ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

Report Title	Committee Supporting Papers	**Agenda Item**	Paper V
Sponsoring Executive	Kathryn Lavery, Chair		
Report Author	Various		
Meeting	Board of Directors	**Date**	25 July 2024

Suggested discussion points (two or three issues for the meeting to focus on)

The following reports, received and discussed by the Quality Committee are presented today to be noted by the Board of Directors:

Accountable Officer for Controlled Drugs Annual Report 2023/24 – The Quality Committee was Assured that the Trust meets its statutory requirements relating to the use of controlled drugs.

Safeguarding Annual Report 2023/24 – The Quality Committee was Assured that there are appropriate systems and processes in place to ensure the Trust is compliant with Safeguarding Children and Adults legislation.

Alignment to strategic objectives (indicate with an 'x' which objectives this paper supports)

Business as usual	x

Previous consideration

The documents have been presented to the Quality Committee (17 July 2024).

Recommendation

The Board of Directors is asked to:

x	**CONSIDER** and note the appended reports for information

Impact

Trust Risk Register							
Board Assurance Framework							
System / Place impact							
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed	

Appendix (please list)

Refer to Agenda Pack B

ROTHERHAM, DONCASTER AND SOUTH HUMBER (RDaSH) NHS TRUST
ACCOUNTABLE OFFICE FOR CONTROLLED DRUGS (CDAO) ANNUAL REPORT 2023-24

Purpose of the report

- To ensure that safe management of controlled drugs (CDs) in maintained as an organisational priority.
- To provide assurance on the systems and processes within RDaSH that lead to the safe management of controlled drugs.
- To describe the range of incidents reported to the CDAO over the 12 month period April 2023 to March 2024

Controlled Drugs

In August 2012 the legislation covering medicines for human use was revised and consolidated into a new act – The Human Medicines Regulations 2012. This legislation updated the 1968 Medicines Act and incorporated various changes introduced by EU legislation together with all the updates and variations to the original act.

There is a degree of complexity surrounding the laws relating to medicines and CDs, but in general terms the main legislative points to note are:

The Misuse of Drugs Act 1971 (MDA 1971)

This act primarily covers the illegal use of drugs and provides a schedule system for classification of these drugs. This system of classification provides the courts with guidance on the maximum sentences to be imposed if this law is broken (Schedules A, B & C).

The Misuse of Drugs Regulations 2001 (MDR 2001) (and subsequent amendments)

Covers the medical use of those drugs listed within the MDA 1971. Within the context of MDR 2001 the classification system for the medical use these drugs defines the drugs by a different system of schedules (1, 2, 3, 4 & 5). Within this context these drugs are classified according to their likelihood of harm versus therapeutic benefit. With Schedule 1 drugs being the most tightly controlled in terms of prescribing, dispensing, storage & transportation and Schedule 5 having the least control. Schedule 4 also includes anabolic steroids.

Within RDaSH services the schedules for oversight are

S2 – strong opioids and major stimulants
S3 – less potent analgesics, minor stimulants, temazepam, midazolam, gabapentin and pregabalin
S4 – benzodiazepines (also includes anabolic steroids)
S5 – low potency opioid products (codeine, low strength morphine solution)

The British National Formulary (BNF) gives details of the legal status of most of the medicines used in the UK. Although the full list of controlled drugs remains under review, the Chief Pharmacist/CDAO would be expected to intervene in all cases where there may be a concern about the use of these drugs by relevant people. Further details can be found on the home office website https://www.gov.uk/government/publications/controlled-drugs-list--2

Management of Controlled Drugs (CD's)

Following the activities of Harold Shipman in the 1990"s it became clear that the systems and process of control that were in place at the time to govern the use of CD"s were inadequate. Following the fourth report of the Shipman enquiry in 2004, the chairman Dame Janet Smith concluded that the governance arrangements for these drugs needed to be strengthened.

Many of her recommendations from the enquiry were incorporated into part three of the 2007 Health Act and statutory instrument No. 3148 The Controlled Drugs (Supervision of Management and Use) Regulations.

One of the key changes introduced by the 2007 Health Act was the statutory requirement for NHS trusts (and other relevant bodies) to appoint an Accountable Officer for controlled drugs (CDAO).

In December 2015 further changes to legislation took place which enforced the use of new controlled stationary by anyone ordering stocks of controlled drugs. While these arrangements were aimed at primary care, an unintended consequence of this legislation has resulted in an additional bureaucratic requirement for NHS trusts who obtain controlled drug stock from another provider.

- Arrangements with our third party providers are in place to ensure that RDaSH meet the legal requirement to use DoH CD requisition forms to underwrite our ordering for stock controlled drugs.
- The Trust Medical Director is the agreed signatory to these requisitions.

In April 2016 the National Institute of Health and Care Excellence (NICE) published guidance (NG46) supporting the safe use and management of controlled drugs.

Statutory role of the controlled drugs accountable officer (CDAO)

The requirement for designated bodies to appoint a CDAO was made in the 2007 Health act and has been reiterated in subsequent legislation. The CDAO must ensure that his designated body has adequate arrangements for the safe and legal management and use of controlled drugs throughout the organisation.

The overriding concern of the CDAO is to protect the patients and public from harm due to controlled drugs by relevant people. There are a number of specific duties of the CDAO. Full details of the duties of the CDAO are laid down in Part 2 of The Controlled Drugs (Supervision of Management and Use) Regulations 2013 (https://www.legislation.gov.uk/uksi/2013/373/part/2/made).

The CQC are required to hold a record of all CD accountable officer (and ensure all relevant organisations are registered with them. See https://www.cqc.org.uk/guidance-providers/controlled-drugs/controlled-drugs-accountable-officers

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Duties of the CDAO include ensuring that:

- The organisation is following “adequate and up-to-date” standard operating procedures (SOPs).
    - The organisation has a range of SOPs governing the management of controlled drugs for inpatient, community services and St John’s hospice. They are reviewed in line with Trust Policy. The current SOPs were due for review in May 2025.
- Appropriate arrangements for monitoring and auditing the management and use of controlled drugs.
    - Regular audits are conducted for regarding adherence to the SOPs. During the period two audits were conducted and reported to MMC, with no concerns of significance regarding storage and process.
- Systems exist to alert the accountable officer of any complaints or concerns involving the management or use of controlled drugs.
    - All medicines related IR1s and complaints are sent to the Chief Pharmacist and reviewed through the Trust patient safety incident reporting framework (PSIRF) process
    - Additionally wards and teams are visited on a regular basis by the pharmacy department with any concerns raised within the department
- The incident reporting system captures untoward incidents involving the management or use of controlled drugs.
    - All controlled drug IR1s are reviewed and form part of the monthly medicines incident review and reporting process through the MMC, a section of which is specifically for controlled drugs.
    - Pharmacy technicians regularly review ward stock for unexpected usage, shortages and CD register issues
- Appropriate arrangements in place for analysing and responding to untoward incidents involving the management or use of controlled drugs
    - Pharmacy follow-up relevant IR1 reports to support teams in investigations and mitigation
    - The Medicines Management Committee receive monthly reports on CD incidents
- Relevant individuals receive appropriate training in relation to controlled drugs.
    - Training on controlled drugs is delivered by the pharmacy to ward and teams
    - Additionally, it is part of induction training for prescribers

    - Through the year there have been 20 training sessions provided, a reduction form 33 the previous year
    - The training has been provided by both MS Teams (12) and face to face (8) sessions. The face to face sessions are more practically orientated and proving more successful in achieving attendance and change, so the direction of travel is to do these sessions as preference.
- Arrangements are appropriate for monitoring and auditing the management and use of controlled drugs by relevant individuals and assessing their performance.
    - Prescribing information is periodically reviewed for inappropriate quantities or use
    - Bespoke refresher training is conducted with individuals where necessary
- The recording of any concerns raised in relation to the management or use of controlled drugs by a relevant individual.
    - This is part of any investigation undertaken and would form part of the IR1 reporting and PSIRF process
- The assessment and investigating of any concerns raised regarding the management or use of controlled drugs by a relevant individual. The CDAO must determine whether these concerns should be shared with a responsible body.
    - While this has not had to done to date, there are good links between pharmacy and the other professional groups involved with CDs within the Trust and through to their regulatory body.
    - The Chief pharmacist additionally reserves the ability to contact any regulatory body as part of their role as Accountable Officer
- Appropriate action is taken to protect patients or members of the public in cases where concerns in relation to the management or use of controlled drugs by a relevant person appear to be well-founded.
    - There is no history of having to do this within the Trust, however it would form part of the follow-up from an investigation.
    - Where misappropriation, by family or others, is suspected by community teams, the incident/suspicion is referred to the police.
    - Historically the Chief Pharmacist has visited community pharmacies dispensing our substance misuse prescriptions to review their SOPs and processes in response to IR1 reporting.
- Appropriate arrangements for ensuring the proper sharing of information.
    - Trust incidents are reported through the national reporting website
    - The Trust CDAO participates in and contributes to regional and national CDAO Intelligence Networks (LINs)

For RDaSH the CDAO is the Chief Pharmacist, this is acknowledged in The Safe and Secure Handling of Medicines Policy, Trust Control Drugs SOPs and training provided for staff. Additionally the CQC hold details (through the period and at June 2024) of the CDAO for RDaSH as Stephen Davies along with accurate contact details.

The last CQC Controlled Drug Annual Report was published since July 2023 with FIVE recommendations –

- Recommendation 1 - **Providers need to ensure their governance of controlled drugs is up to date and fit for purpose.** We continue to find areas that need to improve across health and social care. Good governance of controlled drugs will help services to improve the safety and quality of people's care and the minimise risk of diversion. Good board-level engagement in relevant organisations is an essential element of ensuring the safer management of controlled drugs.
    - RDaSH have suites of SOPs in place and regular audits of wards and teams
    - Incidents are continuously reviewed and regularly reported on to MMC with reporting escalated through the Trust
    - There is regular destruction process in place
    - There is a program of training in place
- Recommendation 2 – **Make sure prescribing at transfer of care is completed safely**. Clinicians must have the relevant medical and medication history before prescribing controlled drugs to patients. Private prescribing services should request these details from a person's NHS GP before issuing prescriptions, and NHS GP services should supply these details in an appropriate way when asked.

    - SystmOne functionality allows us to have full visibility of a patients primary care prescribing record through
        - a shared record with GPs using SystmOne as their clinical system
        - 'EMIS share' enabling us to view the prescribing record of GP's using EMIS as their clinical system
        - direct access to the national summary care record for patients not registered with local GPs
- Recommendation 3 - **Know the identity of your local controlled drugs accountable officer (CDAO) and police controlled drug liaison officer CLDO**. Any organisation with a responsibility around controlled drugs must have these details and know how to report controlled drugs incidents. CDAOs and CDLOs are important partners and can provide help, support and advice on a wide range of controlled drugs issues, as well as for reporting incidents
    - The Trust CDAO is noted in the Trust Safe and Secure Handling of Medicines Policy and is shared at all CD training and prescriber induction
    - CDLO contact is available via the pharmacy department or through the association of police CDLO website https://www.apcdlo.org/
- Recommendation 4 - **Work collaboratively to improve the prescribing, managing and monitoring of controlled drugs**. We have already seen examples of how better collaboration and partnership working as part of a local system can result in improved safety and better outcomes for people
    - The Trust participates in local CD intelligence meetings and Chief Pharmacist forum where collaboration id possible
- Recommendation 5 - **Make sure you have a valid Home Office controlled drugs licence if you are required to have one.** This involves forward planning to check when licences are due to expire, or when a new licence is needed. You must allocate enough time to complete this process, otherwise it will affect your ability to provide care
    - as an NHS Trust we do not need a CD licence for our current activities
    - should our activity change (eg. Research trials of psychodelic medications) then we would apply through the home office.

Incidents reported to the CDAO during April 23 to March 24

A total of 331 incidents were reported to the CDAO throughout the period. This represents an increase of 22% on the previous year (272). This increase has been specifically related to Schedule 2 and 3 drugs.

Table 1 (Breakdown of reports by CD schedule and quarter)

2023-24	Q1	Q2	Q3	Q4	Grand Total
CONTROLLED DRUG (S2/S3)	66	70	78	71	285
CONTROLLED DRUG (S4/S5)	13	13	10	10	46
Grand Total	**79**	**83**	**88**	**81**	**331**

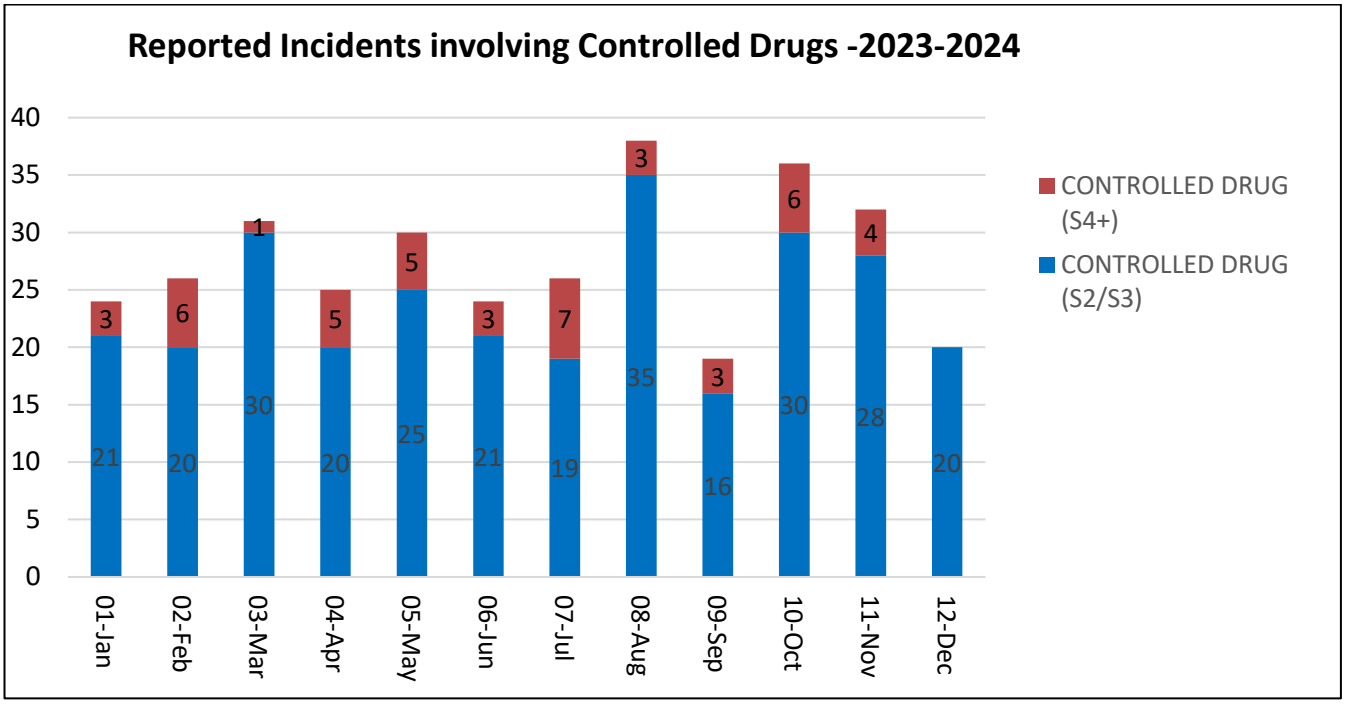


Table 2 (RDaSH involvement in the reported incident by Care Group)

RDaSH involvement	CHILDRENS CG	DONCASTER CG	NTH LINCS CG	ROTHERHAM CG	Grand Total
RESPONSIBLE	4	168	28	23	223
AFFECTED	1	20		2	23
IMPLICATED		24	3		27
NOT		47	9	2	58
Grand Total	**5**	**259**	**40**	**27**	**331**

At the moment data is coming from a data warehouse database. We are awaiting team changes based on the new taxonomy.

Table 3 (Standardised reporting sub-groups used for Intelligence Network (LIN) reporting)

Reported Sub-grouping	CHILDRENS CG	DONCASTER CG	NTH LINCS CG	ROTHERHAM CG	Grand Total
1.PATIENT SAFETY - ADMINISTRATION		59	5	6	70
2.PATIENT SAFETY - DISPENSING		10	2		12
3.PATIENT SAFETY - PRESCRIBING	2	43	11	2	58
4.PATIENT SAFETY - OTHER		42	4	2	48
4.STORAGE - UNSECURED STORAGE		1			1
5.UNACCOUNTED FOR LOSSES		7			7
6.ACCOUNTED FOR LOSSES		24	1		25
7.PATIENT / PUBLIC		1			1
9.GOVERNANCE	2	26	10	7	45
10.RECORD KEEPING	1	46	7	10	64
Grand Total	**5**	**259**	**40**	**27**	**331**

At the moment data is coming from a data warehouse database. We are awaiting team changes based on the new taxonomy.

Of note from the figures in tables 2 and 3

- Doncaster remains the highest reporting Care Group of the Trust accounting for 78% of the reported incidents (roughly the same as the previous year). This largely reflects the breadth and size of the services which it provides – in particular the substance misuse team and the community nursing teams.
    - Doncaster substance misuse team have maintained the same number of reports as the previous year. This represents a significant 31% of the Doncaster reports and is an increase on the previous year. Main issues relate to prescribing, delays in scripts getting to pharmacies, pharmacies not consistently reporting a patients non-attendance for dosing and reflect
        - The complexity of the prescription management and the need to often change prescription midway through its course. Aspire has substantive SOPs governing their processes
        - The substantial dispensing and observation burden conducted in community pharmacies. All incidents involving community pharmacy are referred to NHSE who hold the community pharmacy contracts, who in turn ensure appropriate investigations take place.
    - Doncaster Community nursing has seen a decrease in reporting from the previous year and accounts for 23% of the Doncaster figure.
        - Main reporting is through the intermediate care teams – particularly the unplanned teams and commonly relate to
            - In-correct dose of medication being administered (misread of the instruction or old care plan used). Delayed or missed doses due to supplies of medication. There has been no reported patient harm as a result of these incidents.
            - Our staff administering a patient's own medicines in the home and the difficulty that presents with respects accurate control over storage and access to the drugs by others leading to minor stock discrepancies.
- Rotherham Care Group
    - There has been a very similar reporting number and pattern to last year reflecting a sustained improvement
    - The principal issue has been record keeping and register maintenance
- North Lincolnshire Care Group
    - There has been a significant increase in the number of reports compared to last year
    - Again, the principal issue relates to record keeping and register maintenance

- Regarding responsibility,
    - there has been a shift with a decrease in the number of "NOT" (or incidental' reports) which may reflect time pressures of teams.
    - There has been an increase in both numbers and proportion of reports categorised as "responsible" whereby roughly two thirds of the reported incidents Trust staff have been responsible. The great majority of this increase has been in the reporting of record keeping, register maintenance and not strictly following SOPs.
- The Trust maintains a strong reporting culture.

Investigations and Reporting

All these incidents have been reviewed and where necessary investigated. Additionally they have all been shared with the respective LINs and CDAO network.

The Trust had completed TWO investigations within this time period.

- December 2023 - Hospice,IR1, 160522 –
    - During the administration of Oxycodone 5mg/5ml oral solution a deficit of 24mls was noticed at the end of the bottle. Controlled Drug register entries and calculations checked with no errors found. The figures were run through the Hospice Calculator which showed an unexplained loss of 3.91% which is over the Trust tolerance of 3%. The team are to continue to report, no suspicious circumstances.
- August 2023 – Cusworth, IR1 156425 –
    - When completing a stock check it was noticed that there was a 40ml deficit between the register balance and physical balance of Methadone 1mg/1ml oral solution. A thorough

check was completed and no errors were found. The balance was adjusted to reflect the correct balance. Currently there was only one patient prescribed this on the ward on very small doses so the amount of times the bottle has been in was more than usual and it is believed this has contributed to the amount of justified loss at each administration. Continued monitoring has indicated no further issues.

- Numerous Controlled Drug register entry issues that have been investigated locally at the point of reporting. Administrations are usually entered on to the SystmOne record but not in the register or there has been a missing witness signature. The revised training provided by pharmacy is more practically based, face to face and focuses heavily on the appropriate maintenance of records and registers

There have been a single report to the police.

- May 2023, reported by Virtual Ward - It was noticed in the patients notes that an entry had been placed to say that the patients son had taken 5 x Oxycodone ampoules with them and was not due to return. This was reported to the police and replacement medications ordered with a locked box for storage.
    - the medication was the patient's property and the alert was raised by RDaSH staff.
    - the loss was reported to the police however we are unaware of the outcome of their investigation.

Security and Storage

Ward and relevant community teams have been reviewed by pharmacy technicians during the year.

Wards are on a six monthly cycle and re-audited in September 2023 and March 2024.
These have shown sustained improvement with an overall rating of GOOD against all standards for record keeping and security of storage. Compliance has remained high at 94% and 95% respectively.

All community teams have been visited through 2023-24 and no stock controlled drugs are retained by community teams, on the odd occasion a team may hold a named patient supply however this is stored and record accordingly.

During the period pharmacy destroyed unwanted or out of date CDs. The team made 127 visits and destroyed 794 items (compared to 137 visits and 871 items last year). This has been a continued reduction from the ear before.

As part of these destruction visits Pharmacy staff check CD cupboards and registers (involving a balance and register reconciliation) of all remaining items in the cupboard (with the exception of Hospice where there is a monthly visit for destruction and 5 items are chosen at random to check). Any discrepancies discovered at the time are highlighted and reviewed.

Conclusion

As a Trust, RDaSH meets its statutory requirements.
There is an accountable officer in place and registered with the CQC
There is demonstrable oversight of ordering, storage, prescribing and investigation of incidents related to controlled drugs
The Trust plays an active role in Local Intelligence Networks.
There are no significant concerns relating to the use of controlled drugs in the Trust.

Stephen Davies
GPC number 2030713
Chief Pharmacist RDaSH
CD Accountable Officer
July 2024

Safeguarding Annual Report 2023/2024

Steve Forsyth
Chief Nursing Officer

Author: Louise Bertman
Nurse Consultant for Safeguarding
Date: July 2024

RDaSH nurturing the power in our communities

Contents

Introduction

Welcome to the Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) Safeguarding Annual Report 2023-2024. This report provides an opportunity to celebrate our achievements in 2023-2024 and reflect on where we need to focus our efforts in the year ahead.

The responsibility to safeguard adults and children and promote their welfare is more comprehensive than just protection. To be effective, this requires staff members to recognise their individual responsibility to safeguard and promote the welfare of children and adults who are vulnerable as well as the commitment of Trust management to support them in this.

This report provides assurance that the Trust is meeting its statutory obligations by ensuring staff have access to appropriate training, advice, support and supervision in relation to:

- Children Act (1989, 2004)
- Care Act (2014)
- Mental Capacity Act (2005, 2019)
- Prevention of Terrorism Act (2005)
- Domestic Abuse Act (2021)
- Human Rights Act (1998)
- Health and Social Care Act (2008)

These Acts place a duty on key people and bodies, including NHS Trusts, to make arrangements to ensure that their functions are discharged regarding the need to safeguard and promote the welfare of children and adults with care and support needs.

A new iteration of 'Working Together to Safeguard Children was published in 2023. This new edition of Working together is central to delivering on the strategy set out in Stable homes, built on love (2023), which outlines the Government's commitment to support every child to grow up in a safe, stable and loving home. This guidance focuses on strengthening multi-agency working and sets out key roles for individuals, organisations and agencies to deliver effective arrangements.

Of relevance to RDaSH, the guidance introduces changes to the lead practitioner role. It clarifies that a broader range of practitioners can be the lead practitioner for children and families receiving support and services under section 17 of the Children Act 1989 (Child in Need), and the requirements on local authorities and their partners to agree and set out local governance arrangements. These arrangements have yet to be agreed and this will be a priority area for the upcoming year.

Safeguarding is complex and challenging and our plans for the year ahead are achievable and underpinned by RDaSH values

Governance and Leadership within the Safeguarding Team

The safeguarding leadership and governance structures are well established. The Director of Nursing and Allied Health Professionals is the Executive Lead for Safeguarding. The Deputy Director of Nursing supports the Director of Nursing with the executive role. The Nurse Consultant provides strategic direction for both adult and children's safeguarding, and the Named Nurses/Professionals and Lead Professionals provide expert advice, guidance, and leadership.

The Safeguarding Team is made up of a diverse and multi-professional team who provide expert advice, support, supervision, and training to all Trust employees to fulfil their safeguarding responsibilities and duties on a wide range of safeguarding issues. The team prides itself on ensuring that the person at risk of or suffering neglect, harm or abuse always remains in our 'line of sight', and that we 'hear their voice' and they remain at the centre of all we do.

Quality Assurance

All health providers are required to have effective arrangements in place to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators, and their commissioners that these are working and effective (Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework NHSEI, 2022.)

This includes:

• Safe recruitment practices and arrangements for dealing with allegations against people who work with children or adults.

• Safeguarding policies and procedures that support local multi-agency safeguarding procedures.

• Effective training of all staff commensurate with their role and in accordance with the intercollegiate competencies for safeguarding children and adults.

• Effective supervision arrangements for staff working with children, families, or adults at risk of abuse or neglect.

•Effective arrangements for engaging and working in partnership with other agencies.

• Developing and promoting a learning culture.

• Identification of named safeguarding professionals.

• Developing an organisational culture where all staff are aware of their personal responsibilities for safeguarding and information sharing.

Our Safeguarding Assurance Group (SAG) provides challenge and assurance about the safeguarding arrangements within our Trust. We work with many partner agencies and contribute to local multi-agency Safeguarding Children Partnerships, Safeguarding Adults Boards and subgroups across our footprint. The Trust provides external assurance through a variety of methods including Section 11 audits, Self-Assessments and Contractual Standards required by the Integrated Care Boards.

Progress against priorities 2022-2023

Priority	Progress
Identify whether DA routine enquiry is embedded in the Trust	Domestic abuse audit completed and action plan developed
Promote the use of the electronic referral to the RDaSH safeguarding team	Continues to be included in training and supervision. Evidence of use by number of referrals received.
Deliver the bespoke safeguarding training package for Internationally Educated Nurses and Allied Health Professionals	Training provision included in induction package
Nurse Consultant to have oversight of the Multi-Agency Risk Assessment Conference process across the Trust	MARAC Standard Operating Procedure in place
To evaluate the effectiveness of safeguarding training delivered by the Trust	Audit completed
To improve compliance with level 3 safeguarding children and adults training	Training compliance improving picture
To improve compliance with level 2 domestic abuse training	Training compliance improved
Female Genital Mutilation Policy	FGM policy available on the intranet
Embed staff understanding of the impact of neglect across the lifespan	Neglect training package included in the safeguarding suite of training packages

Safeguarding Training

The delivery of safeguarding training remains a key priority for the safeguarding team, with the requirement that all staff are provided with the appropriate level of training commensurate to their role as defined in the Intercollegiate documents: Safeguarding Children and Young People: Roles and Competences for Healthcare Staff (2018), Looked After Children: Roles and Competences for Healthcare Staff

(2020) and Adult Safeguarding: Roles and Competencies for Healthcare staff (2019).

The aim of the safeguarding training is to ensure that every member of staff is aware of their safeguarding responsibilities, recognises abuse and knows what to do about it, as the minimum requirement. All training delivered by the team meets national standards as described in the Intercollegiate documents.

The Trust contributes to the delivery of multi-agency training programme developed by the Local Safeguarding Children's partnerships and Safeguarding Adults Boards. This includes the Graded Care Profile 2 training in Rotherham and Doncaster.

As a provider of NHS care we are required to have mechanisms in place to train staff to understand the risk of radicalisation. Mandatory Prevent training in line with NHSE Prevent Training and Competencies Framework is accessed by our staff via e-learning.

The table below shows Trust compliance with safeguarding training as of March 2024 and compares data to the previous year. There has been improvement in Adults Level 3, Children's Level 3 and Domestic Abuse Level 2 compliance, which are all now RAG rated. Prevent 1 and 2 has seen a slight decrease falling just under the target, however, this can be attributed to moving from a leaflet to e-learning in order to achieve compliance.

Subject	Target	March 2023	March 2024
Safeguarding Adults Level 1	90%	98.67%	97.24%
Safeguarding Adults Level 2	90%	95.58%	96.27%
Safeguarding Adults Level 3	90%	77.37%	81.11%
Safeguarding Children Level 1	90%	98.75%	97.27%
Safeguarding Children Level 2	90%	96.99%	96.81%
Safeguarding Children Level 3	90%	79.55%	80.86%
Prevent Level 1/2	95%	98.47%	92.98%
Prevent Level 3	95%	94.79%	95.33%
Domestic Abuse Basic Awareness	90%	94.7%	N/A
Domestic Abuse Level 1	90%	97.77%	97.04%
Domestic Abuse Level 2	90%	79.47%	86.83%

The table below identifies the number of specific training courses delivered in 2023/2024 and the number of participants that attended. The safeguarding team have delivered training to 2808 colleagues across the Trust.

Course Name	Number of courses delivered in 2023/2024	Number of participants 2023/2024
Level 3 Core Safeguarding Children	11	564
Think Family	6	70
SC Road Map	6	56
Honour Based Abuse	3	110

Adverse Childhood Experiences [Attachment & Trauma aware]	4	173
Child Neglect	3	135
Safeguarding Supervision	6	88
Level 3 Core Safeguarding Adults	12	591
Self-neglect and hoarding	6	126
Modern Slavery	9	75
PIPOT	9	68
Domestic Abuse Level 2	12	752
Total	**87**	**2808**

Safeguarding Supervision

Safeguarding supervision is fundamental in supporting practitioners in delivering high quality care, providing risk analysis and individual action plans. Supervision ensures that practice is soundly based and consistent with Local Safeguarding Children Partnerships, Safeguarding Adult Boards, and organisational procedures.

Safeguarding supervision is mandatory for all staff working with children & families. RDaSH uses a cascade model for facilitating safeguarding supervision and supervisors act as a visible champion of safeguarding within their own service areas to provide a link between their colleagues and the safeguarding team. Ad-Hoc supervision is available for any staff member who has dealt with either an adult or a child safeguarding issue and requires advice and support or wishes to discuss and reflect on their practice.

The safeguarding team facilitates quarterly safeguarding supervisor learning sessions. Each forum has a different theme and a guest speaker. Topics this year have included Counter Terrorism, Refugees and Honour Based Abuse.

Audits

The Trust has a Safeguarding audit plan that audits several areas of safeguarding practice. See table below:

Activity	Scrutiny	Summary	Outcome	Actions
Referrals into children's social care	Safeguarding Assurance Group	Scrutiny of children's safeguarding referrals	Good	Embed the requirement for an IR1 to be completed following a referral
Safeguarding Training Evaluation	Safeguarding Assurance Group	To provide assurance that the safeguarding team are delivering effective and	Outstanding	To continue to analyse feedback following delivery of training

		appropriate subject-based training sessions for colleagues working across the Trust		
Domestic Abuse	Safeguarding Assurance Group	To ensure that staff understand what Domestic Abuse is and that they respond appropriately/take relevant action to reports of such abuse.	Good	Routine enquiry to be included in Domestic Abuse training Ensure all assessment templates have an ability to record routine enquiry for Domestic Abuse To explore whether Domestic Abuse to be included in the FACE Risk Assessment

Child Safeguarding Practice Reviews (CSPRs) and Learning Lesson Reviews (LLRs)

A CSPR is commissioned when a child or young person dies or experiences serious harm or injuries and there is interagency learning. During 2023/2024, the Trust was engaged in 3 CSPRs and 5 LLRs, however, none were published. Themes identified were:

- Children not in education
- Neglect of health needs
- Serious Youth Violence and links with criminal exploitation
- Cross boundary information sharing
- Substance misuse

Safeguarding Adult Reviews, Domestic Homicide Reviews and Learning Lesson Reviews

The table below shows the number of reviews that RDaSH have been involved in during 2023/2024.

Area	SAR	DHR	LLR
Doncaster	4	5	0
Rotherham	2	3	0
North Lincolnshire	1	1	0
Out of Area	1	3	0

Only one SAR was published: Adult V/Child W, see key learning below:

Learning from Adult V/Child W

Adult V was a white 22-year-old young woman, who died in hospital in April 2020 a few days after paramedics responded to a 999 call and found Adult V on the sofa which she had not been able to move from for the previous two weeks. The paramedics found pressure ulcers and severe psoriasis over her whole-body area. She was dehydrated, had not had a wash for weeks, and had been lying in urine and faeces. Bariatric support was required from fire officers to move her safely before transfer to hospital. A safeguarding concern was raised by the hospital because of possible neglect / self-neglect.

Adult V experienced a difficult childhood and a number of adverse life experiences including domestic abuse, parental separation, mental ill health, sexual assault and was care experienced.

Key findings

Cross boundary transfer of care responsibility and handover in relation to child W (then unborn)

No consideration being made for a Care Act Assessment for Adult Vs own care needs

No consideration for a carers assessment for Child W's father who was supporting Adult V

Recognition and assessment of child neglect, specifically around home conditions and child W being overweight

Poor communication between agencies when visits were cancelled.

Lack of a 'Think Family' approach

Lack of professional curiosity around the indictors of self-neglect

To conclude, there has been significant work that has taken place since Adult V sadly died. There are now policies and guidance around self-neglect which encourages a 'Think Family' approach and stronger communication between agencies. We also need to consider the significant impact of the COVID-19 lockdown on the formal and informal support to the family at that time.

Policies and Procedures

The following policies and procedures have been reviewed or developed:

- Multi-Agency Risk Assessment Conference Standard Operation Procedure
- Female Genital Mutilation Policy

All are available on the Safeguarding page of the Trust internet/intranet.

Newsletters

The safeguarding team produces quarterly newsletters to inform staff of changes to legislation, new guidance and training opportunities. They also contain links to partnership information to support staff to safeguard patients. Newsletters produced in 2023-2024 can be found below:

Spring Newsletter

Summer Newsletter

Autumn Newsletter

Winter Newsletter

Incidents

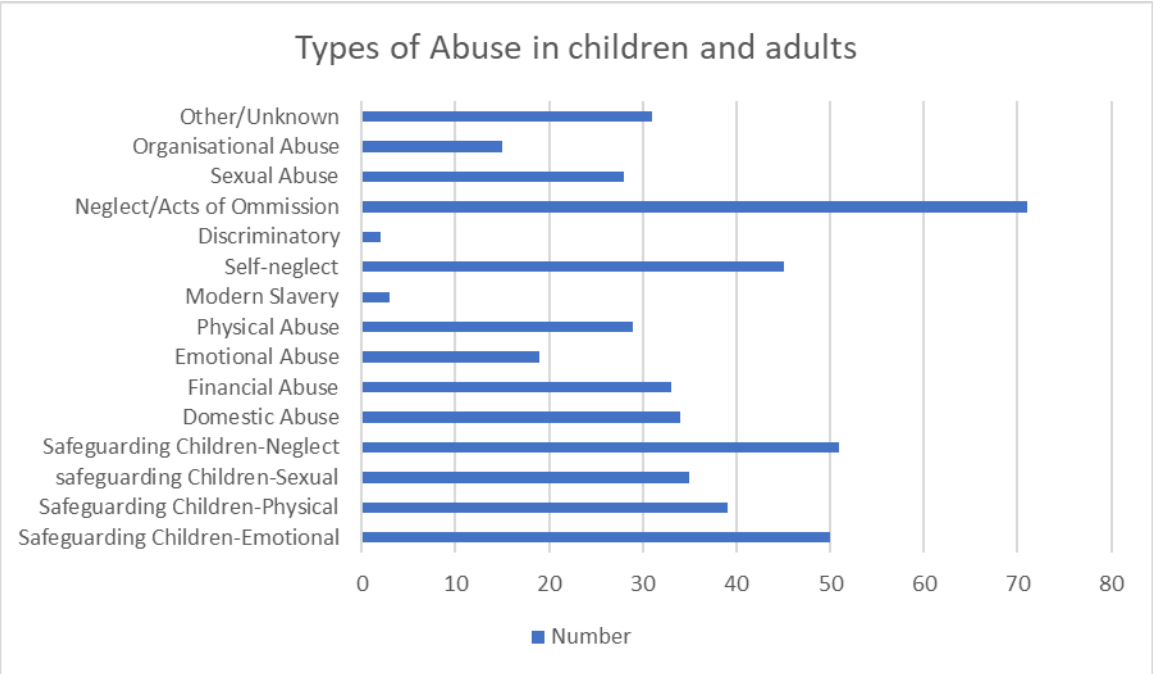
Daily incident meetings are held Monday to Friday to discuss all incidents reported in the previous 24 hours (72 hours on a Monday). Meetings are attended by representatives from all Care Groups, pharmacy, nursing and quality team, safeguarding and other corporate services as required.

From a safeguarding perspective, representatives review the risks and identify further actions that are required. Any incidents where specific safeguarding input is needed will be flagged to the safeguarding team to review and respond. This may include reviewing the patient records and/or contacting the incident reporter for further information and to offer support and guidance.

The table below is a summary of the number of safeguarding incident reports received in comparison to previous years:

This data evidences an increase in reporting of both safeguarding children and safeguarding adults' incidents. This provides assurance that practitioners are identifying where there are safeguarding concerns. The safeguarding team have oversight of all safeguarding incidents which ensures that all required actions are taken to safeguard the individuals involved.

The team also monitor safeguarding themes and trends to identify where additional training or supervision may be required. The table below shows the types of abuse reported:

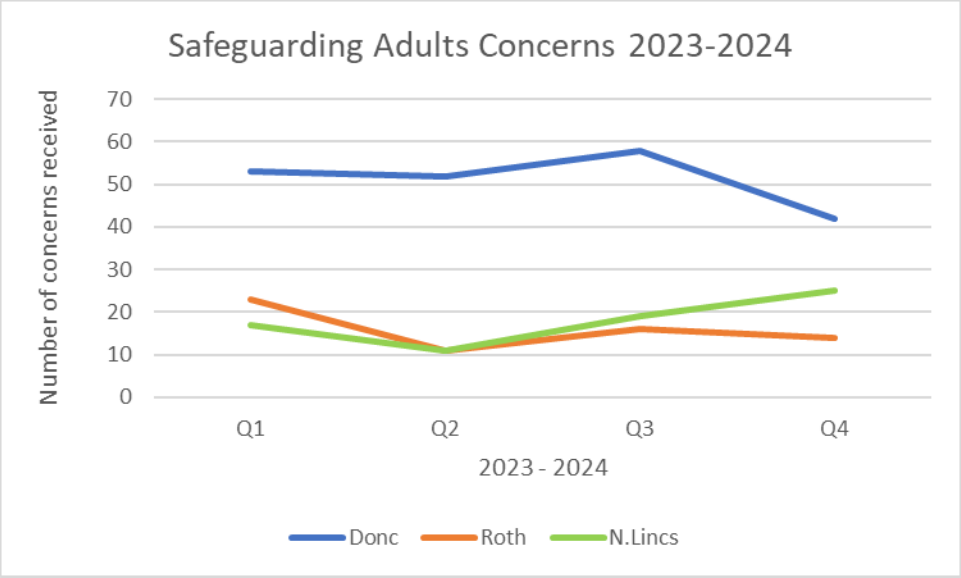


For children, the greatest number of incidents were reported under the categories of neglect and emotional abuse. This correlates to the themes identified in last year's data. Incidents concerned with the theme of neglect and acts of omission far outweighs other incident themes for safeguarding adults, again paralleling the themes identified in 2021/2022.

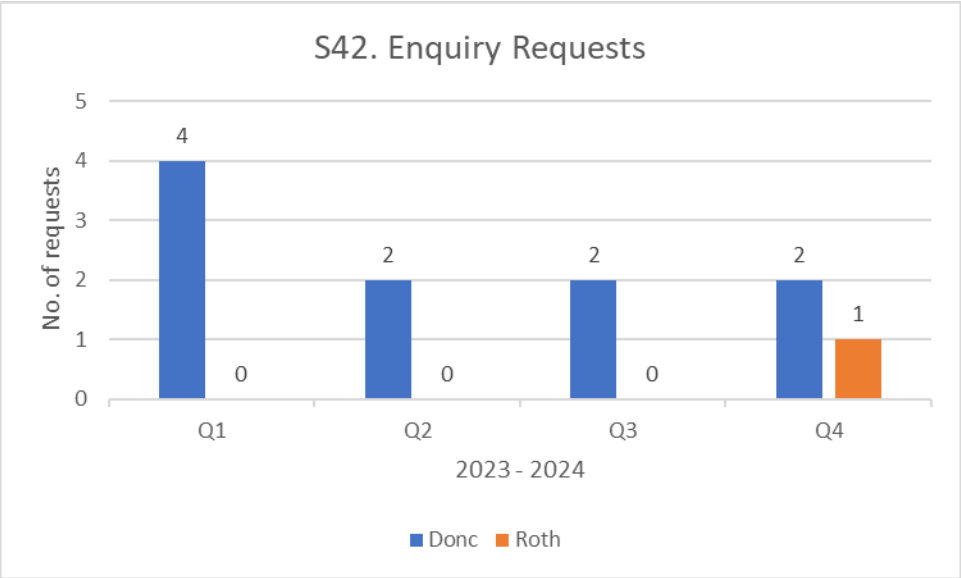
Safeguarding Concerns and Section 42 Enquiries

Safeguarding concerns are raised in line with legislation and policy to the local authority, concerns can be raised by a professional or member of the public. Local authorities must make enquiries, or cause others to do so, if they reasonably suspect an adult who meets the criteria set out in the Care Act 2014, is at risk of or being abused or neglected. The purpose of the enquiry is to decide whether the local authority or another organisation or person should do something to help and protect the adult.

The table below summarises the number of safeguarding concerns that the Trust has been asked to further fact find, for the local authority to decide whether to progress to a Section 42 Enquiry:



Of note, North Lincolnshire Council manage their own safeguarding enquiries and provide an update following conclusion of the investigation. As is evident from the table below, the number of enquiries that Trust staff are asked to lead on are small for both Doncaster and Rotherham.



Prevent

The aim of Prevent is to stop people from becoming terrorists or supporting terrorism. Prevent also extends to supporting the rehabilitation and disengagement of those already involved in terrorism.

The Prevent duty requires specified authorities such as education, health, local authorities, police and criminal justice agencies (prisons and probation) to help prevent the risk of people becoming terrorists or supporting terrorism. It sits alongside long-established safeguarding duties on professionals to protect people from a range of other harms, such as substance abuse, involvement in gangs, and physical and sexual exploitation. The duty helps to ensure that people who are susceptible to radicalisation are supported as they would be under safeguarding processes.

Healthcare professionals have a key role in Prevent because they will meet and treat people who may be susceptible to radicalisation. This includes not just violent extremism but also non-violent extremism which can reasonably be linked to terrorism, such as narratives used to encourage people into participating in or supporting terrorism.

The Executive Lead for Prevent is the Director of Nursing and Allied Health Professionals. The Nurse Consultant for Safeguarding is the Prevent lead for the Trust and provides a point of contact for the regional prevent coordinators. All NHS Trusts are required to submit Prevent data to NHS England and NHS Improvement. This is submitted on a quarterly basis. The table below shows the number of Prevent referrals made across the Trust.

Care Group	Number of referrals
Doncaster Physical Health and Neurodiversity	0
Doncaster Mental Health and Learning Disabilities	3
Rotherham Mental Health	4
North Lincolnshire and Talking Therapies	1
Children's	0

All staff are required to complete Prevent Basic Awareness Training, this is delivered during induction and updated every 3 years with an annual update from the Prevent lead which includes any changes in legislation, changes to local policy and procedure or lessons learnt.

All clinical staff are required to complete Prevent level 3 training, delivered through a combination of face-to-face and e-learning and updated every 3 years with an annual update as shown in the training table above.

Persons in Position of Trust

As a relevant partner to a number of local authorities and an organisation providing care and support services to adults; the Trust is required to have a clear process in place for dealing with allegations against 'Persons in Positions of Trust' (PiPoT).

RDaSH is required to provide assurance to the Safeguarding Adults Boards that arrangements to deal with such allegations within RDaSH, are functioning effectively. The Trust has a robust and mature PiPoT policy in place. The table below details the PiPoT referrals made to the safeguarding team, although the number of PiPoT referrals appear high, only a small amount was substantiated.

Care Group	Number	Substantiated
Doncaster Physical Health and Neurodiversity	12 (2 ongoing)	5
Doncaster Mental Health and Learning Disabilities	35 (9 ongoing)	14
Rotherham Mental Health	45 (2 ongoing)	25
North Lincolnshire and Talking Therapies	22 (3 ongoing)	11

Multi-Agency Risk Assessment Conference (MARAC)

The MARAC is a multi-agency meeting which takes place to discuss high risk cases of domestic abuse, including Honour Based Abuse cases. It is designed to enhance existing arrangements for public protection, including safeguarding children and adults, and has a specific focus on the safety of the victim and any children. The MARAC is attended by representatives from a range of agencies including police, health, child protection, housing, Independent Domestic Violence Advisors (IDVAs), probation, mental health and substance misuse and other specialists from the statutory and voluntary sectors. The MARAC functions on the collective understanding that no single agency or individual can see the complete picture of the life of a victim or is able to identify and manage the risks, but all agencies may have insights that are crucial to the persons safety and risk management plan.

The safeguarding team have oversight of the MARAC process across the Trust and this year has seen the implementation of the MARAC SOP to ensure consistency of MARAC provision across the geographical footprint. The administration of the MARAC meetings is performed by the safeguarding administrators and support to MARAC representatives is provided by the Named Nurses/Professionals. There has been an increase in the prevalence of domestic abuse across the Trust and it is a high priority area of work for all three Community Safety Partnerships.

Partnership Working

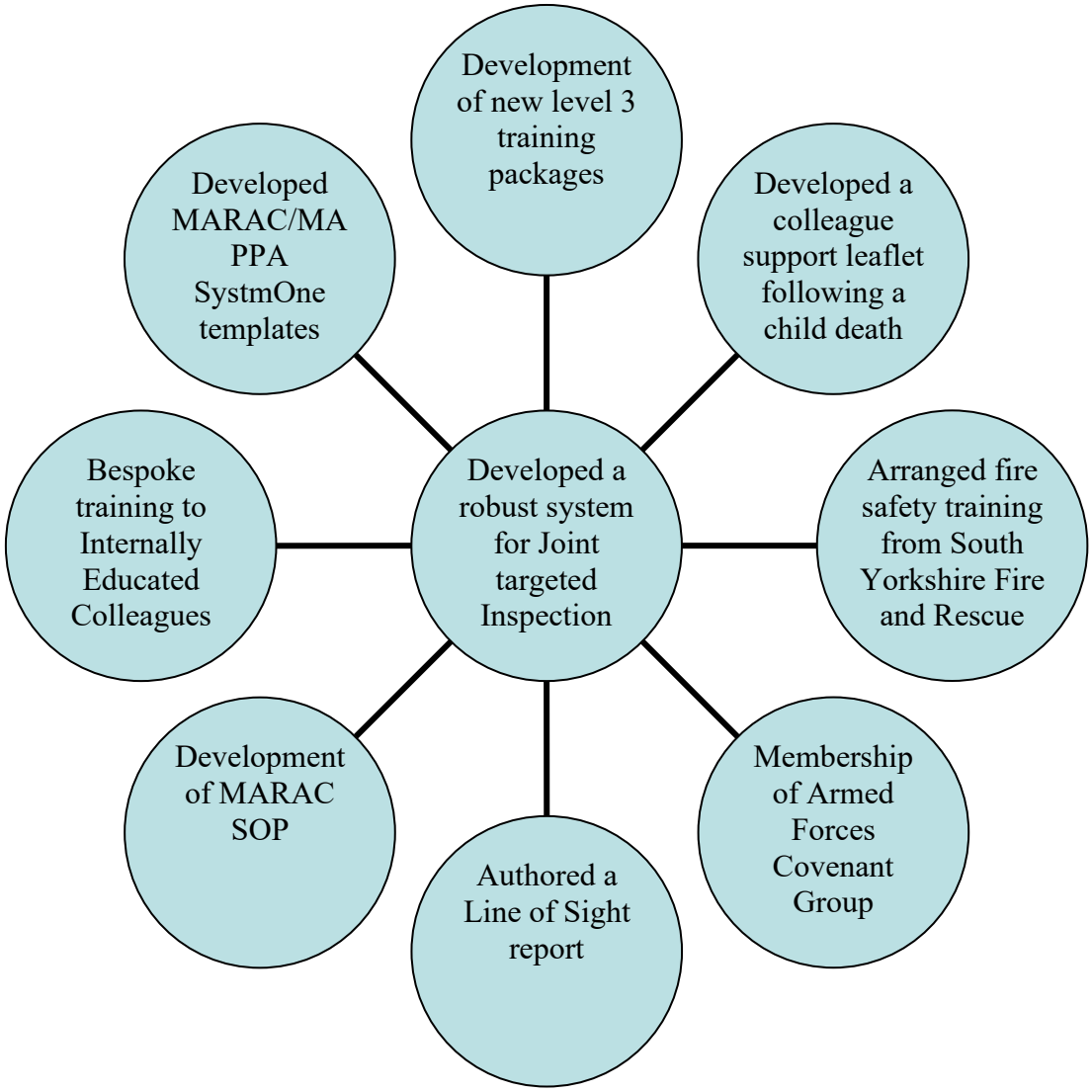
The Trust is fully committed to multi-agency working and ensuring that effective safeguarding arrangements are in place across each of the three locality areas the Trust operates in. This is achieved by:

- Membership of Doncaster Safeguarding Children Partnership (DSCP), Doncaster Safeguarding Adult Board (DSAB) and sub-groups of both.

- Membership of Rotherham Safeguarding Children Partnership (RSCP) and Rotherham Safeguarding Adult Board (RSAB) and sub-groups of both.

- Membership of North Lincolnshire Safeguarding Children Partnership (MARS) and North Lincolnshire Safeguarding Adult Board (NLSAB) and subgroups of both.

Achievements



Challenges

As of last year, the biggest challenge the team faced this year was reduced capacity in the team for much of the year.

Objectives for 2024-2025

Priority	How they will be achieved
Implementation of Working Together 2023	Work together with the safeguarding partnerships to embed the guidance
Development of Multi-Agency Public Protection Arrangements Standard Operating Procedure	Working group to be established and SOP to be written
Improve colleagues understanding of high-risk domestic abuse and how to risk assess	Development and delivery of training
Pregnant inpatients workstream	Working group to be established and SOP to be written
Evaluation of safeguarding training	Audit
Sexual Safety Charter	Participation in the Trust Sexual Safety Charter Group to develop resources and Policy

Conclusion

The safeguarding team has continued to progress the safeguarding agenda significantly during 2023/2024 and the Trust continues to actively respond and contribute to local and national developments.

The 'Think Family' approach ensures that safeguarding is everyone's business and the impact on adults, children and families is clearly understood by all staff groups to identify and respond to concerns/disclosures in line with legislative and professional responsibilities.

The safeguarding team commit to provide leadership, support, advice and guidance to staff within the Trust, ensuring that the Trust provides the highest level of care to all it's patients and their families.

RDaSH strives to ensure that the most vulnerable patients, who are less able to protect themselves from abuse or neglect, are protected. To support this, we aim to have a workforce that recognises safeguarding is not only 'Everyone's business' but is our 'Core Business'.