Royal Berkshire NHS Foundation Trust

Safeguarding, Mental Health & Learning Disability Annual Report 2019/20

Safeguarding & Learning Disability Champion Conference
'Join the Dots' Thursday 21 November 2019, Shaw House, Newbury

Compassionate | Aspirational | Resourceful | Excellent

join the dots

Treat me well

Executive summary

Welcome to the Royal Berkshire NHS Foundation Trust Annual Report for 2019/20.

I am pleased and proud to present a report that demonstrates our commitment to safeguarding vulnerable people. It has been another busy year for safeguarding, mental health and learning disability. Our experienced safeguarding, mental health and learning disability team, provide an integrated and consistent approach to training and supporting staff to meet the needs of vulnerable people. Our single all age family based safeguarding service is in line with national best practice.

The Covid 19 pandemic means we are facing unprecedented challenges to support and safeguard vulnerable people. Following the initial crisis, we are moving to a different stage. Safeguarding adults with care and support needs from abuse and neglect remains a priority. People may be more vulnerable to abuse and neglect as others may seek to exploit disadvantages due to age, disability, mental or physical impairment or illness. During this time of uncertainty, it is particularly important to safeguard children who may be at an increased risk of abuse, harm and exploitation. It is equally important to safeguard families, with parents facing significant pressures to continue to protect and promote the welfare of their children. Parents may already be struggling; with additional pressures the likelihood of harm or significant harm may increase. The relationship between poverty and the safeguarding of children and families is well recognised. During the Covid-19 outbreak, where paid work is threatened or lost or where families are forced to isolate, this risk of poverty increases and challenges the ability of families who would otherwise have managed.

Key achievements:

- The significant amount of daily interagency partnership working to safeguard children, adults and people of all ages with cognitive problems due to mental ill health, learning disability, autism and dementia.
- Effective patient centred collaborative working alongside clinical teams to safeguard our patients
- Training, audit, learning from incidents and review against statutory standards are the foundation of our assurance, reinforced by supervision and management overview.
- We actively participate in the sub groups of the Berkshire West Safeguarding Children's Partnership and Safeguarding Adult Board. Mental Health, Suicide Prevention, Learning Disability, Transition and Mortality strategic partnership meetings. Through participation our safeguarding, mental health and learning disability plans are constantly scrutinised, challenged, renewed and updated.
- The Safeguarding and Learning Disability Conference November 2019 led to the "Treat Me Well" campaign to support patients with learning disabilities in hospital being a Trust Quality Account Priority for 2020/21
- The Safeguarding Team have remained on the Royal Berkshire Hospital site and provided face to face assessments and support for patients, their families and staff in both hot and cold Covid wards and departments
- Our Risk Based Priorities for 2020/21 have been agreed through the Strategic Safeguarding Committee
- **None of this would be possible without the professional curiosity, courage and commitment of our frontline staff and the safeguarding team. I would like to take this opportunity to thank them all for their professionalism, continued support and dedication to safeguarding our patients.**

Patricia Pease, Associate Chief Nurse, Safeguarding, Mental Health and Learning Disability

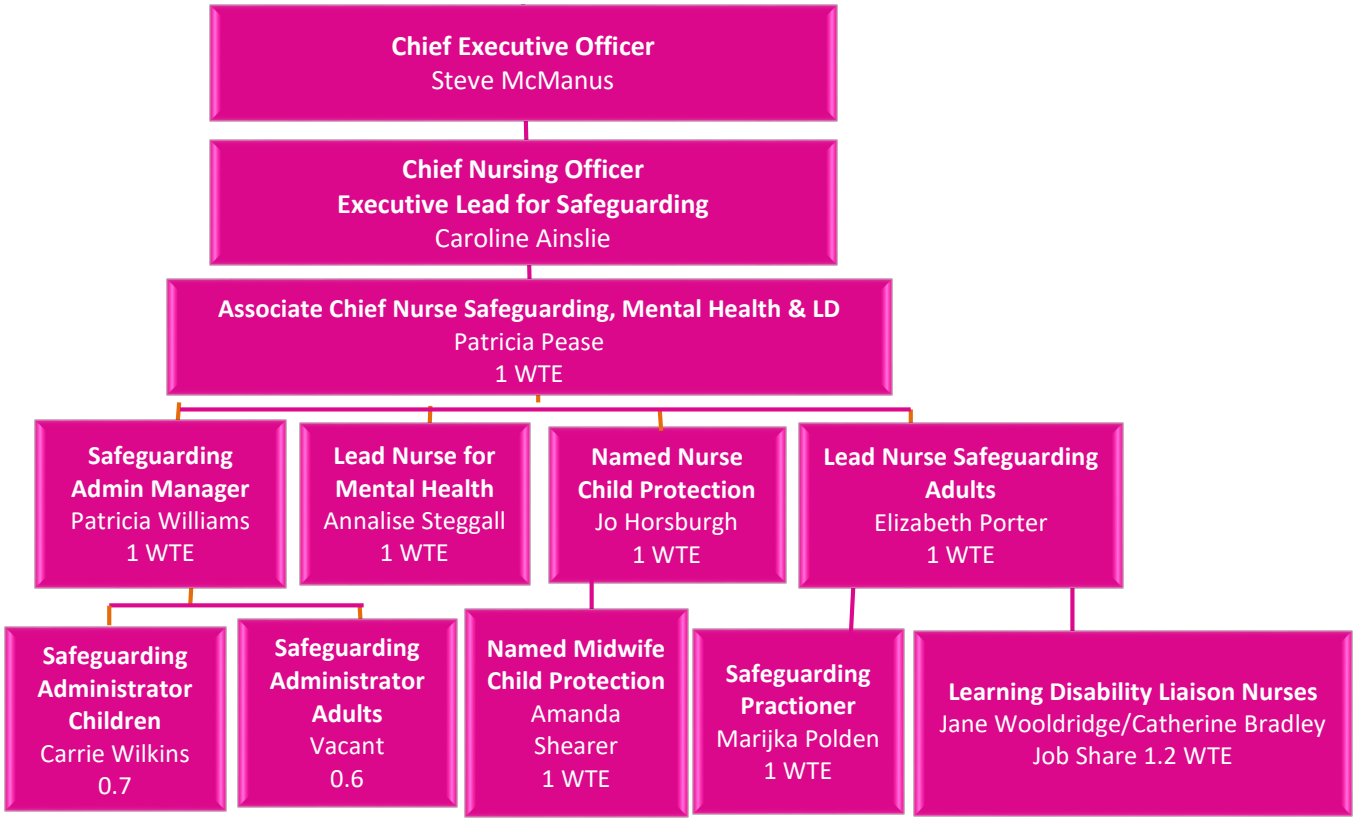
September 2020

Introduction

This report covers all areas of safeguarding, mental health and learning disability work across the Trust and sets out our priorities for further work. Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect (NHSE, 2018). Safeguarding at the RBFT is fundamental to high-quality health care. Safeguarding is everybody's responsibility.

The Safeguarding and Mental Health Team Structure

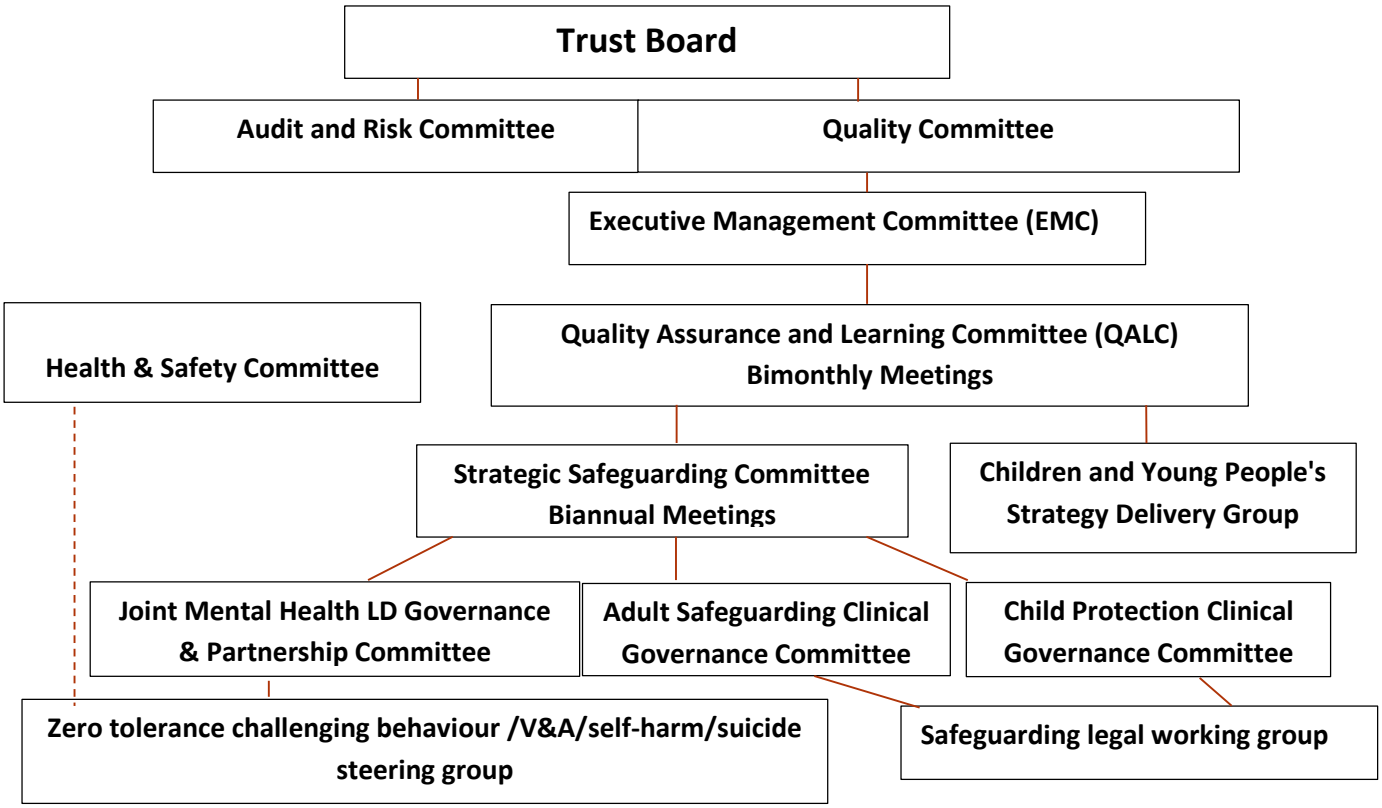
The safeguarding and mental health team structure (nursing and administration) and lines of responsibility and accountability for the RBFT is shown in the diagram below:



Adult Safeguarding Medical Leads:	• Dr Zain Hader: Urgent Care Group • Dr Kim Soulsby: Planned Care Group • Dr Hannah Johnson: Networked Care Group
Adult Safeguarding Matron Leads:	• Georgie Brown, Urgent Care Group • Erin Jarvis, Planned Care Group • Ali Drew, Network Care Group
Child Protection Medical Leads:	• Dr Ann Gordon: Named Doctor for Child Protection • Dr Andrea Lomp: Designated Doctor Child Protection, Berkshire West, CCG • Paediatricians at Dingley Specialist Children's Centre provide Child Protection Examinations • Dr Niraj Vashist: Medical Advisor to Fostering and Adoption Panel
Child Death	• Patricia Pease: Designated Healthcare Professional Child Death Berkshire West, CCG
Sexual Health	• Julia Tassano-Edgecombe: Nurse Consultant
Human Resources	• Suzanne Emerson-Dam: Deputy Director Workforce & OD, Designated HR Officer Safe Recruitment & Allegations Management
Legal	• Sarah Pearson, Head of Legal Affiars

The safeguarding, mental health and learning disability service is accountable to the RBFT Executive Management Committee and Board, Berkshire West CCG, Berkshire West Safeguarding Children Partnership, Berkshire West Safeguarding Adult Board (SAB) and participates in Mental Health, Suicide Prevention, Learning Disability, Transition and Mortality strategic partnership meetings.

Safeguarding and Mental Health Governance Committee Structure



The Strategic Safeguarding, Mental Health and Learning Disability Committee, chaired by Caroline Ainslie, meets twice a year. The Trust has a non-executive Director, Helen Mackenzie, with a responsibility for safeguarding, mental health and learning disability. The safeguarding, mental health and learning disability nursing team meets monthly to discuss operational issues and prepare performance reports; agendas and minutes are kept for these meetings. Safeguarding and mental health quality indicators are reported monthly to the Board and CCG. A bi-monthly safeguarding, mental health and learning disability governance report including key performance indicators is submitted to the Quality Committee of the Board as part of the QALC report. Multi-disciplinary child protection clinical governance is held every two months; chaired by the Named Nurse for Child Protection. Safeguarding Adult Clinical Governance is held every three months chaired by the Safeguarding Adult Lead Nurse. A Safeguarding Legal working group meets, chaired by Sarah Pearson reporting to Safeguarding Adult and Child Protection Clinical Governances. The Associate Chief Nurse, Safeguarding MH & LD chairs a Zero Tolerance Challenging Behaviour, Violence and Aggression, Self-harm and Suicide Steering Group, which reports to the Joint Royal Berkshire NHS Foundation Trust & Berkshire Healthcare NHS Foundation Trust Mental Health and Learning Disability Governance and Partnership Committee and by exception to the Health & Safety Committee. Monthly Safeguarding Concerns and Allegations Review Meetings are chaired by the Designated HR Officer Safe Recruitment & Allegations Management; live cases are reviewed to ensure timely conclusions. At quarterly Safeguarding Review Meetings closed cases are reviewed in order to identify patterns or themes and actions.

The Children and Young People's Strategy Delivery Group monitors work streams to benchmark and improve the quality and safety of Trust services for children: the work of this group has been reviewed and re-launched. In December 2018 an Associate Director for Children & Young People, Kate Egginton was appointed, Kate is leading on developing and implementing a strategy and children and young person's plan that will align with the work of Buckinghamshire, Oxfordshire and Berkshire West (BOB) and Berkshire East and North East Hampshire and Farnham and Surrey Heath (Frimley Health & Care) Integrated Care Systems (ICSs).

Statistics/Activity: The table below sets out indicative statistics for the RBFT for information & background

	2015/16	2016/17	2017/18	2018/19	2019/20	Comment
Population number served	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	
% of population under 18 years	24%	24%	25%	25%	25%	
Number of adult attendances to ED	89,711	94,348	100,324	104,759	111,556	↑ 6.5%
Number of attendances by under 18s to ED	29,087	29,427	28,818	30,495	32,163	↑ 5.5%
No of over 65s attending ED	25,635	27,159	31,133	31,468	35,019	↑ 11 %
No of mental health attendances at ED all ages	2809	2778	3111	3728	3569	↓ 4% CYP ↑10%
Number of adult admissions	90,933	92,791	99,737	102,228	103,730	↑ 1.5%
Number of admissions to paediatric wards	7607	8589	8159	8197	7746	↓ 5.5%
No over 65s who were admitted	39515	39785	41,503	42,190	41,933	↓ 0.6%
No over 75s admitted for >72 hrs	5451	6449	5792	5865	5828	↓ 0.6%
No over 75s admitted for >72 hrs with cognitive issues	1195	1582	553	672	812	↑ 21%
Number of in-patients with a LD referred to LDLNs	315	278	263	226	249	↑ 10%
No of patients admitted because of mental health issues	1596	1610	1710	1841	1611	↓ 12.5 %
Number of babies born	5596	5391	5183	4936	4858	↓ 1.5%
Number of under 18s attending out-patient clinics	62,437	72,539	73,196	73,861	76,207	↑ 3%
Number of under 18s attending clinics providing sexual health services	2356	2059	2032	1663	1859	↑12%
Dingley child protection medicals	120	112	114	143	147	↑ 3%
Number of employees	5360	5470	5531	5431	5014	↓8%

Training

Training is reported monthly to the Board as part of the integrated board report. A Trust annual training plan for child and adult safeguarding 2020 has been completed. On the 6th February 2020 a revised Safeguarding, Mental Health, Learning Disability awareness session was provided as part of junior doctors' induction this was well evaluated. On February 25th a full day level 3 child protection day was well attended and evaluated.

At the end of February 2020 Trustwide Safeguarding training percentages were compliant on MAST with the exception of Child Protection Level 1 training which was 92% against a target of 95%.

On 19th March 2020 all Safeguarding, Mental Health and Learning Disability Training was suspended as part of our Covid 19 pandemic response, however the Safeguarding Team continued to provide face to face case support and learning opportunities in the clinical setting.

All training programmes are regularly reviewed to ensure they include learning from serious case reviews and changes to national policy and guidelines. In 2020/21 there will be a focus on:

- Junior doctors safeguarding, mental health and LD training
- The Emergency and Paediatric Services safeguarding, mental health and LD training
- A gap analysis against current and new standards and a review of existing training methodology that includes virtual class room and digital opportunities developed during Covid, including expanding a 'train the trainer' approach. Aiming to ensure the content of our training is adapted to meet the needs of the organisation.
- The application in practice of the MCA and DoLS
- The training we provide to prevent and minimise challenging behaviour, violence and aggression
- LD/ASD training to support a consistent response to an LD flag or diagnosis 24/7
- Domestic abuse, neglect and self-neglect, prevent/exploitation and concerns and allegations management
- Staff understanding the impact of adverse child hood experiences and the organisation becoming trauma informed
- Professional curiosity, risk assessment, professional challenge and escalation will continue to be included in all of our safeguarding, mental health training and LD training

Safeguarding adults training

All staff are required to undertake safeguarding adults training to the level that their job requires.

Adult safeguarding training has been reviewed following the publication of the Intercollegiate Document: Adult Safeguarding: Roles and Competencies for Health Care Staff, 2018, and an initial gap analysis completed. Staff that make clinical and discharge decisions with patients need to be trained in the mental capacity act (MCA) and its application.

Safeguarding children training

All staff are required to undertake child protection to the level that their job role requires.

Child protection training has been reviewed following the publication of the updated 'Intercollegiate Document: Child Protection Roles and Competencies for Health Staff, 2019' and a gap analysis completed.

Child Sexual Exploitation/Child Criminal Exploitation (CSE/CCE) training

CSE/CCE is embedded into safeguarding children training at all levels. In 2019/20 there was a focus on introducing the concept of contextual safeguarding and the risks to young people outside of their home. One hour updates at level 3 are available concerning sexual violence and assault, modern day slavery and exploitation and substance misuse. The Department of Sexual health holds CSE/CCE case study peer reviews. All staff can access E-Learning via the CSE intranet pages.

Domestic abuse

Domestic abuse is raised in adult and all levels of child safeguarding mandatory and statutory training; specific domestic abuse training is available for maternity staff. Level 3 days for the children's workforce include clear guidance for staff who are working closely with children and families on how to support and refer to other agencies where there are parental risk indicators. During training sessions, we remind staff of the importance of routine questioning in relation to domestic abuse. There is a Domestic Abuse guide available to staff as part of the Safeguarding Tool Kit.

Prevent (Anti-terrorism training)

Prevent awareness forms part of the level one training for all staff and is included in adult and child safeguarding training. The training requirement has been reviewed in line with NHS England guidance and selected staff mostly the children's workforce who require level 3 child protection training identified to receive additional training. This is either a face to face WRAP session or approved e-learning.

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

MCA and DoLS awareness are delivered as part of the part of Trust induction safeguarding adults training and core mandatory training day. For patient facing staff MCA enhanced training is delivered to a selected group of staff to

achieve a minimum of 80% compliance. We have remained above this target level during 2019-20.

Mental Health training

The Lead Nurse Mental Health currently provides training to staff on the Mental Health Act (MHA), mental health disorders, stigma, and the processes in place within the hospital to ensure good patient care. This is delivered through the induction training programme for Registered Nurses, Allied Healthcare Professionals (AHPs) and Clinical Support Workers (CSW). A Mental Health study day runs four times a year. It is available to ED, Acute Medical Unit and Short Stay Unit nursing staff and includes situational discussions, suicide and self-harm awareness, risk assessment, use of the mental health act verses mental capacity act and has input from external speakers including BHFT, Samaritans, addictions services and Post Traumatic Stress Disorder service provider. In 2019/20 this one-day training included risk management in practice.

Mental health features as a session in the 1:1 care training day for Registered Nurses and Clinical Support Workers looking at mental health in an acute hospital, why 1:1 mental health observations might be needed and how staff might respond, interact and assess risk. Individual training sessions have and can be delivered to speciality services through local clinical governance or team meetings. These sessions are delivered by Consultant Psychiatrists to clinical teams. The focus is on the MHA in an acute hospital and individual settings and is situation based.

Allegations and Safer Recruitment training

Safeguarding concerns and allegations awareness is delivered as part of child and adult safeguarding core mandatory training. Additional training for specific staff groups and a larger cohort of managers to investigate allegations was undertaken in September 2019.

Conflict management training and training in physical restraint and holding

Security staff are trained in physical restraint; all are qualified in Caring Intervention level 3 Control and Restraint. Conflict management training is available and mandatory for all clinical staff and includes breakaway techniques and understanding of the application of the Mental Capacity Act, importance of space and communication skills.

Restraint in relation to clinical treatment and best interests is discussed in adult safeguarding training and Level 3 child protection training. We have a Preventing, Minimising and Managing Aggressive and Violent Behaviour Including Restraint Policy CG669, the Restraint Reduction Network (RRN) Training Standards, commissioned by the NHS were published by the British Institute of Learning Disabilities, in April 2019.
https://restraintreductionnetwork.org/wp-content/uploads/2016/11/BILD_RRN_training_standards_2019.pdf

There were discussions during 2019/20 with an external training company about piloting training in priority services that complied with RRN standards during 2019/20. In March 2020 following a series of clinical engagement sessions held as part of our review of preventing, minimising, managing, challenging behaviour and violence and aggression training it was agreed that there would be two pilot areas the Elderly Care Wards and ED and that the training would include Positive Approaches to Behaviour, Introduction to De-escalation Strategies, Personal Safety & Disengagement, Redirection and Guiding and Clinical Holding.

Transition training

During 2019/20 specialties' have been expected to maintain the knowledge and skills of their staff in relation to transition through ward and department training. The Learning Disability Liaison Nurses work with adult clinicians to improve understanding of the cognitively disabled young person moving to adult services.

Learning disability

A DVD is shown at core induction; there are 'raising awareness' sessions for RNs, AHPs and CSW's as part of nurse/CSW induction. A communication session is delivered on a training day for care crew teams and others who are providing 1:1 support. The Learning Disability Liaison Nurses work with clinical teams to improve understanding of the cognitively disabled patient in an acute health setting. The Safeguarding and Learning Disability Conference in November 2019 attended by Safeguarding Champions was well evaluated by those who attended and led to a commitment to review and develop our LD/ASD training. We have committed to providing a Learning Disability and Autism awareness presentation to 90% of relevant clinical governance meetings during 2020/21 and 2021/22. In November 2019 the government announced that training about learning disability and autism would be mandatory

for all health and social care staff and that this would be legislated for by April 2021.

Ongoing challenges / risks:

- Cancellation of face to face level 1 & 2 safeguarding training due to Covid19 restrictions
- Additional level 3 child protection training full days needed due to Covid19 restrictions
- Availability and provision of adult level 3 training to comply with the Intercollegiate Document: Adult Safeguarding: Roles and Competencies for Health Care Staff, 2018 by the next iteration in 2021.
- Availability of training to comply with the standards of the Restraint Reduction Network Training Standards, 2019.
- Consistency of knowledge and confidence to apply the Mental Capacity Act and DoLS training in practice
- Training compliance of all of our staff in the aspects of safeguarding, mental health. Learning disability and autism training relevant to their practice.
- Consistency of knowledge, competency and professional curiosity in practice.
- Consistency of recognition and assessment of risk and confidence of our staff to respond to a significant increase in case complexity
- Availability of transition to adulthood training
- Availability of specific domestic abuse training outside of maternity and sexual health services.
- The need for our staff to have knowledge of and understand Contextual Safeguarding, Trauma Informed Care, Adverse Child Hood Experiences and Think Family.

Safeguarding, Mental Health and Learning Disability Audit and benchmarking against national standards

The Safeguarding Team reviews and updates Trust Safeguarding and Mental Health policies and procedures. They also coordinate an agreed audit program that includes single and multi-agency audits monitored through our internal governance systems and QALC. External scrutiny and challenge is provided through Berkshire West CCG, Health Partners Strategic Safeguarding Committee, the performance sub group of the Safeguarding Adult Board and the Independent Scrutiny Groups of the Safeguarding Children Partnership.

We actively participate in the sub groups of the Safeguarding Children Partnership and Safeguarding Adult Board. Through participation our Safeguarding plan is constantly renewed and updated. The Joint RBFT/BHFT Mental Health and Learning Disability Clinical Governance Committee monitor Mental Health and Learning Disability related standards and audits. In February 2020 we submitted data and information to NHSE & NHSI - Learning Disability Standards Benchmark Review. This was used to develop a Trust Quality Account Priority for 2020/21. To implement the “Treat Me Well” campaign to support patients with learning disabilities in hospital **Appendix 1.**

Ongoing challenges / risks:

- Capacity of the safeguarding team to maintain their agreed audit programme of single and multiagency audits.
- Capacity of the safeguarding team to review existing and write new policies and procedures
- Capacity of the safeguarding team to complete NICE assessments in a timely manner.

Safer Recruitment and Allegations Management

Key Achievements

- Deliver Safeguarding Investigation Training in order to have a larger cohort of mangers able to investigate allegations.
- Incorporated an Annual DBS Declaration section (for clinical staff) in the Trust Appraisal Documentation.
- Undertaken a full review of the Managing Safeguarding Concerns and Allegations Policy.
- Identification of key themes from safeguarding concerns and allegations in order to communicate lessons learnt from safeguarding cases.
- Managing/progressing safeguarding concerns and allegations during the Covid-19 pandemic.

Summary of Cases

In the financial year 2019/20 a total of 18 cases were referred to the Safeguarding Team; 12 cases relating to vulnerable adults and 6 cases relating to children. Of the 18 cases referred 5 were classified as allegations whilst the remainder were classified as concerns. Most of the concerns/allegations related to Trust employees however the concerns/allegations also related to a contractor, an ex-employee and a spouse of an employee. With a couple of the concerns it was not possible to identify the individual.

The safeguarding concerns/allegations were spread fairly evenly across the Trust between the three Care Groups with the most being in Networked Care. Three concerns related to employees within the Estates and Facilities Directorate. The main categorisation of concerns/allegations were physical e.g. rough handling of patients. The majority of cases were categorised as unfounded however lessons to be learnt were identified. Two cases remain open. A few cases were progresses as either a patient complaint or dealt with as an HR matter.

There has been a small reduction in the number of cases compared with previous years 19 in 2018/19 and 20 in 2017/18.

Key Areas of Work for 2020/21

To resume normal activity for safer recruitment and the management of safeguarding concerns/allegations following Covid-19 pandemic. This includes:

- To continue the Monthly Safeguarding Review Meetings to go through all “live” cases to ensure timely conclusion.
- To continue the Quarterly Safeguarding Review Meetings closed cases are reviewed in order to identify patterns or themes and actions identified as a result of identified themes
- To deliver further Safeguarding Investigation Training in order to have a larger cohort of mangers able to investigate allegations
- To increase safeguarding awareness amongst Employee Relations Team.
- To provide pilots of customised safeguarding allegations awareness and lessons learnt training for Out Patient Department Staff, Estates & Facilities and senior nurses (Band 7 and above) in Network Care as part of their safeguarding update.

Child Protection and Safeguarding

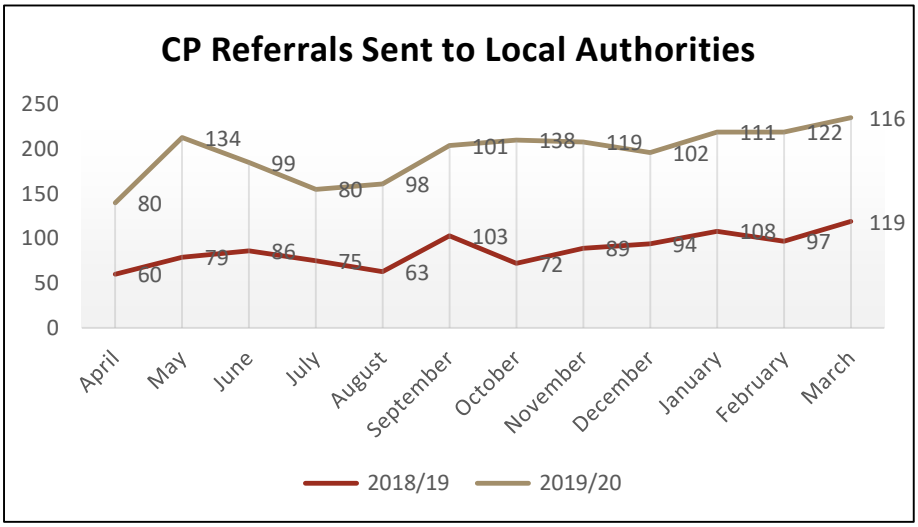
Key achievements

- Child protection has been busy with more complex cases presenting. The Named Nurse, Child Protection continues to work closely with frontline practitioners and partner agencies to ensure that the child remains the focus, is safely managed and discharged from the hospital and our other services.
- The Named Nurse and Named Midwife continue to work closely with our partner agencies, meeting them monthly to discuss cases and operational issues. Having liaison meetings builds relationships with the Local Authorities for joint working. The meetings for all areas are established, consistent and they have proven invaluable during Covid19.
- Referrals to our three key Local Authorities have been audited for clarity, quality and voice of the child. All audits show that referrals made are clear, with concise decisions around safeguarding children who present to RBH. Where issues are identified, reflection with practitioners enhances practice.
- Level 3 child protection training is embedded, delivered, evaluated and adapted to the changing environment within safeguarding and the needs of the staff.
- A Paediatric Associate Specialist and the Named Nurse Child protection have launched debrief sessions for the multidisciplinary team to enable them to have a safe space to reflect on complex cases and learn. This piece of work will be evaluated but appears to be providing valuable support to many staff.
- Child protection Clinical Governance meets bi-monthly and reviews all areas of safeguarding children.
- RBFT have been involved in a significant number of complex partnership and serious case reviews which have required full chronologies, analysis of practice and actions in response to recommendations.
- Attendance by the Named Nurse for Child Protection at the Reading Independent Scrutiny group and the Berkshire West Case Review group of the Berkshire West Safeguarding Children Partnership.
- Safeguarding Children and Child Protection Policy and The Child Protection Protocol have been reviewed
- Work progressed with Information Management and Technology (IM&T) to develop the electronic child safeguarding referrals to support information sharing. All child protection information is now uploaded to the Electronic Patients Records to support a single record and enable staff to have a better understanding of individual children's safeguarding issues.
- The Named Nurse for Child Protection continues to work closely with frontline practitioners in Paediatrics and Emergency Department to raise safeguarding skills and confidence. Safeguarding champions have been identified in the Paediatric Wards and Departments and in the Paediatric Emergency Department. The champions are meeting regularly with the Named Nurse Child Protection to strengthen safeguarding practice.
- The Named Nurse and Named Midwife for Child Protection continue to work and support staff in the Special Care Baby Unit to identify babies who are admitted under social care, monitor babies and families that may need further support and ensure safe discharge.

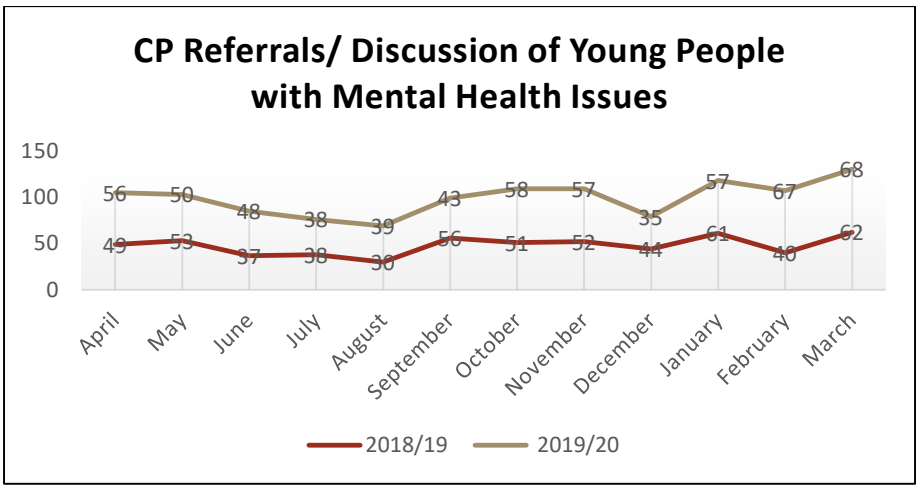
Key concerns

- We have seen an increase in activity and a significant increase in complexity of cases from both a safeguarding and a psycho-social context in relation to needs of specific patient groups:
    - pregnant women and unborn babies
    - babies under six months
    - children and young people from troubled families
    - children, young people with mental health needs, conduct disorders and particularly eating disorders
    - cases involving domestic abuse
    - children, young people with learning disability and autism
- The safeguarding and safe discharge of babies and children who have been abused and children and young people with mental health needs admitted to the RBH is monitored closely by the Named Nurse for Child Protection.

- On-going work with frontline practitioners around the interface liaison/ discussion with children's social care and CAMHS remains a challenge, especially for 14 - 17-year-old inpatients.
- Covid19 will have a huge impact on children and families socially and economically. The impact for RBH will be seen in the complexity and vulnerability of child protection cases presenting to practitioners at the frontline and the safeguarding team and the potential for an increase in the number of Berkshire West cases referred to the National Child Safeguarding Practice Review Panel requiring a Rapid Review.
- The non-urgent child protection medical service provided by Dingley has continued and has been kept under review by the Clinical Lead working with the Named Doctor CP. Initially during lock down there were no referrals for several weeks that trend has reversed.
- Cancellation of face to face level 1 & 2 safeguarding training due to Covid19 restrictions
- Additional level 3 child protection training full days needed due to Covid19 restrictions
- The capacity of the Named Nurse to support the demand for level 3 training, the Rapid Review and learning process and the number and complexity of cases presenting to RBH. These cases require longer admission, more multiagency meetings and the use of the escalation policy internally and externally to partners to ensure the safety/safeguarding of children & young people
- The number of requests from the local authority Joint Legal Team for notes or statements for family court proceedings has increased by 70% from 2018/19 to 2019/20, there has been a corresponding increase in work in Safeguarding Administration



2017/18 – 740 referrals
2018/19 – 1045 referrals, 42% increase
2019/20 – 1300 referrals, 24% increase
COVID impact - April/May 2020/21 reduction 44% compared to same period 2019/20



2017/18 – 513 referrals/discussions
2018/19 – 573 referrals/discussions, 12% increase
2019/20 – 616 referrals discussions, 7.5% increase
COVID impact April/May 2020/21 reduction 35% compared to same period 2019/20
Key Areas of Work 2020/21

- Continue to respond to emerging child protection and safeguarding trends and themes due to the psycho-social impact of Covid19 on the most vulnerable children, young people and families
- Named Nurse for Child Protection will continue to offer supervision/ reflective sessions for all Paediatric and Emergency Department staff as part of their level 3 child protection updates.
- NNCP will work closely with senior nurses in Paediatrics to ensure knowledge and skills are embedded in their practice, alongside the safeguarding champions.
- To continue to audit referrals made to each Local Authority within Berkshire West to ensure that good, clear and concise referrals are being made for children.
- To continue to monitor young people who attend and are admitted to the RBH with mental health needs, conduct disorders and particularly eating disorders and work closely with the clinical teams, Lead Nurse for Mental Health and all partner agencies.
- The Named Nurse, Named Doctor and Named Midwife for child protection are exploring new ways to deliver effective training due to Covid19 and the need for social distancing including e-training, virtual classroom and socially distanced or 'bubble' face to face
- Review of pathways for non-urgent Child Protection Medicals in Dingley & Urgent in ED and Paediatric Wards.
- Provide an additional level 3 child protection training full day due to Covid19 restriction and social distancing
- The Associate Chief Nurse Safeguarding, Mental Health and Learning Disability is ensuring the safeguarding administration team is fully recruited and developing a business case for a Child Safeguarding Clinical Nurse Specialist to support the Named Nurse and Midwife functions.

On-going challenges / risks

- RN nurse vacancies and permanence on Paediatric Wards and ED, safeguarding skills and experience of practitioners in managing complex cases.
- A small group of child and young people 'frequent attenders' who are high profile in terms of self-harm, complex psychosocial issues, significant mental health concerns, including eating disorders and increased length of stay.
- The numbers of children and young people with mental health problems at risk from self-harm and suicidal ideation attending the Emergency Department.
- < 16s admitted to the paediatric unit and 16/17 year olds to ED Observation Bay, Acute Medical Unit or Short Stay Unit detained under the Mental Health Act requiring admission to Tier 4 Child and Adolescent Mental Health, Eating Disorder or Conduct Disorder services and delayed in the Royal Berkshire Hospital.
- The Trust does not have an adolescent or young person service model or facility to support aged 14-18 years who are either admitted to a paediatric or adult ward
- Non urgent child protection medicals being provided at a site remote from the RBH
- Capacity of the Named Nurse for Child Protection to manage the increase in activity and complexity. To mitigate risk by supervising, challenging and escalating. To participate Berkshire West Safeguard Children Partnership groups, Case Reviews for children that have been discussed at the Berkshire West case Review group to deliver training and internal governance responsibilities.
- While Covid19 continues to challenge all services, the greatest safeguarding risk will be to children and young people and ensuring a robust approach to protecting them from harm remains a high priority.

Maternity Child Protection

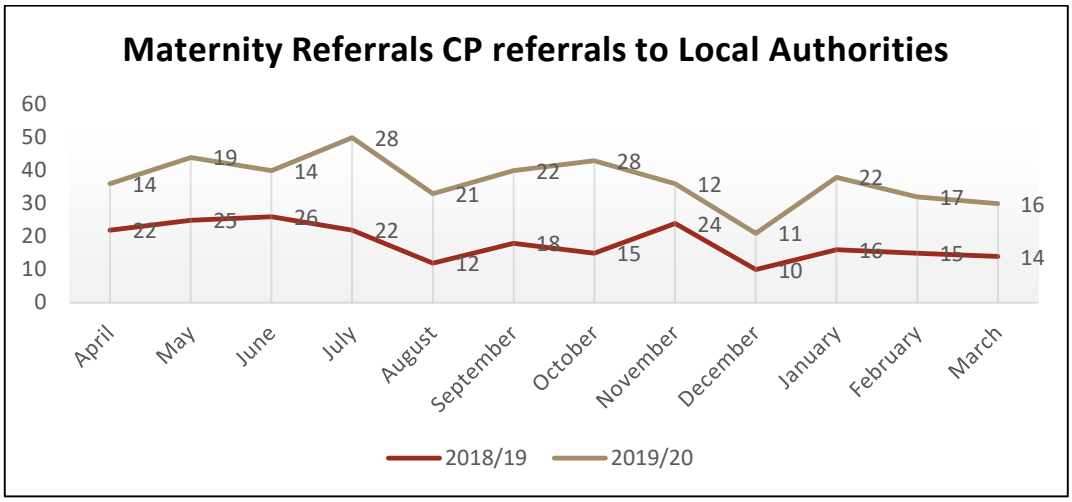
Key achievements

- The Named Midwife for Child Protection has increasingly been called upon to support frontline practitioners in Paediatrics and Emergency Department when the NNCP is on leave.
- Child protection for the unborn, new born babies and vulnerable parents remains busy with more complex cases. The Named Midwife for Child Protection (NMCP) works closely with frontline practitioners and partner agencies to ensure that the unborn, new born remains the focus and is safely discharged.
- NMCP works closely with partner agencies to ensure that the safeguarding needs of the unborn, new born and vulnerable parents are met, appropriate plans put in place and carried out.
- Liaison meetings are held with Wokingham and West Berkshire local authorities these are usually bi- monthly.
- Liaison meetings are now established with Reading. Reading's Pre-birth Team, work intensively with the most vulnerable mothers to improve the outcome for families. One of the aims is to reduce the number of babies going into foster care whilst ensuring the baby is safeguarded and the family fully supported to care for baby. The Poppy team and the safeguarding team work very closely with the Pre-birth Team to support vulnerable families.
- Vulnerable women's meetings are held monthly with representatives from Health Visiting, Perinatal Mental Health, Sexual Health and Poppy teams, Drug Treatment Services, Reading MASH and ward representatives
- The Poppy Team supports our most vulnerable families; the NMCP works closely with the Poppy team and supports them in their practice. Two new members joined the team, NMCP provides training and support to ensure they are aware of the unique role and responsibility of being a Poppy Team Midwife.
- Community midwives are now providing care to women living in East Berkshire who wish to deliver at RBFT; this has increased the work load of the NMCP. It requires the NMCP to participate in out of area conferences and multidisciplinary meetings as well as supporting staff to complete written reports.
- The Concealed Pregnancy Guidelines and Supervision Policy has been reviewed and updated.
- NMCP has:
  - Worked with Brighter Futures for Children, to write new Pre-birth Protocol and attended a workshop with Wokingham Local Authority to look at their Early Help strategy
  - Been part of the group working with Cerner to design Maternity in EPR. This will provide one integrated maternity record covering all stages of pregnancy for both mother and baby including safeguarding.
  - Attended the BWSCP learning and development subgroup providing feedback on training needs and ensuring that our training continues to be of a high standard, meeting BWSCP and national requirements
  - Provided monthly group supervision for the Poppy team and established group supervision and reflective sessions for all Midwives as part of their level 3 child protection updates.
  - Provided newly qualified midwives with on the job support concerning their safeguarding practice, teaches on the preceptorship day and provides additional safeguarding training sessions for Community Teams
- During Covid 19 all of these established pathways, groups and relationships have proven invaluable.

Key concerns

- The on-going impact of Covid19 on the most vulnerable families and emerging safeguarding trends and themes seen in maternity services
- The capacity of the Named Midwife to support the number of complex of cases identified within the Maternity Services. These cases require intense scrutiny, more multiagency meetings and the use of the escalation policy internally and externally to partners to ensure the safeguarding and safety of the unborn and new born, input for MARAC meetings in Wokingham, Reading and West Berkshire, increased demand for level 3 training and the Rapid Review and learning process when a baby has suffered significant harm.

- Band 5 Midwives continue to rotate to the community, this gives them an overview of the community and improves their understanding of all aspects of Maternity services, it is challenging for the safeguarding team to ensure that new community midwives have the necessary skills.



2017/18 – 217 referrals

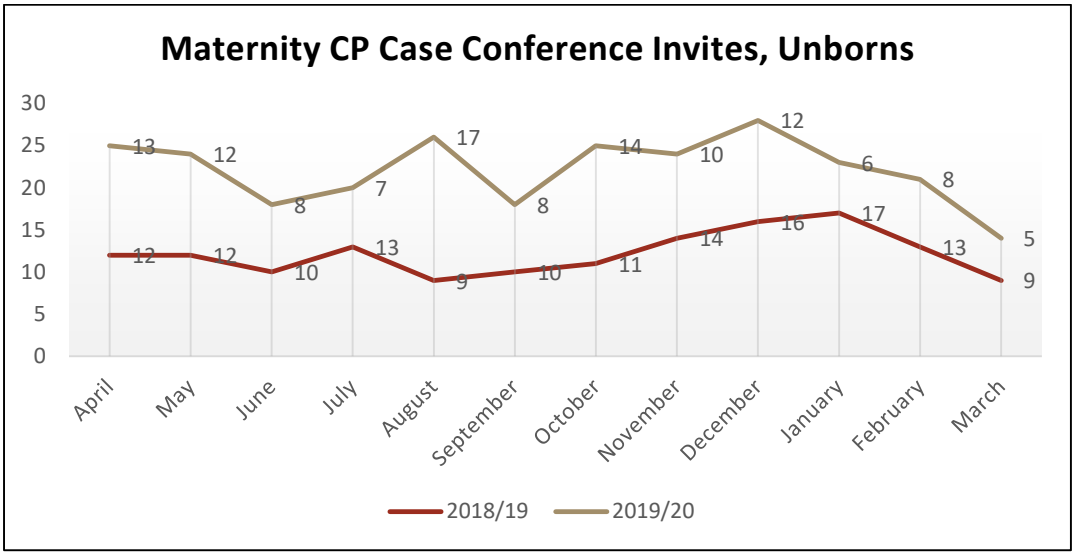
2018/19 – 219 referrals 1% increase

2019/20 – 224 referrals 2% increase

COVID impact April/May 2020/21 – reduction 21 % compared to same period 2019/20

Of the 224 referrals made by Midwives to the three Local Authorities in 2019/20:

- 50% were to Reading, Brighter futures for Children compared to 57% in 2018/19
- 30 % were to West Berkshire CSC, compared to 19% in 2018/19
- 15% were to Wokingham CSC, compared to 18% in 2018/19
- 5% were to our neighbouring local authorities compared to 12% in 2018/19 and 4% in 2017/18. Data for neighbouring local authorities has only been recorded for the past 3 years and will be monitored to see if 2018/19 was an anomaly.



2017/18 – invitations 130

2018/19 – invitations 146, 12% increase

2019/20 – invitations 120, 18% decrease

We were able to attend 94 (78%) this is consistent with 2018/19. The majority of conferences that were not attended were post-delivery when Maternity no longer had an input with the family.
We provided reports for 118 of the conferences 98% this is up from 92% in 2018/19.

- 51% were in Reading compared with 47% in 2018/19
- 26% were in West Berkshire compared with 25% in 2018/19
- 16% were in in Wokingham compared with 24% in 2018/19
- 7% were for neighbouring authorities this is up from 4% in 2018 – 19, due to the increase in workload from East Berkshire.

Local Authority Vulnerable Person figures for 2019

- Vulnerabilities are identified as: Learning disabilities, Domestic abuse, Child protection concerns, significant mental health issues, drug and alcohol misuse, homelessness, FGM, teenager, concealed pregnancy, trafficked women and if mother of a baby was identified as a 'Looked after Child'.
- 174 Reading Local Authority women were identified as vulnerable out of 2937 births this was down by 23 women from 2018. 6% of women in Reading were identified as vulnerable down from 6.5%, there was a 3% rise from 2017 to 2018.
- 23 Wokingham Local Authority women were identified as being vulnerable this was down from 41. Due to a lower birth rate this was 2% of Wokingham births, consistent with 2.2% in 2018.
- 110 West Berkshire Local Authority women were identified as vulnerable this is up from 97, in 2018. Bookings have dropped from 1993 in 2018 to 1799 in 2019 the percentage of women identified as vulnerable increased from 4.8% to 6.1%.
- The total number of women booking at the Royal Berkshire Hospital was 6678, 340, 5.1% were identified as being vulnerable, an increase from 4.8% in 2018.
- An increasing number of women from East Berkshire Local Authorities are booking care with Royal Berkshire Maternity services, 607 in 2019, 33, 5.5% were identified as vulnerable.

Forward planning for 2020/21

- Continue to respond to the on-going impact of Covid19 on the most vulnerable families and emerging safeguarding trends and themes seen in maternity services
- Continue to provide newly qualified midwives with on the job support concerning their safeguarding practice. Teaching on the preceptorship day
- To provide additional level 3 child protection training update opportunities for the Community Midwifery Teams

Ongoing challenges / risks:

- Increase in complexity of cases of at risk families, unborn and new born babies
- Capacity of the Named Midwife to support the number of complex of cases, attend multiagency meetings, meet the increased demand for level 3 training and the Rapid Review and learning process when a baby has suffered significant harm, provide 1:1 safeguarding supervision to the Poppy Team and support safeguarding practice for the increasing number of newly trained midwives throughput their rotation.
- Ensuring Safeguarding and Child Protection is captured appropriately on EPR, Maternity go live Nov 2020.
- Capacity of Poppy Team midwives to write reports and pressure on the Poppy Team and the NMCP to attend child protection conferences, the Poppy Team also provide intra partum care for some of the most vulnerable women
- Increase in the number of Strategy meetings held; these are usually held with only 24 hours' notice and discharge planning meetings.
- Community midwives providing care to women living in East Berkshire increasing the workload of the NMCP, presenting logistical challenges regarding continuity of care and liaison with new partner agencies.
- Maintaining maternity staff compliance Level 3 Safeguarding Children Training.
- While Covid19 continues to challenge all services, the greatest safeguarding risk will be to unborn and new born babies and vulnerable parents and ensuring a robust approach to protecting them from harm remains a high priority.

Maternity mental health

Perinatal mental health continues to be a focus for service development and staff education as per the recommendations of national drivers such as Better Births and the Long Term Plan:

- The provision of Perinatal Mental Health training for the multi-discipline team has been a challenge this year. Traditionally the Berkshire Perinatal Mental Health Team provide training (BPMH), however, due to resource issues BPMH have not been able to offer their usual support. Face to face training is now limited due to Covid-19 precautions. Training is virtual using a national training package hosted on Learning Matters, scenarios relating to maternal mental health continue to be part of our in-house multi-professional emergency training. Maternity has been accepting places on virtual training courses funded by the regional ICS.
- In response to learning from a serious incident the foetal abnormality service has been reconfigured to better support women found to have a foetal abnormality. We are also developing a pathway of support for women when their baby is admitted to Buscot Neonatal Unit as this is a recognised red flag for postnatal depression and suicide (MBRACE-UK Saving Lives, Improving Mother's Care. Lessons learned to inform maternity care from UK and Ireland confidential enquiries into maternal deaths and morbidity 2018.
- The joint perinatal mental health and obstetric clinic continues with the Berkshire Perinatal Mental Health Team. A review of this clinic has found that an additional outreach clinic is required, planning for this additional clinic is due to start in September 2020.
- The Birth Reflections Pilot project continues. A recent evaluation found that 125 women have used the service since April 2019. The majority of women were first time mothers who wanted to better understand the events of their birth. Any emerging themes from the clinic are fed back to the Intrapartum Strategy Group where solutions are identified. Feedback received about individual members of the team are passed directly to those identified and star cards sent when appropriate.
- Screening for perinatal mental health has been included in digital work relating to antenatal and postnatal care in preparation Maternity moving to Cerner.

Forward planning for 2020/2021:

- Continue to respond to the emerging evidence of the impact of Covid19 on the perinatal mental health of parents
- Evaluate the perinatal mental health services to identify where improvements are required in light of recent recommendations from MBRRACE-UK – Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK (2020)
- Scope the possibility of an additional outreach Joint Perinatal Mental Health clinic
- Continue to work with Maudsley Learning to achieve accreditation for our Perinatal Mental Health Training
- Scope the possibility of a case loading team for women with pre-existing and complex Mental Health

Female Genital Mutilation (FGM)

Key achievements

- NMCP provides FGM figures on a quarterly basis to the BWSCP.
- The Trust is fully compliant with adding FGM-IS information to the National Spine; the safeguarding team is responsible for submitting that data.
- An FGM referral pathway has been agreed with the local authorities to ensure appropriate/proportionate information is being shared.
- Funding for the RBFT clinical input into the Reading Rose Centre for adult victims of FGM has been secured.

Activity

- Maternity – 17 cases identified, which is three down from last year. All of those had appropriate referrals to children's social care.
- 16 cases were identified antenatally with the remaining case being identified at delivery due to the woman not knowing she had had FGM performed; 13 were reported to Reading, 3 to Wokingham and 1 to West Berkshire. No referrals were made to neighbouring local authorities.
- There were 8 further referrals to local authorities at delivery when the infants were female. 7 referrals were made to Reading, 0 to Wokingham, 1 to West Berkshire.
- Gynae/sexual health – 1 case reported – NB case identified had already been reported by maternity.
- Paediatrics 0 cases reported.
- General Trust – 0 cases reported.

Key areas of work for 2020/21

- Work with BWSCP to consider how they identify children who may be at risk of FGM particularly around 'high risk' periods such as the summer holidays and when children are not at school due to Covid isolation/lockdown
- Further development of the vision for Reading Rose Centre to become a 'centre of excellence' for Black, Asian, Minority Ethnic and Refugee (BAMER). This has been initiated due to the significant social and safeguarding consequences faced by the BAMER population.

Child Looked After Children (LAC) and Fostering and Adoption

Medicals for children who are being fostered and adopted and the role of Medical Advisor to Fostering and Adoption Panel are provided by the RBFT.

Child death

2019/2020 has been a year of two parts pre-Covid and quarter three onwards during the Covid -19 pandemic, Pan-Berkshire Child Death Overviews Panel exceptionally reviewed a smaller number of cases than usual due to the effects of Covid-19.

Twenty-four children and young people < 18 years' resident in Berkshire West died 01/04/19-31/03/20

Seven of the deaths were in the neonatal period.

- In response to the balance of neonatal deaths among the overall numbers of child deaths reviewed, the Berkshire CDOP established a specialist panel in 2016/2017 to better enable the CDOP to consolidate the possible learning.
- The fourth panel meeting to review all neonatal deaths for the period 01/01/2019 – 31/12/2019 and share learning was originally scheduled for March 2020 but due to Covid-19 was rescheduled to June 2020.
- For the first time the panel was joined by colleagues from the John Radcliffe Hospital, Oxford and the Child Mortality Team from OUH (Oxford University Hospitals). It was very useful to have colleagues from Oxfordshire as many of our infants are treated at the John Radcliffe.
- Not all the cases reviewed strictly met the criteria for Neonatal Death (a death in a child under 28 days old) but the process for reviewing neonatal deaths was felt to be appropriate as all of the care for the cases had been as inpatients on the neonatal units.
- The good practice and learning identified by the panel will be published in the Pan Berkshire CDOP 2019/20 Annual Report.

Twelve Berkshire West, one out of area unexpected child deaths were reviewed using the Joint Agency Review process, five have subsequently been reviewed by CDOP. Joint Agency responses were initiated in a timely way for all unexpected child deaths. Specific areas for learning have been identified by the CDOP around:

- Exam pressures in young people which may lead to self-harm
- The pathway for children, and young people with VP shunts for hydrocephalus
- The need to continue to work sensitively with local communities around consanguinity risks.
- The need to reinforce the safe sleeping message for all contacts with babies/infants less than 1 year.

Key Achievements:

- Berkshire West has implemented the new Child Death Review (CDR) arrangements by establishing a quarterly multiagency Berkshire West Child Death Review group a sub group of Berkshire West Safeguarding Children Partnership. This is going well with a Children's Service Manager allocated to be a representative from each of the three Berkshire West local authorities
- Berkshire West Joint Agency Review Protocol approved by BWCDR group
- Arrangements have been made with the Coroner so that out-of-hours family viewing of a body will be made on a case by case basis. Contact with the coroner's officer is required in all cases as there are various factors that would inform the coroner's decision
- Berkshire West Safeguarding Children Partnership Child Death Review SUDI and SUDIC Covid 19 Interim arrangements drafted in March were approved by BWCDR group in April 2020.

Training

Training was delivered for on-call Detective Inspectors in relation to the unexpected child death process by the Berkshire West Designated Professional and Detective Inspector and as part of a Safeguarding Disabled Children day run by the Consultant for Paediatric Neurodisability, Dingley Child Development Centre.

eCDOP

Embedding eCDOP has continued and awareness and knowledge of eCDOP is much greater within the CDR community. Training with partners has continued to include sessions with GPs, Royal Berkshire Hospital staff, health visitors, school nurses and the CCN team. The CDOP Coordinator provides online support to users and

attends eCDOP and NCMD (National Child Mortality Database) webinars to receive updates; share learning and network with the CDOP community.

Learning Disability Mortality Review – LeDeR

Six deaths of children and young people in Berkshire with LD were notified to LeDeR following a full review at CDOP. Four of the six lived in Berkshire West.

Safer Sleeping campaign

London Irish Rugby Club supported us in Berkshire to launch a major video campaign aimed at preventing baby deaths due to safe sleeping issues.

The video is the result of a yearlong piece of work pioneered by Berkshire West CCG, East Berkshire CCG and a range of health partners.

Launched in London on Tuesday 25 June 2019 the video is called Lift the Baby and is aimed at promoting safer sleeping in younger babies and is aimed at men and their understanding of the issues.

A special website has been developed in partnership with the Lullaby Trust and features a link to the video along with a range of safe sleeping advice www.liftthebaby.org.uk

Learning from Reading Festival 2019

A Reading multi-agency partnership group continued worked with Festival Republic, to further develop safety and safeguarding policy, practice and process. Updates were given to CDOP and the Berkshire West Safeguarding Partnership in the months leading up to 23 – 25 August 2019 and tested at a table top exercise and safeguarding partnership meeting. During the autumn/winter of 2019 we planned an engagement exercise with young people and their parents. The focus was on 'sex, bodies, consent and assault' and 'substances, alcohol, risk and choices' at events and risk reduction. A multiagency group of Royal Berkshire Hospitals NHS Foundation Trust, Festival Republic, It Happens, Brighter Futures for Children, youth services, schools and colleges in Reading, West Berkshire and Wokingham were part of this. Plans were well advanced to carry out a piece of qualitative research – questionnaires and workshops with schools and colleges across Berkshire West during April and May and a quantitative survey later in 2020. This was delayed due to Covid19.

Pan Berkshire CDOP Website

The Pan Berkshire CDOP Website has relocated to the Berkshire West CCG

https://www.berkshirewestccg.nhs.uk/cdop

Themed Reviews

An 11-year review of Neurodisability deaths (ND) in Berkshire was carried out by a Paediatric Registrar while working at Dingley Child Development Centre and presented to BACD: What can we do to improve end of life care for our Neurodisability population? **Appendix 2**

There was a Joint Haematology Oncology Themed Review held in March 2020 on involving the CDOPs of Berkshire, Oxfordshire and Buckinghamshire. Local learning has been shared and applied across the wider system. In particular there was sharing of information about specialist bereavement services available in the region.

Key areas of work for 2020/21

- A Pan Berkshire/Thames Valley Suicide Audit 2015 – 2020 for 0-25 year olds will be led and carried out by NHS England. It will be extended in a second phase (in October 2020) to analyse deaths by self-harm, to

cover the 'suicide and self-harm' categorisation used by the Child Death Overview Panel (CDOP). Child voice and family/significant other experience will be drawn from existing records, in order to avoid unnecessarily re-evoking grief or re-traumatising those affected by suicide.

- A second Joint Themed Review will be held during 2020/21 on SUDEP (Sudden Unexpected Death in Epilepsy) involving the CDOPs of Berkshire, Oxfordshire and Buckinghamshire.
- A local thematic review will be carried out on the role of the key worker, Dr Sarah Hughes will lead this for Berkshire West.

Ongoing challenges / risks:

- Allocating a key worker with the capability and capacity to provide the standard of support described in the Child Death Review (CDR) Statutory and Operational Guidance to every bereaved family. This is the responsibility of organisation where the child dies, the parents should leave with a name/contact details.
- Effective case management of all unexpected child deaths.
- Quality of life issues for children with complex/chronic conditions.
- Supporting frontline professionals following an unexpected child death.
- Knowledge, skills, competence and confidence of multi-agency frontline managers and practitioners who rarely encounter unexpected child death
- Provision of out of hours' joint home visit and immediate family support – unexpected child death.

Sexual Health

Key achievements – service delivery and safeguarding

- Clinical delivery in the hub at 21a Craven Road provides open access from 7am to 7pm Monday to Friday and 9.30 am to 11.30 am Saturday mornings.
- There are specific outreach clinics for young people across the three Local Authorities of Berkshire West, provided in various settings. Staff deliver holistic care from these venues.
- Designated outreach posts dealt clinically with 706 vulnerable cases that would not otherwise have accessed mainstream delivery (11 months of data due to pandemic).
- The designated sexual health outreach nurse for young people is the key front line member of staff exposed to, and dealing with, operational issues and the clinical care of young people affected by or at risk of CSE/CCE.
- Safeguarding process – all young people under the age of 18 (and anyone with vulnerabilities identified during history taking) has a full safeguarding assessment carried out at the time of consultation.
- Sexual Health Department contributes to Level 3 Child Protection Training and CSE/CCE training.
- A consistent and current flagging system exists between the safeguarding team and sexual health to ensure children and young people subject to child protection plans or Looked after Children are identifiable on both EPR and the sexual health systems to alert clinical staff to vulnerabilities.

Key achievements – Child Sexual Exploitation/Child Criminal Exploitation (CSE/CCE)

Close working relationship with Head of Children's Safeguarding for Berkshire West Clinical Commissioning Groups (CCG) sharing good practice. The Trust Safeguarding Exploitation proforma has been reviewed and updated to include questions about weapon carrying and also 'sexting'. Staff training now includes guidance on what actions need to be taken if these issues arise.

- Provision of equal input across all three Berkshire West local authorities which involves Preparation for and monthly attendance at each of the CSE/CCE operational group meetings in two unitary authorities.
- The third authority has undergone a review of their meetings structure and partners involved. RBH staff contribute to the monthly meetings but do not attend unless any specific issues arise

- Attendance at CSE/CCE workshops, review meetings, audit and challenge meetings
- Attendance at the 3 locality strategic group meetings continues
- Internal CSE/CCE Information Sharing processes continue to guide practice
- Pan-Berkshire Information Sharing and Assessment agreement and Protocol is embedded within Berkshire Child Protection Procedures to which all BWSP statutory partner agencies, including the RBFT are signatories
- CSE/CCE is embedded into the Trust Child Protection Clinical Governance agenda as a standing item.

Information sharing

Current guidance regarding information sharing for young people (YP) at risk of Child Sexual Exploitation (CSE) refers specifically to YP under section 17 and 47 of the Children's Act 1989. YP who circumstances do not reach these thresholds and are not under Children's Social Care will fall outside of the CSE information sharing principles. A revised information sharing policy has been developed to ensure a relevant, proportional and consistent approach.

Terms of reference for the Exploitation multi-agency Risk Assessment Committee (EMRAC) are in the process of being updated for each local authority to include 'Contextual Safeguarding'. An overarching 'Pan-Berkshire' policy continues to be developed.

Key areas of work 2020/21

- Ensuring safeguarding protocols continue to be upheld during Coronavirus Global Pandemic crisis. This will continue to be a priority going forward as the Sexual Health Service faces the ongoing challenge of providing the best quality service whilst adhering to new protocols (ie Social Distancing/Telephone Triage/Smart Triage for Vulnerable patients).
- Updated tool for use with Young People at risk of Exploitation (Pan-Berkshire). New assessment tool for use prior to referral to Children's Services in conjunction with all six Berkshire local authorities.
- Continued participation in Pan-Berkshire Exploitation sub group.
- Continued disseminating of The Trust's latest Safeguarding Assessment Tool which includes updated vulnerabilities relating to CSE/CCE (including use of social media and carrying of weapons) and training of staff to deal with disclosures appropriately.

Ongoing challenges / risks:

- Management of CSE/CCE continues to be a challenge in relation to capacity within sexual health services.
- Capacity to attend meetings if they are extended to include more young people will become more challenging.
- Time out of service delivery, if the Specialist Youth Nurse attends/contributes to extended meetings for each local authority each month.
- Time it takes for RBFT (both sexual health and main Trust EPR) patient records to be checked so proportional information can be shared, where appropriate, in line with the information sharing policies.
- Ensuring appropriate input continues into the Local Authority EMRAC pathways as they find different ways of working to consider Contextual Safeguarding.

Safeguarding adults

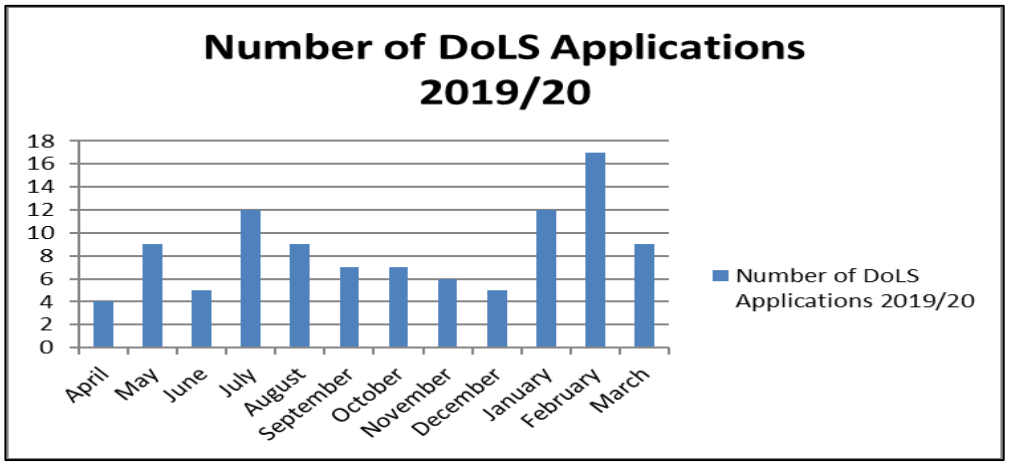
Key achievements

- Safeguarding (adults) clinical governance continued throughout 2019/20, the PCG safeguarding team medical clinical lead and matron have worked with the PCG Board to embed safeguarding governance and accountability

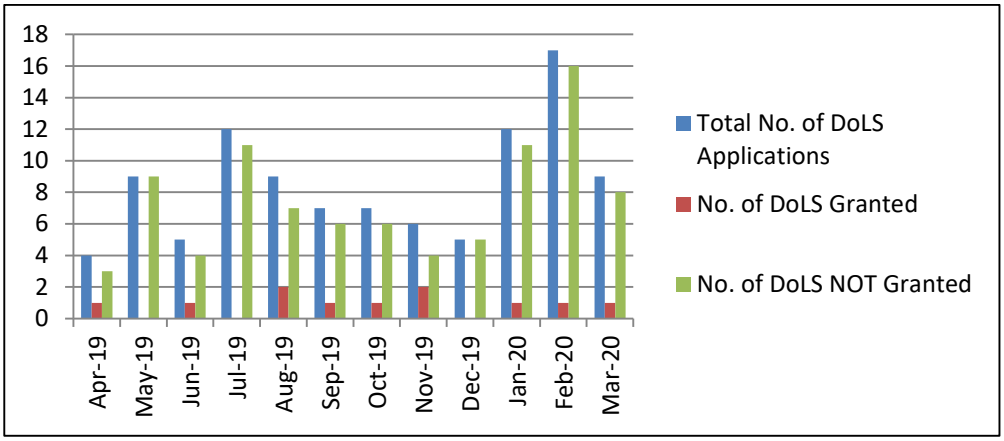
- Safeguarding concerns continue to be raised via the Datix incident reporting system this assists in giving feedback to the individual who raised the concern where available, and means that only one reporting mechanism is used for reporting concerns.
- Learning from Safeguarding Adult Reviews (SAR's) continues to be included in Safeguarding training.
- The Lead Nurse Adult Safeguarding continues to be part of the SAR panel.
- Safeguarding Champions conference was held in November 2019 with a focus on Learning Disabilities.
- The safeguarding tool kit has been launched hard copies have gone out to some ward and department areas and the tool kit is available as an electronic version on the Intranet
- In February 2020 Marijka Polden, joined the team as a Band 6 Safeguarding Practioner
- During March 2020 two adult safeguarding medical leads and two matrons were identified for NCG Dr Hannah Johnson and Ali Drew, UCG Dr Zain Hader and Georgie Brown. Due to Covid they have little chance to develop their roles.

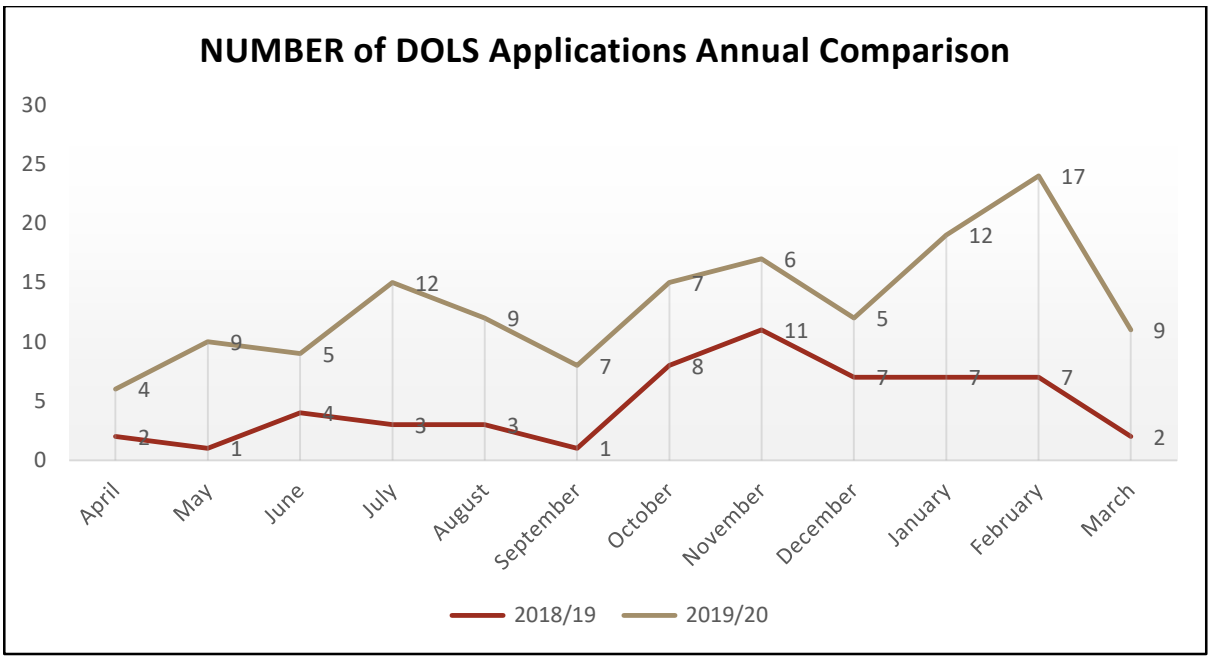
Mental Capacity and Deprivation of Liberty Safeguards (DoLS)

- Staff knowledge of the Mental Capacity Act has improved. While this is a good assessment of the status of the Trust, work is still required to embed the knowledge and skills of staff in application of the MCA.
- Training continues with MCA /DoLS sessions on staff induction and as part of the core mandatory training day alongside ad hoc sessions for specific groups of staff.
- Enhanced mental capacity training has been offered on alternate months through 2019-20, Mental Capacity training also forms part of the managing 1:1 day.
- A ward level spot check audit tool was developed during 2019-20 audits were undertaken in some Elderly Care during wards in Q3 and Q4. Documentation of mental capacity assessments, by either the use of paper assessment forms or the electronic assessment remains intermittently completed. Work is on-going to amend the form on EPR to make it easier for staff to record free text on the EPR form.
- A good response to campaigns to recognise the need for a DoLS increased the number of urgent DoLS authorised by the Safeguarding Team, 102 compared to 56 in 2018-2019 an 82% increase.
- 11 standard DoLS were granted by the local authorities out of the 102 applications made. The majority of patients were discharged prior to the completion of assessments. Delay in DoLS assessment by local authorities in the acute setting is acknowledged as a risk by the Safeguarding Adult Board.
- Urgent DoLS authorised by the Safeguarding Team last for 7 days and can be extended by a further 7 days.



Deprivation of Liberty Safeguard applications 2019 - 20 granted /not granted





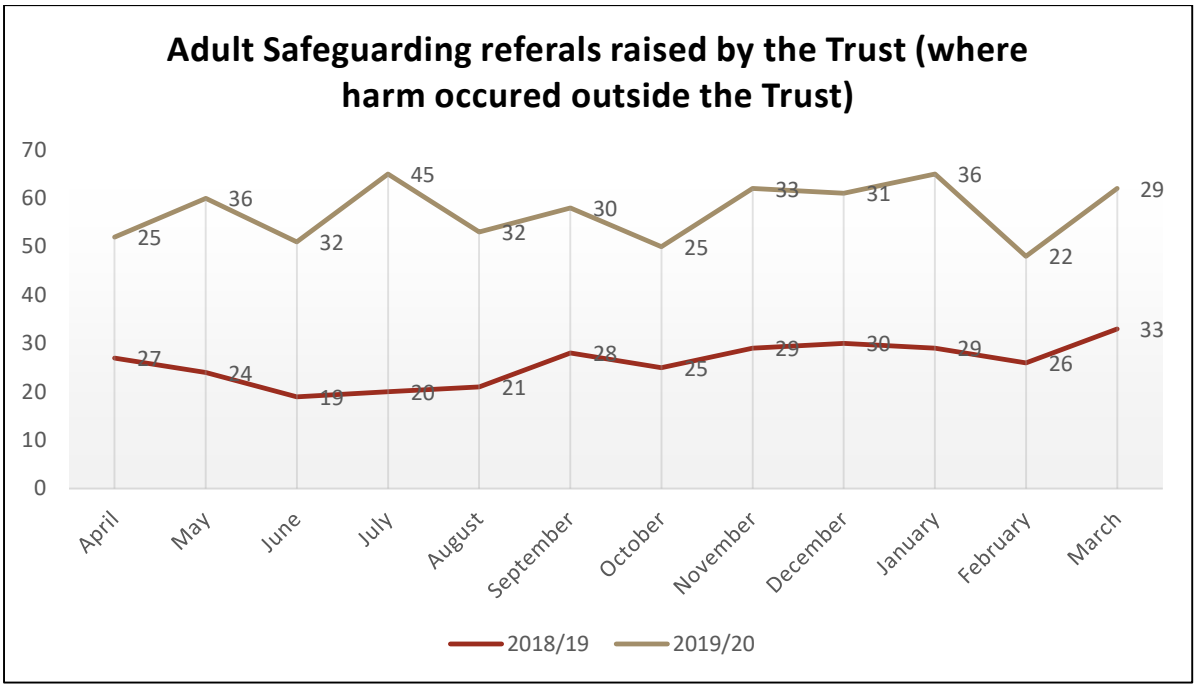
Adult safeguarding concerns

- All concerns raised by our staff about potential harm or abuse outside of the Trust are reviewed by the local authority and if necessary investigated through the safeguarding process.
- For externally raised safeguarding concerns a fact finding exercise is carried out by the Lead Nurse Adult Safeguarding. This information is given to the local authority for them to decide on the type of investigation and outcome of the concern. In most cases the safeguarding concerns raised against the Trust continue to be around pressure damage and discharge processes. In the majority of cases there continues to be a lack of information provided about pressure damage as part of the discharge process.
- Safeguarding concerns reported within or raised to the Trust related to staff members are investigated under our Managing Safeguarding Concerns and Allegations Policy.

Safeguarding concerns raised during 2019/20

Month	Concerns raised by the Trust where harm occurred outside the Trust.	Concerns raised against RBFT	Concerns reported by RBFT where harm alleged to have occurred within RBFT
April	22	2	0
May	36	1	1
June	32	2	1
July	45	2	0
August	32	2	0

September	30	2	1
October	25	0	2
November	33	11	0
December	31	2	2
January	36	4	0
February	22	5	0
March	29	2	1



During 2019/20 341 adult referrals to Local Authorities unchanged compared to 341 in 2018/19 however the complexity of cases increased.

Prevent (anti-terrorism)

No Prevent concerns were discussed with outside agencies in 2019/20. Two members of the Safeguarding team have attended the South East Prevent workshop and regularly attend West Berkshire Prevent steering group.

Domestic Abuse

The Domestic Abuse Working Group continues with representatives from each care group. This group formed part of the consultation in reviewing the Domestic Abuse Policy. Work is on-going to embed principals of good practice throughout the Trust including raising the awareness, routine enquiry and encouraging the use Domestic Abuse Stalking and Harassment (DASH) forms. The Named Midwife for Child Protection regularly attends the three Local Authority Multi- Agency Risk Assessment Conferences (MARAC's). Victims identified as being High Risk by MARAC representatives, continue to be flagged on EPR for 12 months following discussion.

Key areas of work for 2020/21

- Promote the safeguarding toolkit
- Support the multi-disciplinary safeguarding champions and care group safeguarding adult medical leads and matrons to embed safeguarding across the Trust
- Relaunch Adult Safeguarding governance suspended during Covid lockdown
- Extend the timeframe of the Domestic Abuse Task and Finish Group to support a review of training.
- Promote the importance of clear documentation of mental capacity; this can be by either use of paper or electronic documentation of Mental Capacity assessments.

- Prepare for implementation of the Mental Capacity (Amendment) Act May 2019, new Liberty Protection Safeguards.
- Complete a gap analysis against the Intercollegiate Document, Adult Safeguarding: Roles and Competencies for Health and Social Care Staff 2018.
- Implement the following training, delayed because of Covid- 19 pandemic.
  - Level 3 Adult Safeguarding training
  - Advanced Mental Capacity Act training for clinicians
- Working with other members of the safeguarding team review existing training methodologies to include virtual class room and digital opportunities developed during Covid, including expanding a 'train the trainer' approach and reflective peer review sessions.
- Support the Safeguarding Adult Board work on safeguarding and pressure ulcer prevention & financial abuse.
- Participate in 'new normal' Covid recovery and restoration through the Safeguarding Adults Board and working groups with partners.
- Implementation of Mental Capacity (Amendment) Act May 2019, new Liberty Protection Safeguards, originally planned by the government from April 2021 delayed until April 2022.

On-going challenges / risks:

- Year on year increase in activity for vulnerable groups with multiple co-morbidities and complex psycho-social problems. This inevitably impacts on the capacity of the Safeguarding and clinical teams to respond.
- The number of patients admitted with disordered eating/eating disorders.
- Elderly patients living with dementia delayed in hospital.
- Increasing and maintaining workforce knowledge of the Mental Capacity Act, DoLS, Best Interest Decisions and application in practice.
- Increasing and maintaining workforce knowledge of domestic abuse and application in practice.
- Supporting patients and the staff caring for them where there is homelessness or other external service/resource issues beyond our control.
- Service users who don't reach thresholds for statutory or voluntary services and the differences between local authorities.
- Implementation of new legislation and statutory guidance specifically the Mental Capacity (Amendment) Act May 2019, new Liberty Protection Safeguards and the Intercollegiate Document, Adult Safeguarding: Roles and Competencies for Health and Social Care Staff 2018
- Consistency of documentation on EPR especially in relation to Mental Capacity Assessments

Mental Health Service Provisions

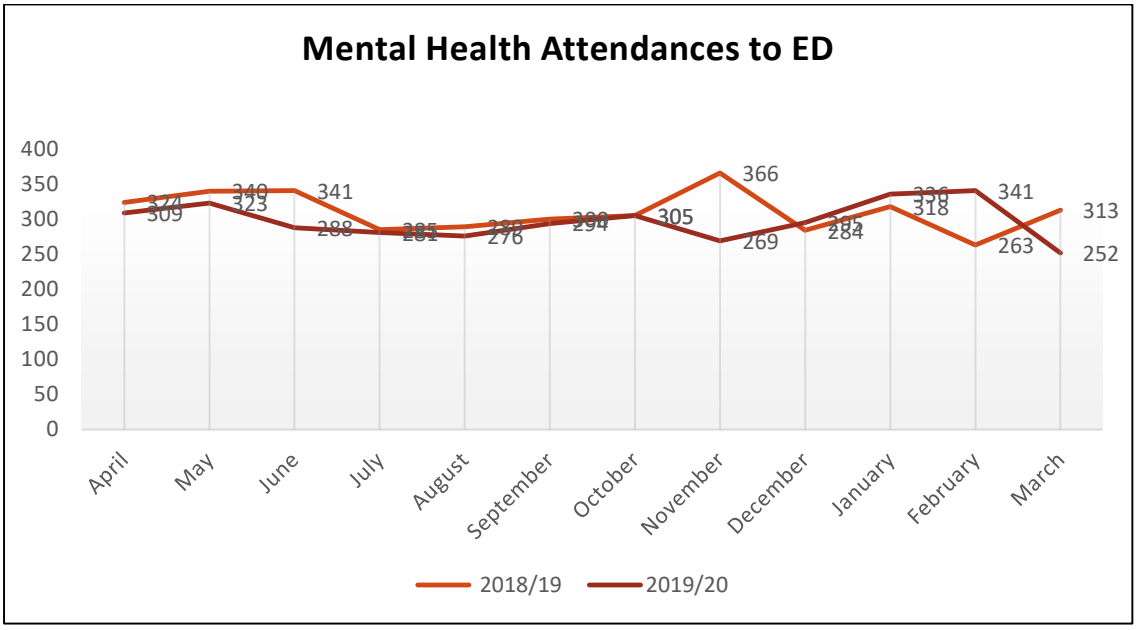
Mental ill health is widespread and can affect people from all walks of life. One in four adults and one in ten children, and many of us know and care for people who do (NHSE 2019). People can recover from mental illness if they receive timely and appropriate treatment and support, but many people struggle to access mental health services when they need them. In Berkshire West it is estimated that 14% of the population suffers from a common mental health condition. Mental Health services are primarily provided by Berkshire Healthcare Foundation Trust (BHFT) commissioned by Berkshire West CCG and additional services commissioned from three local authorities.

Poor mental health is a risk factor in the development of cardiovascular disease, diabetes, chronic lung diseases and a range of other conditions. There are two Berkshire West multiagency forums where the Trust works in partnership to improve the health and wellbeing of people with poor mental health and understand the needs of our population to reduce health inequalities. Berkshire West ICS Mental Health and Learning Disability Programme Board and Future in Mind - a group responsible for developing and monitoring the Local Transformation Plan for Children and Young People's Mental Health and Wellbeing. Additionally, the Trust participates in and works in partnership with the Pan Berkshire Suicide Prevention Group.

Activity

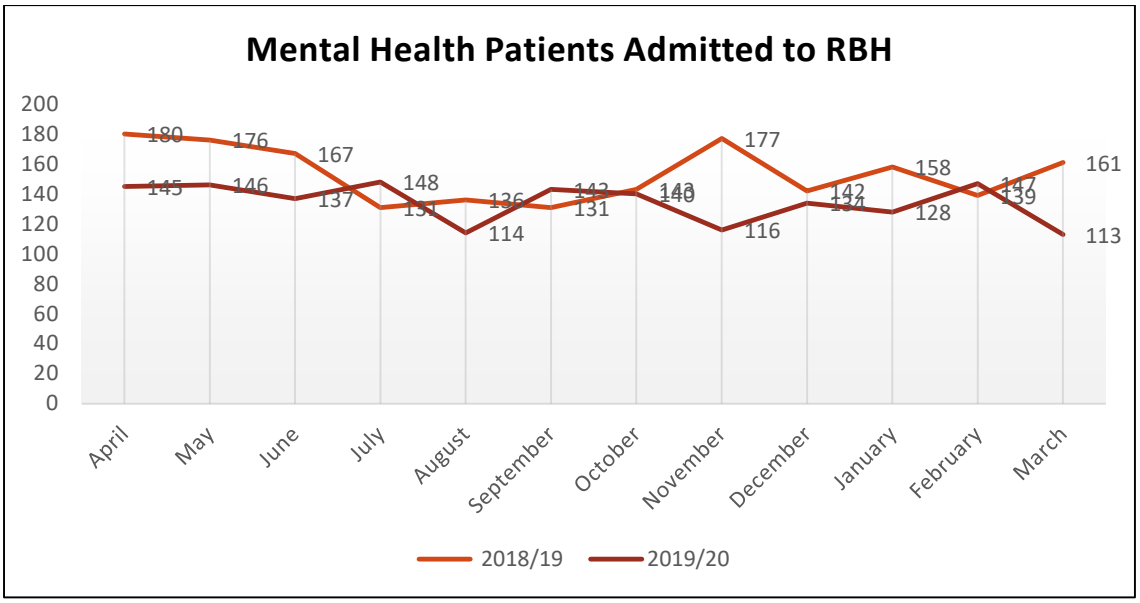
Activity data provided by the Trust's Emergency Department (ED) shows that on average, 298 people per month (reflects a reduction in attendance due to COVID) attended with a primary mental health presentation in 2019/20 approximately 45% were subsequently admitted. This is a decrease of 3.9 % attendance to the department. There was been a small decrease in admissions to RBH wards (including ED Observation Ward) by 4.5 %.

March 2020 saw a dramatic reduction of attendance to ED due to the COVID-19 pandemic.



2018/19 – 3728

2019/20 – 3569, 4%, reduction

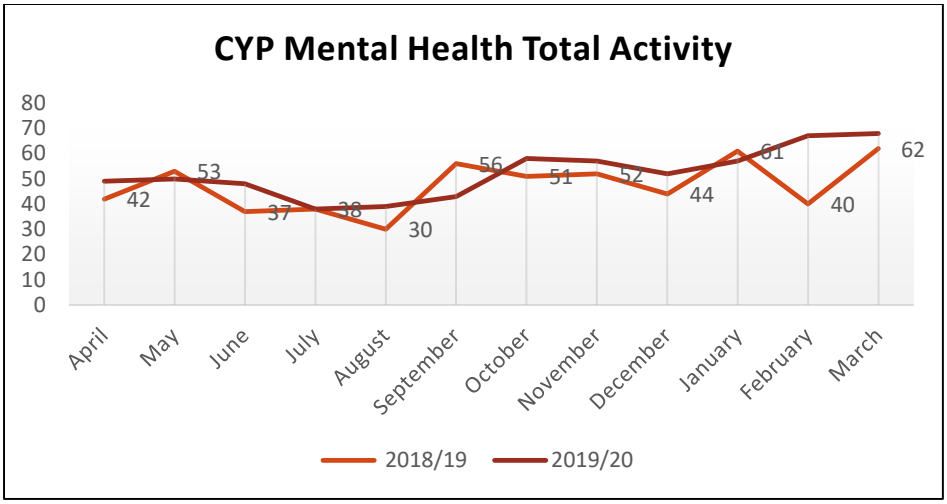


2018/19 – 1841

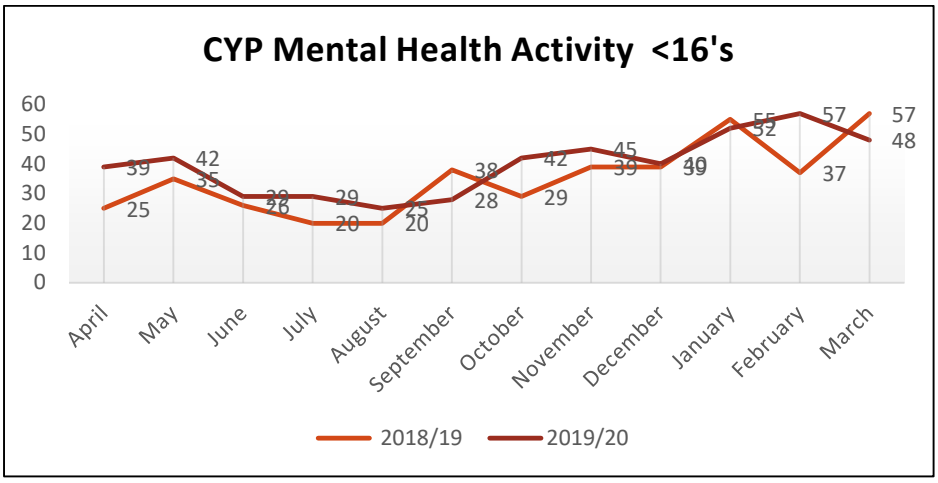
2019/20 – 1611, 12.5% reduction

Attendance of Children and Young People through ED has seen a year on year increase over the past 3 years. The age profile of these attendees has changed with the overall increase due to a higher number of under 16 year olds presenting with mental health issues. Over 16 (16 & 17) has remained quite static.

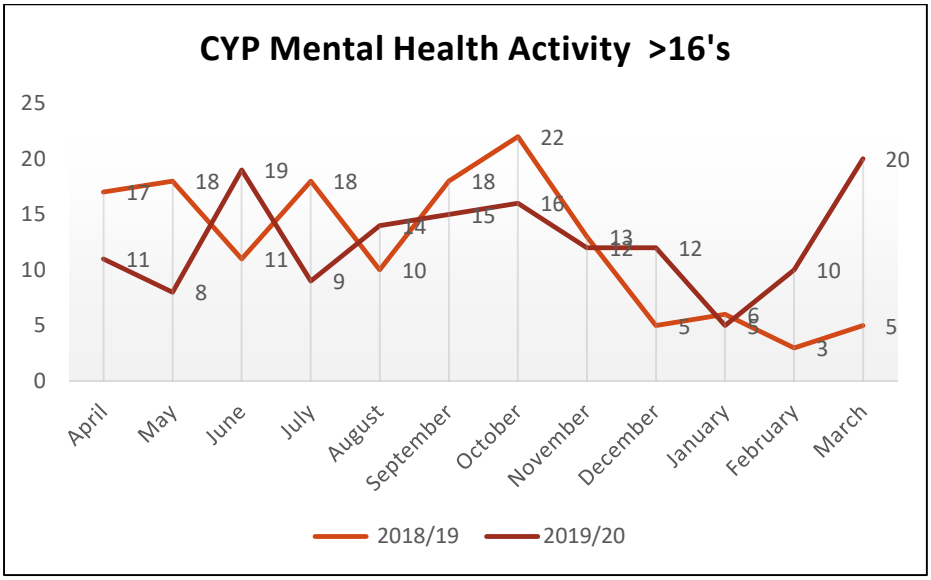
From 2018/19 to 2019/20 there was a 10% increase in attendance for all children and young people and 13 % increase for under 16's. NB the highest attendance over the past 3 years has been between the months of September and December



2018/19 – 566
2019/20 – 626, 10% increase



2018/19 – 420
2019/20 – 476, 13% increase



2018/19 – 146

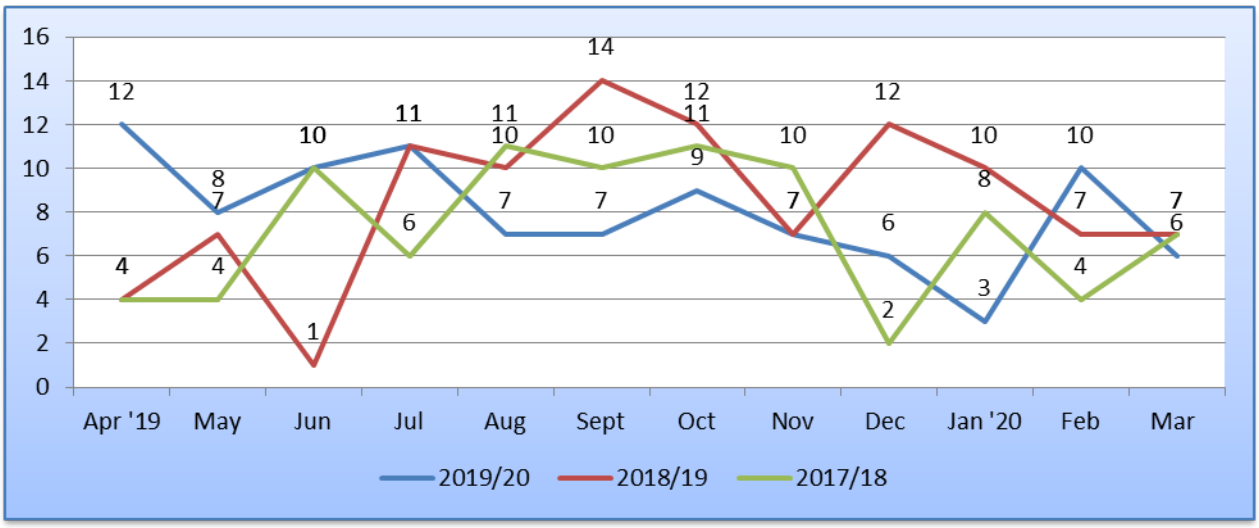
2019/20 – 151, 3% increase

Mental Health Act detentions 1983 (as amended in 2007) to RBH (including S136)

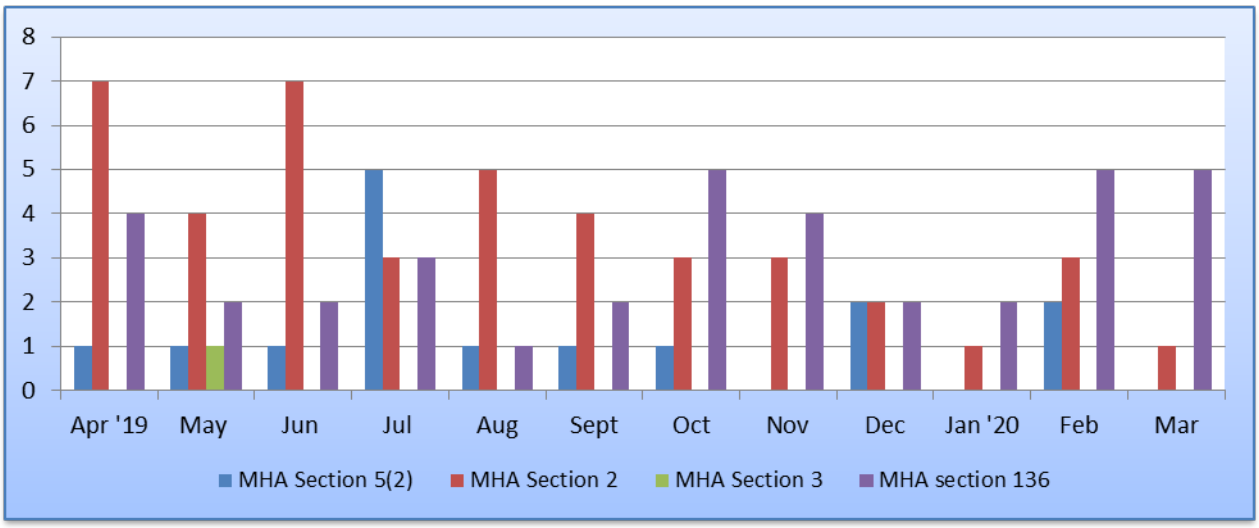
Detentions under the Mental Health Act to the Royal Berkshire Hospital were section 2, 3, 5(2) and section 136 (police powers). There were a total of 59 detentions (section 2, 3 & 5(2)) to the Royal Berkshire Hospital in 2019/20 in comparison to 62 detentions in 2018/19 and 68 in 2017/18. This is a small decrease of 4.8% in the past year.

There were a total of 37 presentations of patients detained on Section 136 at the RBH Emergency Department (ED) in 2019/20, including 2 in the Paediatric ED. This is in comparison to 43 presentations in 2018/19 and to 19 in 2017/18. This is a reduction of 14% in the past year.

Mental Health Act Total detentions to RBH 2017/18, 2018/19 and 2019/20



Mental Health Act detentions by section type to RBH 2019/2020



Please refer to Annual Mental Health Act 2019/20 Report for more detailed information.

NB: while a number of these patients were detained to the wards in the Royal Berkshire Hospital due to requiring treatment for both their mental and physical disorder, there were a number of patients who had no physical disorder and were awaiting a mental health placement.

Summary

- Attendance of Children and Young People has increased due to a higher number of under 16 year olds presenting with mental health issues
- The complexity of those attending continues to increase.
- Presentation of eating disorder diagnosis and increasingly atypical eating disorders or "disordered eating" associated with conduct disorders has continued to rise.
- Lack of availability of Specialist Eating Disorder inpatient beds and CAMHS inpatient beds
- March/April 2020 saw a dramatic reduction of attendance to ED due to the Covid -19 pandemic.

Key achievements

- First Mental Health Appeals Tribunal held in September 2019 with good feedback from the attending Judge and tribunal panel members.
- Suicide and Self Harm Working Group has achieved its targets for reviewing and completing the Self Harm and Suicide Reduction audit in September 2019.
- Challenging Behaviour Risk tool used in ED since November 2018. Paediatric wards using this since March 2019.
- Mental Health Training across RBH is established and under on-going review and development.
- Good liaison between Clinical Site team and MH Lead Nurse around patient flow between Hospitals and around the Mental Health Act administration.
- Managing Illicit substances on Trust Property and Treatments
- We worked in partnership with BHFT to review and redesign the CAMHS Rapid Response Service mental health pathways for CYP and PMS/OPMHLT pathways within RBH for adults during Covid19
- The RBFT Occupational Health Manager worked with BHFT to develop an offer to support the emotional and mental health of our staff, with three elements: Intranet content, including training for managers about implement basic support structures. Access to a confidential listening and support line manned by psychological therapists. Wellbeing Support Hubs for teams facilitated by psychological therapists.
- Focus groups, discussions and plans with clinical teams and an external training company about piloting training in priority services as part of our review of Preventing, minimising, managing, challenging behaviour and violence and aggression training.

Compliance with the Mental Health Act 1983 and Mental Health Act Code of Practice, 2015

The Annual Mental Health Act Report 2019/20 is discussed, consulted on and approved through the Joint RBFT/BHFT Mental Health Committee, the Strategic Safeguarding Committee and the QALC, the Executive Management Team and the Quality Committee. This report provides assurance about key issues, risks and themes, Trust compliance with the Mental Health Act and Code of Practice.

Please refer to Annual Mental Health Act 2019/20 Report for more detailed information.

Liaison Psychiatry in the Royal Berkshire Hospital – Psychological Medicine Service (PMS) and CAMHS Rapid Response Service

There continues to be a high level of support for patients presenting with mental health needs. The mental health liaison teams work collaboratively with RBFT staff to ensure all ages of service users with mental health needs are adequately assessed, treated and signposted as necessary. ED and PMS have regular operational meetings in order

to achieve a collaborative way of working. CAMHS, paediatric and ED staff have developed a similar meeting for children and Young people.

CAMHS Rapid Response Service operates from 8am-8pm Mon-Fri; 10am-6pm Sat and Bank Holidays with out of hour's support for crisis management being provided by an on-call CAMHS Consultant and the nursing team at Willow House. Willow House is a 24/7 9 bedded tier 4 CAMHS in Berkshire.

Challenging Behaviour Self Harm and Suicide Prevention

A Zero Tolerance Challenging Behaviour, Violence & Aggression, Self-harm & Suicide steering group has been launched to identify and action risk reviews and promote safer management strategies. The group is working towards a zero tolerance of violence and aggression towards our staff and of self-harm and suicide attempts within the Trust. In 2020/21 the group will determine and monitor:

- The implementation and review of the Trust's Preventing, minimising and managing aggressive and violent behaviour including restraint Policy CG 669 and associated protocols and guidelines.
- Planning and evaluation pilots of training in the Elderly Care Wards and Emergency Department that comply with Restraint Reduction Network (RRN) Training Standards, commissioned by the NHS were published by the British Institute of Learning Disabilities, in April 2019. That training would include Positive Approaches to Behaviour, Introduction to De-escalation Strategies, Personal Safety & Disengagement, Redirection and Guiding, Clinical Holding
- The implementation of a consistent equitable process for flagging patients with dementia/LD or other clinical conditions impacting cognition e.g. Parkinson's on EPR to allow for our staff to make reasonable adjustments.
- The introduction of the Sunflower Lanyard for hidden disabilities e.g. Learning Disability and Autism
- The implementation of a process for placing a violent patient or antisocial behaviour marker on EPR, the group which includes the Trust Local Security Management Specialist will act as the Trust Warning Marker Review Panel. This will start with a pilot in the Emergency Department.
- Oversee a project to improving Datix reporting of violence, aggression and antisocial behaviour that will start in the Emergency Department.
- A work stream led by the Care Group People & Change Partners that will work on zero tolerance of antisocial/bullying behaviour towards our staff, to include training in relation to the confidence to have difficult conversations and to use the tools available to them in Policy CG 669 e.g.
- Continue to monitor compliance with and the effectiveness of the annual self-harm and ligature audits
- Linking with multi-agency partners through the Berkshire Suicide Prevention Committee.
- Contributing to the Berkshire wide Suicide Prevention Strategy and action plan
- Working alongside the Samaritans who provide regular support for patients within the ED, as well as training for hospital staff.

Key concerns

- Data for patients who are detained under the MHA "transfers in" and S136 remains dependent on staff reporting and is inconsistent.
- Provision of enhanced 1:1 support including RMN cover where required – quality and quantity.
- Consistency of knowledge and skill concerning enhanced 1:1 observation for patients with acute behavioural disturbance including psychiatric observations.
- Delays in discharge of children, young people and adults awaiting specialist mental health beds, including eating disorders.
- The increase in violence and aggression towards our staff and impact and management of challenging behaviour particularly in the ED, AMU and SSU, Paediatric Wards, Elderly Care Wards, Acute Medical Wards, the Neuro-rehabilitation Ward, Trauma and Orthopaedic Wards and Maternity Services.
- Consistency of staff knowledge, understanding and application of MHA in practice, including self-harm and suicide prevention and ability to always recognise and act on risk.

- Challenges presented by the physical environment in an acute health setting.

Key areas of work for 2020/21

- Review of MHA SLA between RBH and BHFT
- Review the Responsible Clinician guidance generally and specifically for CAMHS.
- Illicit Substances on Trust Premises Protocol and Drug Misuse Management in the Acute Hospital Setting Protocol to be approved.
- Review of MHA policy
- Working group with partners/commissioners to develop agreed Transport provision for mental health patients between Hospitals.
- Re-establish work between BHFT and RBFT on communication and transfer pathway for patients being transferred between hospitals.
- Work with RBFT Local Security Management Specialist (LSMS) to review guidance on searching high risk patients.

Key Areas of Multi-agency partnership working looking forward to 2020/21

- Participate in the implementation steering group for the 14 recommendations from the all age Berkshire West Mental Health Crisis Review, approved in April 2020 by Berkshire West ICP Mental Health & Learning Disabilities Programme Board. A detailed implementation plan for action related to the recommendations has been drawn up. Regular monthly meetings from September 2020.
- Participate in COVID recovery & restoration - winter preparation priorities for RBH (including for Covid 2nd spike) will be included in the plan
    - Re-stablish RBH ED Frequent Attender initiative by October 2020
    - Review of secure ambulance use criteria and contract
    - Review of 2018/19 flow charts and documents for our front line to comply with the Homelessness Reduction Act (2017) to refer any person who is homeless or threatened with homelessness to their local authority
    - Establishment of all age 24/7 mental health crisis line local and 111 with triage to 999 in Berkshire
    - Support for teams caring for complex patients with Eating Disorders all ages & CYP with conduct disorders – explore CAMHS liaison in reach post for RBH
    - Prepare for expected surge of Mental Health need and demand
- Participate in 2020/21 Berkshire/BOB review of Adult Eating Disorder pathways
- Take forward the recommendations from the young person who present to RBH HiU audit 2018 through 'Future in Mind' multiagency group
    - Model of working – in partnership with the young, person, family and each other
    - Hospital based children's social worker to ensure timely and collaborative risk assessments with CSC/RBH/CAMHS
- Transformational approach Join the Dots – TVP/RBC/third sector engagement when the opportunity arises
    - Thames Valley Violence Reduction Unit - Hospital Navigator Scheme. Explore in reach post/service model for 10 – 25 year olds for the RBH Emergency Department as part One Reading CYP early help and intervention strategy
- The Trust is participating in:
    - a Pan- Berkshire Suicide Audit 0-25 years organised by NHSE Specialist Advisor, CYP Mental Health, South East. The findings will contribute to a 'life course' renewed suicide prevention strategy and plan in Berkshire in 2021, a second part of the audit will look at death in this age group as a result of self-harm involving substance abuse/alcohol
    - a Pan- Berkshire Suicide Audit in females

Ongoing challenges / risks:

- The number of mental health patients of all ages presenting to ED and being admitted.
- Increase in number of patients with eating disorders from both West and East Berkshire being admitted for re-feeding and discharge delayed due to lack of specialist in patient services.
- Increase in complexity, homelessness, social isolation.
- Gaps in community services for patients who are in crisis, leading to individuals attending ED.
- Delayed Transfers of Care for Prospect Park Hospital and Royal Berkshire Hospital due to lack of specialist beds nationally.
- The number of patients detained to Royal Berkshire Hospital under the Mental Health Act.
- Capacity of the nursing teams and security service to consistently provide a safe environment for high risk patients – enhanced 1:1 care.
- Suitability of acute health care settings when managing patients who are a risk to themselves or others.
- Social care supporting safeguarding risk assessments – in and out of hours, the response is variable
- Challenging behaviour, violence and aggression

Learning and complex disabilities – adults

Key achievements

A Registered Learning Disability Nurse was appointed in October 2019 to work 15 hours which restored the post to full time following a reduction in hours of the other liaison nurse.

- There were 249 inpatients with learning and complex disabilities referred to the Learning Disability Liaison Nurses (LDLNs) during 2019/20. Very few patients require no input at all and a number of patients require significant input. The LDLNs provide support to hospital staff involved with the patient who request advice with strategies to ensure reasonable adjustments are made and patients receive the most effective care and they become involved in more complex cases.
- There were 338 interventions for inpatients by the LDLNs. In March 2020 the way of recording interventions was enhanced to reflect more accurately the number of assessments, documentations of plans of care and administrative actions that the learning disability nurses have to make
- There were five patients who required intensive on-going support over periods of weeks and months, either because of the complexity of the patient's condition, their anxiety, social circumstances, or because of frequent admissions. Four of these patients had no effective family support. One patient was near the end of her life. Two patients had complex discharges and the LDLNs and community professionals and carers had to advocate for these patients in ensuring that social care colleagues fully understood the issues around a safe discharge for both of these patients. The LDLNs aim to provide support for medical, nursing and AHP colleagues in relation to the patient's learning disability and the best interest decision making process.
- 118 outpatients had support from the Liaison Nurses either before for preparation or when attending outpatient appointments. Some of these patients do not meet the threshold for social care support but require help when dealing with health issues, particularly understanding information.
- Overall, there were 265 interventions for outpatients.
- The LDLNs attend the multi-disciplinary case meetings of the Reading Community Learning Disability Health Team so that individuals can be discussed and joint plans developed as necessary for those who need to access care at RBFT. Contact with health professionals from the other teams across Berkshire West takes place via phone and e-mail.

- The LDLNs also attend the West Berkshire Learning Disability Partnership Board meetings when there are issues related to health and RBFT on the agenda. They also attend the health sub- group meetings of that partnership board. The Reading partnership board remains disbanded and contact is maintained with Wokingham via email. The LDLNs have attended the health sub group meetings but not the bigger partnership board meetings as they are on Zoom and are mostly social in content to enable members to stay in touch. The focus of the health sub group in West Berkshire LD Partnership Board is the take up of annual health checks and health screening.

Safeguarding and Learning Disability Champion Conference – 'Join the Dots'.

- Keynote speaker was Paula McGowan who is a campaigner for people with a learning disability following the death of her son, Oliver. Her speech was entitled 'Better health outcomes for people who have autism and learning disabilities'.
- Learning disability practitioners spoke to the conference about supporting people with learning disabilities to live the life they want.
- Graduates of the Route to Recruit supported internship programme who have gained employment at the RBH participated
- The conference also covered the exploitation and domestic abuse of individuals with a learning disability and trauma informed care to support people who help individuals with a learning disability.
- Members of the safeguarding team facilitated scenario based workshops covering the life span of learning disability.

Deaths of patients with a learning disability

- The LeDeR Berkshire West Steering Group is established, chaired by the Assistant Director of Quality and Nursing, Berkshire West CCG and continues to meet bi-monthly.
- RBFT Associate Chief Nurse Safeguarding, Mental Health and Learning Disability, Designated Professional for Child Death attends to ensure senior input and correlation with CDOP.
- There were 6 review meetings during 2019/20. There is a back log of deaths within Berkshire West CCG to be reviewed but only 9 which relate to patients with a learning disability who died at RBFT. Since the start of the Covid pandemic there has been one review meeting over the phone which was lengthy and only covered 2 patients. The CCG are looking to appoint a full time reviewer.
- In 2019/20 – there were fourteen deaths of adults with LD in the RBH. The review group includes a learning disability nurse from BHFT and there are some patients who die in the community who are known to RBFT. Berkshire West children or young people aged 4 – 17 years with LD were reported to LeDeR following review at CDOP.
- Patients who die whilst an inpatient at RBFT are subject to a triage mortality review within the organisation.
- Where concerns are identified about practice the case is considered against Serious Incident Requiring Investigation (SIRI) criteria, one case met the criteria in 2019/20.
- The purpose of the reviews is to gather information about the individual who has died and report to the programme to identify learning and positive practice.
- Themes which are emerging that should ultimately contribute towards the aim of reducing premature death in people with a learning disability are recognition of sepsis, the prevention of community acquired (aspiration) pneumonia, annual health checks with GPs and public health screening e.g. cervical smears and mammograms.
- RBFT using terms such as LD or Down's syndrome on DNACPR forms has not been a feature. However, failure to document mental capacity assessments has been. The LDLNs address the use of such terminology on Respect forms when they come across it with the appropriate Clinical Governance. There have been one or two incidents of this during 2019/20
- The quality of care and compassion provided by RBFT services in relation the people with LD and end of life care identified in Berkshire West LeDeR and CDOP multiagency death reviews has been very positive.

Challenges

- The backlog of cases throughout Berkshire West CCG is growing. The reviews are time consuming whatever format is used. This will be addressed by the appointment of a full time reviewer by the CCG.
- Obtaining documentation from EPR is very time consuming.

Patient experience

- Positive feedback received from families and carers regarding their experience of accessing RBFT services. The overall message is that the planning for individuals which enables in-patient stays and out-patient visits to proceed smoothly is highly valued and appreciated.
- Families and carers feel confident in raising concerns with the LDLNs when they occur.

The Learning Disability Liaison Nurses:

- Work with a number of agencies to support individual complex patients and their health needs. They may not necessarily be in- patients but are frequent attenders at ED or use out-patient services.
- Attended a transition event for young people and parents at Avenue School, Reading.
- Talk to GP trainees regarding patients with a learning disability and making adjustments to enable them to access services. The talk covers primary and secondary care services. A Learning Disability Nurse from one of the community teams is invited to attend. Two sessions were held in 2019/20
- Work with adult clinicians to improve understanding of the cognitively disabled young person moving to adult services.
- Participates in transition clinics in order to meet young people and their families and provide some reassurance regarding adult services at RBFT.

Familiar carers

RBFT continues to fund 1:1 familiar carers for inpatients with a learning disability who require that level of support to make them feel less anxious and more likely to comply with medical and nursing interventions in the hospital environment. Social care will not fund this type of support when an individual is in hospital as their responsibility for funding only applies to people who have been assessed as eligible for funding at home or in the community.

Work continues on streamlining the payment process and taking it out of the job role of the LDLN team to improve timeliness and governance of payments.

Key area of work for 2020/21

- To progress Trust Quality Account Priority 2020/21 to implement the “Treat Me Well” campaign to support patients with learning disabilities in hospital Appendix 1
- To review our process for reviewing the deaths of people with a learning disability, contribute to addressing the backlog of LeDeR reviews in Berkshire West and adopt the BHFT Structure Judgement Review tool for LD deaths.
- Covid- 19 pandemic - the LDLNs will be maintaining and actioning as appropriate a list of patients who have surgery and interventions cancelled because of the pandemic.
- The LDLNs will be liaising with urgent care in the community and PCG regarding adjustments for patients with a learning disability who require covid swabbing and can’t access the mainstream service.

On-going challenges / risks:

- Increase in case complexity and managing the expectations of families, carers and other professionals
- Patients with LD being delayed in hospital waiting for appropriate social care placements.
- Affordability of funding familiar carers.
- Increasing and maintaining workforce knowledge of the Mental Capacity Act and best interest assessments.
- The introduction of Liberty Protection Safeguards due to be implemented in April 2022.
- Capacity of the Learning Disability Liaison Nurses to improve the service provision for young people during transition, participate in LeDeR reviews and progress quality improvement campaigns

Children with Special Educational Needs and Disability including Transition to adult services.

Key achievements

- We have worked with partners to implement Special Educational Needs and Disability (SEND) reforms and prepare for inspection.
- We have worked closely with our LA partners to improve SEND provision across the local authority area with specific focus on improving timeliness of EHC plans and improved co-production with our partner organisations.
- There has been a significant amount of work with Wokingham LA following their inspection

Transition

- Transition to adult services in the RBFT is complex due to the range of specialities.
- Young people who use our services have long term, chronic and life limiting illness. Many will be CAMHS patients and have Special Educational Needs and Disability (SEND) and require an Education and Health Care Plan (EHCP) or have Special Educational Needs (SEN), and there are young people who have an acquired brain injury or new diagnosis.
- Young people with long term, chronic and life limiting illness are living longer, increasing the number who transition to adult services. The number of young people with EHCPs has risen nationally and locally since 2016.
- Young people with long term, chronic and life limiting illness tend to also have complex psychosocial issues.
- We are still exploring different ways of joint funding a transition nurse/professional post.
- The Adult Learning Disability Liaison Nurses are supporting SEND work in Reading, specifically the development of information for young people and families concerning transition.
- The Adult Neurology (Epilepsy), Cystic Fibrosis, Gastroenterology and Diabetes pathways have been stable over the last three years and are functioning well.

SEND and transition gaps / challenges:

Staffing

- A Transition Clinical Nurse Specialist to support young people with complex needs particularly those with long term conditions, vulnerabilities and psycho social problems and to drive a transition QI programme in the RBFT.
- Paediatric Neurodisability CNS to clinically support children and young people with complex neurodisability and their families. This would include their transition journey.

Activity

- Increase in requirement to participate in EHCPs for CYP with SEND.

Looking forward to 2020/2021

- The LDLNs will continue to support young people with complex neurodisability to transition to adult services – a criteria to determine which young people needs to be supported needs to be agreed
- Re-launch the RBFT Transition to Adult Services steering group.
- Include Children and Young People in the Hidden Disability improving access work stream.
- Funding solutions for a dedicated Clinical Nurse Specialist for complex transition particularly those with long term conditions, vulnerabilities and psycho social problems in the RBFT are being considered, this includes a submitting a bid to the Roald Dahl Charity for two years of funding in September 2020.
- Looking to create a neurodisability Clinical Nurse Specialist post from within existing financial envelope, this will help with liaison around transition
- Further capacity is being explored in the joint neurodisability transition clinic to improve this process.
- Progress work on SEND data set.

Ongoing challenges / risks:

- No dedicated nursing resource to support young people with complex needs particularly those with long term conditions, vulnerabilities and psycho social problems and develop and monitor the transition service in RBFT.
- No clinical nurse specialist for young people and families with neurodisability, including transition.
- Capacity to engage with preparation for CQC/Ofsted SEND inspections in three local authorities.
- Commissioning of the medical input into EHCPs.
- Availability of a Community Paediatrics SEND data set.

Risk Based Priorities for 2020/21

1. Workforce capacity

- Review the child protection/safeguarding clinical capacity to reflect increased activity and complexity
- Review the learning disability liaison team capacity to reflect increased activity and complexity
- Continue to develop our Safeguarding Champions network
- Continue to work with operational teams to monitor the impact of increased safeguarding activity/complexity on the workforce
- Work with Berkshire West ICP in relation to our capacity to support increased child protection, transition, CAMHS, SEND, adult mental health, learning disability and adult safeguarding activity and reforms
- Work with Berkshire West ICP to identify additional investment in the LDLN team to support our Trust Quality Account Priority 2020/21 “Treat Me Well” campaign and the LeDeR mortality review programme
- Work with our commissioners in relation to our capacity to implement all aspects of the Child Death Review (CDR) Statutory and Operational Guidance 2018

2. Training review to include:

- Review of existing training
    - COVID-19 recovery and restoration Safeguarding, Mental Health and LD re-launch to include a blend of eLearning, virtual and COVID safe face to face
    - Level 3 child safeguarding training for ED ST3s against their ARCP requirements
    - Safeguarding, mental health and learning disability induction for trainee doctors
    - Learning disability and ASD
    - Preventing, minimising, managing, challenging behaviour and V&A

-Application in practice of the Mental Capacity Act and confidence of staff to assess mental capacity

-Domestic abuse, neglect and self-neglect, exploitation and concerns and allegations management.

- A gap analysis against standards specifically:

-The Intercollegiate Document, Adult Safeguarding: Roles and Competencies for Health and Social Care Staff: 2018.

-The Intercollegiate Document, Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. Fourth edition: 2019.

-The Intercollegiate Document Safeguarding children and young people: roles and competencies for paediatricians: 2019.

-The Restraint Reduction Network Training Standards, 2019 commissioned by the NHS

-Contextual Safeguarding; Trauma Informed Care; Adverse Child Hood Experiences and Think Family in the acute setting.

- Carryout a frontline practitioner self-assessment concerning the effectiveness of our safeguarding training arrangements

3. Partnership work to:

- Implement our Learning Disability Strategy utilising the Mencap 'Treat me Well' Campaign and the NHSI Improvement Tool – Reducing deaths of people with learning disability in NHS acute (hospital) trusts in England to develop a plan.
- Continue to support the partnership improvement journey of Brighter Futures for Children in Reading, including the ONE Reading Prevention and Early Intervention Partnership Board and workstreams.
- Engage with and support the embedding of the new Berkshire West Safeguarding Children Partnership (BWSCP) safeguarding arrangements.

4. Work with IG, IT informatics and EPR:

- To building safeguarding referral forms and risk assessments.
- Progress the flagging of vulnerabilities.
- Ensure safeguarding is a priority in the development of a Digital Hospital.
- Progress improved data sharing with partner agencies to support the work of Community Safety Partnerships and SEND partnerships for children and young people.

5. Multi-agency working to:

- Support system-wide transformation projects e.g. The Berkshire West Mental Health Crisis Review which will include the Children and Young People High Impact User project.
- Continue to engage with the LeDeR mortality review programme.
- Work through CDOP to ensure compliance with all aspects of the Child Death Review (CDR) Statutory and Operational Guidance 2018.
- Continue to engage with Pan-Berkshire Suicide Steering Group to review self-harm and suicide prevention plans, including the support of those bereaved by suicide.
- Implement Berkshire West SCP and Berkshire West SAB priorities e.g. exploitation
- Prepare to implement new Liberty Protection Safeguards, by April 2022.

Appendix 1 – Trust Quality Account Priority 2020/21

To implement the "Treat Me Well" campaign to support patients with learning disabilities in hospital. The national "Treat Me Well" Campaign aims to improve the treatment patients with learning disabilities (LD) receive in the NHS, through better communication, more time, and clearer information. These simple, reasonable adjustments, can make a huge difference to the experience of care as well as the clinical outcomes for patients, their carers and the staff looking after them. During 2020-22, we intend to launch and roll out an awareness raising campaign across the Trust, starting with a presentation to the Board. In addition, we plan to:

- develop a system to flag patients electronically on our patient administration system
- rollout the national 'hidden disabilities' scheme using sunflower lanyards to identify patients with additional needs
- improve 'conflict resolution training' across the Trust in order to equip staff with skills and strategies to recognise triggers, de-escalate and manage challenging behaviours

Key Performance Measures:

1) LD & autism awareness presentation to 90% of relevant clinical governance meetings
2) Implementation of flagging on EPR for LD patients
3) Launch of hidden disabilities sunflower lanyard scheme
4) To pilot training that complies with Restraint Reduction Network standards during 2019/20. training in 2 areas and identify 3 trainers to be accredited

The quality account statement and KPIs reflect the agreed outcomes from workshops at our Safeguarding & Learning Disability Champion Conference 'Join the Dots' 21/11/19 Shaw House and support improvements identified in our NHSE & NHSI - Learning Disability Standards Benchmark Review February 2020

Identifying people with vulnerabilities to support reasonable adjustments

- Flagging adults with LD known to BHFT services on EPR
- Introducing the Sunflower Lanyard
- Include LD in maternity booking assessment
- Review LD passport for use in the Emergency Department
- Adapt '8 Important Things About Me' for use in wards

Implement "Treat Me Well" Campaign

- Training
- Paula McGowan & Oliver's Story - Board awareness presentation
- Review the training offer for LD/ASD and mental health
- Re-launch communication difficulties tool kit to wards and departments
- Include LD/ASD, personality disorders, becoming trauma informed in preventing, minimising, managing, challenging behaviour and V&A training review - pilots of training in Elderly Care and ED

Engagement with our staff, patients and carers – coproduction

- Using RBFT LD strategic statement develop a framework for engagement
- Starting with ED book engagement slots at specialty clinical governance - motivational techniques
- Joint RBFT/BHFT Mental Health Clinical Governance to be expanded to include LD/ASD - BHFT Nurse Consultant for LD to be a member
- Review engagement forums with patients with LD/ASD/MH needs and their carers - golden thread in all we do

Appendix 2

An 11-year review of Neurodisability deaths (ND) in Berkshire was carried out by a Paediatric Registrar while working at Dingley Child Development Centre and presented to BACD: What can we do to improve end of life care for our Neurodisability population?