The Royal Wolverhampton
NHS Trust

Appendix 5 External Audit Programme

Agenda Item No: 10.5.7

THE ROYAL WOLVERHAMPTON NHS TRUST

Safeguarding

DRAFT

Internal Audit Report: 28.16/17

6 March 2017

RSM

CONTENTS

Debrief held	1 March 2017	**Internal Audit Team**	Mike Gennard, Head of Internal Audit Shauna Mallinson, Senior Manager Zoe Baker, Senior Auditor Laura Goodwin, Senior Auditor
Draft report issued	6 March 2017		
Responses received			
Final report issued		**Client sponsor**	Cheryl Etches, Chief Nursing Officer and Deputy Chief Executive
		Distribution	Cheryl Etches, Chief Nursing Officer and Deputy Chief Executive Fiona Pickford, Head of Safeguarding Anne-Louise Stirling, PA to the Chief Financial Officer

1 EXECUTIVE SUMMARY

1.1 Background

An audit of Safeguarding was undertaken as part of the approved Internal Audit Plan 2016/17.

Safeguarding Adults Review (SAR) and Domestic Homicide Review (DHR)	Serious Case Review (SCR)
When a particularly complex or serious Safeguarding adults case occurs in which an adult with care and support needs has died or been seriously injured, and abuse or neglect is known or suspected to be a factor in the death; local organisations will consider immediately whether there are other adults in the same situation who are at risk of harm and need to be kept safe. Once this has been done, Wolverhampton Safeguarding Adults Board will compile initial evidence to see if there are likely to be any lessons that could be learnt from the ways in which organisations and professionals have supported the adult who has died. If there is sufficient evidence, a SAR/DHR will be commissioned by Wolverhampton Safeguarding Adults Board to: • Establish whether there are lessons to be learnt from the case about the way professionals and agencies work together to safeguard and promote the welfare of adults with care and support needs; • Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and • Improve inter-agency working to better safeguard and promote the welfare of adults with care and support needs in the future.	When a child dies, and abuse or neglect are known or suspected to be a factor in the death, local organisations will consider immediately whether there are other children at risk of harm who require Safeguarding. In such circumstances the Wolverhampton Safeguarding Children Board conducts a SCR into the involvement of organisations and professionals with the child and family to: • Establish whether there are lessons to be learnt from the case about the way professionals and agencies work together to safeguard and promote the welfare of children; • Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and • Improve inter-agency working to better safeguard and promote the welfare of children.

A representative from the Trust's Safeguarding Team attends the Wolverhampton Adults Safeguarding Board and the Wolverhampton Children's Safeguarding Board sub-Committee meetings which are specific to SCRs, SARs and DHRs. Actions identified specifically for the Trust are monitored by the Trust's Safeguarding Team at internal meetings.

This review has focussed on the processes that the Trust has in place to monitor the implementation of these actions and how lessons learnt are highlighted as a result of a SCR/SAR/DHR and shared Trust-wide. In addition, following on from our reviews of Safeguarding Children (29.15/16) and Safeguarding Adults (30.15/16), we have also considered the progress made in implementing the agreed management actions.

1.2 Conclusion

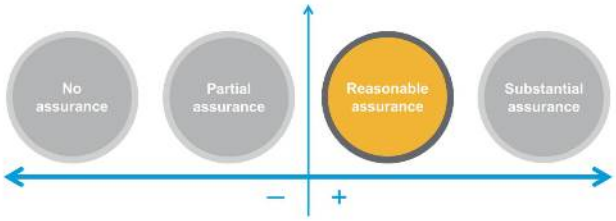
We have identified a number of areas where the Trust could improve the current processes for the monitoring of action plans and sharing of lessons learnt from Serious Case Reviews (SCRs), Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs). This includes documenting the requirements in the respective safeguarding policies, including responsible officers and dates of implementation on the action plans and ensuring that lessons learnt are shared Trust-wide through training provided to staff.

Our conclusion has taken into account that the Trust has made reasonable progress in implementing the agreed management actions as a result of the previous Safeguarding Children (29.15/16) and Safeguarding Adults (30.15/16) reviews. However, there are still steps that need to be taken to ensure that all actions are fully implemented.

Internal Audit Opinion:

Taking account of the issues identified, the Board can take reasonable assurance that the controls in place to manage this risk are suitably designed and consistently applied.

However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risk.



1.3 Key findings

The key areas which require further work include:

- The Childrens Safeguarding Policy (CP41) does not currently include the requirement for sharing lessons learnt as a result of Serious Case Reviews;
- The Action Plan for the Safeguarding Adult Review/ Serious Childrens Review/ Domestic Homicide Group is not consistently fully completed;
- The Adults Safeguarding Policy (CP53) does not currently document the requirements for Safeguarding Adult Reviews or Domestic Homicide Reviews or how lessons are learnt as a result of this;
- The actions in the action plan for the Safeguarding Adult Review/ Serious Childrens Review/ Domestic Homicide Group are not currently aligned to those in the Integrated Single Agency Action Plan; and
- The Adults Safeguarding training does not currently incorporate the lessons learnt as a result of RCAs or DHRs.

1.4 Additional information to support our conclusion

Area	Management Actions		
	High	Medium	Low
To assess the continuing arrangements for Safeguarding both children and adults. This will involve following up on the work undertaken as part of our 2015/16 plan to ensure that all actions identified have been implemented as agreed.	0	3	2
Total	**0**	**3**	**2**

1.5 Progress made with previous audit findings

Safeguarding Children (29.15/16), issued 30 March 2016	High	Medium	Low
Number of actions agreed during previous audit	1	7	0
Number of actions implemented/ superseded	0	6	0
Actions not yet fully implemented:	1	1	0

Safeguarding Adults (30.15/16), issued 30 March 2016	High	Medium	Low
Number of actions agreed during previous audit	1	8	0
Number of actions implemented/ superseded	0	6	0
Actions not yet fully implemented:	1	2	0

Please refer to Appendix A for full details on the actions which have yet to be fully implemented. We have confirmed that these remain open on 4Action.

2 ACTION PLAN

Categorisation of Internal Audit findings:	
Priority	**Definition**
Low	There is scope for enhancing control or improving efficiency and quality.
Medium	Timely management attention is necessary. This is an internal control risk management issue that could lead to: Financial losses which could affect the effective function of a department, loss of controls or process being audited or possible reputational damage, negative publicity in local or regional media.
High	Immediate management attention is necessary. This is a serious internal control or risk management issue that may, with a high degree of certainty, lead to: Substantial losses, violation of corporate strategies, policies or values, reputational damage, negative publicity in national or international media or adverse regulatory impact, such as loss of operating licences or material fines.

The table below sets out the actions agreed by management to address the findings:

Ref	Findings Summary	Priority	Management Action	Implementation Date	Responsible Owner
1	The Childrens Safeguarding Policy (CP41) does not currently include the requirement for sharing lessons learnt as a result of Serious Case Reviews.	Low	The Childrens Safeguarding Policy (CP41) will be updated to include the requirement for sharing lessons learnt as a result of Serious Case Reviews.	September 2017	Head of Safeguarding
2	The Action Plan for the Safeguarding Adult Review/ Serious Childrens Review/ Domestic Homicide Group is not consistently fully completed.	Low	The Safeguarding Adult Review/ Serious Childrens Review/ Domestic Homicide Group Action Plan will be fully completed to include the following in all cases: • An Accountable Officer; • Timeframe for completion; and • Current status (Red, Amber and Green).	September 2017	Head of Safeguarding

3	The Adults Safeguarding Policy (CP53) does not currently document the requirements for Safeguarding Adult Reviews or Domestic Homicide Reviews or how lessons are learnt as a result of this.	Medium	The Adults Safeguarding Policy (CP53) will detail the requirements for Safeguarding Adult Reviews or Domestic Homicide Reviews. The Policy will also include the requirement for sharing lessons learnt as a result of Safeguarding Adult Reviews or Domestic Homicide Reviews.	September 2017	Head of Safeguarding
4	The actions in the action plan for the Safeguarding Adult Review/ Serious Childrens Review/ Domestic Homicide Group are not currently aligned to those in the Integrated Single Agency Action Plan.	Medium	The Adults Safeguarding Team will ensure that the actions being monitored at the Safeguarding Adult Review/ Serious Childrens Review/ Domestic Homicide Group mirror those that are within the Integrated Single Agency Action Plan. This will ensure that there is one consolidated plan which is being followed up and monitored by the Trust and that all actions have been addressed.	September 2017	Head of Safeguarding
5	The Adults Safeguarding training does not currently incorporate the lessons learnt as a result of RCAs or DHRs.	Medium	The Adult Safeguarding Team should review the Safeguarding Training offered to ensure that it incorporates lessons learnt, key themes and steps moving forward. This will ensure that learning from Safeguarding Adults Reviews can be shared wider.	September 2017	Head of Safeguarding

3 DETAILED FINDINGS

3.1 Serious Case Review (SCR) - Children only

Background

Where a SCR is required, the case is presented to the Serious Case Review Committee (SCRC) which is a Sub-Committee of the Children's Safeguarding Board. The SCRC is chaired by the named Doctor who also chairs the internal Trust Safeguarding Adult Review/ Serious Childrens Review/ Domestic Homicide Group meeting.

During 2016/17 there is the one case which is due to undergo a Serious Case Review. However, there have been no other Serious Case Reviews during the year. As a result we have identified the process for the monitoring of the action plans only.

Childrens Safeguarding Policy (CP41)

Within the Children's Safeguarding Policy at section 4.15 there is a section entitled Serious Case Reviews. This highlights the key processes, however, does not currently report the process for sharing and reporting any lessons learnt.

Management Action 1

The Childrens Safeguarding Policy (CP41) will be updated to include the requirement for sharing lessons learnt as a result of Serious Case Reviews.

(Low)

Reporting Structure for following up actions as a result of Serious Case Reviews

Safeguarding Adult Review (SARs) / Serious Childrens Review (SCRs) / Domestic Homicide Group (SHs) (Internal Trust Meeting)

The Trust has introduced a group which meet on a quarterly basis to review the actions arising from SARs, SCRs and DHs. The group is attended by a representative from Adults and Childrens Safeguarding at RWT, Health Visiting, and the Head of Safeguarding. The meeting is chaired by the named Doctor.

All actions arising as a result of Serious Case Reviews are documented within the action plan presented to the group. From review of the action plan presented to the Group on the 9 December 2016 it could be confirmed that there are a number of actions outstanding from previous Serious Case Reviews. It should also be noted that the action plan does not consistently record an 'Accountable Officer' or a timeframe for completion for all actions identified. This is important to ensure that the timely implementation of actions can be tracked and that one individual can be held accountable for implementation.

Management Action 2

The Safeguarding Adult Review/ Serious Childrens Review/ Domestic Homicide Group Action Plan will be fully completed to include the following in all cases:

- An Accountable Officer;
- Timeframe for completion; and
- Current status (Red, Amber and Green).

(Low)

Serious Case Review Committee (External Meeting)

The Serious Case Review Committee is held on a bi monthly basis to review any SCRs. This is attended by a representative from the Royal Wolverhampton NHS Trust and is chaired by the named Doctor.

Wolverhampton Childrens Safeguarding Board (External Meeting)

We have reviewed the website for the Wolverhampton Childrens Safeguarding Board and can confirm that the outcomes of the SCRs are published on the website. Also there are Lesson Learning Briefings published which identify key themes that have been identified and actions that should be taken. These are available in the public domain.

Sharing of lessons learnt from Serious Case reviews

Through discussion with the Childrens Safeguarding Team it was confirmed that Lessons Learnt are shared as a result on Serious Case Reviews in the following ways:

- Once the actions have been identified as part of the initial Route Cause Analysis and as part of the Serious Case Review Report these are shared with key staff involved in order to be implemented;
- The Safeguarding Childrens Board puts on a series of workshops, which are advertised on the website and can be attended by any member of Trust Staff;
- Within the Childrens Safeguarding Level One training there is a slide included which incorporates lessons learnt from one specific SCR;
- Within the Childrens Safeguarding Level Three training there is an activity for all staff around Serious Case Reviews. This includes looking at the key themes that have occurred as a result of SCRs;
- The Safeguarding Team are in the process of issuing a quarterly Trust Wide Safeguarding Newsletter which will incorporate the lessons learnt from Serious Case Reviews. We have reviewed a draft copy of the newsletter as part of this audit.

3.2 Safeguarding Adults Review (SAR) - Adults only

Background

During 2016/17 there has been one SAR which involved the Royal Wolverhampton NHS Trust. The Panel meetings for the case started on 21 March 2016 and the SAR overview report and final action plan was presented to the SAR Committee on the 25 July 2016. The completed SAR identifies actions for the 'Hospital Trust' which have been reviewed by the SAR panel and the Trust are responsible for implementation.

However, prior to the SAR an incident had been logged on Datix which resulted in a full Route Cause Analysis being undertaken. Whilst this is outside the scope of our review it should be noted that an action plan was produced as a result which is being monitored at a Divisional Level.

Adult Safeguarding Policy (CP 53)

The current Adult Safeguarding Policy does not include any details around the process to be followed for Safeguarding Adult Reviews or Domestic Homicide Reviews.

The Policy does not include the requirement to share lessons learnt throughout the Trust which have arisen as a result of SARs or DHRs.

Management Action 3

The Adults Safeguarding Policy (CP53) will detail the requirements for Safeguarding Adult Reviews or Domestic Homicide Reviews.

The Policy will also include the requirement for sharing lessons learnt as a result of Safeguarding Adult Reviews or Domestic Homicide Reviews.

(Low)

Reporting Structure for following up actions as a result of Safeguarding Adults Reviews

Safeguarding Adult Review/ Serious Childrens Review/ Domestic Homicide Group (Internal Trust Meeting)

The Trust has developed a group which meets on a quarterly basis and reviews the actions arising from SARs, SCRs and DHs. The group is attended by a representative from Adults and Childrens Safeguarding at RWT, Health Visiting, the Head of Safeguarding the named Paediatrician.

All actions arising as a result of the SARs should be included within the action plan and discussed at each meeting. Once the actions have been completed they can then be removed from the tracker. We have reviewed the latest tracker dated 9 December 2016 which still has four outstanding actions. However, when comparing the actions within the Group action plan to the Integrated Single Agency Action Plan they were not the same.

Through discussion with the Adults Safeguarding Team it was confirmed that the actions were as a result of the final SAR and RCA. However, these had not been aligned to the Integrated Single Agency Action Plan. Moving forward the team will ensure that the tracker being presented to the SAR/SCR and DH Group will mirror the final Integrated Single Agency Action Plan to ensure that all actions are being addressed and that there is only one consolidated action plan.

Management Action 4

The Adults Safeguarding Team will ensure that the actions being monitored at the Safeguarding Adult Review/ Serious Childrens Review/ Domestic Homicide Group mirror those that are within the Integrated Single Agency Action Plan. This will ensure that there is one consolidated plan which is being followed up and monitored by the Trust and that all actions have been addressed.

(Medium)

The action tracker is updated to record the Accountable Officer, time frames for completion, recommendation status, Evidence update and comments and actions. However, from review of the current tracker the accountable officer and the timeframe has not been completed.

Safeguarding Adult Review (SAR) Committee (External Trust Meeting)

The SAR committee meets on a bi-monthly basis and is attended by representatives from the following areas:

- Wolverhampton City Council;
- Wolverhampton CCG;
- West Midlands Police;
- Wolverhampton Domestic Violence Forum representative; and
- Head of Safeguarding RWT.

We have reviewed the minutes of the meeting and can confirm that the following was discussed:

25 July 2016

A draft version of the SAR was presented to the Committee for comment whereby this resulted in a number of changes. The Integrated Single Agency Action Plan was also presented to the Committee which was reviewed and commented on by the Committee.

26 September 2016

The overview report was presented an accepted by the Wolverhampton Adult Safeguarding Board. It states that the Chair of the Committee (Joint Independent Safeguarding Adults and Childrens Chair Board) and the Adults Safeguarding Manager at Wolverhampton City Council will meet to arrange the lessons learnt briefing note.

28 November 2016

The minutes recorded that the SAR had been published. On the work programme it was noted that the Lessons Learnt Plan was to be compiled and sent to the Committee for sign off. In January 2017 the Lessons Learnt Briefing and Finalised action plan was to be submitted to the Quality and Performance Committee.

Wolverhampton Safeguarding Adults Board (external meeting)

We have reviewed the quarterly Wolverhampton Safeguarding Adults Board minutes that are available on the internet for the period, December 2015 to September 2016. We can confirm that at each meeting the Head of Safeguarding was present and Safeguarding Adult Review (SARs) were discussed at each meeting. The SAR identified for 2016/17 case was presented to the Wolverhampton Safeguarding Adults Board and was the SAR and the 'Integrated single Agency Action Plan' was published on the website on 6 October 2016.

Sharing of lessons learnt from SARs

The lessons learnt arising as a result of Safeguarding Adult Review (SAR) are communicated throughout the Trust via the following ways:

- Staff newsletter

  The Safeguarding Team are currently in the process of producing a quarterly newsletter which will include a section on the SAR identified as part of this review. This has yet to be issued to all staff but is planned as a quarterly all staff newsletter.

- Training

  At present the Adults Safeguarding Team do not include the lessons learnt as a result of any Safeguarding Adult Reviews within the training packages for Safeguarding. However, with the pending introduction of the NHS Intercollegiate guidance document for Safeguarding further training is planned to be provided. When the training is reviewed, consideration should be given to including lessons learnt, key themes and steps moving forward as a result of any Safeguarding Reviews. This would ensure that the lessons learnt as a result of the SARs could be shared wider than just the immediate team involved.

Management Action 5

The Adult Safeguarding Team should review the Safeguarding Training offered to ensure that it incorporates lessons learnt, key themes and steps moving forward. This will ensure that learning from Safeguarding Adults Reviews can be shared wider.

(Medium)

3.3 Domestic Homicide Reviews (DHR)

Background

There are currently no Domestic Homicide Reviews open at the Royal Wolverhampton NHS Trust and there have been no cases for the 2016/17 year. However, we have identified the process that would be undertaken should a Domestic Homicide Review be required.

Adults Safeguarding Policy

The current Adult Safeguarding Policy does not include any details around the process to be followed for Domestic Homicide Reviews. Also, the Policy does not include the requirement to share lessons learnt throughout the Trust which have arisen as a result of Domestic Homicide Reviews. (Please refer to management action 3.)

Reporting of Domestic Homicide cases

Safeguarding Adult Review/ Serious Childrens Review/ Domestic Homicide Group (Internal)

The Trust has a group which meets on a quarterly basis and reviews the actions arising from SARs, SCRs and DHs. The group is attended by a representative from Adults and Childrens Safeguarding at RWT, Health Visiting, and the Head of Safeguarding the named Paediatrician.

All actions arising as a result of Domestic Homicide Reviews are documented within the action plan. From review of the latest action plan, dated December 2016 confirmed that there were seven actions outstanding from Domestic Homicide cases in 2012/2013. These actions are still being monitored by the Trust and cannot yet be closed on the action plan.

Domestic Homicide Committee

There is a Domestic Homicide Committee is chaired by the Trust's named Doctor. Each case would be reviewed by the Committee and an action plan would be developed. There were no minutes or actions plan to review at the time of the audit. Where there are no cases in relation to the Royal Wolverhampton NHS Trust a representative is not in attendance at these meetings.

Wolverhampton Safeguarding Adults Board (external meeting)

The Domestic Homicide Committee reports to the Adults Safeguarding Board.

Sharing of Lessons Learnt from DHRs

Through discussion with the Adults Safeguarding Team it was confirmed that the sharing of any lessons learnt arising from DHRs would be disseminated via the same methods as the SARs.

3.4 Best practice of Sharing Lessons Learnt

We have identified a number of areas that the Trust could consider in order to share the lessons learnt as a result of any Safeguarding incidents. We have detailed below suggestions that have been used at other NHS Organisations:

- Share Safeguarding themes with Directorate Matrons, Sisters and Charge Nurses at monthly meetings (http://www.rbch.nhs.uk/assets/templates/rbch/documents/about_the_trust/compliance/Safeguarding-Annual-Report-2014-2015.pdf)

- Seek staff views on sharing of information, lessons learnt, recommendations and staff needs in relation to fulfilling their Safeguarding responsibilities as part of the annual survey
- Offering staff a range of training opportunities arising from lessons learnt (www.eastbournehailshamandseafordccg.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId...)
- Include the key lessons learnt within the Safeguarding annual report
- Planned local and Trust audits to assess whether learning has been embedded into everyday practice (http://www.mhsc.nhs.uk/media/53518/policy%20on%20embedding%20learning.pdf)

APPENDIX A: FOLLOW UP OF PREVIOUS MANAGEMENT ACTIONS

Management actions that can be closed on the Trust's 4Action:

Based on our current audit findings, we can confirm that the following actions have been implemented or superseded and can therefore be 'closed' on the Trust's 4Action tracking system:

Ref	Original management action and priority
Safeguarding Children (29.15/16)	
2	The Safeguarding Team will document all Safeguarding concerns raised by members of staff throughout the Trust. Information in relation to the advice provided and the actions required will also be documented. This guidance will be sent to the member of staff raising the concerns and the document will be included within the patient's health records as evidence of involvement from the Safeguarding Team. (Medium)
3(b)	The Safeguarding Team will ensure that they work closely with the Health Representative for the Multi-Agency Safeguarding Hub to ensure they are made aware of and involved in all referrals made by the Trust. (Medium)
4	The Safeguarding Team will ensure that there are systems in place to capture the date in which the Safeguarding concern relates to and the date in which the referral was made. The Safeguarding Team will then monitor the Trust's compliance with the Safeguarding Children (CP41) Policy to ensure that all Safeguarding concerns are acted upon the same day. (Medium)
6	The Safeguarding Team will obtain clarification as to who will be responsible for adding and removing Child Protection Plan flags on the systems used throughout the Trust (i.e. PAS, Clinical Web Portal and System One). If it is determined that the responsibility will remain with the Safeguarding Team, it will be arranged for all members of staff to have training and gain appropriate access to the systems so that flags can be updated. (Medium)
7	The Paediatric Liaison will maintain a log of all discharge planning meetings held throughout the Trust. Notes taken at the time of the meeting will be stored securely on the shared drive so that there is a clear audit trail of such meetings taking place. (Medium)
8	The Safeguarding Team will confirm the meeting structure in place for the Wolverhampton Safeguarding Children Board and ensure there is regular representation from the Trust at each meeting. (Medium)
Safeguarding Adults (30.15/16)	
2(a)	The Safeguarding Team will work closely with the Wolverhampton Safeguarding Adults Board to ensure they are made aware of and involved in all referrals made by the Trust. (Medium)
2 (c)	Reminders will be sent throughout the Trust to ensure that copies of all referral forms sent to the Local Authority will be filed within the patient's health records, including the patient's 'skinny files' so that the safeguarding concerns are scanned onto the Clinical Web Portal. (Medium)
3	The Trust's Safeguarding Team will remind all members of staff that they need to be notified of any safeguarding concerns within 24 hours of identification. This involves the Safeguarding Team being copied into the email to the Local Authority so that they have a copy of the referral form. The Team will also begin to monitor compliance with Trust Policy ensuring all referrals are made within 24 hours of identification. (Medium)
4	The Trust's Safeguarding Team will ensure they receive outcomes from the Local Authority/ Safeguarding Board for referrals made on behalf of patients under their care. This may involve the Trust having read only access to the systems used so that they can establish the outcomes. (Medium)

5	The Safeguarding Adults Team will ensure that sufficient evidence is saved to the shared drive for each allegation made against the Trust, this is to include: • Evidence of the allegation (i.e. referral forms); • Evidence of the investigations (i.e. Safeguarding Adults Incident Summary Reports); • Correspondence with the lead for the investigation and with the Trust's Social Care Team; and • Outcomes (i.e. when the case is closed). (Medium)
7	The Safeguarding Team will confirm the meeting structure in place for the Wolverhampton Safeguarding Adults Board and ensure there is regular representation from the Trust at each meeting. (Medium)

Management actions that are not implemented and should be re-opened / remain open on 4Action:

Based on the results of our current audit testing, the following actions have not yet been fully implemented. These actions should remain 'open' on the Trust's 4Action tracking system:

Ref	Original management action and priority	Follow up findings	Responsible officer and revised implementation date
Safeguarding Children (29.15/16)			
1	The Safeguarding Children (CP41) Policy will be updated to reflect the processes in place at the Trust. This will include, but not be limited to: • Reference to the Multi-Agency Safeguarding Hub and the revised Multi-Agency Referral Forms. • Reference to the responsibility for flagging Child Protection Plans on the systems used throughout the Trust (Patient Administration System / Clinical Web Portal / System One) • Guidance on who is responsible for organising discharge planning meetings and what information will be shared and filed on the patient's health records. • Filing of advice provided by the Safeguarding Team within the patient's health records. (Medium)	**Not yet implemented** The Trust's Safeguarding Children (CP41) Policy was last reviewed in June 2015 and, therefore, has not been updated since our internal audit review in March 2016. The Head of Safeguarding explained that updates to processes for Safeguarding children are documented on the Trust's intranet pages, as the Policy itself is not due to be reviewed until June 2018.	Fiona Pickford, Head of Safeguarding September 2017
3(a)	The Safeguarding Team will ensure their service is promoted to the whole of the Trust. Staff will also be reminded of their responsibilities regarding the reporting of concerns and making sure the Safeguarding Team is aware of all referrals. (High)	**Being implemented** The Trust's intranet includes a dedicated page for the Safeguarding Team. The Head of Safeguarding is also in process of developing a quarterly newsletter to be published to all members of staff in Spring, Summer, Autumn and Winter. The draft newsletter, due to be published in Spring 2017 includes the following: • Team photo and contact details for the Trust's Safeguarding Team;	Fiona Pickford, Head of Safeguarding July 2017

		• Introduction from the Specialist Safeguarding Nurse based at the Multi-Agency Safeguarding Hub (MASH); • Information in relation to Deprivation of Liberty Safeguarding and who to contact for support; and • Lessons learnt from Serious Case Reviews / Safeguarding Adult Reviews following investigations carried out by the Wolverhampton Safeguarding Board. In addition, the Trust has a 'Safeguarding Operational Group' and a 'Safeguarding Strategic Group' which is a forum for promoting the Safeguarding Team and the services provided to the Trust.	
Safeguarding Adults (30.15/16)			
1	The Safeguarding Adults (CP53) Policy will be updated to reflect the current processes in place at the Trust. This will include: • Updated training requirements, including how the training will be achieved, the target audience and how often the training will be undertaken. • Filing of advice provided by the Safeguarding Team within the patient's health records • Reference to the responsibility for filing referral forms on the Clinical Web Portal. (Medium)	**Not yet implemented** The Trust's Safeguarding Adults (CP53) Policy was last reviewed in April 2015 and, therefore, has not been updated since our internal audit review in March 2016. The Head of Safeguarding explained that updates to processes for Safeguarding adults are documented on the Trust's intranet pages, as the Policy itself is not due to be reviewed until April 2018.	Fiona Pickford, Head of Safeguarding **October 2017**
2(b)	The Safeguarding Team will ensure their service is promoted to the whole Trust. Staff will also be reminded of their responsibilities regarding the reporting of concerns and making sure the Safeguarding Team is aware of all referrals (High)	**Being implemented** The Trust's intranet includes a dedicated page for the Safeguarding Team. The Head of Safeguarding is also in process of developing a quarterly newsletter to be published to all members of staff in Spring, Summer, Autumn and Winter. The draft newsletter, due to be published in Spring 2017 includes the following: • Team photo and contact details for the Trust's Safeguarding Team; • Introduction from the Specialist Safeguarding Nurse based at the Multi-Agency Safeguarding Hub (MASH); • Information in relation to Deprivation of Liberty Safeguarding and who to contact for support; and	Fiona Pickford, Head of Safeguarding **July 2017**

		• Lessons learnt from Serious Case Reviews / Safeguarding Adult Reviews following investigations carried out by the Wolverhampton Safeguarding Board. In addition, the Safeguarding Team goes out to the Trust's Emergency Department each day to prompt the staff to report any safeguarding / domestic violence concerns. A log is maintained of who was spoken to and what safeguarding concerns had been raised.	
6	Safeguarding Adults Training available to Trust members of staff (Levels 1 to 3) will be revised as a stand-alone training package. The training will be benchmarked against available guidance and then reintroduced into the Trust induction to ensure all members of staff have the minimum required level of training. (Medium)	**Not yet implemented** As at the time of our initial internal audit in March 2016, the Trust's Safeguarding Team were awaiting the Intercollegiate Document for Safeguarding Adults in order to review the training package made available for members of staff within the Trust. The Intercollegiate Document for Safeguarding Adults was issued as a draft in February 2016, but was later challenged and has not yet been issued/ published as a final. The Safeguarding Specialist for Adults explained that the Safeguarding Adults Level 1 training is presented to all members of staff at induction. The Level 2 e-learning training for Safeguarding Adults is still incorporated into the Safeguarding Children's training and as a result the Head of Safeguarding is preparing a Training Strategy for 2017/18 to move this forwards.	Fiona Pickford, Head of Safeguarding **October 2017**

APPENDIX B: SCOPE

Scope of the review

To evaluate the adequacy of risk management and control within the system and the extent to which controls have been applied, with a view to providing an opinion. The scope was planned to provide assurance on the controls and mitigations in place relating to the following areas:

Objective of the risk under review
To assess the continuing arrangements for Safeguarding both children and adults. This will involve following up on the work undertaken as part of our 2015/16 plan to ensure that all actions identified have been implemented as agreed. We will also consider the methodology the Trust utilises for learning from Serious Case Reviews and Domestic Homicide cases to ensure lessons learnt are disseminated and actions are taken prior to the publication of formal investigation reports.

When planning the audit, the following areas for consideration and limitations were agreed:

Areas for consideration:

- Following on from our reviews of Safeguarding Children (29.15/16) and Safeguarding Adults (30.15/16), we have considered the progress made in implementing the agreed management actions.
- As part of this review we have also examined the processes in place to ensure that the Trust learns and appropriately disseminates learning relating to Serious Case Reviews and any cases of Domestic Homicide. We have ensured that wherever possible actions identified as part of these reviews are taken as soon as possible. We have also considered what processes are in place at other Trusts and share best practice where possible.

Limitations to the scope of the audit assignment:

- Our review does not provide assurance that current performance will be maintained or indeed improve.
- Where follow up testing has been undertaken our samples have be selected over the period since actions were implemented or controls enhanced.
- All testing has been undertaken on a sample basis only.
- This review has been limited to the assessment of the identified management actions and has not provided assurance of the complete control framework for the above reports. Therefore, we have not provided assurance on the completed risk and control framework.
- This review has not commented on the accuracy and suitability of actions identified within Serious Case Reviews or Domestic Homicide cases, it has only confirmed that actions are identified, shared and monitored through to completion.
- Our work does not provide absolute assurance that material errors, loss or fraud do not exist.

FOR FURTHER INFORMATION CONTACT

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