**Safeguarding - combined**

**Annual Report 2024/25**

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**Contents Page:**

|  |  |
| --- | --- |
| Section | Page |
| Introduction and Executive Summary | 3 |
| Safeguarding Adults | 4 |
| Prevent | 7 |
| Mental Capacity, Deprivation of Liberty Safeguards (DoLS) and Dementia | 11 |
| Safeguarding Children | 15 |
| Children Looked After and Care Leavers | 18 |
| Sudden Unexpected Death in Infancy and Childhood (SUDIC) | 22 |
| Learning Disability | 25 |
| Specialist Child Protection Medical | 30 |
| Conclusion | 31 |

**Introduction and Executive Summary**

Leeds Community Healthcare NHS Trust (LCH) places high priority on the safety of all children and adults at risk who are or whose parents or carers are in receipt of services. The Safeguarding Team ensure LCH meets its statutory requirements outlined in Working Together 2018, The Care Act 2014 and the Mental Capacity Act 2005. Partnership working in health safeguarding is often referred to as the "golden thread" because it runs through and connects all aspects of safeguarding practice. Effective partnerships are crucial in creating a comprehensive, coordinated approach to safeguarding vulnerable individuals.

The purpose of this suite of reports is to provide LCH Quality Committee and LCH Board with a brief overview of the Safeguarding achievements and challenges in 2023 – 2024 and outline key ambitions for 2024-25.

**Team Structure**

The Safeguarding Team based at White Rose Park, provides both corporate and operational functions and sits within the Quality and Professional Development directorate delivering safeguarding advice, guidance, support, supervision and training for all LCH employees.

The team consists of Named nurses and Named Professionals, and a Designated Nurse (Children Looked After CLA)

also, Doctors and Nurses, Safeguarding Advisors and Specialist Practitioners with responsibility for:

* Safeguarding Adults
* Mental Capacity, Deprivation of Liberty Safeguards and Dementia
* Prevent
* Safeguarding Children
* Specialist Child Protection Medical Services
* Sudden Unexpected Death in Infancy and Childhood
* Children Looked After and Care Leavers
* Learning Disabilities
* Clinical psychologist

**Governance Arrangements**

LCH Safeguarding strategy is due for review July 2024, once completed, bi-annual up-dates on the current strategy are submitted twice a year to the Quality Committee who also receive the minutes of our bi-monthly safeguarding committee after each meeting including any escalations. In addition, outcomes from safeguarding committee are shared with the Integrated Care Board (ICB) who, are core members of the group, and this is followed by an assurance meeting with the HoS for safeguarding and the Designated Nurse for adults and Children at the ICB. We also have membership of the Children’s and Adults Advisory groups and with Leeds Safeguarding Children Partnership (LSCP) and Leeds Safeguarding Adults Board (LSAB) and are subscribed to the relevant sub-groups.

Safeguarding priorities are set down in an annual work plan which is reviewed bi-monthly and shared via the Safeguarding Committee.

The Safeguarding Team is continually learning, improving, and disseminating best practice. Through our contributions to Leeds Safeguarding Partnership (LSCP) practice audits, the continuous cycle of preparation for Ofsted Joint Targeted Area Inspection (JTAI) and Care Quality Commission (CQC), as well as through collaboration with agencies in the Leeds Safeguarding Children Partnership, Leeds Safeguarding Adults Board and Safer Stronger Communities (previously known as Safer Leeds), we have scrutinised, analysed and identified practice learning points as we strive to ensure the people of Leeds receive the best possible care.

A further layer of safeguarding assurance is provided through a series of yearly audits, section 11 audit for LSCP, self-assessment to the LSAB and a Safeguarding Annual Declaration to the ICB

**Key achievements are set out at the head of each report.**

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**Safeguarding Adults**

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| **Key achievements 2023-2024**:   * Production and successful launch of a Safeguarding newsletter. * Raising awareness of the use of the Routine Enquiry for domestic abuse template on the electronic record system. * Raised awareness for the use and value of Professional curiosity. * Positive partnership working with Leeds Safeguarding Adult Board contributing to the Multi-agency Practice Audit. * Participation in national and local safeguarding campaigns. * Continued facilitation and embedding of the Safeguarding supervision training within LCH. * Positive partnership working alongside the LSAB and partners to embed the self-neglect strategy. * Successful launch of the Level 3 refresher safeguarding training package. * Integration of Wharfedale rehabilitation unit. * Introduction of the new Safeguarding Team backdrop for MS Teams. * Created links with West Yorkshire Police Safeguarding unit, processes in place for requesting information. * Created links with probation service. * Attendance at the non-fatal strangulation working group. |
| **Key ambitions 2024-2025:**   * Working towards the addition of an electronic SA1 safeguarding referral form for S1. * Raise further awareness of the Exceptional Risk Forum for self-neglect. * Undertake Audit(s) for example The use of the Routine Enquiry template on the electronic record system. * Partnership working to review Domestic Violence and Abuse responses across the city via the use of the DASH Risk Assessment in response to recent law changes regarding Non-Fatal Strangulation. * Continuation of Safeguarding Supervision training for senior adult practitioners across LCH. * Partnership working to review the communication with the Public Protection Unit. * Ongoing work to support staff to manage cases of self-neglect. * Continued partnership working with the Leeds Safeguarding Adult Board and the Leeds Health Economy. * Participate and increase awareness for staff across the trust via 60-minute updates. |

A key priority for LCH is to raise awareness and empower staff to recognise the signs and symptoms of abuse. The aim is for all staff to feel informed and confident to access the team for support and advice. The Safeguarding Adults Team does this by continuing to provide advice, training, and support to staff, in line with our statutory duties. The main form of contact with the safeguarding team is through telephone contact. Calls are received into the team from staff across the Trust. The staff within the safeguarding team respond to these and share a plethora of advice/recommendations. Audit of the calls can provide thematic data which can be used to target. Awareness raising/training or/and support.

We recognise that there are many different platforms for learning and always incorporate different techniques to help facilitate learning, there are also many different aspects of safeguarding.

**Training**

The team prioritised and worked hard to create and facilitate the introduction of the refresher Level 3 Safeguarding Training as per [Adult Safeguarding: Roles and Competencies for Health Care Staff | Royal College of Nursing (rcn.org.uk)](https://www.rcn.org.uk/Professional-Development/publications/adult-safeguarding-roles-and-competencies-for-health-care-staff-uk-pub-007-069). The team are continuously reviewing and developing training packages in line with the changing horizon of safeguarding in Leeds and Nationwide. Despite the pressures of staff capacity, Safeguarding is prioritised within LCH, and compliance currently sits (as of March 2024) at 82% with an aim to achieve over 85% by the end of Q4 this year.

**Safeguarding Supervision Training**

Safeguarding supervision training is not mandatory but deemed crucial to help staff to reflect, process and understand their role in safeguarding patients.

It allows an opportunity to:

* Discuss individual cases.
* Reflect, review, and change practice if needed.
* Identify areas of good practice.
* Identify gaps in learning.

Leeds Community Healthcare recognises the importance of this and continues to facilitate training to clinical managers within the trust as per LCH strategy 2023/26. Safeguarding supervision is also available for any specialist unit for example Continence, Urology, and Colorectal Service (CUCS). To date we have managed to train 74 senior staff members.

**Examples of Campaigns facilitated by safeguarding and involving partnership working across Leeds.**

**16 days of action campaign to end violence against women/white ribbon campaign.**

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Description automatically generatedSafeguarding week in Leeds is held in June each year and gives the health economy and partners the opportunity to highlight and raise awareness of Safeguarding by offering additional opportunities for staff learning on current safeguarding issues. Last year sessions were facilitated in person, virtually and by use of social media platforms.

**Multi-agency working** is a crucial element of safeguarding, and the safeguarding team works in partnership within the health economy and with colleagues in other provider organisations, Adult Social Care, West Yorkshire Police, and voluntary and private sector organisations to safeguard and protect the people of Leeds. Multi-agency working in safeguarding is a key benefit that can dramatically reduce the risk of abuse, by enabling different services to join forces to prevent problems occurring in the first place.

The key principles of multi-agency working are the commitment to hold each other to account, to understand interlinking risks and needs from all perspectives, and to take collective responsibility to help and protect all involved. Multi-agency working is evident with our involvement in the Multi-agency Practice Audit. This is led by the Leeds Safeguarding Adult Board and the current and ongoing theme is **Self-neglect.** This theme links in with our inter-agency Policy and Procedure and is a subject the team continue to be passionate about.

A person looking through a telescope

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**Inter-agency Policy and Procedure**

In response to lessons learned from previous and current Safeguarding Adult Reviews (SAR) we continue to raise awareness and focus on self-neglect. Self-neglect is a complex subject which frequently requires a multi-agency response.

The LSAB board members (including LCH) worked with developed a city wide, self-neglect policy [LSAB Self neglect policy (v1).pdf (leedssafeguardingadults.org.uk)](https://leedssafeguardingadults.org.uk/Documents/Safeguarding/LSAB%20Self%20neglect%20policy%20(v1).pdf) and a self-neglect strategy [Leeds Self-neglect Strategy (leedssafeguardingadults.org.uk)](https://leedssafeguardingadults.org.uk/safeguarding-adults-board/leeds-self-neglect-strategy#:~:text=The%20Leeds%20Self%2Dneglect%20strategy,%2C%20Prevention%2C%20Partnership%20and%20Practice.) .

The Leeds Safeguarding Adults Board self-neglect strategy is based around four core pillars:

* People
* Prevention
* Partnership
* Practice

These four P's build upon the learning from citizens, practitioners, services, and our Safeguarding Adult Reviews in Leeds and reflect the areas of development that need to be taken forward across the city.

The Exceptional Risk Forum (ERF) continues to take place having been established by the Leeds Safeguarding Adults Board in recognition that sometimes, despite the best efforts of agencies, an exceptional risk to their safety can remain. The LSAB Exceptional Risk Forum can offer agencies with a fresh perspective and multi-agency advice and recommendations as to how that person's risk could be reduced, LSAB (2021).

[LSAB Exceptional Risk Forum (leedssafeguardingadults.org.uk)](https://leedssafeguardingadults.org.uk/lsab-exceptional-risk-forum) link to guidance, checklist, and referral forms.

LCH staff are encouraged to use the referral checklist as an aide memoire to support them when managing complex cases of self-neglect in the community. This assures and reminds staff of all expected actions prior to referral to ERF and often solves issues before it gets to that critical point. The ERF panel has a core membership of Health, Social Care, Housing and Forward Leeds with the option of co-opting in any other agencies deemed relevant e.g., West Yorkshire Fire Service, Police, Yorkshire Ambulance service etc. LCH are a core member of this group.

The Care and Support Statutory Guidance (March 2020) states that self-neglect is a form of abuse and neglect. It defines self-neglect as: “a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding” (Section 14.17).

This may include people, either with or without mental capacity, who demonstrate:

* Lack of self-care (neglect of personal hygiene, nutrition, hydration and/health, thereby endangering their safety and wellbeing)
* Lack of care of one’s environment (squalor and hoarding)
* Refusal of services that would mitigate the risk of harm.

**Leeds Community Healthcare previously gained an overall opinion of High Assurance following an external audit relation to the controls in place to manage and support our patients who self-neglect and continue to work to maintain this assurance.**

**The Domestic Violence/Abuse agenda** continues to be a priority area for Safeguarding and the Trust. The team have continued to work hard to fulfil the requirements to maintain the Domestic Violence Quality Mark previously awarded by Safer Stronger Communities. We continue to build on this achievement with the use of the routine enquiry template embedded within our electronic record system. The use of which will be reviewed by audit this coming year.

LCH continues to be an open and reflective contributor to Domestic Abuse Related Death reviews (DARD) (previously known as - Domestic Homicide Reviews (DHR) and Safeguarding Adults Reviews (SAR) where required. Both processes allow for analysis of findings from investigations carried out by individual agencies involved in the case, to make recommendations for improving future practice where this is necessary.

A close-up of a computer screen

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**Domestic Violence/Abuse Champions**

Safeguarding champions act as ambassadors for safeguarding in LCH, imparting their enhanced safeguarding knowledge to their teams’, ensuring safeguarding is on the agenda at team meetings, managing a safeguarding information board, and encouraging staff to maintain alertness to safeguarding in all that we do. Safeguarding Adult champions can be any band, and any speciality (including children’s services)

The Safeguarding team continues to engage virtually and face to face with LCH Adult Safeguarding Champions; this is set to reach a wider audience supporting staff to learn by sharing identified cases, receiving bespoke training, and developing their knowledge and understanding of the wider safeguarding strategy and agenda. Champions feedback included that they value the meetings, gain a greater understanding of safeguarding issues, themes, and trends, and feel more confident sharing learning to colleagues in their own teams.

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**PREVENT**

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| **Key achievements 2023-24:**   * Monitored and encouraged training uptake. * Maintained up-to-date information and resources on LCH dedicated webpage for Prevent. * Provided regular updates to staff via briefings and newsletters. * Supported LCH to deliver on our Prevent Duty * Maintained strong multi-agency relationships including contribution to the Channel Panel. * Continued to raise the Prevent agenda across the organisation. |
| **Key ambitions 2024-25**   * Continue to raise the profile of Prevent. * Maintain up-to-date information and resources on our dedicated Prevent intranet page. * Support the organisation to be compliant with our Prevent Duty. * Work alongside other health agencies in Leeds to ensure staff are kept updated and there is a forum for Prevent leads to share concerns and learn from practice. * Explore the potential of having Prevent champions across the organisation. * Continue to share the Local Authority Prevent newsletter with LCH staff to support clarity and uniformity messaging in relation to the Prevent agenda. |

Prevent is one strand of the Government’s counter terrorism strategy known as CONTEST. The Prevent strategy aims to stop people becoming terrorists or supporting terrorism. Prevent addresses all forms of terrorism but prioritises these according to the threat they pose to our national security. Prevent is delivered in partnership by a wide range of organisations including LCH. Together we recognise that the best long-term solution to preventing terrorism is to stop people been drawn into terrorist behaviour in the first place. The objectives of the Government’s Prevent strategy are to:

* Tackle the causes of radicalisation and respond to the ideological challenge of terrorism.
* Safeguard and support those most at risk of radicalisation through early intervention, identifying them and offering support.
* Enable those who have already engaged in terrorism to disengage and rehabilitate.
* Safeguarding vulnerable people who may be at risk of being drawn into terrorism is an essential part of the Prevent Strategy. Terrorism is a real and serious threat to us all because terrorists actively seek to harm us, to damage community relations and to undermine the values we share. Throughout the country there is a requirement for Prevent local action plans, to be in place to support vulnerable individuals underpinned by a robust training package.
* Health has a key role to play. Partnership involvement ensures that those at risk have access to a wide range of support, from mainstream services, through to specialist mentoring or faith guidance and wider diversionary activities.
* A joined-up approach, motivation, and commitment to drive standards forward have resulted in achieving and maintaining our training compliance levels; this is a testimony to staff /services’ resilience and commitment.
* The e-learning resource is available for all staff members; meeting the WRAP (Workshop to Raise Awareness of Prevent) training requirement for level three practitioners and counts toward the intercollegiate safeguarding competence / training requirements.
* Regular meetings continue to take place across the health economy, where a shared learning approach and response is being explored. This ensures continuity and reassurance around matters such as advice, consent, confidentiality, and documentation as well as support around each other’s organisational practice.
* LCH continues to support a dedicated staff intranet Prevent page, with access links to training, information, resources and contact details for concerns. Resources are regularly shared across the health economy to be used for staff dissemination.
* It is also important to note that prevent, remains a legal duty and all NHS Trusts continue to be contractually obliged to collate and provide performance data; this is reviewed regionally before scrutiny by the National Safeguarding Steering Group.

**Local Overview**

* The national safeguarding website [www.actearly.uk](http://www.actearly.uk), continues to encourage family and friends to act early, share concerns and seek help if they are worried that a loved one is being radicalised. The website includes case studies, signs to spot, FAQs and details of the national advice line staffed by trained Prevent officers.
* The site also provides toolkits for staff and partners to access a range of support materials, from templates to posters to business cards and tweets. <https://www.counterterrorism.police.uk/actearlypartners/>
* Throughout the last year, prevent concerns have continued to be addressed; regular monthly Channel Panels have continued via Teams; and a new Hybrid approach has been adopted allowing staff to meet face to face or via MS Teams. The prevent team/police/chair and vice-chair continue to keep in close contact with any concerns across the city adapting practice as the prevent climate continues to shift in complexity and dynamics.
* National support for Channel and Prevent comes through the Channel Duty guidance providing a robust framework for building on much of the good work we know is already being delivered, whilst strengthening the quality and consistency of panels and the practice of panel members across England and Wales. This enables us all to manage the vulnerability of individuals at risk of being drawn into terrorism more effectively. The long awaited [Prevent duty guidance](https://www.gov.uk/government/publications/prevent-duty-guidance/prevent-duty-guidance-for-england-and-wales-accessible) has now been refreshed and updated to reflect several recommendations of the [Independent Review of Prevent](https://www.gov.uk/government/publications/independent-review-of-prevents-report-and-government-response/independent-review-of-prevent-accessible). This includes, updated language and terminology, and a refocus on tackling the ideological causes of terrorism.

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Safeguarding vulnerable people who may be at risk of being drawn into terrorism is an essential part of the Prevent Strategy. Terrorism is a real and serious threat to us all because terrorists actively seek to harm us, to damage community relations and to undermine the values we share. Throughout the country there is a requirement for Prevent local action plans, to be in place to support vulnerable individuals –hence the necessity for a robust training package.

Health has a key role to play. Partnership involvement ensures that those at risk have access to a wide range of support, from mainstream services, through to specialist mentoring or faith guidance and wider diversionary activities.

A joined-up approach, motivation, and commitment to drive standards forward have resulted in achieving our training compliance expectations and maintain, what has been, an improving figure. Which is a testimony to staff /team’s resilience and commitment.

We acknowledge that face-face training generates a conversation and would be the gold-standard in an ideal world. However, within the current climate and risks around extremism, we felt we needed to reach out to all staff, regardless of roles and responsibilities. The e-learning resource is available for all staff members; meeting the WRAP (Workshop to Raise Awareness of Prevent) training requirement for level three practitioners and counts toward the intercollegiate safeguarding competence / training requirements.

Regular meetings continue to take place across the health economy, where a shared learning approach and response has been adopted. This ensures continuity and reassurance around matters such as advice, consent, confidentiality, and documentation as well as support around each other’s organisational practice.

LCH now has a dedicated staff intranet Prevent page, with access links to training, information, resources and contact details for concerns. Resources are regularly shared across the health economy to be used for staff dissemination. It is also important to note that prevent, remains a legal duty and all NHS Trusts continue to be contractually obliged to collate and provide performance data-this is reviewed regionally before scrutiny by the National Safeguarding Steering Group.

**Local Overview**

The national safeguarding website [www.actearly.uk](http://www.actearly.uk), continues to encourage family and friends to act early, share concerns and seek help if they are worried that a loved one is being radicalised. The website includes case studies, signs to spot, FAQs and details of a new national advice line staffed by trained Prevent officers.  The site also provides toolkits for staff and partners to access a range of support materials, from templates to posters to business cards and tweets. <https://www.counterterrorism.police.uk/actearlypartners/>

Throughout the last year, prevent concerns have continued to be addressed, regular monthly Channel Panels have continued via Teams and a new Hybrid approach will be adopted moving forward allowing staff to meet face to face or via MSteams. The prevent team/police/chair and vice-chair continue to keep in close contact with any concerns across the city adapting practice as the prevent climate continues to shift in complexity and dynamics.

National support for Channel and Prevent comes through the Channel Duty guidance providing a robust framework for building on much of the good work we know is already being delivered, whilst strengthening the quality and consistency of panels and the practice of panel members across England and Wales. This enables us all to manage the vulnerability of individuals at risk of being drawn into terrorism more effectively. The long awaited Prevent review is due and we look forward to the recommendations and challenges I am sure this will bring.

**Leeds Prevent Referrals**

Referrals into the Prevent local authority and Police team come from many areas, schools, colleges, universities, healthcare professionals, social care members of the public, family members, the police themselves. The Local Authority Prevent team continue to support organisations/schools/educational settings with Prevent training and guidance.

LCH staff remain engaging and vigilant when assessing concerns and are contacting the team for discussions around potential Prevent issues. However, we mustn’t become complacent, but ensure we remain professional and always work within our remit of roles and responsibilities and are constantly developing and evolving, to ensure we offer the best experience of channel/prevent for clients/families and people who come through our services.

**Leeds local Issues**

The demographic of Leeds provides us all with lots of challenges within our practice and daily life, many communities now find themselves within a national if not global financial crisis, touching, not just our deprived areas of Leeds, but working families also, which may lead to an increase in people’s susceptibility to being exploited and radicalised. The online space continues to be a focal point for those out to exploit people’s vulnerabilities with mis-informed information and ideologies.

The Extreme-right-wing groups in Leeds continue to cause concern feeding off people’s anxieties and emotions within the current financial climate, offering mis-guided and ill-informed information and often, what appears help and support to people suffering; however, this always comes with a price and steps into the criminal space.

Vulnerabilities have more opportunity to be preyed upon, and those using the internet for work/school/pleasure maybe taken advantage of, also, there is an increased opportunity for people to self-radicalise in the home.

**LCH Response**

Safeguarding accessibility remains on full capacity, and we will continue to offer support and advice through a range of media platforms. LCH continues to have representation at Channel and Silver meetings, being an ideal platform for learning, reflection and ensuring that LCH continues to be compliant, effective, and efficient around the Channel Duty.

The PREVENT partners newsletter (from the local authority prevent team) continues to provide partners with a reflective, platform of information around prevent. Highlighting the shared approach to keeping the citizens of Leeds informed and as safe as possible.

Training for staff remains at a constant, which is really reassuring that we have that commitment from staff during these challenging times. Latest quarterly training figures report. **89%** level 3 uptake (B5 staff and above) **91%** level 2 uptake (B4 staff and below). Development of a resources page accessible for all staff is now active, information is available on the safeguarding adult’s intranet page, covering a wide range of topics, including, Prevent, domestic violence, cuckooing, modern slavery, with further support available from the safeguarding team.

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**Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and Dementia**

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| **Key Achievements 2023/24**   * Welcomed new Mental Capacity Lead to the Safeguarding Team. * Supported health audit of referrals to ASC from agencies across the health economy, where professional concerns relate to issues of self-neglect. * LPS future ambitions ‘delayed beyond the lifetime of this government’. * Supported rehab unit at Wharfedale Recovery Hub with offer of further training and onsite support. * Mental Capacity Assessments forms updated in line with correct sequencing of assessment case law. * Easy Read MCA for Service Users, Families and Carers developed alongside learning disability project manager. * One minute guide for patients/ citizens with dementia experiencing domestic abuse co-produced and delivered across the health economy. * LCH staff have now attended the minimum training of dementia awareness enabling them to be a Dementia Friend. * Facilitated a lunch and learn with the dementia and mental health practitioners for the neighbourhood teams to raise awareness of their roles and referral process. * Hosted available session to all LCH staff on MCA with guest speaker solicitor Ben Troke. * Bespoke advocacy session provided by Advonet to increase awareness of advocacy services available across the city. * Lasting Power of Attorney (LPA) One Minute Guide (OMG) updated for Health and Welfare. * Updated reporting system for Deprivation of Safeguards (DoLS) supporting the recording and communication of patients under the DoLS system. * Supported staff in complex Best Interests meeting particularly from dental services. |
| **Key Ambitions 2024-2025**   * Support movement towards community of practice following suggested changes from mental capacity local implementation network. * System updates for MCA on System1. * Exploring training development platform on Leeds Health and Care Academy with the rest of the health economy with potential to host MCA training resources. * Mental Capacity Assessment and LD diabetes guidance for practitioners. * To increase Dementia Training figures, package to be implemented and accessible via e-Learning. * With Leeds Partnership re-development of the Dementia Pathway for screening and referrals. * Key MCA/ Dementia topics for lunch and learns alongside 60 min updates imbedded within the safeguarding team. * Continue to offer staff education/ support sessions for staff who care for family/ friends living with dementia. * Review of MCA/Dementia Champion forums. |

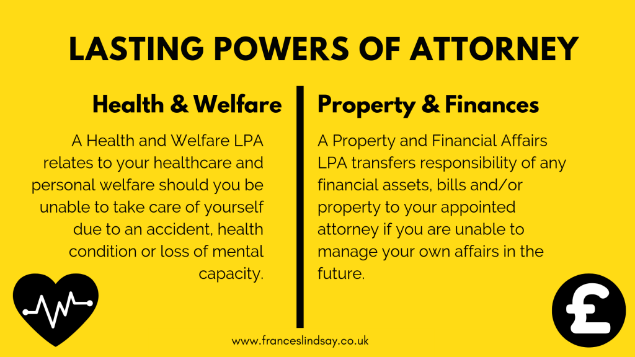
The Named Nurse for MCA/DoLS/Dementia left post in April 2023 and as her replacement the new Named Professional for MCA /DoLS/Dementia did not start post until September 2023. To provide additional support in the interim period our MCA/dementia trainer was contracted to support LCH staff further in this period.

The Named Professional has remained actively involved in the health audit of referrals to Adult Social Care from agencies across the health economy, where professional concerns related to issues of self-neglect. Exploring further analysis of MCA and related safeguarding concerns within the self-neglect remit.

There had previously been focus with the trust managing Wharfedale Recovery hub where it was to become a ‘Responsible Body’ in the context of the MCA amendment bill: Liberty Protection Safeguards (LPS). However as of April 2023 the government stated that such would be delayed “beyond the lifetime of this parliament’.

Figures for MCA statutory training have continued to increase since beginning in post with an internal drive to promote the accessibility via the new acquired e-learning package which was implemented in January 2023. MCA training figures have continued to increase since December 2023 and at end year March they remained at 91%; above the expected requirement for stat/man training compliance.

There remains a drive to support Wharfedale Recovery Hub with MCA on a needs led basis, with training offers continuing to be made available to the service. Time was allocated to the unit to offer support to staff and patients to encourage a person-centred approach to the care and treatment for people living with dementia (PLWD) underpinned by the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Within this bespoke face to face training, role modelling and clinical supervision was made available to all staff on the unit. The ‘This is me’ document has been integrated into the Wharfedale Units clinical records. There has been a continued focus on updating supporting documents for staff and patients, with the update of Mental Capacity Assessments (MCA1 forms) to reflect the correct sequencing for mental capacity assessments, alongside that there has been an update of the ‘Best interests decisions’ form (MCA2). Working alongside the learning disability project manager easy read documents have been developed for MCA, as well as updated information on Lasting power of attorney (LPA) for health and welfare decisions.



The Named Professional has continued to support the dental service in ‘best interest decisions’ especially in cases that remain complex. We have seen the successful completion on a three-way court of protection application with our NHS colleagues at LTHT and LYPFT.; ‘This was a considerable piece of work with 20 colleagues from LCH, LTHT and LYPFT who worked remarkably well together to ensure a range of procedures were completed together to ensure patient experience of feeling safe and accessing the care they needed at one time’. A bespoke training session was kindly made available to staff at LCH provided by specialist solicitor Ben Troke addressing areas of the MCA and DoLS. To develop stronger links with our advocacy service within Advonet and ensuring statutory requirements are adhered to when required for IMCA representation, a session was made available for staff to access, outlining the different advocacy roles available from statutory to non-statutory advocacy.



**Dementia** level 2 initial/ refresher training figures continue to remain below the expected requirement for stat/man training compliance with a yearly average of 68%, however at end year as of March 2024 training figures have increased over the last 3 months to 75%; this is because of a drive to increase attendance numbers by removing the cap of how many staff members could attend the allocated training sessions. It has been often reported that staff have had to cancel attendance due to a lack of capacity and the focus must always be on patient care. To further address the declining figures, we have agreed there needs to be a move to more availability of e-learning, given the success with MCA training. This is to support staff and allow the flexibility of training packages being available to access as and when, fitting around rapidly changing environments in community services. Moving forward the aim is to trial the implementation of e-learning with bespoke virtual trainings sessions on dementia topics being provided as lunch and learn sessions/ 60 min updates.



The Dementia steering group has been stepped down with reconsidering how Dementia is everyone’s business. Following this the dementia work plan will now be implemented through each relevant work stream within LCH. We are currently working with our Leeds Dementia Partnership group regarding the redevelopment of the Dementia Screening and Referral Pathway and how that becomes more person centred across the city.

Everyone working in health and social care who make decisions for people who lack capacity has a legal responsibility to know and follow the [Mental Capacity Act Code of Practice - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice). LCH has a statutory duty to ensure we comply with the legislations on consent and MCA (2005), to ensure the care and treatment delivered is lawful and best practice. Effectiveness domain which looks for assurances in this area. The safeguarding team support the embedding of MCA (2005) into everyday clinical practices and ensures this can be evidenced for assurance purposes. Routine work that promotes best practice for MCA and dementia includes giving specialist MCA & dementia advice and guidance to staff, including the use of relevant legislations on consent and MCA (2005).

Through changes to the Mental Capacity Local Implementation Network, the Named Professional will continue to be part of the proposed new working group which will aim to focus on supporting a movement towards a community of practice. There will be continued focus on working with our dementia partnership on the development of the dementia screening and referral pathway.

To support a knowledge gap between MCA assessment and diabetes care and support for those with an identified learning disability an available support tool to support assessment will be made available for staff to assess mental capacity in this area. The Named professional will aim to bring dementia training availability in line with current availability of MCA training through our e-learning platform.

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**Safeguarding Children** 

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| **Key achievements 2023-2024**:   * We explored work undertaken in previous years and completed audits to establish how effective and embedded in practice the previous work has become. * We shared some audit outcomes with services so that collectively we can celebrate what is working well and where improvements could be made. * We supported our Children Social Work Colleagues in undertaking multi agency audit. * Safeguarding have maintained our statutory presence with strategy discussion requests from Children’s Social Work Service (CSWS). We ensure accurate data collection regarding these discussions and share information across the health economy where relevant. We continue to work with CSWS and Police colleagues to achieve tripartite strategy discussions whenever possible. * There has been significant demand on LCH practitioners for attendance at strategy discussion, see chart below depicting a steep trajectory year on year.      * We contributed to the city wide Joint Targeted Area Inspection (JTAI) around Serious Youth Violence (SYV). Working with LCH services and practitioners this was a demanding piece of work, undertaken in a short timeframe.   <https://www.gov.uk/government/publications/joint-targeted-area-inspections-of-the-multi-agency-response-to-serious-youth-violence/joint-targeted-area-inspections-of-the-multi-agency-response-to-serious-youth-violence>  A close-up of a text  Description automatically generated   * The safeguarding team continue to support various meetings in relation to preventing and reducing the growing concern around SYV and Gangs. * We worked with LCH services and partner agencies to establish a united Early Help registration process within our current I.T system. Going forward we hope to enable this to capture and share data. * We developed an LCH Level 3 children’s safeguarding training package to accommodate the wide range of services within LCH. We also maintaining the use of the LSCP Level 3 training for some services as a gold standard of multi-agency working. * We also developed a Non-Fatal Strangulation presentation highlighting this concerning issue.   A close-up of a card  Description automatically generated A close-up of a person's face  Description automatically generated   * We contributed to and updated the successful launch of the Safeguarding newsletter. |
| **Key ambitions for the children’s safeguarding team 2024-2025:**   * Continued response to practitioners calling for support/advice in a timely manner. * Repeat and update audits undertaken where improvements have been identified. * Review group work around Domestic Violence and Abuse within the trust and contribute to a training package for practitioners. * Update the trust Quality Mark award, evidence, for Domestic Violence and Abuse. * Update the Section 11 audit evidence for the trust. * Continue to attend and contribute to Leeds Safeguarding Children Partnership subgroup meetings. * Continued facilitation of learning from Child Safeguarding Practice Reviews and other safeguarding issues via 60-minute updates and directly with services where needed. * Continue to embed learning within the trust |

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| **Who are we?** | **What do we do?** |
| Named Nurse for Safeguarding children. (full time)  Senior Specialist Safeguarding Nurse. (Part time)  Three Specialist Safeguarding Nurses, one part time. One Nurse has a specific focus on the Front Door Safeguarding Hub. | We are a dedicated and experienced team who provide a trust wide service to all staff across LCH who manage safeguarding complexity and risk.  We work within the guidance of Working Together to Safeguard Children (2023) to safeguard children, offer compassionate specialist guidance, advice, and direction to practitioners, escalating concerns where needed. We work closely with other parts of the health economy and multi-agency partners, participating in a variety of collaborative meetings and subgroups.  Our work is underpinned by statutory responsibility, evidenced based practice, reflection, peer review and supervision which assists our learning & supports consistency in our decision making.  Our team demonstrates resilience and is committed to supporting LCH and wider colleagues by adopting a positive approach that enables others. |

LCH Children’s safeguarding team continue to fulfil the daily commitment to LCH practitioners. There work is underpinned by Working Together to Safeguard Children which was updated in Dec 2023.

The team believe that safeguarding is everybody’s business. As accountable practitioners we work hard to enable confidence and competency in LCH practitioners, who are valued and supported in all aspects of safeguarding work they do.

In efforts to support and raise awareness of current and ongoing Safeguarding messages the team facilitate briefing sessions, recently these sessions have included Trauma Informed Practice, Professional curiosity, Perplexing Presentation and Was Not Brought. They participate in National and Local Safeguarding Campaigns sharing messages and signposting practitioners to the Safeguarding My LCH page, external training & further information. We will often seek support from external speakers for some 60 min briefing sessions or to support our Champions meetings, such as Police colleagues to talk about the Police Information Portal (PIP) or Claires Law, or private speakers with expertise in identifying safeguarding risks of Hidden/Invisible/Unseen men.At times we have also had speakerswith lived experience who offer a perspective that has huge impact.

Supervision is integral to the role and responsibility of the Children’s team. We strongly believe it promotes staff resilience. Over 2023/24 we have continued to offer Child Protection (CP) Supervisor Training and we facilitate Child Protection Group supervision. We offer 1:1 supervision and Safeguarding Peer Supervision. In doing this work the safeguarding team are constantly listening to difficult and distressing information so it’s important that there emotional wellbeing is recognised and that they are supported by good leadership. The trust has several resources we can access and have utilised. Going forward we will also have regular psychological support.

We audit our Safeguarding Peer Supervision sessions and below are some examples of the feedback given by practitioners.

* ***‘I would like a clear model when offering supervision. This form doesn’t apply to child protection doctors.’***
* ***‘The LCH Safeguarding Team are wonderful’.***
* ***‘We have a fantastic team who support with everything.’***
* ***‘I find LCH Supervision is very good having had a very different experience previously.’***
* ***‘I would like to add that the quick access to the LCH Safeguarding Nurses for advice and guidance is excellent*.’**

This is a case example. It demonstrates how the Children’s Safeguarding team supports work in practice, across several processes.

**Case example**

*It is a statutory responsibility of all agencies to offer information in the event of an LSCP Rapid Review. The review involves exploration and analysis of information held by agencies regarding a child and family when a child has come to significant harm. This process supports the identification of learning and good practice.*

*When the Named Nurse for Safeguarding Children was undertaking an LCH record review of this nature, and despite the tragic events surrounding the issue in question it was excellent to establish how LCH Safeguarding Children team had supported valuable decision making and promoted excellent multi agency working.*

*From the child’s electronic patient record it was apparent that concerns had been raised regarding a man living with a woman due to have their baby. The LCH practitioner felt clear that this was a safeguarding issue however unsure how to manage the concerns raised from the information that had been shared with her. She contacted LCH Children’s Safeguarding team and was directed and supported to Make a Claire’s Law application, which she did.*

*Claires Law enables the police to disclose information to a victim or potential victim of domestic abuse about their partner’s or ex-partner’s previous abusive or violent offending.*

*Anyone can make an application about an individual who is or was in an intimate relationship with another person, and where there is a concern that the individual may harm or have harmed another person. (West Yorkshire Police)*

*Domestic Violence Disclosure Scheme factsheet - GOV.UK (www.gov.uk)*

*Following the application for Claires Law being submitted, the LCH practitioner went on to liaise with mum’s Midwife. The midwife had an appointment with mum and at that appointment, once establishing it was safe to speak to mum, she was able to share why a Claire’s Law application had been requested by the allocated LCH Practitioner. Mum accepted that the request had been made to help inform her decision making. It also raised awareness of the practitioners supporting her enabling them to offer more support if needed. Mum shared that she felt safe and understood why practitioners might be concerned. The LCH practitioner also liaised with the Family Outreach Worker, who planned on-going support to mum.*

*The one call to LCH Safeguarding Children’s team resulted in both mum and professionals being in a more informed place to safeguard mum and baby. The scenario demonstrates several practices that support safeguarding children. It demonstrates appropriate information sharing, appropriate use of LCH safeguarding children team, support, and appropriate guidance in seeking a Claire’s Law application, appropriate consideration of the needs of an unborn child and potential vulnerabilities of mum. It demonstrates professional curiosity and multi-disciplinary working. It highlights domestic violence and abuse (DV&A) and considers impact of DV&A on the child; it reiterates the importance of information sharing where there is a need to safeguard. For me as Named Nurse this sequence of events overall demonstrates good safeguarding children practice and is something that is part of the daily duties within the children’s safeguarding team in collaboration with LCH services.*

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**Children Looked after and Care Leavers**

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| **Key achievements 2023-24:**   * Review Health Needs Assessments (RHNA) delivery continues to meet Key Performance Indicators (KPI’s) and National performance targets, with audit indicating high standard of health assessments. This is despite every service delivering RHNA’s being under tremendous capacity pressure. * Maintaining the delivery of training to those supporting Looked After Children at level three standard as per the Intercollegiate Document 2020. * Looked after children and care leavers health needs are seen as a priority population in Leeds. |
| **Key ambitions 2024-25**   * To gain consensus that Leeds looked after children and care leavers can expect a similar level of healthcare and support offered in other places across WYICB, to ensure we can work effectively to begin to reduce the health inequalities they experience. To have the start of a transition plan to move towards this. * To have developed and begun to deliver on a cohesive city-wide health plan for CLA care leavers that plans to deliver the CYP plan for Leeds, Leeds corporate parenting strategy 24-27 and implement recommendations from “Understanding the health needs of children who are looked after in Leeds”. * To improve LCH’s ability to provide the Initial Health Needs Assessment to inform the planning at the first childcare review, in line with statutory requirements. * To work with our young people in care and care leavers to give them a voice and influence in health service provision. * To ensure statutory training from level one to five, Intercollegiate Document 2020, is accessible for all staff needing this. * To meet key targets for health for immunisations and SDQ’s. * To explore outcome-based service targets in addition to inputs and activity-based targets. |

**Areas for improvement:**

* IHNA delivery continues to be on the Trusts and WYICB risk register as the delivery is not within statutory timelines.
* The impact of CLA capacity continues to be on the Trusts risk register. CLA Specialist Nursing Team Capacity will continue to be critical until team expansion is in place. Plans are in place to support the team until then.
* Identification of health needs and health outcomes for children placed in other authorities and in residential settings.
* SDQ completion for 11–17-year-olds and immunisation take up rates for the 13–17-year-old looked after children.

**Future planning 2024-27**

* There are discussions taking place between WYICB Leeds commissioners and public health commissioners regarding the future completion of RHNA’s for 0–12-year-old looked after children living in Leeds. This could have implications for the Specialist Nurse CLA team case load and capacity needs.
* A service development document and options appraisal for the Looked After Children Specialist Nursing Team was completed March 23. Following this the CYP Population Board commissioned work to map out health service provision and need for the looked after children population in Leeds with a brief to deliver recommendations for improvement. This was completed and presented to the CYP Population Board in January 24. 20 recommendations were made. These have been prioritised and a plan is being developed for implementation.

**Annual Report**

This is the annual looked after children and care leavers report 2023-24 for Leeds Community Healthcare (LCH), covering the period form 1st June 2023 to 31st May 2024. It forms part of Leeds assurance arrangements in relation to services delivered to Leeds children placed in and out of Leeds and children placed in Leeds by other local authorities. It reflects the priorities set out in the Looked After Health Team Service Level Agreement, “A child of Leeds” Leeds Corporate Parenting Board Strategy 2021- 2024, and The Looked After Children and Care Leavers Health Improvement Plan. The primary objective is to ensure that all looked after children and Leeds care leavers are supported to improve their health outcomes.

Each child and young person will have a unique journey into care, the most common reason for becoming looked after is abuse or neglect (65%). These are major adverse childhood events (ACEs) which can cause trauma. Most children in care will have experienced a minimum of 4 ACE’s, this is linked to significant health inequalities.

**Leeds Looked After population:**

The demographics of looked after children in Leeds has changed significantly over the past 6 years and is predicted to continue to change. As of 31/03/24, 1548 children where in care and looked after by Leeds Local Authority, an increase of 300 over the last 6 years. Additionally, there are 254 children placed in Leeds by other authorities.

1,238 CLA live in Leeds. Leeds City Council also place children and young people in other authorities; 564 live in other authorities with 141 of those being placed in external residential settings. These are some of our most vulnerable children and young people, the majority meeting the criteria for complex care needs under continuing healthcare funding.

**LCH Looked After Children Health offer.**

LCH are commissioned to provide one WTE (whole time equivalent) Designated Nurse for looked after children and 0.2 WTE Designated Doctor. The Specialist CLA nursing team consists of one WTE Professional lead nurse and 4.9 Band 6 Specialist nurses. This team have responsibility for all looked after children living in Leeds who are in year 9 school year up until when they reach their 18th birthday or cease to be in care (or 19th if they have an EHCP (Education Health and Care Plan)). They are commissioned to see all children regardless of age who are living in the other WYICB places, for Review Health Needs Assessments (RHNA’s) and to monitor/coordinate the delivery of their health plans. Additionally, they have responsibility for oversight of all looked after children placed beyond the WYICB area and should monitor/coordinate health plan delivery. They are also commissioned to provide as service to care leavers. The 0-19 team currently complete RHNA’s for all looked after children from birth up until the end of school year 8 who live in Leeds and the Inclusion Nurses complete assessments for CLA attending SILCs (Specialist Inclusive Learning Centres). Integrated Children Additional Needs (ICAN) services are commissioned to carry out all Initial Health Needs Assessments (IHNA’s).

**Performance v targets**

Table one showing performance against targets and key health indicators.

* The completion of IHNA’s in a timely manner to meet either statutory or local KPI targets continues to be a challenge. Considerable effort has been invested in systems working to improve timely requests for IHNA’s, this work is ongoing. WYICB Leeds is to provide cost pressure monies to support extra clinics to reduce the backlog of appointments.
* The completion of RHNA’s remains high across Inclusion Nursing, PHIN’s and the Specialist Nursing team for CLA. This work has been prioritised by the Specialist Nursing team, and only statutory work has been completed over the past year. This is in line with risk assessment analysis and Business Continuity Plans for the team.
* The Strength and Difficulty Questionnaire (SDQ) is an evidence-based tool used to assess children and young people’s emotional and mental health. National guidance is that all looked after children and young people over the age of 4 have SDQ assessments, which should inform the health assessment. Nurses completing RHNAs are required to facilitate the completion of SDQ for all looked after children between the ages of 11 and 16. In quarter one 56.6% were completed, this fell slightly in quarter four to 56.4%.
* LCH has a target of 85% of looked after children’s immunisations being up to date, which is in line with the national schedule. 75.5% were fully immunised in Quarter one 2023 and 76.5% in quarter 4, showing little change. When we look at different cohorts, 91.8% of under fours, 83% of 5–12-year-olds and 67.8% of 13 -17-year-olds had up to date immunisations at the end of quarter 4.
* In quarter one 87.6% of children had an up-to-date dental check (a check in the last 12 months) this increased to 89.1% in quarter four. When we look at different cohorts, 98.6% of under fours, 90.4% of 5–12-year-olds and 80% of young people aged 13-18 had an up-to-date dental check at the end of quarter four.
* The percentage of children and young people having met key health indicators are lower for the 13 plus population, which is reflective of the capacity issues the Specialist Nurses CLA have been facing. The commitment to fund extra capacity for this team will ensure this can change in the future.

**Quality Assurance.**

Two new audits were conducted over the past year, focussing on children placed in other authorities, as this is an area of concern recognised nationally and locally.

* Audit of timely record reviews 23, which highlighted that reviews were not being consistently reviewed.
* In depth complex case, multi-agency audit February 24, which gave clear indication of improvements needed to meet the needs of these children and young people.
* Monthly reports are produced showing performance against Key Performance Indicators.
* Health Needs Assessments (HNA’s) completed out of area are audited for quality against national standards.
* HNA’s completed by LCH practitioners are audited every 2 months, with all services audited at least Once a year. This allows any issues around slip in standards to be addressed quickly. Individual practitioners are given feedback for exemplary HNA’s and when the standard needs to be improved. If there is a broader issue within a service, training updates are offered, and the service is re audited in the coming months.

These reports and audits tend to measure inputs and not outcomes for children and young people. The Multi Agency audit of children with complex needs highlighted that we need to improve outcomes to meet the health needs of this cohort.

**Foetal Alcohol Spectrum Disorder (FASD)**

Last year’s annual report highlighted the higher incidence of FASD in the Looked after children population and the need to develop improved diagnostic and support services in Leeds. Work is currently being undertaken by the SEND Board to examine how the Neuro diversity Pathway can be improved, which includes exploration of provision for FASD.

**Unaccompanied Asylum-Seeking Children (UASC’s)**

Leeds continues to be a welcoming host for unaccompanied asylum-seeking children There has been a significant increase in the numbers coming to Leeds in the last 12 months, in line with Home Office revised guidance. There are no extra monies for health, consequently health care must be sourced from current resources.

**Care Leavers**

As of 31/3/24, Leeds Children’s social care services offer support to 690 care leavers, 38 of whom have a recognised disability, 69 are parents and 205 are former UASC’s.

The Care Leaver Hub at Archway, Roundhay Road, Leeds was delayed in opening, but began offering care leaver services from the beginning of March 2023. This Hub offers support to Carer Leavers 18-25. There is a creche for children, cooking and washing facilities and leisure activities where young people can connect with others. There is a recording studio and pool tables and therapeutic quiet rooms which care leavers can utilise. There has been a great deal of discussion about health’s offer to this project, which can be revisited considering the proposed increase in capacity to the service.

Discussions are underway to explore a care leaver offer from maternity services, consulting with care leavers to ensure coproduction.

Consideration across Leeds health system is needed to explore what Care Leaver protected status means to health.

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**SUDIC (Sudden Unexpected Death in Childhood)**

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| **Key achievements 2023-24:**   * Maintained and facilitated the SUDIC process in Leeds to a high standard. * Stabilised the team following periods of long-term absence and staff changes. * Continually reviewed systems and processes to support practice. * Accessed the online, basic training modules developed as a national training programme * Delivered with West Yorkshire Police (WYP) partners a biannual SUDIC training event to support professional development. * Led with WYP partners, the sharing and standardising of regional SUDIC practice via the Child Death Peer Network (this has replaced the SUDIC Strategic Reference Group). * Attended national Child Death professional network meeting to share and learn from practice across the country * Developed a new SystmOne SUDIC template to better support CDOP data collection. * Established a relationship with Child Bereavement UK in relation to the family support they can offer following a SUDIC |
| **Key ambitions 2024-25:**   * Maintain the high standards of service delivery achieved in previous years and continue to develop practice. * With WYP partners, continue to deliver biannual professional development events to support practice development. * Continue to develop and expand the regional Child Death Peer Network * Team members will access regular psychological support to assist with maintenance of mental wellbeing. * Identify additional medical cover to support maintain SUDIC service delivery throughout the year. * Develop and embed partnership working with CBUK to ensure families are supported and guided through the bereavement stress and trauma which accompany the sudden or unexpected death of a child. |

This report provides a summary of the activity of the Leeds Community Healthcare NHS Trust (LCH) Sudden Unexpected Death in Childhood (SUDIC) Rapid Response Team for the period April 2023 – March 2024.

***‘The death of a child is a devastating loss that profoundly affects all those involved. The process of systematically reviewing the deaths of children is grounded in respect for the rights of children and their families, with the intention of learning what happened and why, and preventing future child deaths’.***

Working together to safeguard children - GOV.UK (www.gov.uk) chapter 6.

Working Together to Safeguard Children (2023) sets out the framework within which the statutory child death review partners (i.e. the Local Authority and the Integrated Care Board) arrange to review the deaths of children. The immediate response to an unexpected child death, the Joint Agency Response (JAR) is facilitated by a multi-agency partnership under the aegis of Leeds Local Safeguarding Children Partnership (LSCP). The LCH SUDIC Team is responsible for facilitating the statutory JAR, also known as the SUDIC Process, when the death of a child, (under the age of 18 years) normally resident in Leeds occurs that:

• is or could be due to external causes

• is sudden and there is no immediately apparent cause (including sudden unexpected death in infancy or childhood)

• occurs where the initial circumstances raise any suspicions that the death may not have been natural

• occurs in the case of a stillbirth where no healthcare professional was in attendance

Following the Royal College of Paediatric Child Health, Sudden and Unexpected Death in Infancy and Childhood: multi-agency guidelines for care and investigation (2016*)* the LCH SUDIC team work together with the relevant agencies to respond to child deaths in a thorough, sensitive and supportive manner.

The objectives are to:

*• establish, as far as is possible, the cause of the child's death*

*• identify any modifiable contributory factors*

*• ensure the provision of ongoing appropriate support to the family*

*• learn lessons to reduce the risk of future child deaths and promote the health, safety and wellbeing of other children*

*• ensure that all statutory obligations are met*

LCH SUDIC team consists of medical, nursing and administrative staff who are responsible for the co-ordination of the SUDIC process for the city. The team is also supported by LCH Child Safeguarding colleagues when required. Reports on the circumstance of the child’s death are provided by the team to His Majesty’s Coroner and Leeds LSCP Child Death Overview Panel (CDOP). SUDIC activity is reported into the LCH Child Death Review Group and LCH Performance Monitoring who further report to the West Yorkshire Integrated Care Board (ICB).

**SUDIC Activity:** Between April 2022 to March 2023 there were 31 deaths of children normally resident in Leeds which met the SUDIC criteria. Some comparative data is set out in the tables below:

**Table 1 Table 2**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Under 1yr | Under 5s | 5-12 | Teenage | Number |  |  | Male | Female | Number |
| 2021/22 | 5 | 2 | 2 | 3 | 12 |  | 2021-22 | 8 | 4 | 12 |
| 2022/23 | 10 | 7 | 5 | 9 | 31 |  | 2022-23 | 19 | 12 | 31 |
| 2023/24 | 6 | 5 | 2 | 4 | 17 |  | 2023-24 | 10 | 7 | 17 |
| Total | 21 | 14 | 9 | 16 | 60 |  | Total | 37 | 23 | 60 |

Thankfully, the number or sudden or unexplained deaths of children in Leeds remains a small subset of the child population; with children under 1year tending to be the most vulnerable and boys being more susceptible than girls. No single cause of death predominates, but road traffic collisions and unsafe sleeping arrangements are recurrent themes.

The number of SUDIC cases in 2022-23 (31) is anomalous, though anecdotally in keeping with the experience of other areas regionally and nationally. Speculative attributions have been made to increased deaths from infection e.g. invasive group A streptococcus, following emergence from Covid-19 “lockdown” periods, but scientific data or research is yet unavailable to account for that tragic surge.

The SUDIC process has been completed for 9 children who died during 2023-24. Post-mortem reports, Final Meetings or Child Death Overview Panel (CDOP) meetings remain outstanding for the other 8 children.

**SUDIC team visits to the scene and the child’s family**

Integral to the Joint Agency Response are the visits made by the SUDIC team to the scene of the child’s final collapse and/or death (if it occurred out of hospital) and to the family to obtain as much detail from them as possible. The visit to the family is also an opportunity to assess for any immediate support needs of the family and to explain our roles in finding out, if possible, more about why their child died.

Where appropriate, home or scene of death visits were carried out by the team for all the children who died during 2023-24. Ideally these occur within 24-48 hours of the child’s death; this is not always achievable due to the work pattern of the SUDIC team (Monday – Friday, 08:30 – 17:00), the need to be guided by any police investigative parameters and the wishes of the child’s parents.

The response timeframe for the visits carried out is set out below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SUDIC Visits to Family 2023-24** | | | | |
| **24-48 hours** | **48-72 hours** | **over 72 hours** | **No visit** | **Total** |
| 5 | 5 | 3 | 4 | **31** |

**Initial SUDIC Meetings & 28 Day Reports**

The initial meeting seeks to establish the circumstances of and, if possible, the reasons for the child’s death, consider the immediate needs of all family members, and contribute to the identification of any learning about how best to safeguard and promote children’s welfare in the future.

Initial multi-agency meetings were held for all 17 of the Leeds childhood unexpected deaths occurring during 2023-24. This is consistent with performance over the preceding two years.

During 2023-24, 28 Day Reports to HM Coroner have been provided by the SUDIC Consultant for 17 of the deceased children.

**SUDIC Final Case Discussion Meetings & Final Reports**

Final meetings have been held for 10 of the 17 children who died during the 2023-24 period and reports have been provided to HM Coroner and the Child Death Overview Panel (CDOP).

The SUDIC Team are awaiting the Post-mortem Reports for 7 of the children who died during 2023-23. Final Case Discussion meetings will be convened once the PM Reports are available.

**Governance**

The SUDIC Team are members of the Leeds Safeguarding Children Partnership Child Death Overview Panel(CDOP) which is a statutory group.

The responsibility of CDOP is to review information in relation to the deaths of all Leeds children. The CDOP review seeks to establish whether any modifiable factors were identified in relation to the child’s death and to make recommendations accordingly. Following review, a summary of information is submitted to the National Children’s Mortality Database by the CDOP Administrator.

The LCH SUDIC Team is responsible for providing the SUDIC reports for each child to the Leeds CDOP and ensuring that any relevant recommendations made by the panel are fed back to LCH Child Death Review Group.

**LCH Child Death Review Group**

The SUDIC Team are members of the LCH Child Death Review Group.

All SUDIC deaths are reported into the LCH Child Death Review Group along with the expected deaths of children under the care of LCH services.

The deaths are reviewed with the aim of ensuring that a critical appraisal of LCH input is carried out and where necessary, action is taken, and lessons learned. CDOP recommendations relevant to LCH services are communicated through this group.

Information from this group is reported to the LCH Mortality Review Group which provides assurance to the LCH Trust Board.

**Process & Performance:** The work of the SUDIC Team is reported into LCH Performance systems and to the ICB monthly. Actions related to SUDIC processes are captured within the Safeguarding Teamwork plan which is governed within the Safeguarding Committee.

Tailored psychological support to the team has been procured externally, however this will be provided internally 2024-25 onwards. This is a much needed and appreciated support to the team.

**SUDIC Process Awareness Raising:** An online “Child Death Review Processes in Leeds” learning package has been offered via the Leeds LSCP training programme. This gives practitioners across the multi-agency partnership an opportunity to gain some basic understanding of the SUDIC process.

Biannually, a one-day training event facilitated by West Yorkshire Police and the, SUDIC Paediatricians is delivered to ensure local and regional processes are well understood by all those involved, particularly in those areas where there may be significant turnover of staff, e.g. Emergency Departments.

**Family Engagement:** This has remained a key priority. A leaflet is given to grieving families which sets out brief details of the SUDIC process in accessible language, contact details for the team, information on how to give feedback and how we use and look after personal information. Families are also given leaflets detailing a range of bereavement support groups including the Community Bereavement Service offered by Martin House Hospice.

During 2023-24, discussions took place with third sector colleagues in Child Bereavement UK (CBUK) resulting in the establishment of a relationship which will enhance the support families receive, ensuring there is someone available to guide the family through the whole process, from the initial shock of bereavement through to the coroner’s hearing and beyond should they wish it.

The post, which covers West Yorkshire, has been funded by CBUK and another charity acting in support of bereaved families, Elliot’s Footprint. Throughout 2024-25 we will continue to build on this relationship to enhance service delivery to the families of Leeds experiencing the sudden or unexpected death of a child.

**Review of links with partners:** The SUDIC Team has maintained links with the national Child Death Peer Network, formed from teams across England. The virtual meetings give participants an opportunity to share practice, discuss common issues and creates the potential to influence local and national practice.

The Leeds SUDIC team, alongside West Yorkshire Police leads on the development and delivery of our regional training programme and regional peer network.

**Partnership working and actions related to identified modifiable factors:** Where necessary SUDIC cases are taken forward by the Named Nurse for Safeguarding Children for consideration by the LSCP as a Child Safeguarding Practice Review (CSPR).

The SUDIC team also draw early attention to any modifiable factors CDOP members may need to action as there can be considerable delay between a child’s death and case discussion at CDOP.

**Conclusion:** 2023-24 has seen the SUDIC team stabilise and coalesce into a strong interdependent unit; this has enabled us to reflect on the team’s success whilst continuing to develop practice internally; across the multi-agency Child Death Review Partnership; and to look at developing new partnerships to continually enhance the service offer made to grieving families.

The SUDIC Team would be unable to carry out their work without the support of colleagues within LCH and across a wide variety of partner agencies; we are grateful for their professional and caring support of bereaved families as well as their co-operation with, and their contributions to this important work.

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**Learning Disabilities**

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| **Key achievements 2023-24:**   * Development of the LD workplan through recruiting a project manager * Development of the LD Hub- internal intranet page for staff to access information and guidance relating to LD. * Ask Listen Do * Development of the accessible complaints form & close working with the ‘Ask Listen Do’ champion to help make the complaints process more accessible and user friendly for people with LD. * Development & roll out of Easy Read COPD “keeping me well” booklet. * Development of the “what makes good care” flow chart. * Reasonable adjustments made to mortality process. * End of Life mapping of accessible documents * Increasing accessible information across the Trust * Commenced implementation of The Oliver McGowan Mandatory Training in Learning Disability and Autism * Awareness raising sessions. |
| **Key ambitions 2024-2025:**   * To support the implementation and identification of the Reasonable adjustment flag. * To review how we can identify people with a Learning Disability, for services that do not use system 1 * Participate in all benchmarking Networking events and support improvement specifically as a specialist organisation. * To Support the roll out across the city of phase 2 of The Oliver McGowan Mandatory Training in Learning Disability and Autism * To continue the development of easy read material * To analyse the data for those with a learning disability and review what is required. * To analyse the data from incidents, complaints, and concerns to identify themes for learning, and areas where improvements are required. * To Audit the use of sensory boxes in services and whether this improves outcomes and experiences. * To Audit the mortality process for those with a Learning disability, to gather areas of good practice and any learning. |

This is the first annual report completed to highlight how the organisation is improving care for those with a learning disability (LD). The Named Nurse for Learning disability is now part of the Safeguarding team. This aligns with other Learning disability Leads and / or teams across west Yorkshire giving assurance through safeguarding structures that care and improvements are made.

The Named Nurse for Learning Disability has a role that is key in supporting the organisation to deliver the trust goals to the people who have the highest inequalities in accessing health care. Ongoing development of this role is vital, and the organisation has supported the named nurse to complete the PG cert in learning Disability and /or Autism, and then continuation to become an Advanced Clinical Practitioner. To ensure improvements in care continued a project manager was appointed on secondment for 15 months.

Improvements are made through participating and compliance with the learning disability improvement standards for NHS trusts and learning from the lives and deaths of people with a learning disability and autistic people (LeDeR). Both are national quality improvement initiatives.

# The learning disability improvement standards for NHS trusts were developed by people with a learning disability, their families to state what is expected from the NHS. The four standards concern:

* respecting and protecting rights.
* inclusion and engagement
* workforce
* learning disability services standard (aimed solely at specialist mental health trusts providing care to people with learning disabilities, autism or both)

The organisation has participated in the NHS Benchmarking which gathers baseline information from providers on their compliance with the standards, the views of staff and people who use NHS services.

The LeDeR programme was set up as a service improvement programme to look at why people are dying and what can be changed both locally and nationally to improve the health of people with a learning disability and reduce health inequality.

LeDeR works to:

* Prevent people with a learning disability and autistic people from early deaths.
* Reduce health inequalities for people with a learning disability and autistic people.
* Improve care for people with a learning disability and autistic people.

A detailed project plan has been produced through the appointment of a project manager for Learning disability. This has ensured focus, review and highlighted success in a consistent manner giving assurance that we are improving care for those with a learning disability across our organisation and working in partnership across the city and region.

LCH continues to work across the city and across the west Yorkshire region. The Named Nurse for LD is an active member of both citywide and regional groups.

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| **Key Achievements: 23-24** |
| **Development of the LD workplan through recruiting a project manager**  The LD workplan is an incredibly detailed document based around the Learning Disability Improvement Standards and learning form LeDeR. This is a newly created tool, which captures all activity and progress made because of outcomes and findings from benchmarking. This ensures a focused approach to quality improvement capturing success and outcomes.  **A screenshot of a website  Description automatically generatedDevelopment of the LD Hub- internal intranet page for staff to access information and guidance relating to LD.**  Development of LD Hub is a useful online platform where staff can access up-to-date and relevant information, guidance, easy read documents, and links to useful resources. This will improve the quality of care for people with an LD by equipping clinical and support staff with information, advice, templates, leaflets, and documents that can help them provide better care to people with LD in their everyday practice. To date, the LD Hub and pages contained within it have amassed over 1100 views.  **Ask Listen Do (ALD)** is about making it easier for people to give feedback, raise a concern or complain about their health care. This improves lives, the services people receive, and it helps to keep people safe. A presentation was produced to increase awareness, which included a video for the engagement team to ensure they understand the principles of Ask Listen Do. A Patient Engagement Team (PET) officer will be the champion for ALD and the PET will now lead this initiative. This has ensured all members of the engagement team improved their skills and knowledge on the initiative.  **The complaints form** **was reviewed**, and an adapted process was identified including an accessible form for people with LD This will be reviewed by the Learning Disability Project Manager and evaluated. It will ensure that patients with LD and those who may have limited comprehension or difficulty understanding complex language, find it easier to engage with the complaints process, understand this and know what to expect. It also empowers the staff and patient experience officers who are handling the calls to support people with reasonable adjustments.  **Development & roll out of Easy Read COPD “keeping me well” booklet**.  The COPD easy read document which has been rolled out for use within community respiratory and nursing services is a way of helping people with an LD or their carers to be more proactive in their care, understand their early warning signs and know when to escalate/ seek further advice, care and treatment. This is a fantastic way of ensuring people are equipped with information in an accessible format which is easy for them to understand.  The person this was made for said, **“Normally I would pass letters to my wife, but I like the pictures on it, and I can understand it better than the normal leaflet. It's better and I like the big writing”.**  A diagram of a disability  Description automatically generated**Development of the “what makes good care” flow chart.** A flowchart was developed as a direct result of LeDeR outcomes and findings from the LD standards benchmarking. This is to support staff when working with people with a learning disability. It is currently on the LD Hub and is uploaded as a separate document so staff can download and print it. The process can be followed when working in all services and has headings that can be used when reviewing care under the mortality process. It highlights key areas for staff to consider that if followed will support the person with a learning disability to access health care, feel listened to and offered any support they need to achieve the best outcomes possible.  **Reasonable adjustments made to the mortality process.**  Following a review of the trust’s mortality process it was noted that if a person with a learning disability and/or Autism dies after 24 hours of being admitted to hospital we do not review care. Changes have been made to the process and for the next year, when someone dies, the teams should review every death of a person with a learning disability and/or Autism, even if they died in hospital to ensure learning is identified. The Learning Disability Lead will then review for themes and consider any areas where improvements can be made.  **End of Life mapping for accessible documents**  Working across the city work has commenced to review end of life care documentation. This has included mapping what is available for all people and then ensuring easy read versions are available or in process. This document will then be available for all staff to use and ensure person centred accessible information is available.  A group of white speech bubbles with black text  Description automatically generated**Increasing accessible information across the Trust**  The Project manager has increased accessible information across the trust. A branded easy read template was developed and is being used to create accessible information for services across LCH. We have 6 live documents and 28 are in production. Documents are completed in conjunction with staff and are taken to groups for people with a learning disability, to ensure the documents are fit for purpose. Any feedback is acknowledged, and amendments are made accordingly. People have expressed their appreciation, about being asked for their opinion.  **The Oliver McGowan Mandatory Training in Learning Disability and Autism**  The E learning element of The Oliver McGowan Mandatory Training in Learning Disability and Autism was mandated across the trust for all staff, compliance and feedback is very positive. The organisation continues to be involved in how the city will implement the Face-to-Face element of the training.  **Awareness raising**  Presenting at events both within LCH, the city and the region ensure staff who support people with a learning disability are aware of the support available to them, it can include peoples experience, culture, how care should be, access to care and sharing of improvements.This year has included attending the matrons conference, west Yorkshire school events, clinical forums within the organisations, preceptorship events and the launch of LD champions and newsletter. The topics covered can include the offer of consultation and accessible information, the improvements made, the health needs of people with a learning disability, health passport and annual health checks.  **Feedback from a preceptorship event:**  *‘It is such a refreshing change not having a PowerPoint and having the opportunity to have*  *an open and honest discussion.’*  ‘Never really had any training around LD prior to this session.  Will feel more confident now  when I care for a patient with LD.’  **‘The statistics mentioned around poor health outcomes for people with LD was sad and**  **shocking.  Knowing this will help me think about the bigger picture when dealing with patients’**  **who have LD.**  Knowing about the easy read leaflets was interesting and useful.  **Benchmarking**  The organisation participates in many areas of Benchmarking but specifically two associated with people with a learning disability. The learning disability Providers was a new Benchmarking exercise for LCH.  **Mental Health, Learning Disability and Autism (MHLDA) indicators**  The project benchmarks data in many areas of care, it includes data, staff survey and a survey of those accessing our services with a Learning Disability  **Learning Disabilities Providers**  This project benchmarks data for all specialist providers of learning disability and autism services. LCH provide specialist support to children with a moderate and severe learning disability.  Through participating in these projects areas of improvement are added to the Learning disability action plan.  This year, we achieved full return on the staff survey (150 responses in total). This was met with congratulations at a benchmarking event, and we were asked how we achieved this. The benchmarking project managers said they would love to write a story on what we have achieved to share with people participating in the programme and nationally.  **Clinical Consultation**  Clinical consultations are available to all staff across the organisation. Over the past year, this has included advice via email, M S Teams, attendance at meetings / clinical appointments and joint visits when required. The Named Nurse for LD supported a young male and their family with other members of the team during an acute situation which required high level of skill, knowledge, leadership, and expertise over a 6-week period requiring flexibility of the role. Consultations over the year have resulted in staff having increased knowledge, quicker access to specialist services, ensuring legal processes are followed and care is safe, effective, and responsive.  ***‘We brought cases to discuss where there have been concerns regarding Learning Difficulties, Learning Disabilities, Neurodevelopmental Difficulties, Cognitive impairment, or cases that have felt stuck to reflect and consider next steps.  We have been able to use the consultation model to inform our clinical practice, develop our practice and increase awareness of services available to the teams we support. This has been valued by the team attending the consultation, the staff we support through case catch up in the youth offending services and the young people that are involved with the Youth Justice Service.’***  ***“We both wanted to thank you for your commitment, care and professionalism”.*** |

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**Specialist Child Protection Medical Services (SCPMS) June 2024**

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| **Key achievements 2023-24:**   * The staffing has been better and for the last 6 months I have been a ‘floating’ consultant to cover some of the leave. There have still been a few gaps but better than it was. This has been improved by one colleague doing weekly CP sessions. * Continued to improve our interaction around strategy discussions and Child Protection. * Continued to engage in regional peer review and Named Doctor regional meetings * Maintain strong links with the LCH Children Looked After and Safeguarding team * Continued to develop the working relationships with acute paediatricians in LTHT * Increasing engagement in strategy meetings and case conferences where child abuse or neglect is suspected – many by remote access e.g. teams. * Involvement with the Risk and Vulnerability Subgroup of Leeds Safeguarding Children Partnership regarding child victims of Female Genital Mutilation. We also provide an FGM assessment to several other authorities. * Attendance at Multi-agency Safeguarding Operational Group (MASOG) by Named doctor to look at operational processes for community paediatrics, police and social care * Majority of team members now trained on ALSG Child Protection Recognition and Response course * Named doctor is increasing networking between the Named and Designated doctors for other areas and across Leeds. * Named Doctor joined a national named doctor group set up during lockdown. This continues to run but less frequently- attended irregularly * Named Doctor– continued to deliver training to a range of professionals – social worker, education, police and health including GPs, also front door team. * RCPCH key standards for CP medicals audited- we did extremely well and only have a few areas to improve, mainly leaflets for families etc, feedback from social care etc. see attached with report. * It was recognised that security around child protection, adoption and fostering clinics was not in place. There is now a security guard in place daily to cover these clinics. There have been some challenges with this, but it has led to staff and the dept feeling safer in this high-risk environment. | |
| **Key ambitions 2024-25**   * Have a full complement of doctors including enough to ensure there is cover for annual and study leave. * Ensure we have extra Peer review sessions as the increased numbers of cases has led to us being delayed with our sessions, at one point up to 4 months behind, this has improved recently to 2 months. We do ~6 cases per hour, need 71 hrs per year, currently 58 hrs. having some extra longer sessions to catch up and stay on top of this. * Re-establish our psychology support as the previous psychologist left. * Apply for SARC service again. - Commissioning process starting in next months. * Undertake our first CPRR course- planned for October. * Named Doctor involved in developing new Safeguarding training for paediatric trainees through the region due to significant change from current provision. * Address the gaps from our RCPCH audit along with the LGI team, shared leaflets etc. | |
| **Who are we?** | | **What are we proud of?** | |
| 10 community paediatricians,  band 5 nurses,  1 play therapist and a health care support worker,  2.8 admin staff and  1 clinical services manager  Part of ICAN (Integrated Children with Additional Needs) services.  commissioned by Leeds CCG | | Providing a daily **senior doctor led** clinic to see children  (0-18) referred for all forms of child abuse  **Trained and skilled administrative staff**to take referrals from 09:00-17:00 on weekdays  **Compassionate, highly skilled nursing staff** to chaperone and support families & medical staff in clinic  Clinical work underpinned by **peer review and supervision** to challenge practice & offer support  **Dedicated team**, who show great strength and resilience to rise to the many changes this year  Continuing to provide **medical training** in child protection  **information sharing** and working together to safeguard children  **Monthly governance programme** for continuing professional development and links with the regional peer review programme. | |

**What we did in 2023-2024**

* The team saw 446 children between April 2023-March 2024. This is an increase on the number of children we saw in the previous year for referrals (previous year 444 referrals). We continue to see cases that would have been seen by LGI but were redirected to us on the new SOP.
* 69% physical abuse; 13 % neglect; 4% anogenital examination for medical issues or Female Genital Mutilation, 13% siblings of index children. Clearly many of the children would have neglect alongside the physical abuse. We noted the neglect cases have significantly increased in the last few years, see chart below, likely due to the impact of austerity and Covid. We also saw 35 children for follow up, this is a significant increase and is due to the unmet health needs of the children and needing to review them.
* We aim to provide child protection medical reports to Social Care in 4 working days. Performance has improved over the last year, approx. 60% (previously 28%) reports sent within 4 days to social care. The main delay is with the Drs providing the reports to be typed up or checking theirs or a trainee’s report.
* Clinical governance sessions have been well attended face to face. Sessions to discuss departmental safety for staff led to a change in staffing. A journal review looking at hyperpigmentation post injury and the research. Multiagency discussion with police and legal re reports. We had a session on report writing which generated a useful discussion. We undertook a notes audit looking at the proformas.
* Held 51 peer review meetings last year.

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**Conclusion:**

This year we welcomed our LCH Learning Disability lead nurse into the team. We also had some staff movement and are about to welcome a new Named Nurse for Adult Safeguarding and a Specialist safeguarding Adults Nurse. Following a service review the CLA team will be appointing more staff to the team in addition to current staff, to enable them to meet the increasing service need and meet statutory requirements.

The increase in all safeguarding needs across the country is driven by various factors, reflecting societal changes, heightened awareness, and the complex challenges facing vulnerable populations. There is growing recognition of the vulnerabilities within various populations and the importance of protecting those at risk. We work hard to understand the factors contributing to this rise enabling the implementation of strategic responses, to better address safeguarding challenges and ensure the safety and well-being of individuals in need. Enhanced training, improved reporting mechanisms, multi-agency collaboration, community-based support, policy, advocacy, and the use of technology are critical components of an effective safeguarding strategy.

**Key themes** emerging from this report point to the priorities for the team:

* The setting and maintaining of quality standards across all safeguarding.
* Fast effective responses to emerging safeguarding themes.
* Continuous development of training packages in line with emerging safeguarding themes
* The essential development and maintenance of internal and multi-agency relationships and networks to ensure high quality service delivery with safeguarding of vulnerable children and adults remaining at the core of all we do.
* Resilience across the whole (and wider) team
* Flexibility and adaptability of all staff in support of each other

**2024-25** will see the Safeguarding Team:

* Continue to support the self-neglect agenda and raise awareness of non-fatal strangulation
* Continue to support the PREVENT agenda and work alongside other health agencies in Leeds to ensure staff are kept updated and there is a forum for Prevent leads to share concerns and learn from practice.
* Explore a training development platform on Leeds Health and Care Academy with the rest of the health economy with potential to host MCA training resources.
* With the welcome additions to the CLA workforce, plan to developed and deliver on a cohesive city-wide health plan for CLA and care leavers, that plan to deliver the CYP plan for Leeds. Leeds corporate parenting strategy 24-27 and implement recommendations from “Understanding the health needs of children who are looked after in Leeds”.
* Develop and embed partnership working with CBUK to ensure families are supported and guided through the bereavement stress and trauma which accompany the sudden or unexpected death of a child.
* Support the roll out across the city of phase 2 of The Oliver McGowan Mandatory Training in Learning Disability and Autism
* Work towards a full complement of doctors including enough to ensure there is cover for annual and study leave.

To conclude this year’s report, it is important to reflect on a period marked by significant achievements, notable challenges, and profound growth in our health safeguarding efforts. Our commitment to protecting and promoting the well-being of vulnerable populations has driven numerous initiatives, improvements, and collaborations that underscore our dedication to excellence in safeguarding practices.