to spot the vulnerabilities that may lead to a person

becoming radicalised. The purpose of Prevent is for staff to identify and report concerns where they believe young people or adults may be vulnerable to radicalisation or exploiting others for the purposes of radicalisation. The Local Security Management Specialist is the Prevent lead for the Trust.

- 18.2 Referrals will be made where appropriate and the Prevent Lead (or nominated replacement) will attend the Local Authority Channel panel when requested. This multi-agency panel discusses the risk posed by vulnerable people who are referred for multi-agency support. There have been no referrals from the Trust to the Channel panel in 2018/19.
- 18.3 The Trust submits a quarterly return to the Regional Prevent Co-Ordinator and NHS England. The data submitted monitors the key elements of the prevent duties and responsibilities which include:
- Identification of Prevent leads – strategic and operational
 - Delivery of training
 - The levels of referrals made via the Channel process
 - Representation and engagement with local and regional Prevent leads
- 18.4 All staff are required to receive basic awareness Prevent training and the Trust has achieved over 90% compliance. Basic Awareness Training is delivered via e-learning upon induction and through mandatory updates.
- 18.5 The Workshop to Raise Awareness of Prevent (WRAP) training is required for specific staff groups and the Trust undertook a training needs analysis to increase compliance. The Trust undertook the move to the approved e-learning module at the start of 2019. This has seen an immediate rise in compliance and the Trust continues to work towards the national targets. The Trust is in liaison with the Regional Prevent Co-Ordinator to provide updates.
- 18.6 The Trust continues to attend and participate in Prevent workshops and events in London and has previously held one day conferences on site to promote awareness not only for our staff but also partner organisations and healthcare providers. These conferences have included specialist speakers, internally and externally, to provide delegates with additional skills and knowledge to further their ability to meet the Prevent objectives.

19. Modern Slavery

- 19.1 Despite slavery being banned in the majority of countries for over a hundred and fifty years, modern slavery takes many forms. Forced labour, people trafficking, debt bondage and child marriage are all forms of modern-day slavery that affects the world's most vulnerable people. It is estimated that there are over 13,000 people in modern slavery in the United Kingdom.
- 19.2 Modern slavery is incorporated within the Safeguarding Children and Adult mandatory training from levels 1 -3, which applies to all staff employed by the Trust.
- 19.3 The Trust has reported 1 case of suspected Modern Slavery and 1 of Human Trafficking during this period.

20. Achievements in 2019/20

- Kingston Safeguarding Adults Board rated the Safeguarding Adults Team as mainly compliant in all areas assessed for the 2019/20 Safeguarding Adults at Risk Audit Tool. The main area of risk was the change of Adult Safeguarding Specialist Nurse and requirement for a Locum for a period of time.
- The Trust has established its own unique safeguarding adult's referral form. Staff has found this improves the efficiency of making a safeguarding referral.
- The safeguarding adult's intranet page has been reviewed and updated to provide an easy reference point for Trust staff
- A training matrix has been developed in conjunction with the Learning and Development Team to align safeguarding adults and MCA training levels with staff roles in line with the RCN Intercollegiate training guidance in preparation for its roll out in the following period.
- Face to face safeguarding adults training is now provided as part of the Trusts Corporate induction day and includes a session from the Trust's Independent Domestic Violence Advocate.
- In moving to an E Learning platform for mandatory safeguarding adults training the Trust is able to use the results from assessments undertaken by staff as part of the modules to have greater assurance that staff have met the competency requirements.
- Basic Awareness Prevent training across the Trust has attained over 90% compliance. The introduction of an approved E Learning module at the start of 2019 for WRAP has seen an immediate rise in compliance with this training and the Trust continues to work towards national targets.

21. Priorities for 2020-21

- Adopt and establish the Liberty Protection Safeguards (LPS) system in the Trust.
- Consolidate Level 3 safeguarding adults mandatory training using the Health Education England designed workshops and e learning package.
- Continue to work towards improving safeguarding adults mandatory training compliance rates.
- Continued attendance at the KSAB and multi-agency partnership meetings to enable the Trust to meet statutory responsibilities and engage with wider partnerships and services.

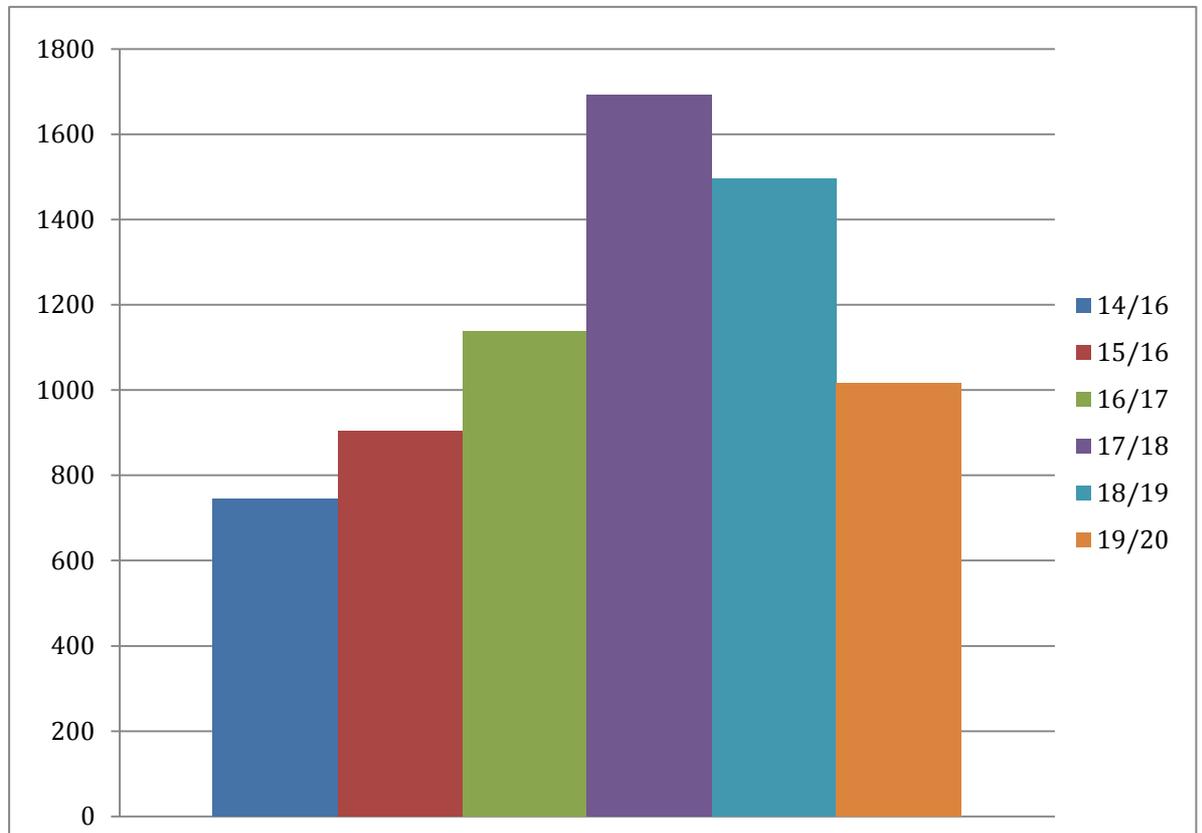
Safeguarding Children

- 22.** KHFT is committed to ensuring that all patients including children and young people are cared for in a safe, secure, and caring environment. KHFT adheres to its statutory duties in line with Section 11 of the Children Act. The Safeguarding Children's Team are committed to safeguarding and promoting the health and wellbeing of all unborn babies, and those babies, children and young people attending the Emergency Department (ED), as outpatients or, those admitted to the Paediatric wards, Emergency Assessment Unit, or any adult wards where

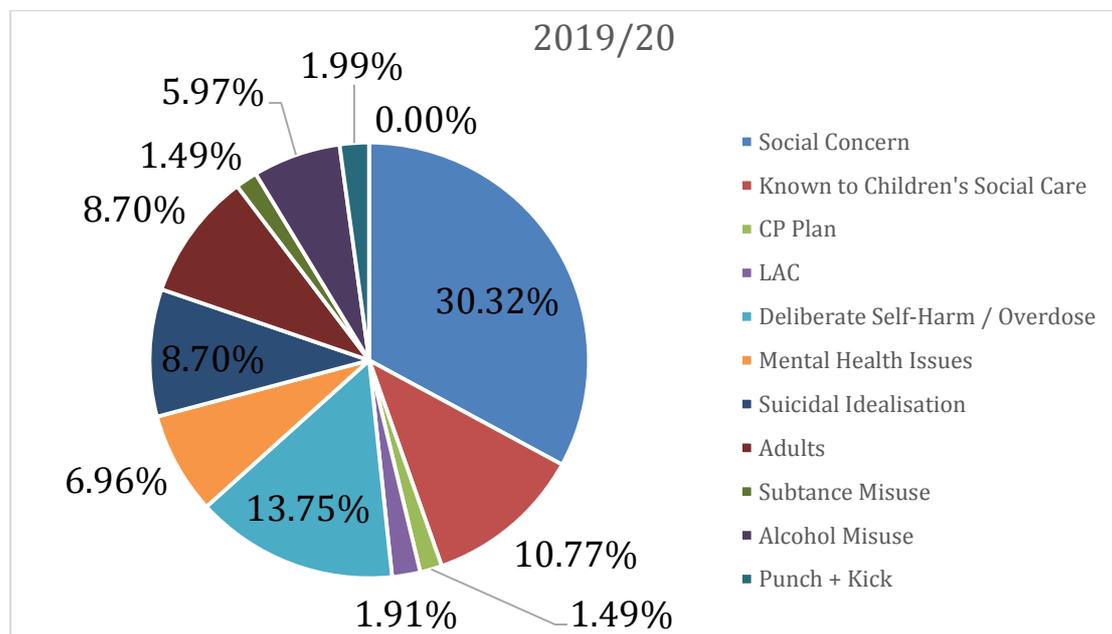
16 year olds and over have requested this. The Trust also have a 'duty of care' toward 'unseen' children whose parents have been admitted, or, have attended ED where there may be safeguarding concerns, for example, presenting with alcohol and drug misuse, suicidal ideation or in a mental health crisis.

23. Activity

23.1 There have been a total of 1017 Information Sharing Forms that have been sent to Children's Social Care Team's. The number of information sharing forms has decreased for two consecutive years, compared to a sustained increase from 2014 to 2017.



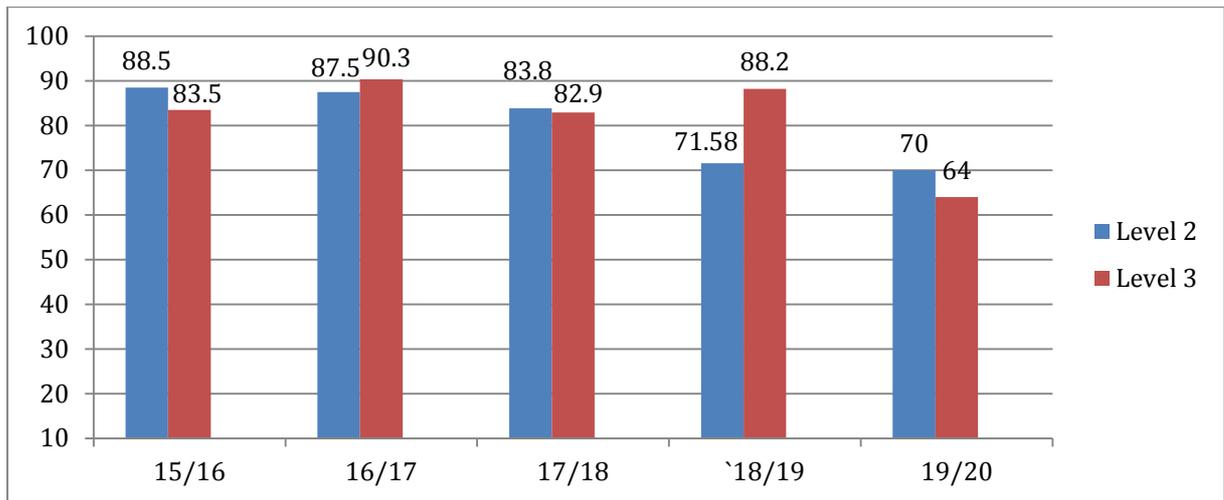
23.2 The pie chart below presents the primary reasons for Information Sharing by the Trust.



- 23.3. 30.32% of referrals were for children known to social care; this is a slight decrease from 34% last year.
- 23.4. Children and young people attending KHFT for deliberate self-harm and overdose has remained stable at 166 presentations during 2019/20 compared to 164 in 2018/19. Children and young people who present to hospital following self-harm have a greater future risk of suicide compared with other children and adolescents which may persist for several years.
- 23.5. The number of children and young people attending with suicidal idealisation has risen from 53 in 2017/18 and 72 in 2018/19 to 105 in 2019/20 which is a significant rising trend. This correlates with national figures released by NHS Digital [2018/19] as the number of children and young people attending ED with psychiatric problems over the past 10 years has increased by over 300%. A wide range of factors contribute to suicidal thoughts, such as family disruption through separation or death, parental mental disorder and adverse childhood experiences, together with contemporaneous factors such as issues with family or friends, bullying (including cyber-bullying) sleep disorders and mood instability.
- 23.6. In response to the sustained, significant increase in mental health issues in Child and Young People, the Safeguarding Children Team will include this subject in the training delivered to staff at Kingston Hospital each year.

Safeguarding Children Training

- 24.1 KHFT has a target for mandatory training of 85%, however the Safeguarding Children Team strive towards achieving a 90% figure for Safeguarding Training as recommended by CQC. KHFT has a robust training policy in place to deliver training which is aligned to the 'Intercollegiate Document: Safeguarding Children and Young People: roles and competencies for health care staff' (RCN 2019). Training uptake is reviewed quarterly at the Safeguarding Children's Committee and monitored as a key performance indicator. Staff access level 1 safeguarding children training prior to commencing at KHFT. Level 2 Safeguarding training is now part of the Corporate Induction on day 2, with a face to face session, followed up by completion of E-Learning Safeguarding Children Level 2 training from Health Education England.
- 24.2 Level 3 compliance within the Paediatric Teams in 2019/20 is 86.5%, which is above the KHFT mandatory target. These figures are collated by the Safeguarding Children Team through a database held within the department. However, Level 3 compliance across KHFT is 64%. Unfortunately, the planned Safeguarding Children Level 3 Seminar in March was cancelled as all Statutory and Mandatory Training in KHFT was suspended due to the Covid-19 outbreak. This has impacted on achieving the 85% Trust mandatory target. Training compliance figures for Level 2 in 2019/20 across KHFT is 70%, which is below the required target of 85% set by the Trust.

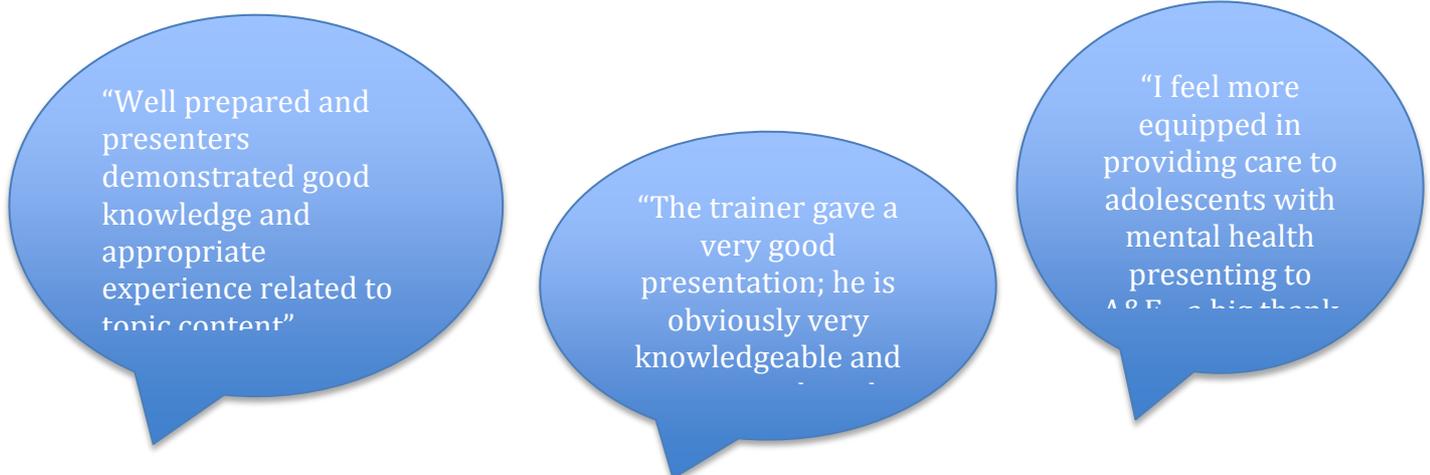


24.3 To improve compliance in 2020/21, the Safeguarding Children Team will:

- Introduce Level 3 on-line learning via ESR.
- Deliver Level 3 Training Seminars quarterly instead of the traditional March and October which should allow training to be more accessible to staff throughout the year.
- A Passport or Learning Log will be implemented which be of a participatory nature and will count towards compliance.

24.4 In October 2019 the Safeguarding Children Team facilitated Level 3 Safeguarding Training Seminar was delivered by external speakers. The programme included session on Children and Young people coming into A&E with Acute Mental Health issues, Child Sexual Exploitation and County Lines.

24.5 The feedback from the training delivered has been highly positive. This has included:



25. Supervision

- 25.1 Effective professional safeguarding supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support professionals to reflect critically on the impact of their decisions on the child and their family (Working Together to Safeguard Children 2018). Regular supervision sessions are attended by the named and designated safeguarding professionals who will maintain a record of the meetings and topics discussed as part of continuing professional development.
- 25.2. Individual and group supervision continues to be delivered across the Trust. A model of Peer Group Supervision for staff in ED, paediatric wards, and neonatal unit has been implemented and is now well established within the teams. There is a fully embedded and recorded Safeguarding supervision process in place.
- 25.3. The Trust supports its staff by holding monthly Schwartz rounds. These rounds are multi-disciplinary with the opportunity for attendees to hear and discuss similar experiences in their daily practice. By creating a safe space for reflection, Schwartz Rounds give staff the opportunity to share some of the emotional, psychological and ethical aspects of their work that may otherwise build up, causing stress and anxiety and impeding their ability to deliver compassionate care.
- 25.4 Staff can also be supported by the Staff Hospital Chaplain, Pastoral & Spiritual Support team who can help to debrief after critical incidents or traumatic cases.

26. Liaison Health Visitor

- 26.1 The Liaison Health Visitor provides the vital link the Trust and community staff, such as GP's, health visitors and school nurses. Pertinent and timely information of children aged 0-19 years (and beyond if the child/young person has a disability or is a looked after child) and their families is shared with the professionals in the community for continuity of care and to safeguard and promote the welfare of children and young people.

27. Designated Officer (LADO)

- 27.1 The Designated Officer (formerly known as the Local Authority Designated Officer or LADO) in Kingston and Richmond is informed by the Trust of all cases in which it is alleged that a person who works with children has behaved in a way that has harmed, or may have harmed a child or behaved in a way that indicated they may pose a risk to children.

28. Section 11 Audit

- 28.1 Health related organisations providing services in Kingston and Richmond are required to undertake a Section 11 Audit for the Local Safeguarding Children Partnership. The Section 11 audits are a self-assessment undertaken by agencies every three years to quality assure their processes in respect of their statutory duty to safeguarding children as laid out in Section 11 of the Children Act 2004. The audit is intended to help organisations critically reflect on the adequacy of their arrangements, to identify any gaps, and to take any remedial action. The audits also provide an overview for commissioning bodies and partners of local

safeguarding arrangements. KHFT completed the Section 11 audit in August 2017.

29. Serious Case Reviews

- 29.1 There were 2 Learning Lessons Review (LLR) undertaken in which the child was known to KHFT during 2019/20. This is where a serious incident involving a child fails to meet the criteria for undertaking a Serious Case Review. The chair of the Local Safeguarding Children Partnership can decide to undertake a Learning Lessons Review where it is identified that there are lessons to learn about single or multi-agency practice.
- 29.2 The Trust actively participated with the LLR and any learning from the LLR will be embedded into practice and disseminated through training.

30. Child Protection Information System (CP-IS)

- 30.1 CP-IS was introduced in March 2018 and identifies children subject to a child protection plan, children who are looked after, and unborn children nationwide. The CP-IS flag is adjacent to the current safeguarding flag in the electronic records. By sharing data across regional boundaries CP-IS helps health care professionals build up a picture of a child's visits to unscheduled care settings supporting early help detection and intervention in cases of potential or actual abuse.
- 30.2 KHFT uses the Care Record Service (CRS) an electronic record keeping system. Flags are used to identify children with Child Protection Plans from Kingston, Richmond, Wandsworth, Sutton, Surrey and Merton. The Flag alerts the user in any department to the child's status. Information regarding a child's attendance at KHFT can be shared with the relevant Children's Social Care team or Children Looked After team.

31. Achievements in 2019/20

- Implementation of Peer Group Supervision for paediatric staff in ED, paediatric wards, and the neo-natal unit.
- Safeguarding Children's Team has been audited by external company with the rating of 'Significant Assurance'.
- The Voice of the Child training has been delivered by Named Nurse to nursing and medical staff in ED and paediatric wards. Following this training, an audit was completed which provided assurance that staff were able to capture the child's voice in ED records.
- Safeguarding Children and Young People drop-in sessions open to all staff at KHFT have been introduced by the Named Nurse, Safeguarding Children, and the Safeguarding Lead Nurse in the Wolverton Centre for Sexual Health.
- 1 successful Safeguarding Children Level 3 Training Seminar.
- Continued close working relationship with multiagency partnerships.

32. Priorities for 2019/20 The priorities for the forthcoming year are to:

- Continue to promote and develop the Safeguarding Children and Young People drop-in sessions.
- Continue to work towards improving Safeguarding Children Compliance rates.
- Ensure KHFT maintains a focus on 'The Voice of the Child'
- Continued attendance at the KRSCP and multi-agency partnership meetings to enable the Trust to meet statutory responsibilities and engage with wider partnerships and services.

33. Safeguarding Within Kingston Hospital and Community Maternity Services

33.1 Bridge Team - Safeguarding and Perinatal Mental Health Support

The Named Midwife for Safeguarding is supported in this role by 1.0 WTE job share post consisting of two Band 7 Safeguarding Midwives and one 0.4 WTE Band 6 Safeguarding Midwife rotational post. The aim of this rotation is to increase the opportunity for midwives to work within the maternity safeguarding team to increase safeguarding knowledge and experience within the midwifery workforce.

The safeguarding team is also supported by a Band 3, Maternity Support Worker 0.6 WTE. The Maternity Support Worker role is administrative and also assists the safeguarding midwives to provide emotional support, providing access to charities, as well as providing some postnatal care and support for vulnerable women. The maternity safeguarding team supports both hospital and community based midwives and support workers, and ensures that safeguarding is embedded into practice.

33.2. The Safeguarding Midwives (Bridge Team) are responsible for caring for vulnerable women and their families where there are safeguarding adult and children concerns, social care involvement, a learning disability or difficulty during the perinatal period. The Bridge Team Midwives provide safeguarding support for all Trust midwives and also provide antenatal continuity of midwifery care for vulnerable families, working as part of a multi-agency team which includes the KHFT Child Safeguarding Named Nurse, social workers and other health professionals.

33.3. Within the team the Band 6 midwife provides antenatal support and antenatal continuity of care to young women, aged 17 and under and also provides some postnatal care to young parents, in addition to the named community midwives. The Band 6 midwife facilitates antenatal parent education classes for young parents aged 22 or below, with the Babettes group (Infant Feeding Supporter, Health Visitor, Hub Worker and Peer Supporters) at The Hub in Kingston town centre. It has not been possible to run the group face to face antenatal parent education classes due to infection risks during the COVID-9 pandemic; however these classes will be provided virtually with a midwife facilitating the group sessions with the Babettes group. In addition short information videos have been produced for young parents by the Band 6

midwife, and are available on-line via the Trust maternity website pages and via social media platforms.

- 33.3. The Band 7 Safeguarding Midwives provide two antenatal clinics a week to provide care for women with the most complex safeguarding needs. Plans of care are formulated and agreed with the women and her Safeguarding Midwife. For women with less complex safeguarding need plans of care are formulated between the woman and her Community Midwife with specialist support from the Safeguarding Midwives as required. These safeguarding plans of care are now available to staff providing maternity care within the woman's electronic Computer Records System (CRS). The Safeguarding Midwives provide specialist safeguarding knowledge and support to the hospital and community midwifery teams and obstetricians for safeguarding issues which may arise at any point of the woman's maternity care pathway.
- 33.4. Safeguarding Midwives chair a monthly multi professional Maternity Concerns Meeting to facilitate information sharing with designated health and local authority professionals. The safeguarding midwives with the named midwife for safeguarding children also represent the maternity service at the Trust multi-agency Child Safeguarding Committee meeting.
- 33.5. The Safeguarding Midwives are responsible for referral of cases where appropriate to the Local Authority Children's Social Care Services to ensure adequate safeguarding plans are in place for the safe discharge of women and new-born babies. Where an unborn baby is placed on a child protection or child in need plan, the Safeguarding Midwives will attend associated meetings, or support the named midwife to attend. This ensures that robust plans of care are in place in the form of a pre-birth plan. These plans are then communicated to the maternity team (and if necessary, the neonatal team) to ensure health professionals involved in the families care are aware of the safeguarding concerns and care plans prior to discharge of the woman and baby from hospital or community midwifery care. The mother and baby are usually discharged together, but in some families where there is high risk safeguarding concerns the local authority will obtain an interim care order and the baby is placed into foster care. The maternity team will continue to support the parents in the postnatal period providing postnatal care for women and their baby. If a baby is placed in the care of foster parents within the local community the Trust maternity team will provide postnatal care for the baby.
- 33.5. In February 2019, the expansion of the Southwest London Perinatal Mental Health Team (SWL PMHT) was launched and a dedicated multidisciplinary team providing mental health care for women living in Kingston and Richmond was developed. The team consists of a Consultant Perinatal Psychiatrist, Psychiatric Speciality Perinatal Doctor, Consultant Obstetrician, Perinatal Mental Health Midwife, Mental Health Nurse and a Clinical Psychologist. Care provided is centred on the woman's mental health needs and provides effective communication and care planning for women with moderate to severe mental health illness. This care model has had great success in providing a specialist mental health service for women during the perinatal period (throughout pregnancy and up until the baby is a year old), including preconception advice.
- 33.6. Women with pre-existing or newly developed moderate to severe mental illness can be referred to the specialist Perinatal Mental Health (PNMH) team by health professionals. The referrals are reviewed on a weekly basis and are

discussed at the weekly multidisciplinary meeting which the PNMH Midwife attends.

- 33.7. Women who are referred to the PNMH team and who are booked for their maternity care at Kingston Hospital NHS Foundation Trust are invited to attend an appointment in the PNMH multidisciplinary team clinic based within the Antenatal Clinic at Kingston Hospital. This clinic consists of the Lead Obstetrician for PNMH, a Speciality Perinatal Doctor and/ or the Perinatal Psychiatrist from PNMH team and PNMH Midwife. In addition, a speciality PNMH Midwifery clinic also runs at Queen Mary's Hospital, Roehampton, on a Monday morning alongside the PNMH doctor.

Pre-birth mental health care planning meetings take place for the women with high risk/complex care needs with Severe Mental Illness (SMI) between 32-34 weeks gestation. In addition the Perinatal Mental Health Midwife and Band 6 support midwife provide midwifery care to women with significant mental health concerns, plan their care and attend any professionals/safeguarding meetings.

- 33.8. The Support Worker role is administrative and also assists midwifery colleagues in the team with emotional support, providing access to charities as well as providing some postnatal care for women. However, in the last year another focus of the Support Worker has been to offer additional emotional support and practical help to vulnerable women. The Support Worker has developed connections with the charity Growbaby based in Kingston upon Thames which helps to provide practical maternity equipment or clothing for the woman or her baby when needed. The Support Worker has attended appointments such as housing to provide further emotional support to women from more vulnerable backgrounds when the woman requests this.

34 Training

- 34.1. Safeguarding training for 2019-2020 has included the maternity team's roles and responsibilities for information sharing and referral to Children's Social Care. Themes within the 2019-2020 training programme have focussed on Forced Marriage, Honour Based Violence and Female Genital Mutilation (FGM). Changes to recording FGM within maternity health records and within the FGM-RIS national electronic reporting system recording have also been highlighted during this year's maternity safeguarding training.

- 34.2. Training for 2020-2021 will be focussing on the role of safeguarding within maternity care, provide an opportunity to discuss and share learning from safeguarding cases and to ensure maternity staff have knowledge and understanding of the process to refer safeguarding concerns to Children's Social Care and the writing of reports for Children's Social Care.

35. Supervision

- 35.1. All Bridge Team Midwives receive quarterly child protection supervision. The Bridge Team midwives receive child safeguarding supervision from the Trust Named Nurse. The Safeguarding Midwives and the Deputy Director of Midwifery provide Child Protection Supervision for Band 5 and Band 6 Midwives. Child Protection Supervision is provided for those midwives providing antenatal care within community midwifery teams and the hospital antenatal clinic team. The Support Worker is able to access Child Protection Supervision from either of the Safeguarding Midwives or Named Nurse where needed as they do not provide care without supervision from the

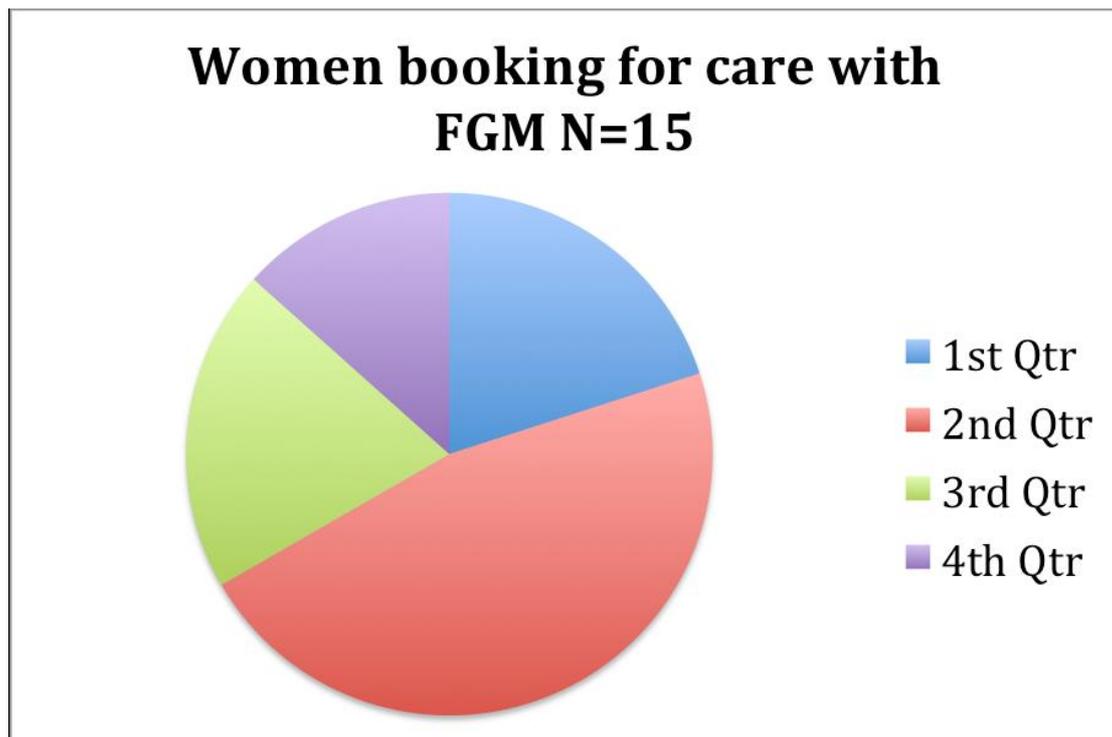
safeguarding midwives. On a day to day basis midwives will access the Safeguarding Midwives for ongoing case discussions when required.

- 35.2. Both Safeguarding Midwives and the Deputy Director of Midwifery have undertaken additional safeguarding training to enable them to provide Child Protection Supervision. In the final quarter of this year group supervision for midwives providing antenatal care within continuity of carer teams has commenced.

36. Female Genital Mutilation (FGM)

- 36.1. There are low numbers of women booked for maternity care with Kingston Hospital who have undergone FGM. Figure 1. below demonstrates the numbers of women who had sustained FGM and were booked for care within 2019-2020. In line with national policy the maternity service made one mandatory disclosure to the Police this year regarding FGM.
- 36.2. Contact was made with each local authority for women booked for maternity care at KHFT. Two out of the local authorities wish to be notified if women book for care with a history of FGM, the remaining four only want to know if there are Safeguarding Concerns. Data will be collected for next year for the number of cases referred to Children’s social care.
- 36.3. The Safeguarding Midwives add an alert to the national spine entry for every female child born to a mother who has sustained FGM. The national information system is called FGM IS. At the moment this information is not accessible by Health Visitors and School Nurses but is being addressed as an initiative to improve accessibility of information by wider health professionals to the FGM IS system.

Figure 1. Women booked for maternity care at KHFT who have experienced FGM, 2019-2020



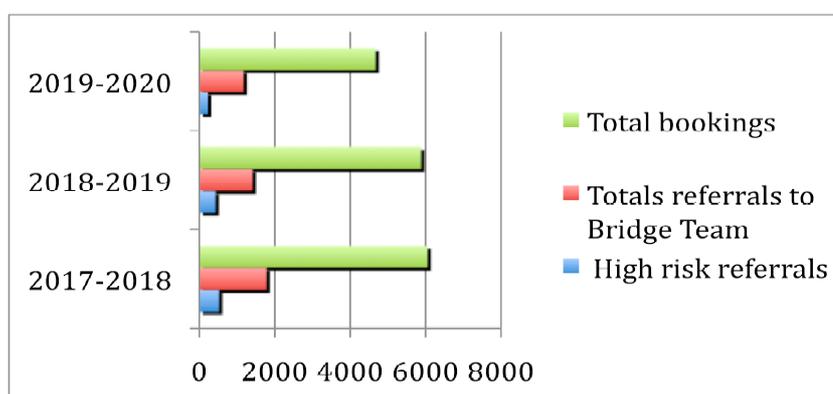
38. Maternity Concerns: Multidisciplinary Information Sharing Meeting

The maternity Concerns meeting is held monthly. Health Visitor representation from Surrey resumed this year which is hugely beneficial. Health visitors from Merton receive minutes and provide updates but do not attend. There is generally good attendance from Community Midwives and Achieving for Children and Kingston Wellbeing Service (Drug and Alcohol service). Minutes are circulated within a week of the meeting and the agenda sent 5 working days before the meeting.

39. Referrals to Bridge Team and appointments 2019-2020

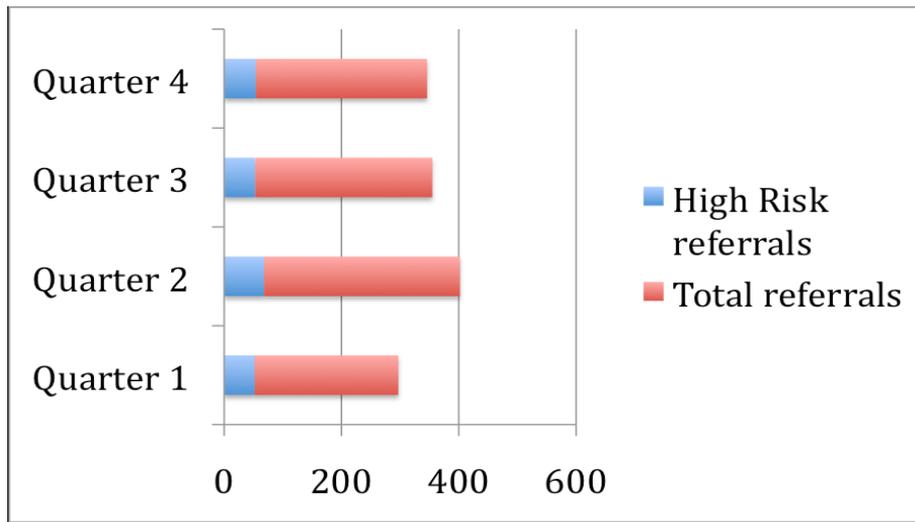
There were 1173 referrals to Bridge Team for 2019-2020. 5674 women booked for care in 2019-2020 and 4846 mothers had their babies at Kingston and 4929 babies were born. Booking numbers and mothers giving birth will be different as women may book in one year and delivery in the next.

Figure 2. Referrals to Bridge Team over the last 3 years



The number of referrals to Bridge Team has reduced again this year most likely to reflect the lower birth rate. Less referrals were also risk assessed as high risk due to changes in how the team works and the development of the perinatal mental health team. In previous years approximately 30% of referrals were considered high risk, this year it was 18%.

Figure 3. Referrals to Bridge Team for 2019-2020



Bridge team are responsible for following up those who do not attend (DNA) Bridge team appointments by phone and letter. Along with follow up phone calls, reminders are sent by text in order to try to improve attendance. Women are also encouraged to attend appointments with their named community midwife.

There were a total of 1173 referrals for 2019-2020 and this was split evenly across the year (Quarter 1= 245, Quarter 2=334, Quarter 3=302, Quarter 4=292).

A small proportion of women decline the support of Bridge Team Midwives. There were 19 women declining support from the Bridge Team for the last year. Where women have declined Bridge team appointments, the team have supported the community midwives in the woman's care as needed.

Figure 4. Referrals to Bridge Team for 2019-2020

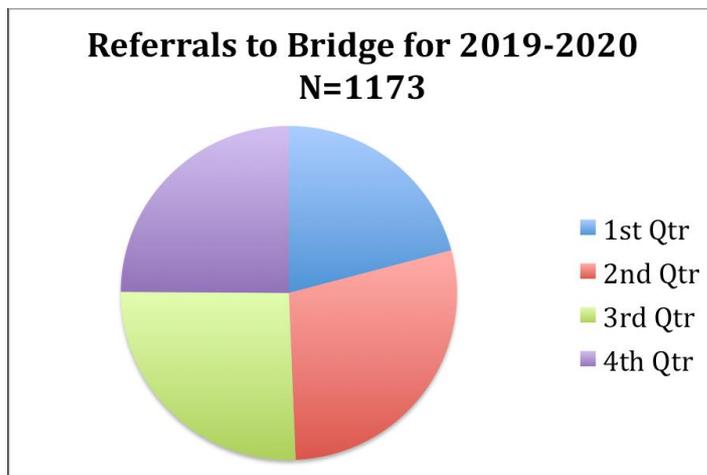


Figure 5. Breakdown of Referrals by level of safeguarding/perinatal mental health risk factors, 2019-2020

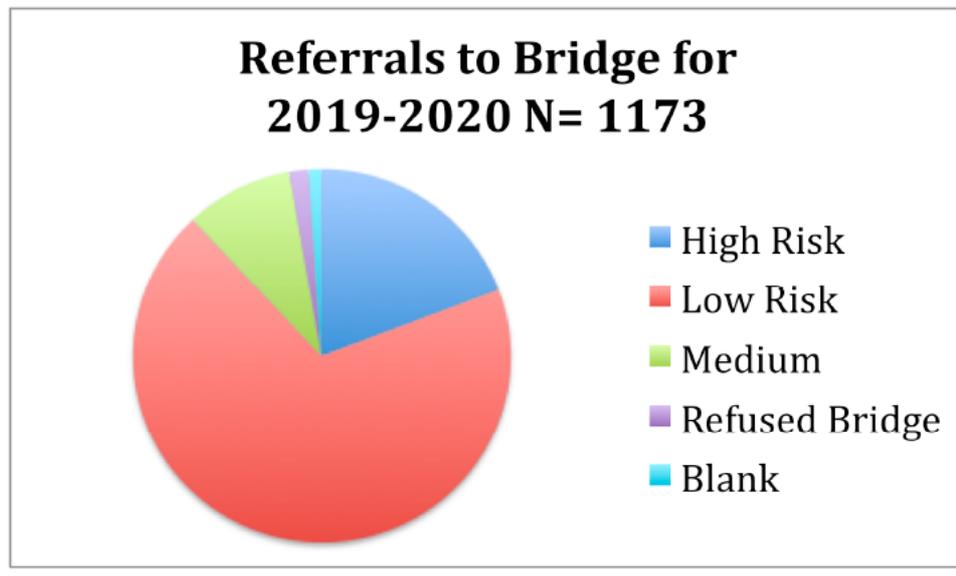
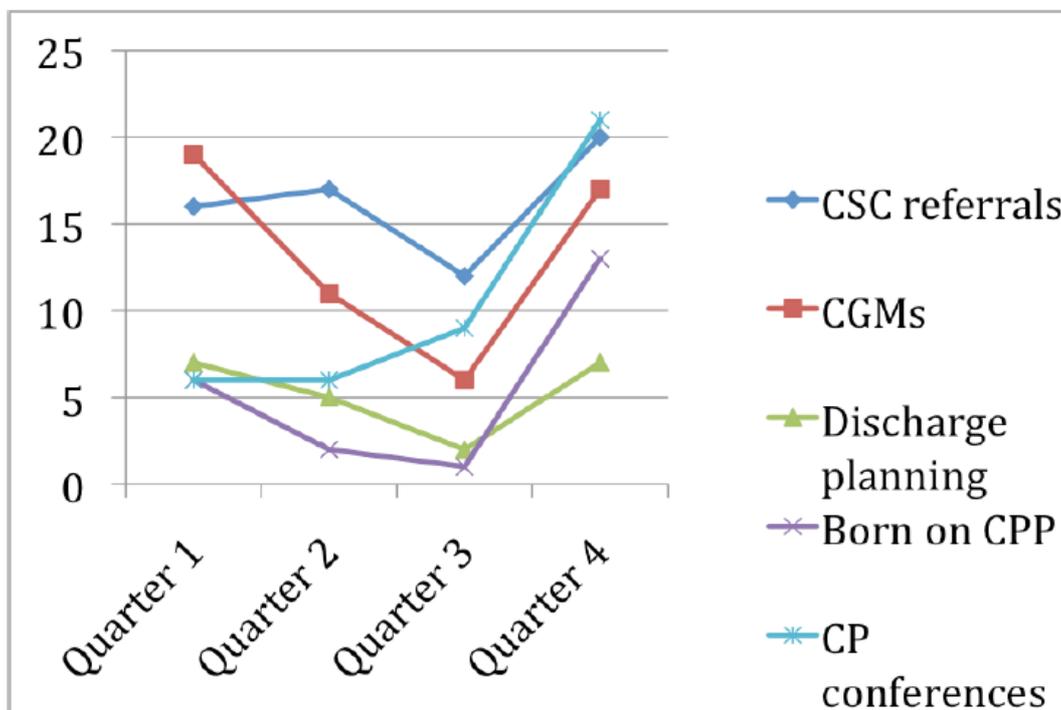


Figure 6. Safeguarding Activity by Quarter, 2019-2020



Quarter 4 was exceptional in regards to the combination of child safeguarding referrals, child safeguarding core group meetings, discharge planning meetings, babies born subject to a child protection plan and child protection conferences. This was in part due to some premature births of babies in quarter 4, who would otherwise had planning meetings and conferences in

Quarter 1, 2020-2021. However, Quarter 4 safeguarding activity was also expected to be higher in terms of number of babies born who were subject to a child protection plan. What was unusual was the number of babies born in Quarter 4 who were discharged from hospital on an Interim Care Order, in total 7 for the last quarter of 2019- 2020. A contributor to this was the number of mothers who gave birth in Quarter 4 who had previously had babies/children removed from their care, this accounted for 5 out of the 7 babies.

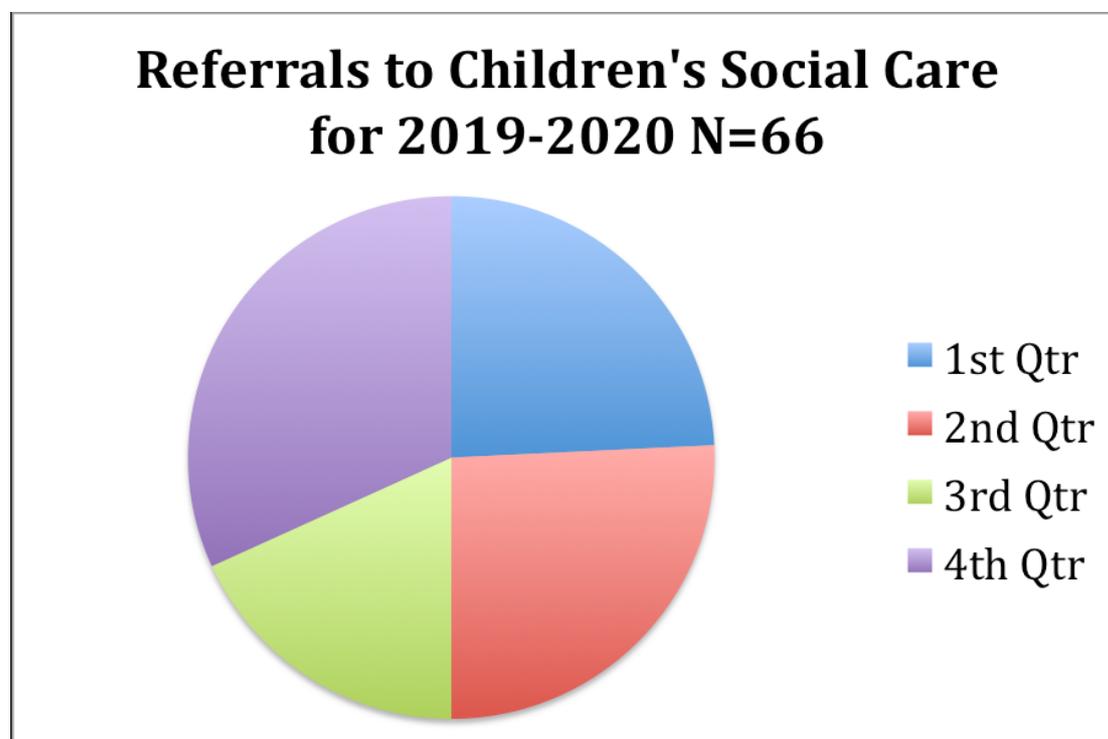
Contraception was provided for mothers whilst inpatients within the postnatal ward prior to discharge from hospital for 2 of the 4 mothers. Bridge Team have developed good links with the Wolverton Centre Team to try and ensure contraception has been offered and provided for women before discharge from hospital postnatally.

40. Referral to Children's Social Care

All referrals to Children's social care are now stored within the mother's Trust electronic computer record system (CRS), unless the referral is made after the baby's birth in which case the referral would be stored within the baby's electronic care record.

For the coming year 2020-2021 the Safeguarding Midwives will be collecting data on these referrals to see which met the threshold for an assessment by Children's Social care and which had no further action. This data has not been collected this year but anecdotally the majority of referrals do lead to an assessment by Children's Social Care.

Quarter 7. Referrals from KHFT Maternity Service to Children's Social Care



Achievements in 2019/20

- Implementation of Peer Group Supervision for community midwifery staff.
- KHFT Safeguarding Children Teams have been audited by an external auditor with the rating of 'Significant Assurance'.
- Safeguarding adult and children training has been delivered by the Bridge Team Midwives and the Liaison Domestic Abuse Worker for all maternity staff.
- Successful development of the multiprofessional perinatal mental health team.
- Continued close working relationship with multiagency partnerships.
- The maternity service continued all antenatal and postnatal care with face to face appointments in both hospital and home settings combined with managing infection control of Covid-19, whilst ensuring safeguarding needs for women and their babies were recognised and prioritised during this pandemic.

32. Priorities for 2020/21 are to:

- Continue to promote and develop the Safeguarding Children training themes from national and local learning of case reviews.
- Develop on-line parent education and virtual antenatal classes for young parents as face to face group antenatal classes have ceased during the Covid-19 pandemic.
- Maintain multidisciplinary communications via secure virtual platforms to maintain safety within child and adult safeguarding during the Covid-19 pandemic such as virtual core group child safeguarding meetings, maternity concerns meetings and discharge planning meetings.

References and Further Reading

- Bournemouth Competencies (2015) National Competency Framework for Safeguarding Adults Bournemouth: National Centre for Post-Qualifying Social Work and Professional Practice, Brandon (2011)
- Care Act (2014)
- Children's Act (2004)
- Counter Terrorism and Security Act (2015)
- Deprivation of Liberty Safeguards (2009)
- Domestic Violence, Crime and Victims Act (2004)
- Female Genital Mutilation Act (2003)
- Health and Social Care Act 2008
- Laming (2003)
- Mental Capacity Act (2005)
- NHS England (2015) 'Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework' HMSO: Department of Health
- Hospital Accident & Emergency Activity 2018-19 - NHS Digital
- Northamptonshire Safeguarding Adult Board Procedures
- Safeguarding Children and Young People Intercollegiate Guidance Roles and Competencies for Healthcare Staff (2019) HMSO: Department of Health
- Supreme Court (2014)
http://www.supremecourt.uk/decidedcases/docs/UKSC_2012_0068_Judgment.pdf
- Working Together to Safeguard Children and Young People (2018) HMSO