



**The Leeds  
Teaching Hospitals**  
NHS Trust

# **Safeguarding Annual Report 2024-2025**



**Leeds Safeguarding  
Children Partnership**



**Leeds Safeguarding  
Adults Board**

## Foreword

As we move into 2025, the Safeguarding Annual Report provides an opportunity to reflect on where we need to focus our efforts in the year ahead and celebrate our achievements from the previous year. We continue to make good progress in relation to our ambitions as set out in our 2023-24 report. Leeds Teaching Hospitals NHS Trust (LTHT) recognises that one of the most important principles of safeguarding is that it is 'everyone's responsibility.'

Safeguarding the unborn, children, young people and adults cannot be done in isolation; it is only truly effective when we work collaboratively and restoratively with our partner agencies to 'Think Family' and protect all those at risk of harm, abuse or neglect. This city-wide approach is being embedded across all our services, whilst focusing on developing evidence-based approaches to safeguarding practice that balances the rights and choices of an individual, with the Trust duties to act in their best interest to protect the patient, the public and the organisation from harm.

Safeguarding is complex and challenging and our plans for the year ahead are ambitious, but they are achievable and underpinned by the 'Leeds Way' to ensure our service is patient-centered, fair, collaborative, accountable and empowering.

The Safeguarding Team wants to thank all our dedicated staff, our supportive partners, the Executive Team, and the Trust Board who continue to work so positively with us to make Leeds Teaching Hospitals Trust a safer place to work and Leeds a safer place to live.

**Our Mission:** To provide outstanding safeguarding support, supervision and training, in partnership with others to prevent harm and safeguard our patients, their families and communities.

**Our Vision:** To be a trusted, safe organisation where all children, young people and adults at risk of harm, abuse or neglect are safeguarded by staff who feel empowered, valued and supported. Working collaboratively and innovatively with our patients and their families to ensure the best support and outcome is achieved.

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# 1. Introduction

Welcome to the combined Leeds Teaching Hospitals NHS Trust (LTHT) Safeguarding Annual Report 2024-2025. LTHT, the Executive team, safeguarding leads and managers are committed to ensuring that the safeguarding of our patients, their families, our staff and our communities are at the foundation of our Trust values and are embedded throughout Leeds Way.

A joint children and adult approach have been adopted in line with the Trust's shared safeguarding agendas, principals and duties of care as it is only truly effective when we work collaboratively and restoratively with our partner agencies to 'Think Family' and protect all those at risk of harm, abuse or neglect. This report will provide a declaration of assurance that the Trust is fulfilling its duties and responsibilities in relation to promoting the welfare of children, young people, adults and their families or carers who come into contact with our services.

The 2024-2025 annual report provides the Trust Board with:

- An overview of the local, regional and national context of safeguarding.
- An overview of safeguarding practice within the Trust.
- The Safeguarding and Mental Capacity Act and Mental Health Legislation Teams activity, achievements and progress during 2024-2025 to develop a culture that puts safeguarding at the centre of all care delivery.
- Assurance that the Trust is meeting its statutory obligations and the required national standards regarding safeguarding and mental capacity.
- 2025-2026 challenges, future priorities and work plans for the safeguarding teams to demonstrate continuous improvement on the arrangements currently in place.
- The Mental Capacity Act and Mental Health Legislation Teams Annual Report (Section 11).
- The Annual MISPERs Report (Appendix 2).

Everybody has the right to be safe and free from abuse and protected from harm, regardless of who they are, or what their circumstances. The term 'safeguarding' encompasses all activities to assist the unborn, children, young people and adults at risk to live a life that is free from abuse and neglect and to enable independence, wellbeing, dignity and choice. Safeguarding includes the early identification and/or prevention of harm, exploitation, and abuse by using national guidelines, local multi-agency procedures and by disseminating 'lessons learnt' and promoting best practice from serious incidents to improve future service development for patients and staff.

The Safeguarding Team strives to ensure all safeguarding processes are robust and effective; we are responsive to emerging local and national needs. This enables us to achieve full compliance with all our safeguarding standards. But more importantly we ensure that the person at risk of or suffering neglect, harm or abuse always remains in our 'line of sight,' we 'hear their voice' and they remain at the centre of all we do.

In doing so, the Trust discharges part of its responsibility for Board-level assurance, scrutiny and challenge of safeguarding practice within the Trust, in line with the statutory requirements of section 11 Children Act (2004), Working Together to

Safeguard Children (2023), the Mental Capacity Act (2005) and the Care Act (2014).

In addition to the requirements of the Children Act (2004), the Trust, as a registered provider with the Care Quality Commission (CQC), must have regard for the Regulations as established under the Health and Social Care Act (2008). In relation to Safeguarding, including but not limited to, Regulation 13 and Regulation 17, relating to protecting service users from abuse and good governance, respectively.

This report presents the integrated safeguarding portfolio and is arranged sequentially under safeguarding the unborn, children, safeguarding adults, mental capacity and mental health legislation.

## **2. Statutory Frameworks and National Policy Drivers**

The NHS is founded on a common set of principles and values that connect the communities and people it serves - patients and public, and its staff, identified within this NHS Constitution. Safeguarding is encompassed within all the principles as a core value in accordance with individual's human rights; the principles lend themselves to ensuring that LTHT, by law, takes account of this Constitution in its decisions and actions.

Whilst safeguarding shares the same agendas and principles for adults and children, there are significant differences in the laws and policies that shape how we safeguard these groups. The legal framework to protect children is contained in Working Together to Safeguard Children (2023) and the Care Act (2014) for adults. However, the overarching objective for both is to enable children and adults to live a life free from harm, abuse or neglect.

The Children Act (1989) and Section 11 of the Children Act (2004) place a statutory duty on all NHS Trusts to plan to ensure that it has regard for the need to safeguard and promote the welfare of children when exercising its functions.

The statutory guidance 'Working Together to Safeguard Children (2023) supports the multi-agency safeguarding arrangements set out in the Children and Social Work Act (2017).

The Care Act (2014) sets out a clear legal framework for how local authorities and other agencies should protect adults at risk of abuse or neglect. The focus is on personalised and outcome focused care with an emphasis on making adult safeguarding 'personal.' Adults should therefore be seen as experts in their own lives and safeguarding means working 'with the adult' and not a process that is done to or for an adult.

Trust safeguarding policies, procedures and training are up to date with current child and adult safeguarding legislation and includes new Leeds Safeguarding Children Partnership (LSCP) definitions and arrangements and how Leeds Teaching Hospitals Trust discharges its statutory safeguarding duties in relation to:

- Human Rights Act (1998)
- Working Together to Safeguard Children (2023)

- Children and Social Work Act (2017)
- Children Act (1989, 2004)
- Care Act (2014)
- Serious Crime Act (2015)
- The Marriage and Civil Partnership (Minimum Age) Act 2022
- Modern Slavery Act (2015)
- Counter-Terrorism and Security Act (2015)
- CQC registration standards, Health and Social Care 2008 (Regulated Activities) Regulations 2014: Regulation 13
- CQC national standards of quality and safety - Outcomes 7-11: Essential standards of quality and safety
- Domestic Abuse Act (2021)
- Female Genital Mutilation Act (2003)
- Safeguarding Vulnerable Groups act (2006)



## 2.1 The Counter-Terrorism and Security Act 2015

The Counter-Terrorism and Security Act 2015, places a specific duty on statutory bodies including the police, local authorities and health organisations to have 'due regard' to help 'prevent' people being drawn into terrorism. It also makes representation at the CHANNEL process (a standardised voluntary multi-agency programme for people at risk of radicalisation), a legal requirement for public bodies across the country.

The overall aim of the government counter-terrorism strategy, CONTEST, is to reduce the risk from terrorism to the UK, its citizens and interests overseas, so that people can go about their lives freely and with confidence. Prevent remains one of the key pillars of CONTEST, alongside the other three 'P' work strands:

- **Pursue** - to disrupt terrorist activity and stop attacks;
- **Protect** - strengthening the UK's infrastructure to stop or increase resilience to any possible attack;
- **Prepare** - should an attack occur then ensure prompt response and lessen the impact of the attack.

The NHS and its partners have a role in the 'Prevent' section of this strategy which is underpinned by the Counter-Terrorism and Security Act (2015). Prevent is a key strand of NHS England's safeguarding arrangements.

A considerable proportion of work under the Prevent duty in healthcare relates to safeguarding vulnerable people at risk of exploitation or abuse. Healthcare professionals should consider both the person's best interests and the public interest. Preventing someone from being radicalised into terrorism should be managed in the same way as other safeguarding responsibilities within healthcare - for example, child



abuse or domestic violence. Radicalisation is a form of exploitation like other forms of exploitation, such as grooming and child sexual exploitation.

## **2.2 Current Position of LTHT**

- The Executive lead for Prevent at LTHT is the Chief Nurse; LTHT Prevent Lead is the Head of Nursing, Safeguarding, Mental Health Legislation, Learning Disabilities and Autism. The Prevent lead provides a point of contact for the Regional Prevent Coordinators. On a quarterly basis, Prevent activity undertaken by the Trust is reported to NHSE.
- The Safeguarding Team provide advice and support for LTHT staff reporting Prevent cases and liaise with Counter Terrorist Regional Police to share information for CHANNEL or high-risk cases.
- LTHT is represented on the Leeds city 'Silver' Prevent panel by the Head of Nursing for Safeguarding, Mental Health Legislation, Learning Disabilities and Autism and on the Leeds, CHANNEL panels by the Lead Professional for Safeguarding Adults.
- Prevent training is mandatory for all NHS trusts and foundation trusts. LTHT delivers Home Office Level 1 Prevent training; this is embedded into corporate induction.
- LTHT has transferred its Prevent Level 2 (HealthWrap) training offer to the Health Education England Prevent platform to ensure staff have access to the most up-to-date and quality training in this area.
- The Trust submits a quarterly return to NHS England. The data submitted monitors the key elements of the Prevent duties and responsibilities which include:
  - Identification of Prevent leads - strategic and operational.
  - Delivery of training.
  - The levels of referrals made via the Channel process.
  - Representation and engagement with local and regional Prevent leads.
- The outcome of the terror-related incident at the Trust in January 2023 has seen that the individual responsible was found guilty and sentenced to life imprisonment. The collation of the learning and actions of this case from a human resources and Safeguarding perspective continues.
- The Lead Professionals collaborate with the city-wide Health Economy Prevent leads to ensure a consistent approach in terms of training and response to Prevent related concerns.
- Considering recent national incidents, including the knife attack in Southport, Lancashire, the focus on Prevent, its role in identifying and supporting individuals, through the Channel process in the pre-criminal space, has come under intense scrutiny nationally. As a health-care provider and employer, it is essential that our staff continue to understand the crucial role they can play in safeguarding these individuals.
- The Safeguarding team continue to advise and support staff with escalating Prevent related concerns, collaborating closely with Leeds City Council Prevent team in seeking expert advice and in accessing training opportunities.

## **3. Governance Arrangements for Safeguarding**

### **3.1 LTHT Internal Safeguarding Governance**

LTHT is accountable for ensuring that its own safeguarding structure and processes meet the required statutory requirements of the Children's Act (2004), the Care Act (2014) and other statutory and national guidance. The safeguarding roles, duties, and responsibilities of all organisations in the National Health Service (NHS) including the Trust, are laid out in the NHS England 'Accountability and Assurance Framework' which was published in 2015. Therefore, robust governance processes are in place to ensure that services delivered are keeping people of all ages safe.

The Trust has a statutory duty to maintain mandated roles within the organisation in relation to safeguarding. These have been fulfilled throughout 2024-2025. The Chief Nurse is the Executive Lead for Safeguarding. The Named Nurse and Named Midwife for Safeguarding are also statutory roles.

The Deputy Chief Nurse and the Head of Nursing for Safeguarding, Mental Health Legislation, Learning Disabilities and Autism provide strategic direction for both adult and children's safeguarding and support the Chief Nurse in the Executive role.

Lead and named professionals provide the organisation with operational advice, support and input and are committed to supporting the workforce in understanding safeguarding, embedding it into 'everyday business' and improving outcomes.

The Trust Safeguarding Combined Team is committed to providing an integrated and consistent approach through its organisational structure. The Trust also provides additional external quarterly reporting to the NHS West Yorkshire Integrated Care Board (ICB).

A full revision of the internal governance for safeguarding assurance was introduced in Quarter 1 of 2024 to ensure a stronger more robust mechanism of assurance and internal scrutiny.

This included the trust wide Quarterly Safeguarding Governance Meeting (QSGM) and the bi-monthly Safeguarding, Mental Capacity and Mental Health Act, Learning Disabilities and Autism, Sub-group (SMHLDA) to provide challenge and assurance with regard to the safeguarding arrangements within the Trust, monitor compliance and benchmarking with external standards and key clinical effectiveness indicators, including Care Quality Commission (CQC) outcomes, and report, advise and act on findings to address any gaps in service.

The LTHT Safeguarding, Learning Disabilities & Autism, Mental Capacity, and Mental Health Teams are committed to strengthening collaboration with CSUs through greater engagement, so the new arrangements also include improved mechanisms of data collection and safeguarding information within safeguarding teams and the CSUs. Now two Clinical Service Units (CSU) present their Safeguarding, Learning Disabilities, Mental Capacity, and Mental Health information and data on a slide deck at each Quarterly Safeguarding Governance Meeting (QSGM) governance meeting.

Quarterly assurance reports (or minutes from these meetings) are shared with the Quality and Safety Assurance Group, which in turn feeds into the Quality Assurance Committee, which informs the Trust Board. These assurance reports are also provided

to the ICB in line with reporting requirements.

In addition, the Safeguarding teams contribute to the clinical service units Chief Nurse Quality and Patient Safety dashboards. The dashboards present the data for safeguarding activity, where a harm has occurred within the Trust, mandatory training compliance, and safeguarding associated lessons learnt following incidents from a Trust-wide perspective, reflecting themes and common occurrences revealed through investigations.

**Figure 1. LTHT Safeguarding Board to Floor Governance**



The Children's and Midwifery and Adult Safeguarding Teams contribute to the local Safeguarding Partnership Annual Reports and the Safeguarding Annual Work Programme. In addition, the Children and Midwifery Team complete an annual 'Organisational Safeguarding Assessment' as part of Section 11 duties under the Children Act 2004. The Adult Safeguarding team also provides assurance to LSAB via the annual self-assessment and Dashboard.

The Trust Safeguarding Team provides assurance to the ICB Quality Group through the 'Annual Safeguarding Standards for Providers' return. LTHT Safeguarding also provide a quarterly return to NHS England via a national provider dataset.

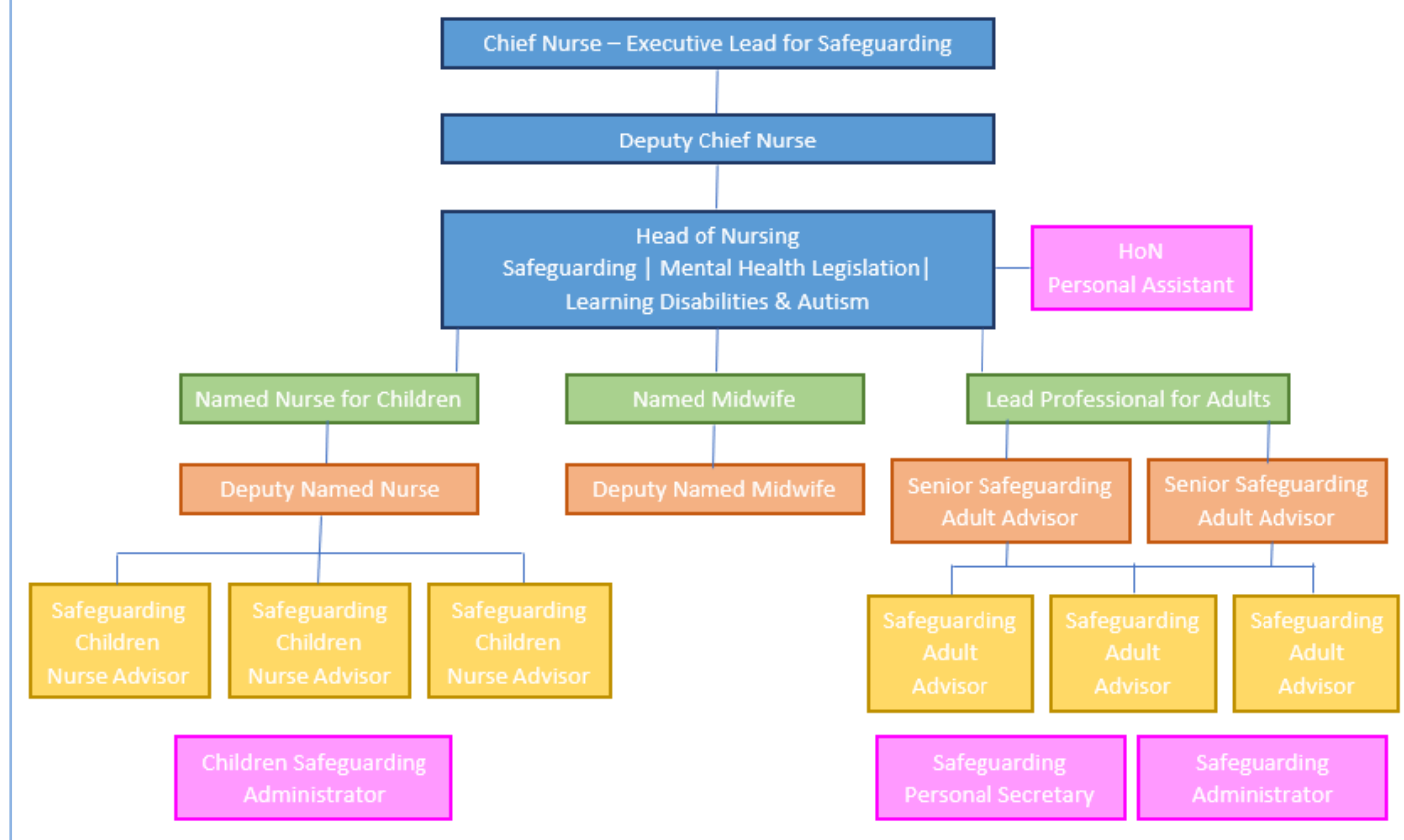
The 2023-2024 Standard NHS Contract for All Services: Schedule C, Part 7.2 has also been met and the contract for 2024-5 with new safeguarding Key Performance Indicators has been agreed. The Trust will continue to report quarterly on its progress throughout the year.

The Combined Safeguarding Team is made up of a diverse and multi-professional team who provide specialist and expert safeguarding training, advice, support, and

supervision to all Trust employees on a wide range of safeguarding issues affecting the unborn, children, young people, adults and their families and carers.

Our monthly Combined Safeguarding Team meetings provide an opportunity for the Adult and Children and Midwifery Safeguarding Teams to come together to share and disseminate good practice, develop training and monitor the implementation and effectiveness of our safeguarding strategies.

### Safeguarding Children and Adults Organogram



## 3.2 External Safeguarding Governance and working with partners

LTHT remains fully engaged with the safeguarding agenda with a high safeguarding profile within the city and regionally. LTHT is a committed and key partner for safeguarding across the city of Leeds. This is achieved by:

- Membership of Leeds Safeguarding Adults Board (LSAB) and Leeds Safeguarding Children's Partnership (LSCP) and active participation of the sub-groups of both Boards.
- Active contribution and participation in the Annual Reports and associated key work streams of the LSAB and LSCP.
- Multi-agency audit and multi-agency training with the LSAB and LSCP and Leeds City Council Domestic Abuse Team.
- Active contribution to Safeguarding Adult Reviews (SAR's), Child Safeguarding Practice Reviews (CSPR), Fatal Incident Review (FIR), Rapid Reviews (RR) and

Domestic Abuse Related Death Reviews (DARDR).

- LTHT is a standing member of the LSAB Exceptional Risk Forum.
- Active participation at complex safeguarding meetings.
- Weekly attendance at the Emergency Department citywide MDT.
- Attendance and dissemination of information at both the Multi-Agency Risk Assessment Conference (MARAC) and Daily Risk Assessment Meeting (DRAM) when appropriate.
- Attendance at city wide Domestic Violence Strategic Group, Non-Fatal Strangulation Group and Domestic Violence and Abuse Health group.
- Commitment to support the Prevent agenda in Leeds, with LTHT membership on the Leeds Prevent Silver panel and Channel panel.
- Close liaison and dissemination of information with the Leeds Multi Agency Safeguarding Front Door.
- Active contribution to the Multi-Agency Child Exploitation Meeting (MACE).
- Active contribution and participation at the Guiding a New Generation Meeting (GANG).
- Active contribution and participation at the Girls in Gangs meeting.
- Named Nurse for Children, attends a multi-agency allegation management group once a quarter to ensure staff are kept up to date and best practice standards are met.
- Attendance at the Quarterly Health Agency Safeguarding Group.
- Attendance at the City-wide Modern Slavery Operational and Strategic Groups.
- Representation in the City-wide Organised Crime Gangs, Girls in Gangs and other Violent Crime and Child Exploitation forums.
- Attendance at the Quarterly Hate Crime Operational Group.
- Representation at the Anti-Muslim Hatred Group.
- LTHT is also leading on a variety of city-wide work streams including the LSAB Self-Neglect Strategy and the Non-Fatal Strangulation clinical pathway.



### **3.3 Leeds Safeguarding Children Partnership (LSCP)**

The Trust continues to be represented at the Leeds Safeguarding Children Partnership (LSCP) by the Chief Nurse, Deputy Chief Nurse and Head of Nursing for Safeguarding, Mental Health Legislation, Learning Disabilities and Autism.

LTHT is considered a 'relevant partner' and is represented at the new Leeds Children Young People Partnership (LCYPP) by the Chief Nurse, Deputy Chief Nurse and Head of Nursing Safeguarding, Mental Health Legislation, Learning Disabilities and Autism, Children's CSU clinical director and Head of Nursing.

To establish the priorities of 2024-2025 the LSCP Executive considered the progress with the current priorities, learning from reviews, inspection findings, the reviewed Working Together to Safeguarding Children (2023) guidance, alongside an OBA event with partners and a Takeover event with young people.

LTHT Children and Midwifery Team has undertaken extensive work which is evidenced in this report to address the LSCP 2024-2025 priorities of:

- Domestic abuse - children as victims
- Safeguarding through Family Help
- Safeguarding Teenagers- serious youth violence and exploitation



### 3.4 Leeds Safeguarding Adults Board (LSAB)

The Trust is represented on the LSAB by the Chief Nurse, designated Deputy Chief Nurse and Head of Nursing for Safeguarding, Mental Health Legislation, Learning Disabilities and Autism. The Adult Safeguarding team also continue to attend and represent LTHT at various sub-groups.

The LSAB's 2024-2025 strategic plan continues to focus on its four key ambitions:

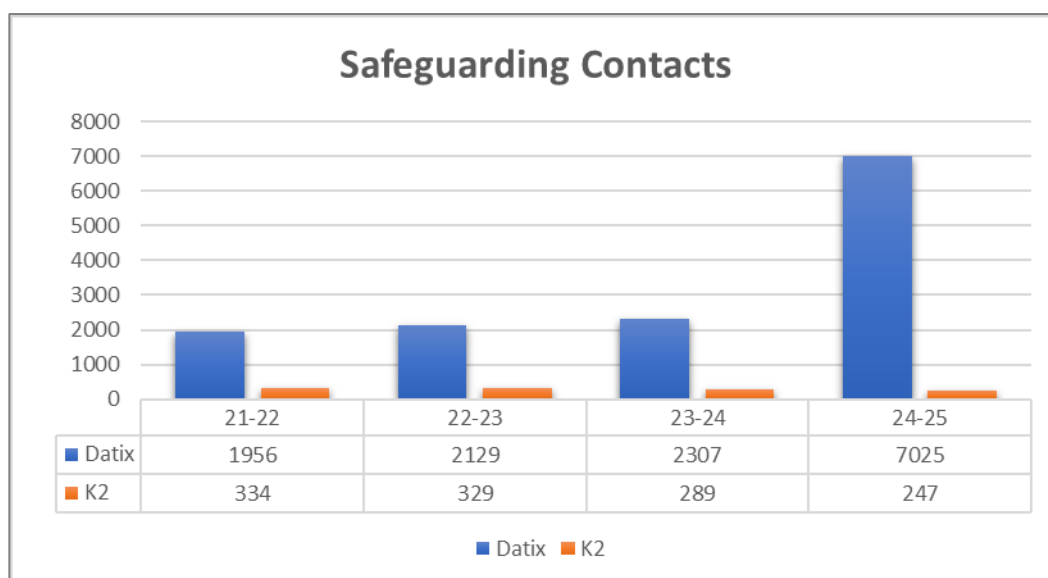
- Develop citizen-led approaches to safeguarding.
- Improve awareness of safeguarding across all communities and partner organisations.
- Develop city-wide approaches to safeguarding practice.
- Learn from previous experience to improve how we work.

LTHT has continued to support the LSAB strategic plan by promoting the Hear My voice agenda and contributing to Safeguarding Adult review learning. We also partake in city wide campaigns such as Yorkshire Safeguarding week to promote safeguarding awareness, contributed to LSAB development sessions, led on the city-wide Self Neglect Strategy and shared any learning via our LTHT pathways.

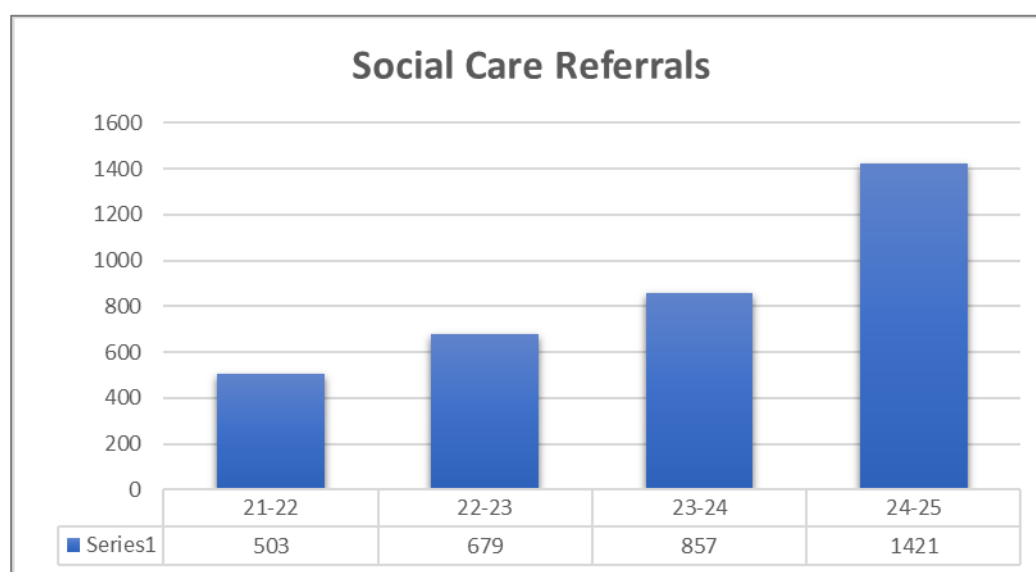
## 4. Safeguarding Team activity and data

### 4.1 Children and Midwifery Contacts and Referrals

All contacts into the Children and Midwifery Team are either captured on a bespoke Datix Safeguarding reporting page or within the K2 digital specialist maternity records. In 2024-2025 the Children and Midwifery Safeguarding Team processed **7025 safeguarding contacts and 247 maternity specific safeguarding contacts** via the K2 digital maternity records. Safeguarding **contacts** have **increased by a significant 204%**- this is in part because of better data collection by the team since last year but also demonstrates the significant increase in all areas of work the team are seeing as per the data below.



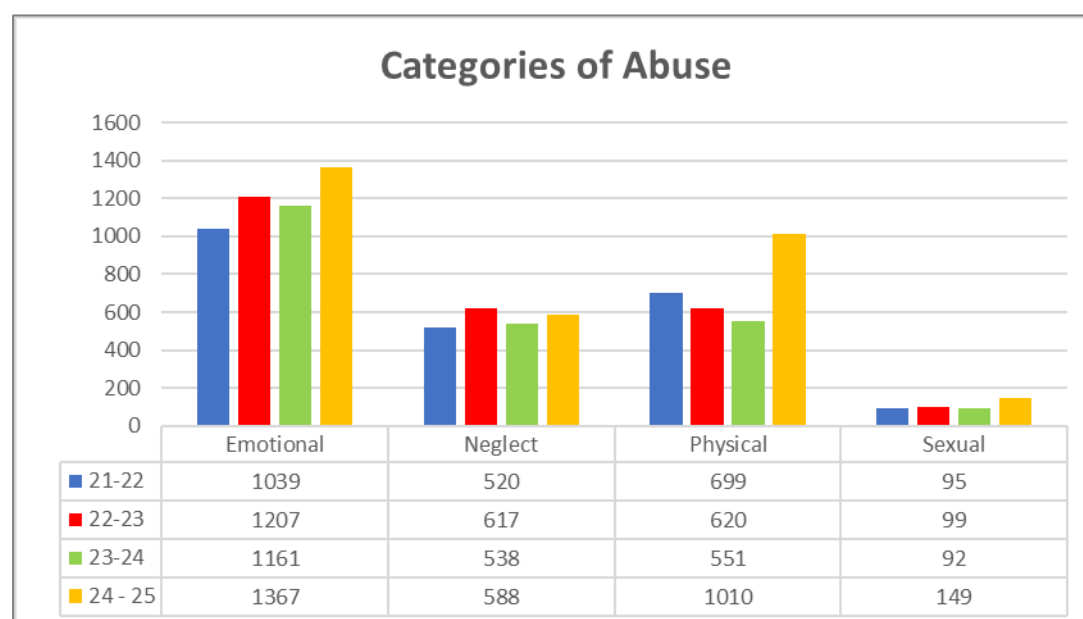
The Children and Midwifery Safeguarding Team reviewed **1421 new children social care referrals** sent by LTHT Trust staff for quality assurance; if they have a Datix record that predates the previous rolling year these are not captured. This is a **significant increase of 66%** from 2023-24. This may be in part due to the new process in the Emergency Department which makes referring to social care easier for operational staff to complete, which was implemented last year.



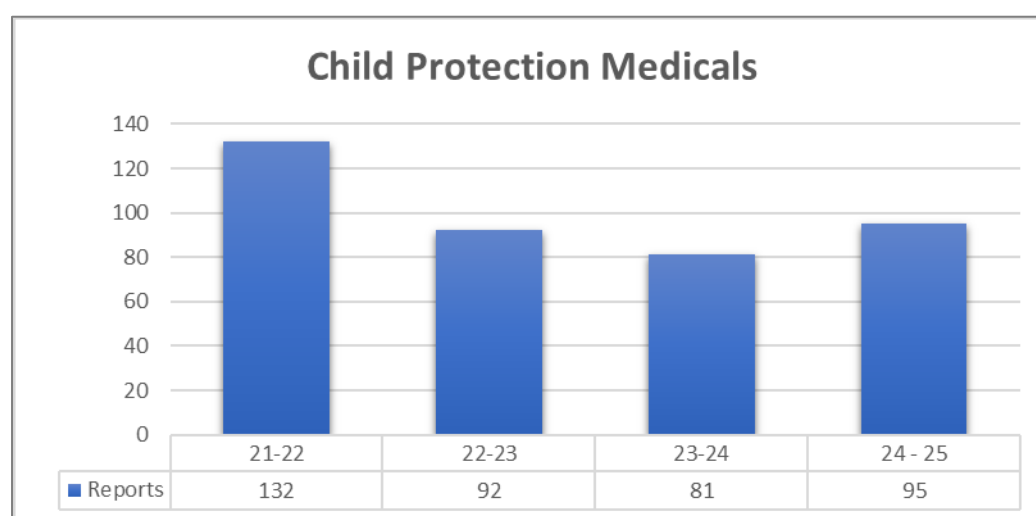
LTHT also notified the local authority under **Section 85 of the Children Act of 35 children** who have been an in-patient in the Children CSU for more than 90 consecutive days. This statutory process began in 2022-23, when we processed 58 notifications, so this demonstrates a decrease in length-of-stay in-patients under 18.

LTHT referrals to Children Social Care indicate emotional abuse remains the highest recorded category in children. However, **reports of physical abuse have increased by nearly 83% and sexual abuse by 62%**. This is due to staff increased knowledge, skills and confidence at identifying and reporting abuse. It should be acknowledged that it is likely children may have suffered more than one type of abuse in one episode

and that emotional abuse is recognised as always inherent with all other types of abuse.

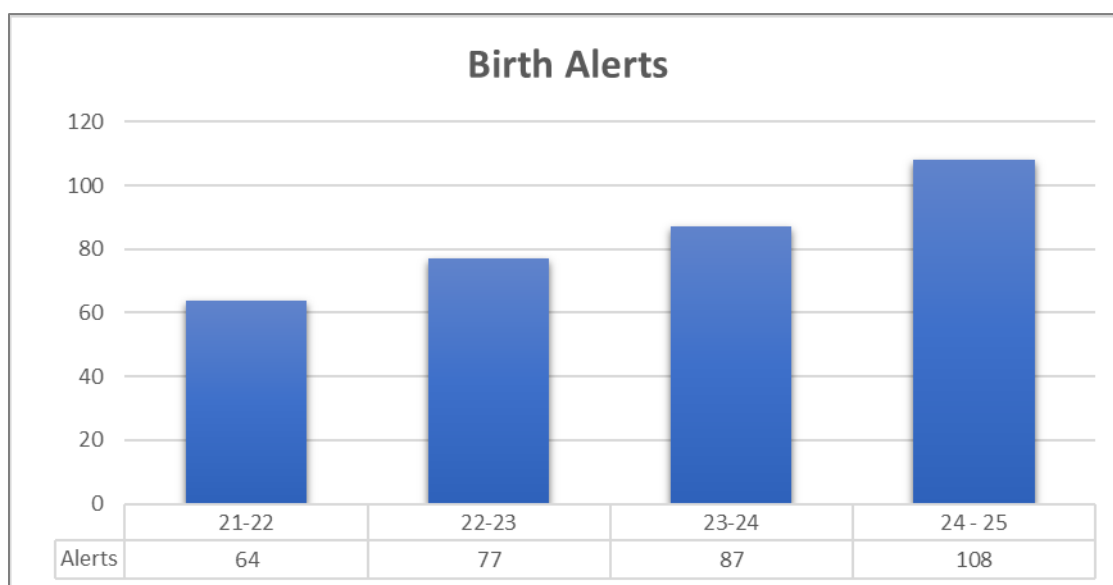


During 2024-2025, 95 **Child Protection Medical Examinations** were undertaken by LTHT; **an increase of 18%** since last year. This figure includes the additional addendum reports or additional findings reports also provided to Children Social Care.



The team processed and reviewed **108 new birth alerts** where Children Social Care has identified serious concerns for unborn babies and their mothers. This is an **increase of 24%** since last year.



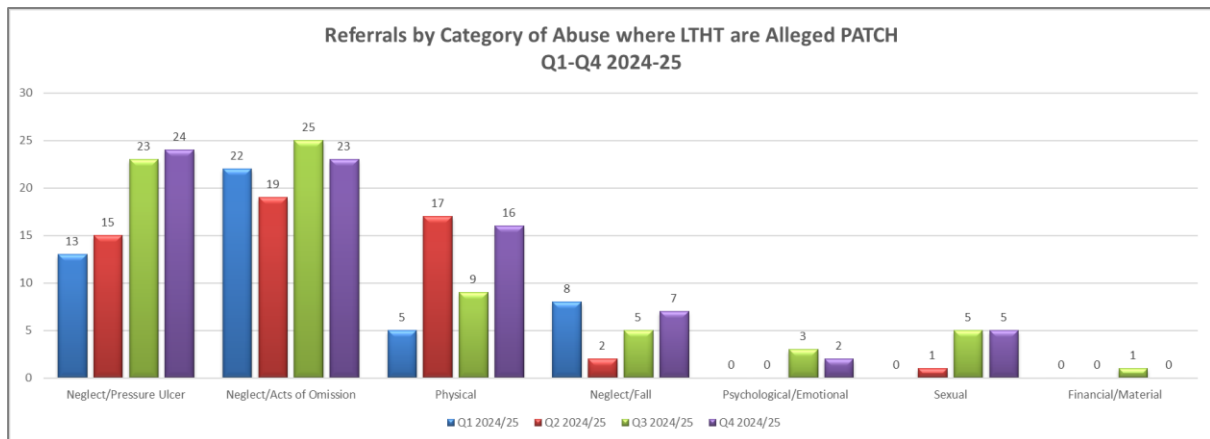


The Children and Midwifery Team attended over **133 strategy meetings** with police and social care due to the risk of significant harm for a child in 2024-2025 an **increase of 33%**. This figure does not include strategy meetings attended by LTHT clinical staff out of hours, or other multi-disciplinary professional or discharge meetings the LTHT Children and Midwifery Safeguarding Team attend. The Children and Midwifery Safeguarding Team also discussed over **339 children and young people at the weekly Emergency Department (ED) MDT (Multi-Disciplinary Team)** during 2024-2025. This **positive decrease of 25%** has been due to the joint work by the Emergency Department and LTHT Children and Midwifery to streamline and improve communication processes via digital solutions on PPM+.

The Children's & Midwifery Safeguarding team focuses on delivering direct safeguarding supervision to teams that are identified to have a high-risk safeguarding caseload. All other case loading teams are being trained to deliver safeguarding supervision based on the peer model where identified trained staff will be trained by the children's & midwifery safeguarding team to facilitate group supervision for their own teams. All other teams receive safeguarding supervision on an ad hoc basis which is in line with the safeguarding supervision arrangements in the maternity. In total, **41 Children specialists MDT's, children departments or wards received safeguarding supervision** in 2024-2025.

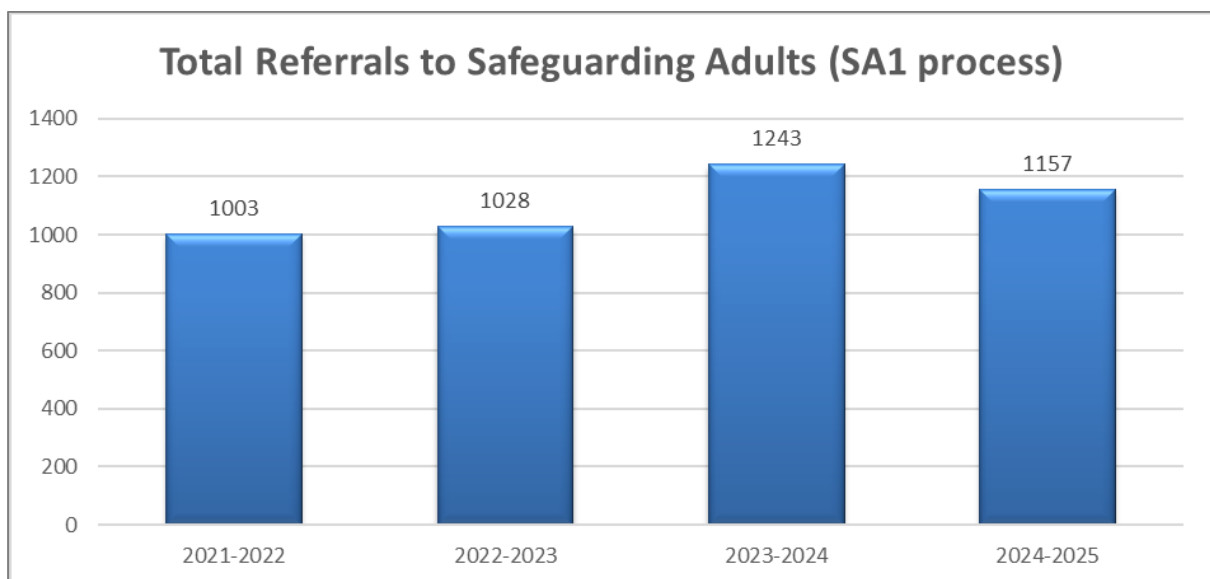
## 4.2 Adult Contacts and Data

The Adult Safeguarding team has continued to provide quarterly Chief Nurse Safeguarding dashboards for every adult CSU highlighting where the Trust has been the Place or Person Alleged To have Caused Harm (PATCH) and shared themes or concerns raised along with the offer of any additional support from the Safeguarding Adult Team if required.



All allegations are reviewed and triaged, not all referrals are deemed to meet the S42 criteria so the Adult Safeguarding team will liaise with the referrer to agree an alternative pathway e.g. PALS/complaints. Where the Safeguarding criteria are met, the team will liaise with the clinical area to ensure a Datix is completed, and the incident is reviewed. The majority of Pressure ulcer and falls will be reviewed under the LTHT PSIRF (Patient Safety Incident Review) Framework.

During 2024-2025 the LTHT Adult Safeguarding team triaged and processed **1157 Adult Safeguarding Referrals (SA1's)**. Of these 869 met the criteria for Section 42 of the Care act and within those the categories of abuse are listed below



2024-2025- neglect and acts of omission remain the highest category of abuse in safeguarding adult referrals where the source of abuse is either internal (LTHT PATCH) or external (Any other community based), and as mentioned the Trust have implemented the PSIRF process for investigation of pressure ulcers and falls which require safeguarding referrals.

Both Domestic Abuse and Self Neglect continue to be a city-wide concern, and the Adult safeguarding team continue to feed into City wide conversations about these two categories.

The above graph continues to show a similar number of safeguarding referrals being made by our LTHT staff year on year and continues to reflect the awareness our staff have at identifying abuse and the impact of societal factors increasing the disclosure of abuse.

Routine enquiry is well established within the documentation for our inpatient areas enabling patients to disclose any harm or abuse they may be suffering in a safe environment. Other outpatient and day case areas have begun to embed this in their local areas, and the questions are now part of the Adult further assessment documentation in the ED settings.

Increased challenges include staffing pressures, acuity of patients, requirements for enhanced care planning, and shortages of discharge options for complex patients.

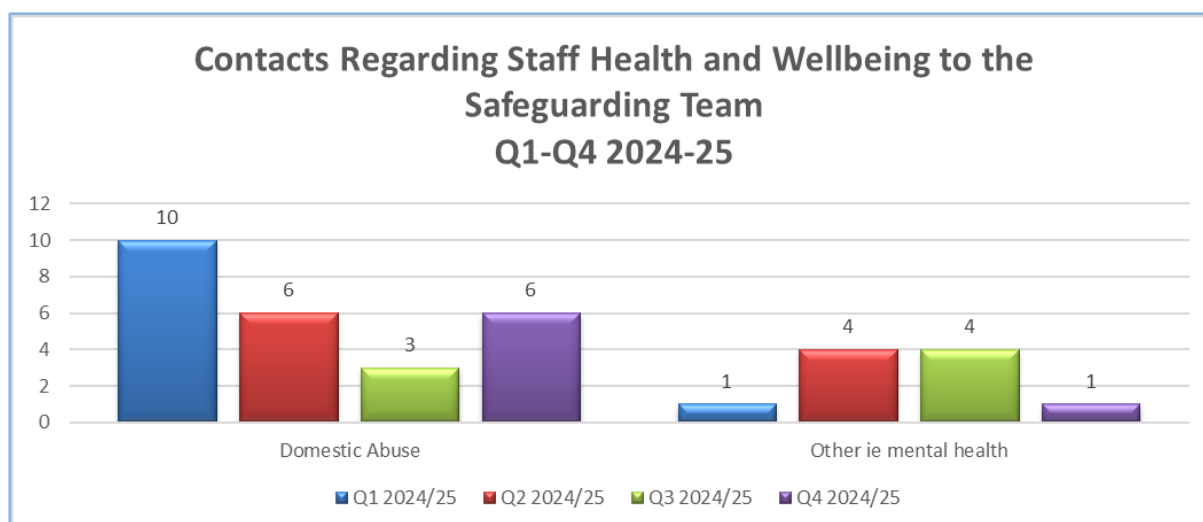
### 4.3 Staff Allegations Data

In 2024, following the launch of the combined Managing Allegations Policy and developed risk assessment tool, training was delivered to support senior managers with the policy and managing difficult situations where allegations occur in relation to LTHT staff. The policy includes a clearer process both when working with children (Local Area Designated Officer- LADO) and when working with adults (People in Positions of Trust - PIPOT) and advice on the Disclosure Barring Service (DBS).

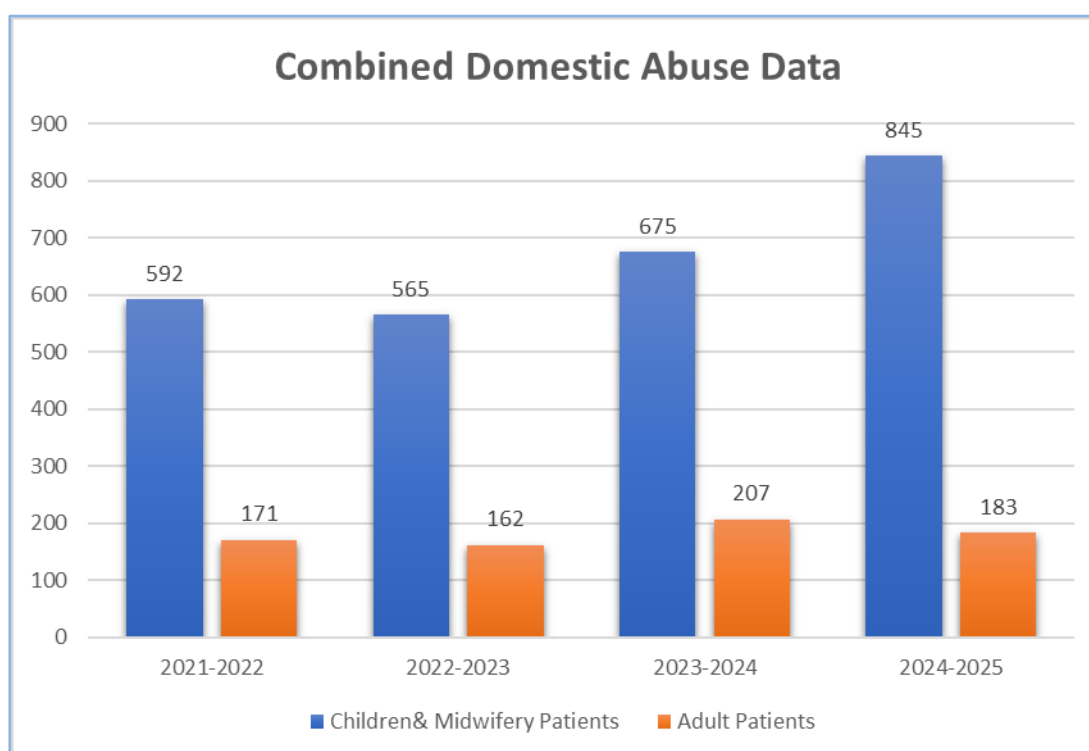
The Children & Midwifery Safeguarding Team processed **42 (61% increase from last year)** allegations against LTHT staff during 2023-2024 **of which 23 met the threshold for a referral to LADO**, 4 were transferred to the adult team for a PIPOT referral and 19 were noted to be related to non-LTHT or for LTHT staff requiring support. LTHT were required to complete referrals for some of the non-LTHT staff.

The Adult Safeguarding Team processed **80** allegations against LTHT staff of which **7** met the threshold for PIPOT referrals. This also included staff who work for the LTHT Bank. Statistically, there is not enough evidence to meet the threshold for PIPOT or further police action where LTHT staff have been alleged but risk mitigation plans are put in place as per safeguarding processes to protect the patients in these scenarios whilst fact finding and investigations take place

Both Safeguarding teams continue to offer support and guidance to staff who are victims of safeguarding concerns and health and wellbeing concerns where supervisors and managers call for advice. We continue to receive calls in relation to domestic abuse, forced marriage and honour based abuse and acknowledge our vast workforce particularly those who are globally trained and those younger staff members who are statistically in a high-risk group for domestic abuse.



#### 4.4 Combined Domestic Abuse Data



The safeguarding team continues to provide support and advice for patients identified as domestic abuse victims/survivors. This not only is the most frequent call for advice across both safeguarding teams but often involves the most complicated and emotive cases of abuse and vicarious trauma. Over the last year there has been **a 25% increase in patients suffering from domestic abuse** compared with the previous year. The bar chart below provides a comparison of numbers to previous years. It is worth noting that most maternity domestic abuse cases, who are adult patients, are advised through the Children's & Midwifery Safeguarding team but will also include mothers who are defined as children too.

The overall numbers consist of contacts from:

- Children who are victims in their own right

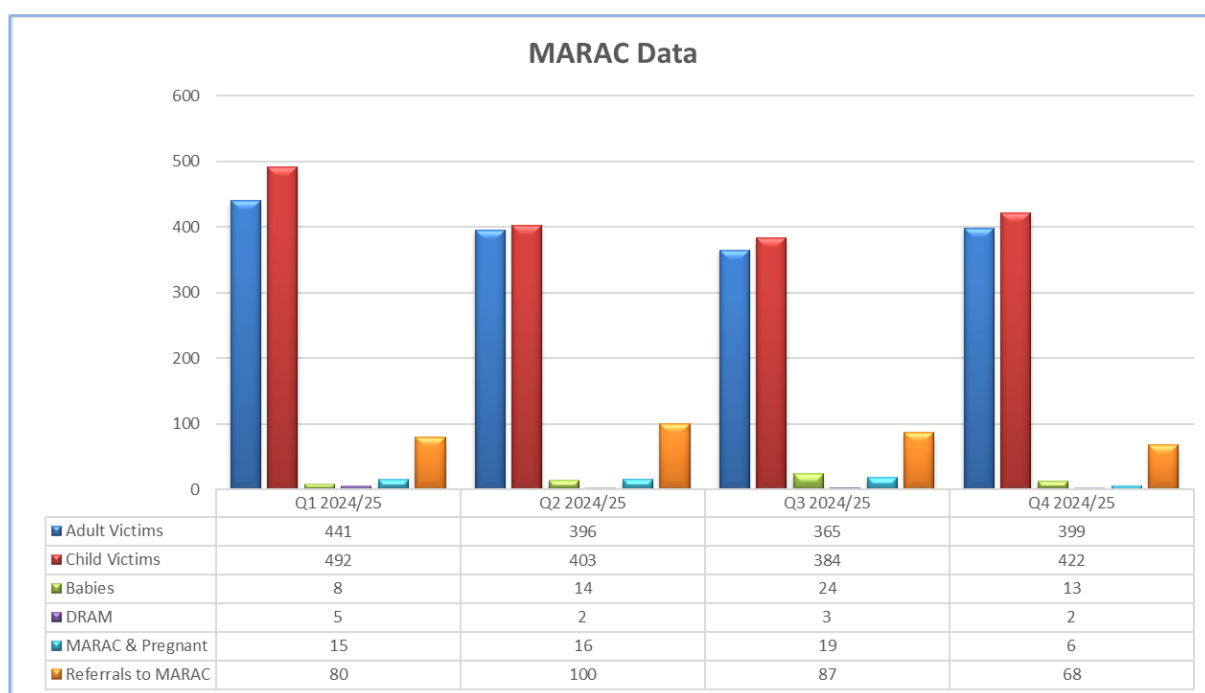
- Parents of children suffering domestic abuse
- Pregnant women suffering from domestic abuse

The safeguarding team continues to strengthen internal processes to recognize and respond to victims/survivors of domestic abuse that present as patients within our organisation. There is staff guidance in the adult and children's safeguarding policy of how disclosures of domestic abuse should be responded to and a quick glance flow chart. Digital solutions have been employed enabling staff to make timely risk assessment and referrals, increasing accessibility of these resources by frontline staff. In addition, the safeguarding team offers various enhanced safeguarding training on a wide variety of subjects related to domestic abuse.

The safeguarding team filters into the city-wide Multi-Agency Risk Assessment Conference (MARAC) information sharing process by daily scoping of cases of high-risk domestic abuse.

Over the past year LTHT have flagged 3361 PPM+ records with a clinician alert highlighting high risk victims of domestic abuse and referred 335 high-risk patients to the Multi-Agency Risk Assessment Conference (MARAC) for further support.

The graph below provides a detailed breakdown of the numbers above.



Members of the safeguarding team form part of a pool of staff delivering city wide multi-agency training relating to domestic abuse and are key stakeholders of the City-Wide Domestic Violence and Abuse Workforce Development Group, Domestic Violence and Abuse Strategy Working Group and the City-Wide Non-fatal strangulation task and finish group which all shape the landscape of how the domestic violence and abuse strategy will be delivered in the City of Leeds.

LTHT have been proactive in addressing the needs of patients who have been victims

of NFS and produced an SOP for clinicians on what steps need to be taken and considered. This has now gone live on Leeds Health Care Pathways.

Due to the risks associated with NFS further questioning on the DASH risk assessment question 15 are in the process of being added to PPM + so staff capture a correct picture of the abuse perpetrated and the next steps required to ensure patient safety and appropriate signposting

The DASH risk assessment tool has been questioned nationally as to its suitability in assessing the risk of older people. Given many of the questions asked are around sexual relationships, pregnancy and children where staff score on information shared and consider referring to MARAC it is questioned “were we missing high risk older people” as many of the questions would give a negative response. LTHT were approached and asked to trial an older persons DASH. This commenced six months ago and is highlighting the probability that current DASH risk assessment is not adequate for the needs of older victims.

## 5. Key Safeguarding Team Achievements in 2024-2025

### 5.1 Safeguarding Week June 2024

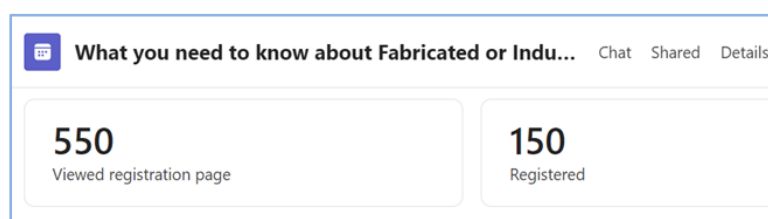
Every year, health, social care and city-wide organisations in Leeds join to promote ‘Safeguarding week.’ The campaign runs over five days in June to raise awareness of safeguarding the unborn, children and young adults, and adults at risk of harm, neglect and abuse and showcase and celebrate the fantastic work that all agencies undertake to protect and safeguard all people in Leeds; it allows sharing of good practice and raises awareness of the services provided to protect and support families and promote this across the city.

The LTHT ‘theme’ for the 2024 campaign was ‘**#FeelSafeInOurCare**’ which we asked staff to endorse via pledges and screensavers.



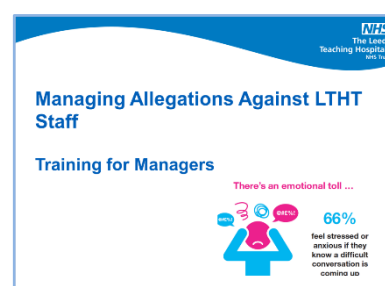
## 5.2 National Safeguarding Week, 18 November 2024

The LSCP, LSAB, SAAN and Safer Stronger Communities work together to deliver a 'Leeds Safeguarding Week', during November to provide practitioners with more training and learning opportunities across a multi-agency audience. LTHT were asked to deliver an on-line training / learning session on an aspect of safeguarding children and young people, that was open to anyone, in any role. The Named Nurse and Named Doctor delivered a session called "What you need to know about Fabricated and Induced Illness". 150 delegates from across social care, police and health joined the session and the positive feedback was overwhelming. The LSCP have requested we repeat the session again in the summer



## 5.3 Allegations Against Staff Training

Over 2024-2025, the Safeguarding Team rolled out 'Allegations Awareness' training to managers across all CSU's, alongside managers from Human Resources over to raise awareness to LTHT managers of the Allegations Against Staff policy, risk assessment tool and procedure to follow if an allegation is made about an LTHT employee. Since it was launched on 28th January 2025, the team have provided three Trust wide sessions **attended by 191 staff and provided 3 bespoke CSU sessions to 67 (Total staff trained to date 258).**



Prior to the session, a survey indicated 66% of staff were unaware of the LTHT Allegations Against Staff policy and risk assessment tool and had an average confidence score of 4.7 (10 being most confident) in managing allegations against staff. Following the session, delegates scored an average confidence score of 7.8 with positive comments shared including;

*"Very engaging and thought- provoking session" and "I found the session very valuable and since the training session have used the information provided on the course to direct another member of staff. "*

## 5.4 Digital Update- PPM safeguarding alert and IG Safeguarding alert

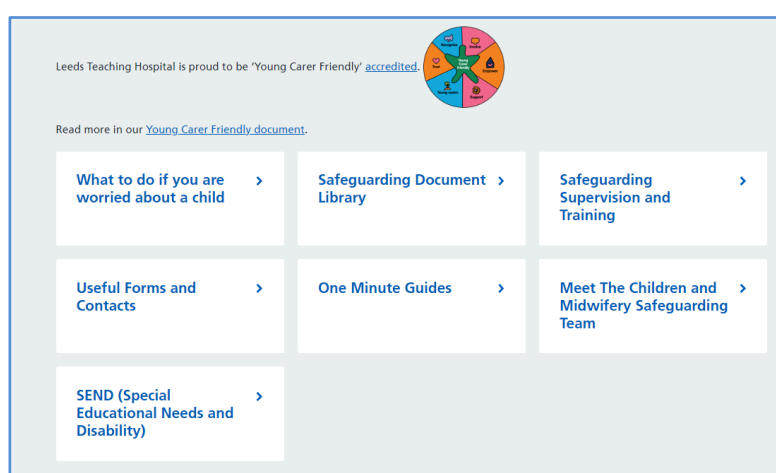
The DIT team in collaboration with the Safeguarding team have introduced a 'Safeguarding Alert' onto PPM+ to help us inform and signpost staff to patients with safeguarding concerns and those that may pose a risk to staff or other patients. This work was launched in August 2024 but ongoing work to use the alert in a meaningful way is being undertaken in both teams.



Patient Clinical Alerts		
Date	Name	Description
<b>High Priority Alerts</b>		
28-Mar-2025	Safeguarding Alert	Please search 'safeguarding' in the filter events for the relevant information in the clinical record. Please take this alert into consideration as you decide the appropriate treatment or discharge plans for your patient.
<b>Administrative Alerts</b>		
23-May-2022	Data Quality	Possible Duplicate Patient Exists
Patient history		

## 5.5 Children and Midwifery intranet

Over 2024-2025 the Children and Midwifery Team set the ambitious goal of updating and re-vamping our intranet pages. The Children and Midwifery Safeguarding Team intranet site now includes the easy to navigate option boxes and access links below as well as information on the Young Carer Friendly accreditation and Special Educational Needs and Disabilities (SEND).



## 5.6 White Ribbon Campaign & 16 Days of Action

In November 2024, LTHT participated again in the Safer Leeds 'Sixteen days of action' and in the National White Ribbon Campaign. This international campaign is aimed at raising awareness of Domestic Abuse and ways to support and protect those who experience domestic abuse. The campaign began on 25th November, the International Day for the elimination of violence against women (White Ribbon Day), until 10th December, International Human Rights Day.

This year, the team sent a Trust-wide request to support the Love Grace hand-bag appeal - a national initiative in memory of Grace Spillane who was murdered; her family set up the appeal in Grace's name to collect handbags (which Grace loved) filled with care products to be distributed to women who are victims of domestic abuse. The appeal resulted in a phenomenal response from our staff, with over 120 either gently used or new bags full of products being donated to local charities and agencies including St Georges' Crypt (recipients in the photo below), Behind Closed Doors, Basis Leeds, and Kirklees domestic abuse service. The team has a few additional bags and products in case of patients being discharged from our services. The Trust campaign was acknowledged by the Love Grace team and shared widely on social media. Our staff appreciated being able to contribute with a tangible response, and for a concern which impacts many staff directly, and indirectly.





Combined Safeguarding Team awarded 26 **Safeguarding Recognition Awards** to LTHT staff for their outstanding contributions to safeguarding during 2024-2025



## 5.7 A&E Navigator Project



**Navigator Service - LTHT:** Since its creation in February 2021, the Navigator Service at Leeds Teaching Hospitals Trust (LTHT) has been a vital part of the multi-agency response to serious youth violence and vulnerable young people in Leeds. With over 1,600 referrals received to date, the service has played a significant role in supporting children and young people at risk of harm, offering timely intervention and a coordinated approach to safeguarding.

## Key Highlights and Contributions:

- **Referrals and Impact:** The Navigator Service has handled more than 1,600 referrals from healthcare settings, offering support to children and young people who are at risk of harm, neglect, or exploitation. The service continues to ensure that these vulnerable individuals are promptly connected with the right support services, reducing the likelihood of future harm, and improving long-term outcomes for young people in Leeds.
- **Girls in Gangs:** The Navigator Service has been actively involved in the planning and development of the 'Girls in Gangs' intervention programme, which is set to roll out soon. This initiative aims to address the specific needs and challenges faced by girls who are involved in or at risk of gang activity and exploitation. The Navigator team's expertise in working with vulnerable young people has been instrumental in shaping the programme content, ensuring it is both relevant and impactful for the target audience.
- **Guiding a New Generation - Multi-Disciplinary Team (MDT) Approach:** The Navigators have been key participants in the 'Guiding a New Generation' meetings, which bring together professionals from various sectors to address youth violence in Leeds. By collaborating in this multi-disciplinary setting, the Navigators help identify and support the young people who are most at risk of being drawn into violence or exploitation, contributing to a more integrated approach to safeguarding and early intervention.
- **School Knife Crime Awareness:** In response to the growing concerns about knife crime in the region, the Navigators have been actively involved in delivering school knife crime awareness sessions across Leeds alongside health professionals and police colleagues. These sessions aim to educate young people about the risks of carrying knives and offer guidance on how to stay safe. Through these engagements, the Navigators work to raise awareness, provide prevention strategies, and empower young people to make safer choices.



**Conclusion:** The Navigator Service continues to make a significant contribution to the safeguarding landscape in Leeds, supporting vulnerable young people at the critical intersection of health, safety, and wellbeing. By working alongside other agencies and contributing to initiatives such as 'Guiding a New Generation' and the knife crime awareness schoolwork, the service is helping to create a more cohesive and proactive approach to supporting young people in our city.

## 5.8 Enhanced Safeguarding Training Calendar

The enhanced Safeguarding training sessions calendar was shared with our external partner agencies, including third sector organisations. This has the added benefit for our colleagues in health and social care roles accessing the same education and training opportunities, therefore improving knowledge and skills in recognising and responding to abuse in a huge range of subjects with a consistent and standardised approach. To date we have delivered **86 Sessions to 915 Staff**

### **5.9 Access to Records SOP for Women's and Children CSU**

Over the past year, the Children's and Midwifery Safeguarding Team has undertaken work to streamline the process for managing Access to Health Records requests where safeguarding documentation requires review prior to disclosure. Previously, requests were submitted through multiple channels, resulting in inconsistent expectations regarding the appropriate reviewer. Following collaborative discussions with the Women's and Children's CSU Quality Teams, a revised process was agreed: safeguarding documentation will be reviewed initially by the CSU. Should further clarification or a more detailed safeguarding review be required, the request will then be escalated to the Safeguarding Team for final assessment.

### **5.10 Statutory Safeguarding Reviews and CSU Involvement.**

In 2024-2025, the LTHT Safeguarding Team introduced a strengthened, collaborative approach to managing statutory safeguarding reviews involving both the Safeguarding Team and Clinical Service Units (CSUs). Statutory safeguarding reviews are initiated when a child or vulnerable adult suffers serious harm or death as a result of abuse or neglect, aiming to identify lessons and improve future safeguarding practices.

A clear process was established to ensure that CSUs are promptly notified of any statutory safeguarding reviews via formal email communication and DATIX reporting. While no immediate action is required at the point of notification, CSU involvement is critical during the review process, particularly in validating information, contributing to chronology and Independent Management Reviews (IMRs), identifying SMART recommendations, and highlighting good practice.

The review process includes:

- Early consultation with CSU Tri Teams to support report development.
- CSU input into draft report reviews and recommendation setting.
- Final sign-off of reports by the Deputy Chief Nurse for Safeguarding prior to external submission.

Immediate actions to address patient or staff safety concerns identified during reviews are discussed directly with CSU teams to enable prompt action. All learning outcomes, actions, and recommendations are monitored via DATIX and reported through the Safeguarding Governance Group.

Key improvements achieved through the new process include:

- Earlier and clearer CSU engagement.
- Enhanced accuracy and accountability in information gathering.
- Stronger governance of safeguarding learning and action implementation.

The new process promotes a culture of continuous learning and improvement, ensuring that safeguarding reviews lead to tangible service enhancements across the Trust.

## 5.11 Safeguarding One Minute Guides



The Children and Midwifery Safeguarding Team have developed a series of One Minute Guides or 'OMGs' to help staff identify abuse in children. These 'One Minute Guides' are designed to provide you with concise, information on key topics related to child safeguarding. Whether you are seeking quick tips, need a refresher on specific procedures, or want to ensure best practice in protecting

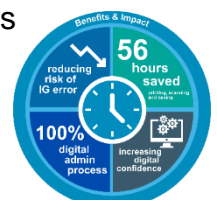
children's safety and well-being, these easy-to-follow guides cover essential information, ensuring that everyone is equipped with the knowledge needed to create a safe and supportive environment for children.

This year we have created six new [One Minute Guides - Leeds Teaching Hospitals NHS Trust](#) related to findings and lessons learnt from serious children related incidents.

- Disguised compliance
- Domestic abuse and violence
- Fabricated illness
- Young Carers
- SEND- special education needs and disabilities
- Voice of the Child

## 5.12 Safeguarding in the Children ED

Work was completed to streamline the administrative safeguarding children's tasks for clinical staff in the Emergency Department. Our previous process led to inconsistent management of referral processes, documentation errors, difficulty tracing safeguarding information back to the child and delays to critical safeguarding actions. The new process uses the PPM+ custom lists to increase clinical staff time with patients and



- Improve efficiency and accuracy
- Reduce Information Governance risks
- Support and collaborate working together
- Impact on sustainability





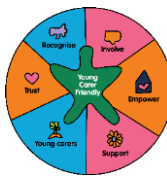
This new work was shared in Friday Focus, Start the Week and Report Out.



In addition, the PED clinical educators are sharing a monthly safeguarding news bulletin following the weekly Child Protection MDT across the Urgent Care CSU, to help share good practice and identify areas for improvements.

### 5.13 Young Carers

Leeds Teaching Hospital Trust (LTHT) is delighted to have achieved “Young Carer Friendly” accreditation from Leeds Young Carers Support Service, due to establishing routine questions about caring responsibilities for under 18’s, the development of a One Minute Guide on Young Carers, inclusion of Young Carers in safeguarding training packages and the development of resources on the safeguarding webpages. LTHT are committed to raising awareness of young carers under 18 across the trust to ensure they are appropriately identified, supported and signposted to Leeds young Carers Support Service [www.family-action.org.uk/services/leeds-young-carers](http://www.family-action.org.uk/services/leeds-young-carers)



### 5.14 Child Exploitation Awareness Day



On 18th March 2025, the Children’s and Midwifery Safeguarding Team highlighted the issues surrounding Child Exploitation. Child Exploitation is a form of abuse that involves the manipulation and/or coercion of young people under the age of 18. This year we encouraged everyone to **think, spot, and speak out** against abuse and adopt a zero tolerance to child exploitation.



### 5.15 Safeguarding related DATIX to CSU’s

During the reporting period, the Safeguarding Team implemented a new process whereby a DATIX incident report is completed in instances where safeguarding procedures have not been appropriately followed. The primary aim of this initiative is to enable the Safeguarding Team, in collaboration with the Clinical Service Units (CSUs), to identify specific staff groups that may benefit from targeted safeguarding training or development. Additionally, this approach will support CSUs in monitoring and evidencing progress in safeguarding compliance and staff competency over time.

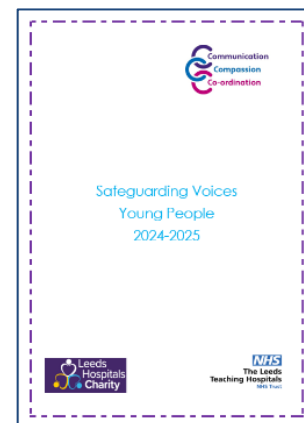


- all professionals are aware of their responsibility to protect vulnerable children and how their behaviour may be perceived;
- ensure all children/families/carers receive the same standard of care without bias or favouritism;
- enhance the effectiveness of our practice by reflecting on the appropriateness of all our relationships and interactions.

The Leeds Children Hospital have shared with LTHT medical illustrations team for printing in 2025-2026.

#### 6.4 Safe Voices Work progress

The experience and insight of children/young people when safeguarding concerns have been raised is rarely captured (using qualitative methods) meaning associated improvement work lacks their insight. The Children's Safeguarding team were keen to rectify this position as were the Patient Carer and Public Involvement (PCPI) team. A submission was made to the Leeds Hospital Charity for funding to support a joint project to seek the views of fifteen young people aged 16/17 who had attended the Emergency Department between November 2024 and February 2025 and either:



Safeguarding concerns noted whilst receiving care and treatment or; Were involved in activities deemed 'risky' or in some cases illegal. The final report and accompanying video will be ready for wider sharing in June 2025.

#### 6.5 LTHT Safeguarding, MCA/MHA, and Learning Disabilities & Autism Champions Role Review and Implementation of Lead Professional Role

In 2024-2025, a review was undertaken of the Safeguarding, Mental Capacity Act (MCA)/Mental Health Act (MHA), and Learning Disabilities (LD) and Autism leading to the revised Champions roles and implementing of Lead Professionals in the CSUs. The aim was to strengthen and streamline the approach, ensuring these agendas are better embedded within Clinical Service Units (CSUs) and clinical areas.

Historically, separate champions were recruited for each agenda area with varying expectations and support, identifying significant inconsistencies. Currently, there are 228 Safeguarding Champions and 254 LD and Autism Champions, but no MCA/MHA Champions, with some CSUs lacking representation entirely.

##### Champions Responsibilities:

- Acting as a link and signposting resource for staff, rather than providing direct advice.
- Attending learning events with protected time.
- Keeping local safeguarding resources up to date.
- Promoting safeguarding, MCA/MHA, and LD & Autism topics in daily practice and governance forums.

##### Lead Professional Role Summary

- A senior CSU member responsible for leading Safeguarding, MCA/MHA, and LD & Autism agendas. Deputise and make decisions on behalf of the CSU.
- Embeds the above agendas and principles into clinical practice and governance processes.
- Works alongside Champions to drive improvements and support implementation of learning.
- Oversees data collection, audits and service improvements for the above agendas.
- Promotes consistent, equitable practices and a culture of learning across CSUs in relation to the above agendas.

This approach is intended to improve governance, ensure equity across CSUs, and enhance the delivery of the safeguarding, MCA/MHA, and LD & Autism agendas and inclusion standards Trust-wide.

## 6.6 Was Not Brought Progress

In collaboration with the health inequalities team the Adult Safeguarding team cohosted two citywide Missed Appointment events. The first event focused on reducing missed appointments and looking at barriers to patients not attending health appointments with an emphasis on those dependent on being brought to appointments (as per the Was not Brought pathway). From this a task and finish group was created to improve patient letters, making them easier to understand (easy read) and with clearer directions.

The second conference focused on missed appointments from a health inequality perspective, and we were fortunate to have presentations from patients and service users with lived experience explain how difficult it was for them to understand the health system and get to physically get to an appointment. In this conference there was representation from the prison service, homeless agencies, advocacy, Forward Leeds, sensory impaired, third sector charities as well as colleagues from LYPFT, LCH and the ICB.

Work continues to create a local Was Not Brought SOP as well as improve the attendance of outpatient appointments for our most vulnerable groups.





## 6.7 Complex Cases, Risk Management

Complex safeguarding cases and risk management in an acute hospital require a robust risk management approach due to the high acuity of patients and the potential for multiple vulnerabilities in relation to service users, staff and visitors. This includes addressing issues such as Identifying Vulnerabilities, assessing violent and sexual risk to adults and children, Mental Capacity Assessments, mental health challenges, Safeguarding Policies and Procedures and most of all robust information sharing and care planning amongst multi-Agency teams.



Cases relating to Children's and Midwifery Safeguarding have required senior input from CSU's, the trust risk team and executive management which have resulted in ongoing discussions with regards to the development of a robust risk management tool that is comprehensive in assessing different types of risk, the level of risk which can be used operationally.

Over the past 12 months many child and adult clinical areas have cared for patients and relatives who have presented staff with exceptionally challenging behaviours in terms of violence and aggression, discrimination, and personality-related behaviours, and as a result of these often extremely prolonged and complex discharge arrangements.

The Safeguarding team have been able to offer 'in-person' de-briefs for ward staff. This has now become an at least weekly provision with regular contact with ward staff. In addition, the teams have become an integral part of the frequent MDT meetings convened which provide regular communication to the multiple professionals involved in these cases.

These cases have prompted recognition for the need for a joint approach to a thorough risk assessment tool which will provide all staff with clear care plans, risk management plan, and support with discharge planning.

## 6.8 Adult LSAB Self-Neglect Strategy

A key priority for the Leeds Safeguarding Adults Board (LSAB) remains the Self-Neglect Agenda. LTHT is an active member of the LSAB Self-Neglect Strategic Group, chaired by the Head of Nursing for Safeguarding, Mental Health Legislation, Learning Disabilities, and Autism. This group is responsible for driving the workplan and supporting the implementation of the city-wide Self-Neglect Strategy.

As previously reported, and in line with both national and local safeguarding trends, the prevalence and complexity of self-neglect cases continues to rise. The LTHT Adult Safeguarding Team is actively engaged in several city-wide workstreams aimed at strengthening our response to self-neglect, including the promotion of the ALWAYS

framework.

LTHT played a key role in the planning and delivery of the LSAB Self-Neglect Conference held in January 2025. This practice-focused event brought together professionals from statutory, voluntary, and third-sector organisations across the city to share learning and improve interagency working. Collaborative work continues with partners from the Leeds Health Economy and the Local Authority to implement the recommendations arising from the previously reported city-wide Self-Neglect audit.

The Self-Neglect enhanced training offer from the LTHT Adult Safeguarding Training has been well received with attendance from colleagues from other health providers and adult social care, reflecting the relevance and value of the content.

## **6.9 Audits**

To continually improve Safeguarding practice and to ensure LTHT adheres to external governance requirements, the safeguarding team undertake regular audit to review safeguarding practice. This year audits include:

- Annual Q2 Trust-wide combined midwifery, children and adult audit
- Routine enquiry questions on wards using the nursing specialist assessment
- Weekly DASH audit on PPM+
- Weekly Children Social Care referrals on PPM + audit
- Making safeguarding personal audit
- Fabricated and Induced Audit and report

The results have been used to provide evidence for the team to undertake targeted work where there are found to be gaps in staff knowledge, and to share with staff the positive impacts of recognising and responding to safeguarding-related disclosure and information.

As a result of changes in the Trust audit programme, a new working group has been created to review and develop a new annual safeguarding survey to replace the Annual Q2 Safeguarding Audit on the Clinical Audit Database.

## **6.10 Sexual Violence and Domestic Abuse at Work NHS Charter**

The NHS Sexual Safety Charter is a set of principles and actions aimed at addressing and preventing sexual harassment and abuse in the NHS workplace. It was launched by NHS England in September 2023 and required all NHS trusts and integrated care boards to sign up and implement the charter. The charter focuses on creating a culture of zero tolerance for unwanted, harmful, or inappropriate sexual behaviors, providing support for those affected, and ensuring clear reporting mechanisms and timely action against perpetrators. LTHT has signed the charter and has been proactive in our commitment with this work led by our Executive Director of Human Resources and Organisational Development.

As a joint project, the Trust Human Resources (HR) department and Adult Safeguarding have developed and launched a 'toolkit' with clear support and guidance in how disclosures can be made supportively, help accessed, and how HR will support

allegations to be investigated, and outcomes determined. Promotional resources includes two videos made with the support of the Trust Communications team and Medical Illustrations teams, introduced by the Trust Executive Director of Human Resources & Organisational Development, Jenny Lewis. The videos depict 'voiced' (by other members of staff) lived experiences of staff who have experienced sexually inappropriate behaviour at work, and who are victim-survivors of domestic abuse. The experiences were real-life examples, presented alongside statistics of incidents to provide stark evidence of the prevalence of these violations and offences.

The Safeguarding team continues to offer support to staff and managers in every CSU to understand the pathway of raising concerns and reporting to the correct agencies for support and advice. This work intersects with the recently rolled-out training in Managing Allegations against Staff.

Work continues with other roles such as the Freedom to Speak Up lead and champions, the Staff Health and Wellbeing team, Occupational health, and the Mental health wellbeing champions to empower colleagues to disclose incidents of harm and abuse experienced by our staff.

### **6.11 Digital Workstream**

The safeguarding teams have continued to work collaboratively with the trusts DIT team to make safeguarding more accessible to frontline staff, which will in turn allow the safeguarding team to collect data as required.

The Children and Midwifery Team are revising the current Children Social Care referral on PPM with colleagues in the DIT team to ensure the best possible version is available to staff at LTHT, alongside looking at the development of an online chronology tool for staff for chronic neglect or fabricated illness cases. In addition. The Children and Midwifery Team have collaborated with ED consultants to develop a new 12-17-year-old e-risk assessment to replace the 16-17 paper-based risk assessment currently in use. This was piloted between October and December 2024, and it was identified that further work is required to streamline this form further to make it more efficient for staff to use.

The combined safeguarding team supported by the DIT created a new Safeguarding alert on PPM+ which has started to be used for patients who are known to be a risk to the public via MAPPA process and those that the adult team may be concerned about such as regular attenders to ED and self-neglect cases.

Further work has included looking at potential use of the 'bots' that can help with data inputting that is repetitive and lengthy to free up administration team to focus on other workstreams. The admin teams have also worked collaboratively to flag a back log of patients with learning disabilities as patient dependent so that if they do not attend an appointment they will be followed up as 'Was not Brought' and trigger a review and safeguarding processes if needed.

### **6.12 Special Educational Needs and Disabilities (SEND)**

The Children and Families Act (2014) places a statutory duty on the NHS to work with

local authority partners to provide help and support to children, young people aged 0-25 years, and their families, who have Special Educational Needs and Disabilities (SEND). Code of Practice 2015 defines SEND as: 'A child or young person has SEN if they have a learning difficulty or disability which calls for special educational provision to be made for them'. The SEND code of practice provides statutory guidance to many organisations, including health providers, who support children and young people with special educational needs and disabilities.

Many children and young people who have Special Education Needs (SEN) may have a disability. Disability is described under the Equality Act 2010 as a physical or mental impairment which has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities.

Special educational needs can result from:

- a long term condition or life-limiting condition, such as Duchenne muscular dystrophy
- a congenital condition, such as cerebral palsy
- a learning disability
- autistic spectrum disorder
- attention deficit hyperactivity disorder (ADHD)
- serious illness or injury, such as acquired brain injury
- a sensory impairment
- behavioral issues

The benefits of early identification of SEND are widely recognised: identifying need at the earliest opportunity, and then making effective provision, improves long term outcomes for children. Leeds Teaching Hospitals NHS Trust (LTHT) has a statutory duty and important role to play in early identification for all patients at the point a disability is recognised.

In order to provide assurance regarding health duties and responsibilities in relation to SEND, services who assess or provide services for children/young people with SEND the Head of Nursing for Safeguarding, Mental Health Legislation, Learning Disabilities and Autism is leading on the strategic oversight for the Trust. LTHT is represented at the various city wide SEND partnership.

As part of this work Leeds as a city is preparing for a SEND Joint Targeted Area Inspection (JTAI). Joint Targeted Area Inspections (JTAI) are unannounced, short, area-focused multi-agency inspections carried out in partnership with Ofsted, the CQC, HM Inspectorate of Constabulary, HM Inspectorate of Probation and, where relevant, HM Inspectorate of Prisons (Ofsted 2016).

The inspection will focus on the specific 'targeted' area of SEND and how well different agencies work together across the city. The scope is to look at multi-agency arrangements, including the quality and timeliness of assessments, and to carry out a 'deep dive' investigation of the response to specific children and young people (usually described as the 'theme' of the inspections).

West Yorkshire ICB along with all health providers including LTHT are working together as part of the preparation for our Local area SEND JTAI inspection.

### **6.13 Making Safeguarding Personal**

The LTHT Adult Safeguarding Team remains committed to promoting Making Safeguarding Personal (MSP) across the Trust. We believe in a personalised approach that enables safeguarding to be done with, not to, patients. We recognise the importance to capture the voice and views of the adults at risk of abuse and/or neglect to achieve good outcomes that promote the safety and welfare of our patients. The MSP approach is promoted through our daily safeguarding activity and through our comprehensive training endeavors.

Over the past year, the team undertook an MSP audit, reviewing 1,194 safeguarding referrals to assess whether the views of the individual were sought and recorded where it was safe and appropriate to do so. The data from the audit is being analysed and consolidated to inform an action plan. The final audit report will be disseminated widely, and our training packages will be updated to incorporate the findings to strengthen our approach further.

### **6.14 Hate Crime and Anti-Muslim Hatred Group**

The Safeguarding team teams have continued to attend the City-Wide meetings in relation to the Hate Crime and Anti-Muslim Hatred groups to assist in shaping the city's response against hate related prejudice and discrimination. The trust has worked hard to support staff and service users to raise concerns when such incidents take place using the internal LTHT reporting process. Current findings find LTHT staff are reluctant to report hate related incidents perpetrated by service users to the Police, although the trust fully supports this and this year police were invited to some areas to support logging of Hate Crime concerns. All workstreams relating to equality and diversity are implemented with support and careful consideration following consultation with the LTHT Executives and EDI teams.

### **6.15 Maternity Safeguarding Dataset**

In 2024-2025, the Named Midwife for Safeguarding developed a new Maternity Safeguarding Dataset to better understand safeguarding activity and acuity within maternity services. Historically, maternity-specific safeguarding data was not captured separately, as the data fell into the adult or children's safeguarding arena, presenting challenges in understanding what safeguarding looks like in maternity services but also service planning and staff support.

Following a regional benchmarking exercise, the Named Midwife for Safeguarding collaborated with maternity leaders and matrons to identify a relevant safeguarding maternity dataset, formulate data collection processes, and determine governance routes for reporting. The dataset aims to:

- Provide insight into safeguarding activity and risks.
- Identify areas of good practice and areas needing focused improvement.
- Support service planning, staff support, and audit activities.
- Enable deeper analysis through parameters such as BMI, ethnicity, age, and

smoking status.

Challenges remain in capturing certain safeguarding details within digital maternity records, particularly regarding unborn children under safeguarding plans and babies removed at birth. Work is ongoing with maternity services and local authority partners to address these gaps.

Next steps include the quarterly reporting of data, annual thematic reviews, and development of visual dashboards to enhance understanding and drive improvements across maternity and safeguarding governance structures.

## 7. Safeguarding Training

The Trust continues to demonstrate on-going commitment to safeguarding training for all our staff collaborating with Organisational Learning and Development partners ensuring the correct levels of training are assigned and accessed under guidance of the Intercollegiate Document for Safeguarding Children (RCPCH 2019) the Intercollegiate Document for safeguarding children and young people (RCN 2019, updated 2025) and the Intercollegiate Document for safeguarding adults RCN 2018, updated 2024) and local executive level directives. The current safeguarding training is designed to ensure that every member of staff is aware of their responsibilities, can recognise abuse, and knows how to respond to, and escalate concerns.

New staff are supported with specific inductions, updates and training to supplement the mandated offer. The Safeguarding team has used a variety of approaches in several formats, made more accessible with the standardisation of the use of 'virtual' training, which has allowed more staff, including those from external agencies to access training very easily.

### 7.1 Safeguarding Training Compliance

In addition to delivering and facilitating the mandatory training of which the Combined Safeguarding Team have delivered **Corporate Induction/Level 1 to 1530** staff and delivered **Level 3 to 1880** LTH staff via Microsoft Teams the Safeguarding team also delivered and facilitated for external expert speakers, a wide and varied programme of additional bespoke training sessions throughout 2024-2025. These sessions support the wider agenda of safeguarding children and adults and focus on specialist areas or individual needs of CSUs.

- The Safeguarding team hosts a combined children and adult presentation at each weekly induction for staff new to the Trust. This presentation is also used for the level 1 update (three yearly). The presentation has now been updated.
- The Level 3 'live' combined training session continues:
- one session facilitated once a week
- support for staff to access dates and receive joining links and resources
- additional sessions provided for children's hospital staff
- increase in maximum number of attendees to support attainment figures
- evaluation of sessions continues to be positive
- the content is in the process of being updated including.
- The Safeguarding team has delivered bespoke training to several CSU's and

specialty teams which include AHP's and Training Nurse Associates.

- The Named and Deputy Named Midwife for Safeguarding have continued to deliver safeguarding training for both children and adults across various groups:
- First and second-year midwifery students at the University of Leeds: Two sessions were delivered, reaching a total of 140 students.
- Maternity-specific domestic abuse training: Delivered as part of the annual mandatory update for midwives, with five sessions held and 80 midwives trained.
- Newly qualified midwives' local induction: Four sessions were delivered, training a total of 100 staff.
- Maternity Big Breakfast sessions: Three sessions were held, providing safeguarding updates to 80 midwifery staff.
- Community Midwifery Target Days: Six sessions were delivered, with 120 midwifery staff trained.
- The Safeguarding teams supported various CSU's induction training for all new staff working in the Trust including specialist ED induction training.
- The Children Safeguarding Team provided bespoke induction sessions for 70 new Children Hospital staff.
- The LTHT Safeguarding Team also delivers safeguarding training to the Nursing Associate students at Leeds Beckett University, preparing them to join LTHT for employment. One session was delivered with 40 students trained.
- The Children & Midwifery Safeguarding Team have provided 2 'Train the Trainer' sessions training to 30 staff, 8 Supervision of Supervisor sessions for 48 staff and 383 midwives have completed safeguarding supervision.
- The Safeguarding Team also supports partners in LSCP and across the city, including Stronger, Safer Communities in multi-agency safeguarding training delivery including three specific domestic abuse packages.
- The Safeguarding team continues to respond to bespoke requests for training to ward or specialist areas in specific safeguarding issues relating to their need.
- The Safeguarding teams' welcome colleagues including those from external and new roles to 'shadow' providing insight into a 'day in the life' of the service and building further links with partners across the Trust and city-wide.

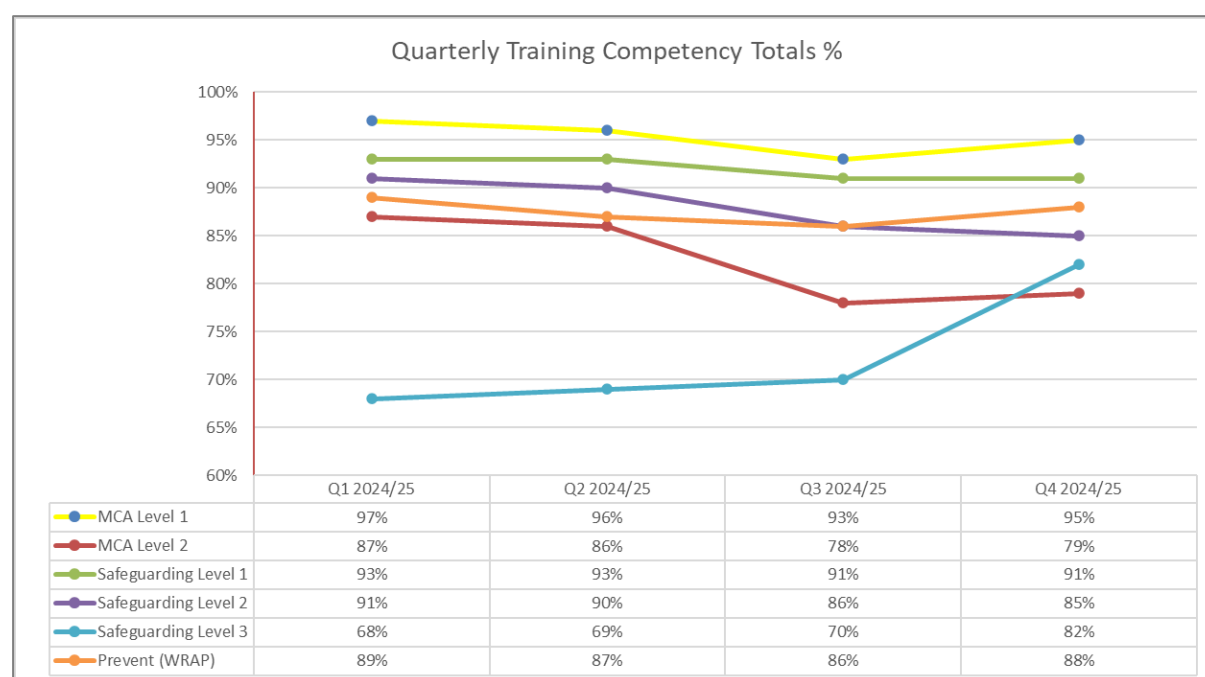
The Named Doctor for Safeguarding Children provided safeguarding training to over 356 fourth year medical students at the University of Leeds, over 30 radiology registrars, 30 General Practitioners, and 100 general paediatric registrars, trained over 150 delegates during LSCP safeguarding week, trained 30 new regional paediatric registrars in PROTECT training and chairs the weekly peer review meeting where over 83 child protection medicals were discussed by our consultant general paediatricians.

Whilst mandatory training compliance is monitored and reported through the Trust Workforce Committee, the Safeguarding team also monitors training compliance across the Trust, including Prevent training. The team analyse each CSU performance and where the area falls near or below 80%, support is offered to highlight staff requiring training and consider how best to support completion of the training.

During 2024-2025, training was tracked and progress reported on a quarterly basis; the results demonstrate that by quarter 4, all levels of safeguarding training met the minimum compliance target of 80%. Meeting or maintaining this is a challenge for

CSUs for several reasons. The training is half a day over Teams, some CSUs have a transient workforce, 'Training Grade' doctors may be already compliant in any other Trusts when rotating to LTHT and operational pressures. This is a national issue which it is understood is being addressed through NHS England. There is continual contact with the training lead where it has become known that individuals were not assigned the correct training level for their role. This has had the impact of increasing the overall number of individuals requiring level 3 this year which subsequently affects the compliance data. It can be seen as a positive action that senior managers are acknowledging that their staff require the training and are requesting the assignment of Level 3.

Whilst the compliance of mandated safeguarding training is of the highest importance, the Safeguarding team must also ensure that the training provided meets both the Intercollegiate and RCPCH guidelines, be of high quality and beneficial for LTHT employees. With the introduction of the SGLDA Governance forum, the onus has been directed increasingly to the CSU leads to manage instances of training non-compliance. CSU leads are being asked to scrutinise why there is poor attendance and offer improvement plans.



## 8. Serious Incidents and Reviews

There were no serious incidents (level 3) related to safeguarding children during 2024-2025.

There were **no serious incidents** (level 3) relating to safeguarding adults during 2023-2024 however safeguarding processes were followed for significant moderate to severe incidents as per the PSIRF and SA1 procedure. The Adult team also continued to work with the complaints team and CQC lead with investigations that crossed into these arenas.



Child Safeguarding Practice Reviews (CSPR), Learned Lesson Reviews (LLR) and Serious Adult Reviews (SAR) form part of the multi-agency LSAB/LSCP safeguarding strategies for the city. The Trust also works in partnership with 'Safer Stronger Communities' to scope and provide panel members for Domestic Homicide Reviews (DHR) in the city. The LSCP has recently created a multi-agency online, SharePoint XCEL tracker, for members involved in Children's Statutory reviews to update their actions. This allows a central database for the LSCP to track actions in relation to each agency but also for agencies to offer any comments if they have been involved.

Where a serious childcare incident and serious adult incident does not meet the criteria for undertaking a CSPR or SAR the chair of the LSCP or the LSAB can decide to undertake a local Learning Lessons Review (LLR) where it is identified that there are lessons to learn about single or multi-agency practice.

The Trust is fully committed to identifying the learning with regards to safeguarding and review processes, thus promoting the welfare of those who are vulnerable and to make changes that will improve practice, multi-agency working and outcomes.

Any finalised overview reports and individual management reports are presented through the Trust and partner agency governance structures. Any identified Trust actions are monitored through the Trust Wide Safeguarding Governance Groups which report bi-annually to the Quality Assurance Committee. The minutes of the governance groups are reviewed at Quality Safety and Assurance Group.

## **8.1 Child Safeguarding Practice Reviews**

The Children and Midwifery Team provided 15 Scoping Reviews for potential Child Safeguarding Practice Reviews in 2024-2025. There have been 3 new CSPR's commissioned by the Local Safeguarding Children Partnerships across the region to date this year. Two were commissioned by Leeds Safeguarding Children Partnerships and one for Bradford.

## **8.2 Safeguarding Adult Reviews**

During 2024-2025, the adult safeguarding team were asked to scope for six Safeguarding Adult Review (SAR) by LSAB, and one for a regional partner safeguarding adults board, which is closed. The Leeds-related cases are yet to be declared for a full review. LTHT Adult safeguarding continues to work with LSAB, ASC and citywide colleagues to review self-neglect cases for LTHT patients.

## **8.3 Domestic Abuse Related Deaths (DARD)**

Nationally, it is now acknowledged that a review can be commissioned when individuals die by suicide and it is known that domestic abuse was a factor in the individual's life, in line with the Domestic Abuse bill (2021). These are referred to as fatal incident reviews (FIR).

There were four new domestic homicide reviews (DHR's) and one FIR commissioned in the reporting period (2024-2025). Work continues to finalise a few cases commissioned in the preceding three years and the ongoing actions related to these.

Learning from each of the CSPR's, SAR's and DARD's is disseminated via training and where significant lessons are taken from the reviews, the safeguarding teamwork with the CSU leads to support with changes to practice in clinical areas.

#### **8.4 Joint Safeguarding Review**

In cases where the learning is significant and involves both children and adults the three Boards (LSAB/LSCP/Safer Leeds Board) can call a joint review. There has been no Joint Safeguarding Reviews commissioned during this reporting period

### **9. Safeguarding Complaints/PALS**

The Annual Safeguarding Complaints and PALS Summary Report provides oversight of cases that involve a safeguarding element or formal safeguarding concerns, enabling thematic analysis and identification of emerging trends

This summary covers the period from October 2023 to March 2025, it highlights a low number of formal safeguarding complaints, with only one recorded case involving a disputed Deprivation of Liberty application, which was resolved at ward level.

A total of 56 complaints included a safeguarding element, often alongside clinical concerns, primarily from high-traffic areas such as emergency departments, medicine, and surgery. Themes included delays, care standards, communication issues, perceived discrimination, and concerns related to mental health, dementia, and safeguarding referrals for children.

PALS logged 81 safeguarding-related contacts, mainly concerning staff behaviour and access challenges. Complaints involving safeguarding copied information totaled 67. There was a notable increase in complaints during the winter months, aligning with higher hospital activity.

There are no specific financial or risk implications outside existing complaints processes. The Safeguarding Governance Group is asked to note the low volume of safeguarding complaints relative to Trust size and to be assured of staff responsiveness, with a recommendation for continued annual review.

### **10. Priorities for 2024-2025**

- Continue to support CSU's and teams across the Trust to maintain and improve on the current 80% compliance at all levels of Safeguarding Mandatory Training.
- Continue to support the Women's and Children CSU to maintain compliance with their mandated safeguarding supervision requirements.
- Work around 16/17-year-old deaths & CDOP requests from out of area.
- Publish the finalised and approved "Professional Boundaries for staff working with Children Guidance".
- Embed the learning from the 'Safeguarding Voices of Young People' work within the safeguarding training and share the report and learning across the Trust.
- Continue to develop evidenced processes to ensure that LTHT Safeguarding is led and informed by the voice of the patient/child. With a focus on making

safeguarding personal.

- Review and devise stronger internal audit program to assess and review the application of safeguarding duties across the organization.
- Continue to progress the Self-Neglect agenda across the Trust and in partnership across the city.
- Continuing to work closely with the Occupational Health and Human Resources teams to ensure the health and well-being of our staff is a priority.
- Continue the delivery of the Was Not Brought process, with a focus on developing a policy for LTHT staff.
- Continue to embed the LSAB and LSCP key priorities and city-wide work streams into the LTHT safeguarding approach.
- Safeguarding is leading on the internal strengthening of the SEND agenda across the Trust and preparation work for a future SEND JTAI Inspection in Leeds.
- Continue to work in partnership with the SEND Designated Officer and other partners to strengthen the city wide SEND approach.
- Continue to work collaboratively with all CSUs to understand their challenges around safeguarding and how the safeguarding team can support to make safeguarding more effective, meaningful and improve compliance with process.
- Commence work on risk management processes for patients that challenge us with the Deputy Chief Nurses.
- Embed the new Safeguarding alert/MAPPA PPU pathway.
- Continue to deliver the collaborative Allegations training/HR workstream.
- Supporting CSUs to look for patient voice and present as patient story via Governance processes.
- Support the CLF to introduce an Adult protection medical pathway for the Trust
- Contributing to trust wide psychological trauma workstream and Trustwide improvements on supporting staff H&W in complex patient care.
- Trauma informed training -explore within wider organisation the potential to develop a safeguarding training package.
- Dissemination of lessons learnt following incidents where LTHT is found to have caused harm to service users (PSIRF), and from CSPRs/DHRs/SARs in order to share learning and change and improve practice to keep service users and staff safe.
- The LTHT Safeguarding Team will review and refresh the current LTHT Safeguarding Strategy to align to all the Trust 7 Commitments.
- Continue to monitor safeguarding related complaints and support CSUs with their responses.
- Continue to work collaboratively with the MCA/MHA legislation team and the LD Autism teams.
- Explore internal and external opportunity to embed the A&E Navigator service as a substantive service in LTHT.
- Continue to work with the city in raising awareness and tackling hate related crime and support Trust wide workstreams.

## **11. Mental Capacity Act and Mental Health Act Annual Report**

**Our Mission:** To provide outstanding advice, expertise, education, leadership, assurance and governance in relation to the legal frameworks of Mental Capacity Act & Mental Health Act.

**Our aim:** To ensure that the Leeds Way values apply equally to those individuals in our care who may not be able to make decisions for themselves or who are affected by mental ill health.

## 11.1 MCA/MHA Governance/Assurance

### Governance

Flowing from last year's MCA/MHA whole service review (reported in last year's annual report), the internal Governance structure for MCA/MHA has changed significantly.

Local external structures have remained largely unchanged though strengthened - linking MCA/MHA agendas across the city.

The focus was on aligning more closely with our Leeds Way Values and 7 Commitments and strengthening the collaborative approach with our sister teams across the Safeguarding agenda.

## 11.2 Service Offer

The MCA/MHA team continues to lead on education, policy/procedure, quality assurance and legal scrutiny & administration for all matters arising from Mental Health Act and Mental Capacity Act/Deprivation of Liberty Safeguards.

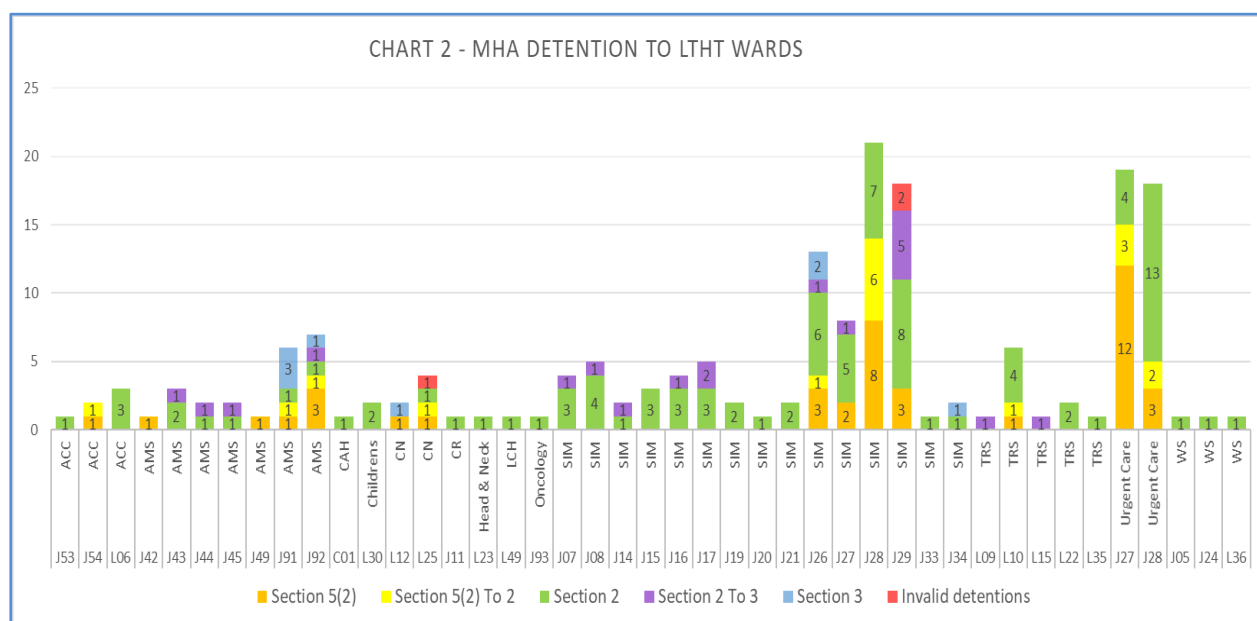
The team also provides on-request advice, bespoke training, complex case management, supervision and support relating to any patient who lacks capacity to make decisions or who are detained under the Mental Health Act.

## 11.3 Use of MHA at LTHT

The MCA/MHA team continues to provide compliance oversight, monitoring, co-ordination, triage, audit and operational roles for all MHA functions delegated down from Board level.

<b>Chart 1 - MHA detention at LTHT</b>	<b>total</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>
Informal to Section 5(2)	41	14	7	12	8
Section 5(2) to 2	17	4	3	6	4
Informal to Section 2	95	24	29	20	22
Section 2 to 3	19	5	6	6	2
Informal to Section 3	8	2	1	4	1
CTO / Recall / Revocation	2		1	1	
Transfer In Section 2 (H4 In).	7	2	2	3	
Transfer In Section 3 (H4 In).	10	3	3	1	3
Section 17 Leave	31	8	10	13	
Forensic	1				1
Invalid detention					3
<b>Total - 234</b>		<b>62</b>	<b>62</b>	<b>66</b>	<b>44</b>

**Chart 1.** There were 234 patients treated under MHA at LTHT in 2024/25. The totals by section type and by Quarter are in red above.



**Chart 2.** This shows the use of MHA across LTHT admission wards. The MCA/MHA team use the data to help us target our support into areas across the trust.

As an example of this, this year we have identified and begun work which is focused on the use of Doctors' holding Powers - section 5(2). We have noticed that its use has increased and that less than 50% of those held on this 72hr power have reached the threshold for detention under the Act on assessment.

Though there can be a variety of legitimate reasons for this, it is the collection and monitoring of these trends that allows us to target our monitoring and assurance work. As a result, we have begun some work to investigate the use of S5(2) and will be working with Liaison and medical teams over the next few months.

We have consulted on and reviewed the MHA Section 5(2) policy, are redesigning the audit, working with Medical Education and Liaison psychiatry to increase opportunities for engaging with doctors and to provide guidance, feedback and support.

	Q1 Apr-Jun 2023	Q2 Jul-Sept 2023	Q3 Oct-Dec 2023	Q4 Jan-Mar 2024
Informal to Section 5(2)	10	12	10	6
Section 5(2) to 2	2	4	2	2
Section 5(2) to 3				1
Informal to Section 2	32	30	23	31
Section 2 to 3	8	4	6	5
Informal to Section 3	1	2	6	3
CTO Revocation				1
Transfer In Section 2 (H4 In)		2		1
Transfer In Section 3 (H4 In)	3	1	1	1
Section 17 Leave	4	11	3	12
Forensic	1		1	
Invalid detention		1	1	1

## 11.4 MHA Scrutiny 2024-2025

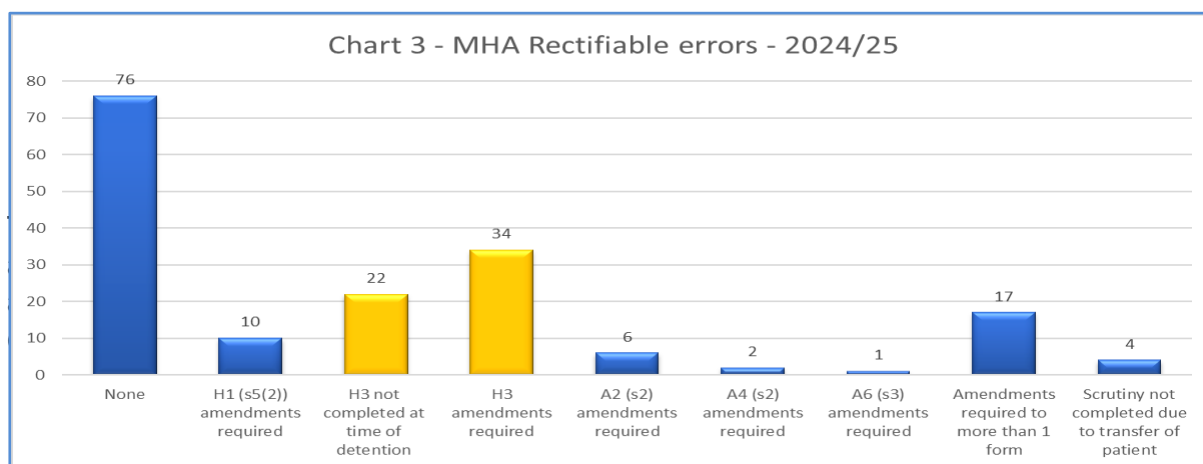
This year the team identified rectifiable (minor) errors on 44% of MHA detention papers. A rectifiable error may be a spelling mistake or correct data being entered in the wrong section of the form. The team ensured rectifications were made within statutory timescales thus ensuring compliance with MHA Section 15.

The Chart 3 sets out the errors identified across the year and the Forms that required rectification. Errors on or non-completion of the H3 form (completed by Nurse in Charge) remains the greatest area for potential improvement.

In response the MCA/MHA team has distributed guidance 'Grab sheets and other communications to Matrons and Heads of Nursing as well as targeting in-reach sessions to wards where errors are common.

In addition, this year we have added learning bursts to the Enhanced Safeguarding Calendar.

**Chart 3. Rectifiable Errors**



## 11.5 MHA Section 132 Rights 2024-2025

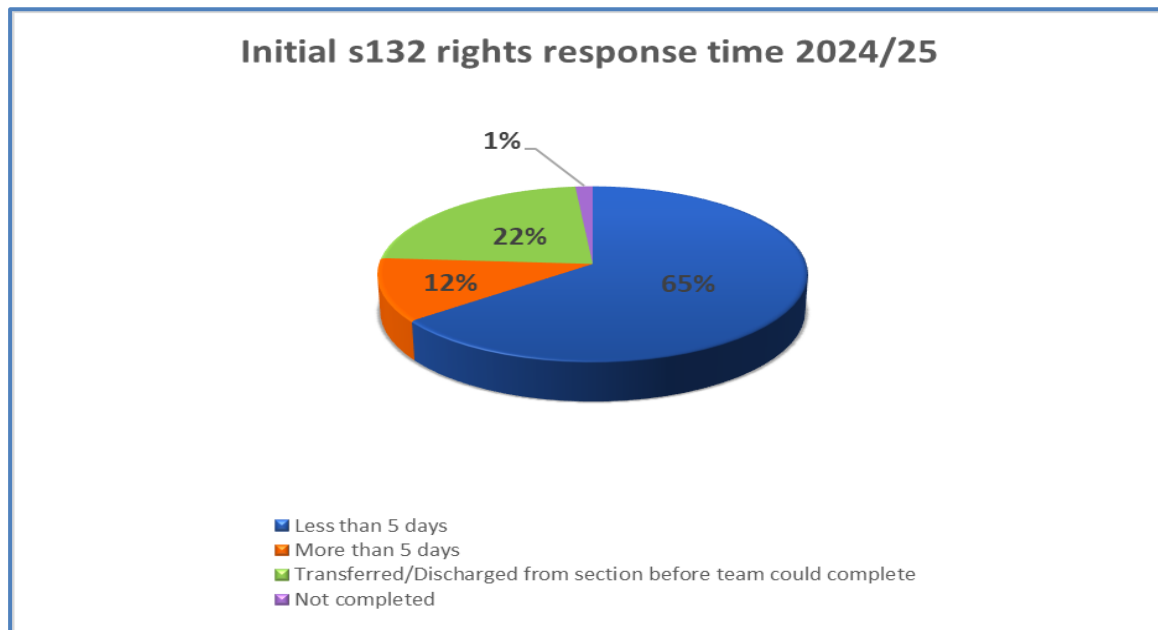
Patients have the right to an explanation of their rights and the implications of detention as soon as possible after they become subject to MHA.

The Trust board has a duty under Section 132 MHA to ensure that patients detained to the Trust have their rights explained to them as soon as possible after they have been made subject to MHA compulsory powers. In LTHT this duty is delegated down to nursing staff on the ward and to any member of the MCA/MHA Team.

To support this duty the MCA/MHA team deliver an in-reach s132 rights service to supplement the information that nurses, and other clinicians should have with detained

patients.

The chart below shows the team's response times across the whole of the year.



## 11.6 Supporting Detained Patients to Exercise Their Rights

The MCA/MHA team continue to make referrals to Independent Mental Health Advocacy for any detained patient who lacks mental capacity to take up that support themselves. We also monitor patients' requests for Hearings and Tribunals as well make applications directly with the Tribunal service when required by law and best practice.

HMCTS Tribunals & Hospital Managers Hearings 2024-2025	Q1	Q2	Q3	Q4
Tribunal applications for Section 2	1			
Tribunal applications for Section 3		3	1	
Tribunal applications Re-listed		1		
Hospital Managers Hearing				1

## 11.7 Restraint and Restrictive Intervention

The MCA/MHA team continues to review any Datix reports that indicate that staff used a form of restraint whilst working with a patient. A Datix notification is received by the team for each reported incident, and these are reviewed in real time by a senior member of the team for any concerns/escalations. When any concerns are identified about the proportionality and necessity of the restraint, the team alert the appropriate clinicians to support the investigation.

During 2024-2025 this restraint monitoring process was reviewed jointly with our safeguarding colleagues and now forms part of our weekly joint Complex case Huddle.

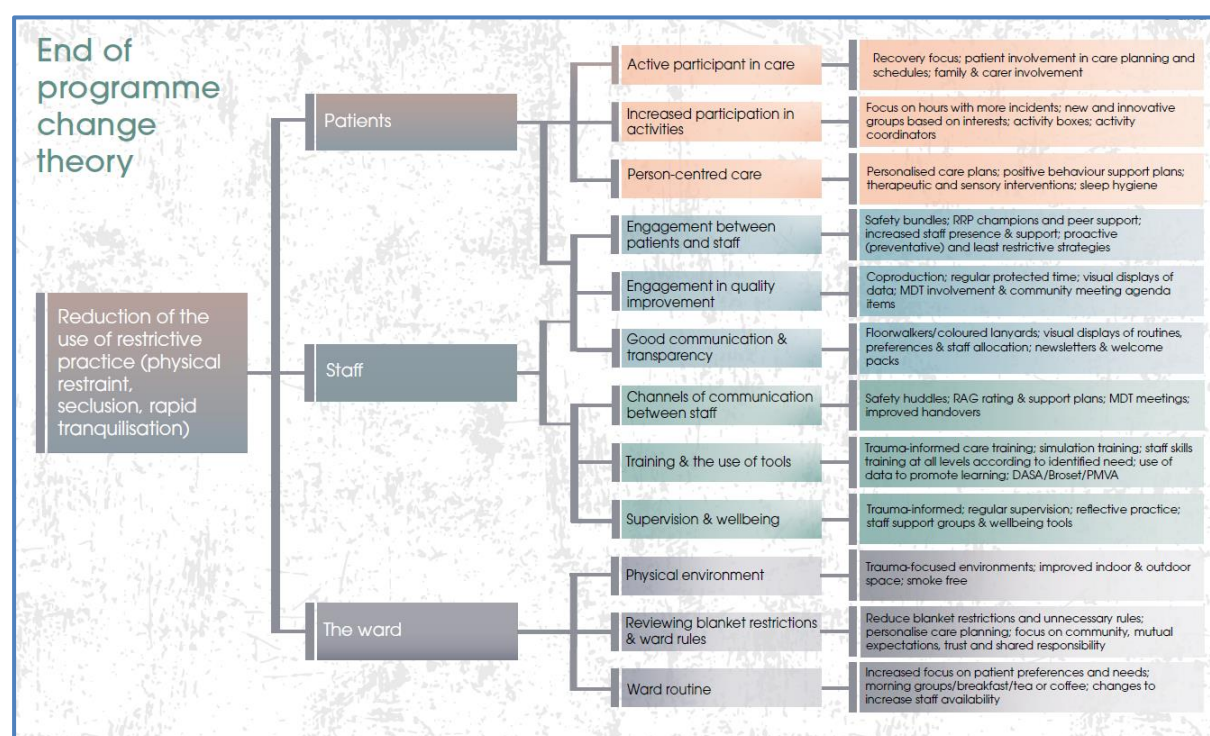
During 2024-2025 we have also worked on streamlining the Restraint and Restrictive intervention policy framework, with a separate policy being developed for the



Children's Hospital and aligning the adult policy with the new Violence reduction Policy, and other new workstreams in the Trust related to Use of Force Act and the development of a new in house Prevention and Management of Violence and Aggression (PMVA) training model at LTHT.

We continue to use the Restraint Reduction programme for change model to identify workstreams and track progress (below) and the team have contributed to a range of these workstreams:

- Policy development
- Training on restraint and deprivation of liberty
- Ligature reduction and rescue programme - developing environment audit and process for use of ligature cutting tool
- Hearing the voice of the patient
- Developing the nursing Restraint Care Plan
- Designing restraint incident reporting Dashboard
- Reviewing clinical guidance of use of rapid tranquilisation



## 11.8. Advance Care Planning

This year we have built on our successful 12 month project on Advance Care Planning which ended in 2024.

We have developed and maintained a suite of resources for patients, staff and the public, with links on our internal and external website.

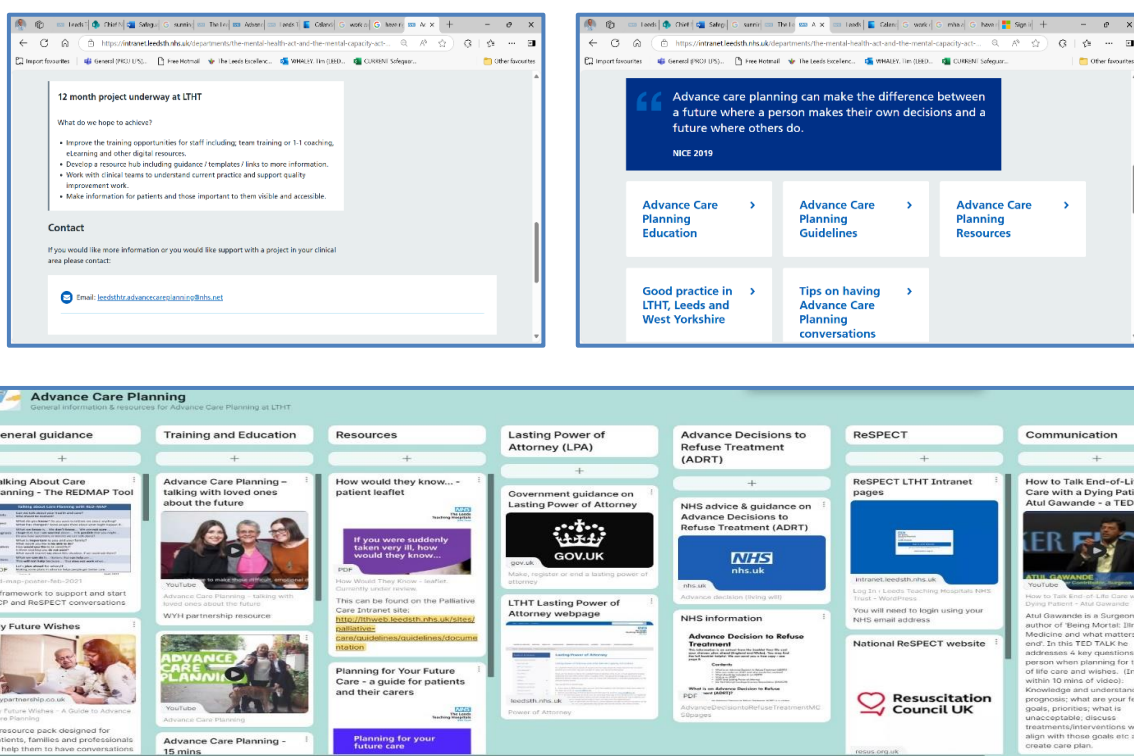
We have continued to deliver learning bursts on Advance Care Planning and have given bespoke advice to over 50 people on aspects such as Advance Decisions to

refuse treatment, making a Power of Attorney, and providing signposting for support.

During 2024-2025 the team received, verified and uploaded to patient records, 125 Lasting Power of Attorney Documents, each with specific advice notes explaining the detail of the power.

We made nearly 200 requests for information from the Office of the Public Guardian and shared these appropriately to clinicians and on PPM+.

We also delivered advice to large numbers of staff who had enquiries about aspects of LPA process, including concerns raised about patients' mental capacity when an LPA was applied for, concerns about certificate provision during application and how to raise concerns about the decision making of someone holding an LPA.



## 11.9 Deprivation of Liberty Safeguards (DoLS)

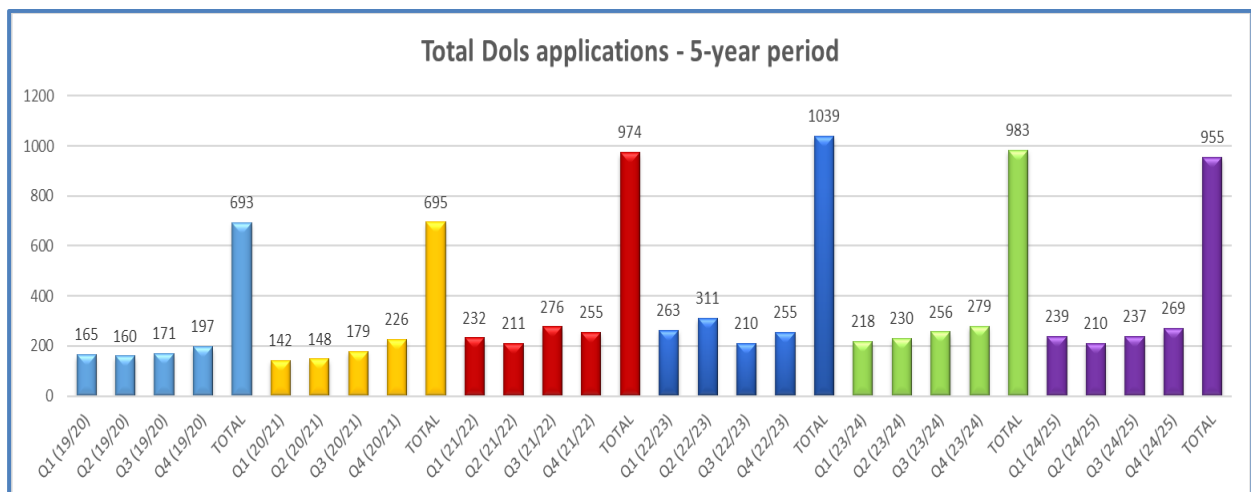
The number of DoLS Urgent Authorisations remains high at LTHT; this year the team have received, triaged and actioned 955 applications.

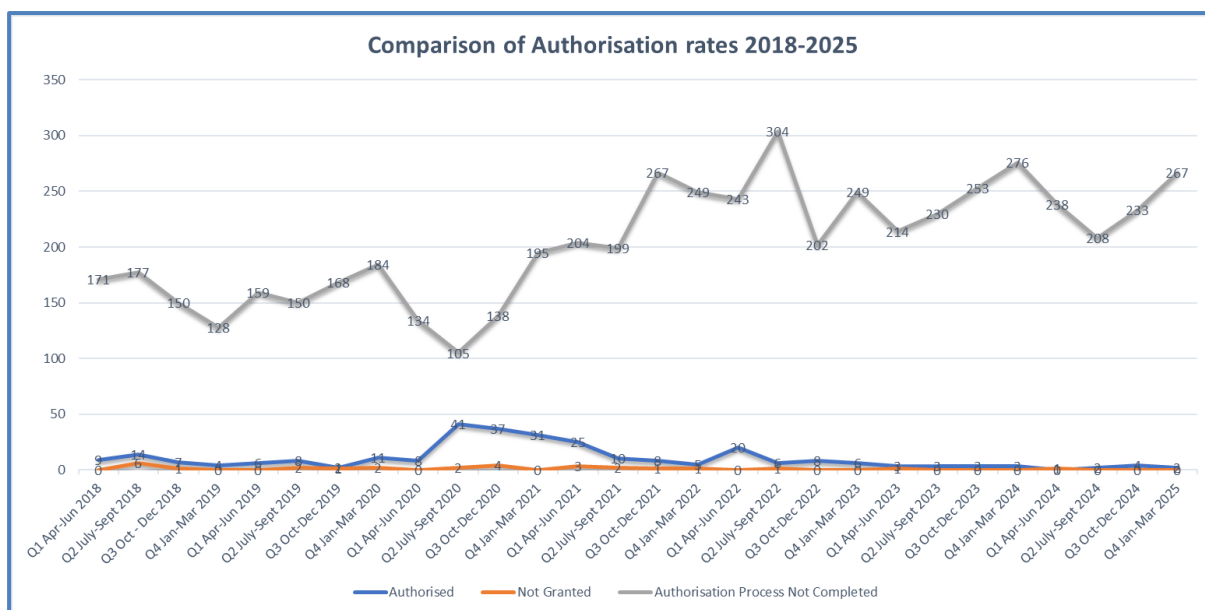
'Unauthorised dols' - Only 247 of the 955 were authorised by Local Authorities leaving 708 patients subject to care that amounted to deprivation of liberty, but without access to the safeguards of DoLS, for a significant period during their admission.

This is of course a national issue, and our tracking indicates that we are not an outlier when we compare percentages of authorisation with comparable Trusts.

With the much-anticipated MCA amendment Act not being implemented and thus no new solution for DoLS on the horizon, our focus this year has been on what we can do to address this issue internally. We have done this by doing the following during 2024-2025:

- identifying the risks, controls and gaps in control and adding this to the corporate Risk register.
- Strengthening our tracking and monitoring arrangements for patients on an unauthorised DoLS.
- Strengthening the audit process including not just desktop review but also in-reach audit and action planning so that we have assurance evidence from clinical staff that they are regularly reviewing mental capacity, necessity/proportionality of restrictions, consulting with family/advocates when using restraint.
- Providing more regular Advice notes to prompt and advice about monitoring restrictive intervention/deprivation of liberty.
- Offering additional learning bursts and guidance, and remodeling mandatory training materials to include all of these aspects.
- Providing a regular list of outstanding assessments to all appropriate Supervisory Bodies (local authorities).
- Redesigned our escalation criteria so that we can support Local Authorities to prioritise high risk cases.
- Working with Risk Management team to agree criteria for highlighting those cases that may need internal escalation or where legal advice might be warranted.





## 11.10 Education and Training

### Mandatory Training Figures

This year the MCA/MHA team have delivered corporate induction and Level 1 MCA training to over 1500 staff and over 500 people at MCA Level 2.

Using the SQL training data server, the team track compliance rates by clinical service unit and professional roles, allowing us to target support where compliance is lower. The team also review new staff roles and position number data monthly against our MCA Training Needs Analysis, to ensure staff have the right MCA training competency attached.

This year we have particularly focused on MCA level 1, identifying and delivering bespoke training sessions as well as identifying other regular teaching we offer and making small changes so that it meets the MCA 1 competencies. This has led to MCA 1 compliance rates across the organisation reaching over 90% throughout the year, for the first time.

MCA level 1 compliance	31/03/2025		
	In Date	Required	Compliance
Total numbers	5487	5790	94.77%
MCA level 2 compliance			
	In Date	Required	Compliance
Total numbers	5921	7477	79.19%

We report mandatory training (MCA 1 and MCA 2) quarterly through our Governance Group and during 2024-2025 the group have developed a system that requires CSUs to present metrics regarding MCA/MHA and identify action plans, including when mandatory training compliance requires improvement.

During Quarter 3 and 4 of 2024-2025, MCA level 2 training dropped below the minimum compliance target of 80%. This drop is largely owing to a dropping compliance amongst medical staff across the organisation (currently 40%).

This workforce faces some challenges across the system, regarding training compliance:

- Portability - 'Training Grade' or locum doctors are a transient workforce and whilst they may already have received MCA training in another Trust, there is no standard way they/we can evidence this and therefore likely are recorded as not compliant until they access the training offered when they arrive at LTHT.
- There is no nationally agreed TNA for MCA training even though it is mandated in law. This has led to some variance in NHS settings in competencies across professional roles, making it even harder to provide any regional 'training passport' to reduce duplication.
- National work to address the issues of standardisation and portability has so far not included MCA training; which currently is not one of the 12 mandated subjects included in the work around NHS core competencies.
- We have also identified that significant numbers of medical staff were given the MCA 2 competency in error because they share an employment position number with other medical roles who do need the training.

During the latter part of this year the MCA/MHA team have been working to address these issues:

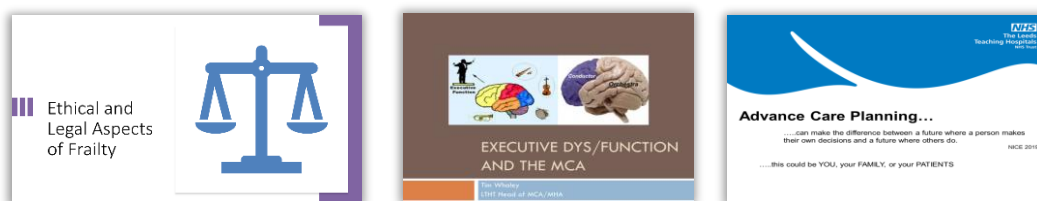
- We are working closely with LTHT medical education team and Doctors to develop a broader range of platforms, materials, opportunities for them to meet compliance more easily.
- We are leading some work regional work across acute hospital MCA leads to identify opportunities for portability and competency standardisation.
- We are feeding into the national work regarding core competency framework, with the aim of MCA being included in future iterations.
- We are also reviewing the MCA 2 training materials considering some significant case law and our focus on deprivation of liberty, where there is no Standard authorisation in place (see section on DoLS in this report).

In addition to our mandatory training commitments, this year the team have delivered a range of additional and bespoke sessions on topics related to MCA and MHA:

- We have delivered nearly 20 sessions on the Introduction to Professional Practice programme
- We have delivered MCA basics to more than 100 staff on the New to Care programme run by the Care Academy
- Mental capacity assessment in ED
- L24 support - pilot new risk assessment Enhanced care - learning bursts for MCA/restraint - over 4 weeks
- Band 5 international nurses - DoLS
- SIM CSU - MCA DoLS Restraint
- Dentist programme - MCA Capacity assessments
- The legal and ethical aspects of Frailty



- Executive functioning and mental capacity
- Planning care in advance
- MCA for clinical Psychology Masters Students on placement
- Monthly Band 3 development day - MCA refresher/ enhanced care/restraint
- We have delivered regular sessions on the Enhanced Safeguarding training Calendar and are adding sessions into the calendar on practical guide to mental capacity assessment, care planning for restrictive intervention, your role under the MHA
  - MCA obligations for consulting in Best Interests
  - Myth buster - the problem and risks of the term 'Next of Kin'
  - We have worked with external partners to add sessions to the calendar on Liaison Psychiatry, Child and Adolescent psychiatry, Independent mental Capacity Advocacy



## 11.11 Additional Workstreams

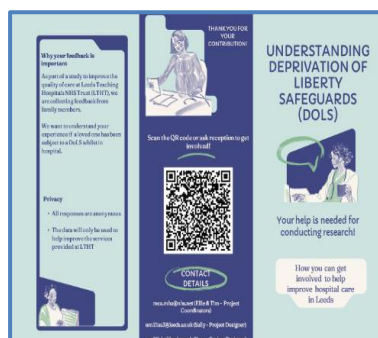
### Complaints Monitoring

The senior team continues to provide a quality assurance function for complaint responses and the team work closely with complaints and Pals service to ensure we are notified of any complaint with a MCA or MHA element so that we can support the complaint lead, monitor for trends or identify aspects that need our expertise or support.

### Voice of the Patient

This year we chose 'voice of the patient' as our focus value and have been using this as a key driver throughout the year, when delivering workstreams as well as our core work.

We have begun a specific project this year in response to this Value:



We have worked with 2 university research students to design and roll out a survey to better understand what our customers know about DoLS. The project identifies patients who are subject to DoLS in our hospitals and then reaches out to family members to ask a range of questions about their understanding, how well they were communicated with and how they think we can support them.

This year we have developed the methodology, designed the process and have now begun the engagement work. We hope to have the data and report presented in October 2025.

## **11.12 Digital**

This year we have been working with colleagues at Mid Yorkshire NHS Trust to redesign the PPM+ mental capacity assessment tool. This redesign changes the order of steps involved when assessing mental capacity - in line with Supreme Court Decision and guidance that will be in the new MCA Code when published. The redesign also improves pop up prompts for clinicians and requires them to document a better standard of evidence and consider steps that will be taken if making best interests decisions.

This piece of work has been approved and has been allocated to the Digital team for delivery.

LTHT are piloting a new E-Consent digital package during 2025 and MCA team are supporting improvements to the tool to ensure it better reflects requirements of the MCA during this stage of development. If this goes well, this would be an opportunity to greatly improve our ability to monitor and audit the quality of both mental capacity assessment and best interest decision making - as both these are designed into the digital tool.

## **11.13 Summary**

The team continues to have high volumes of patients for whom the MCA or MHA are applicable.

This coming year our aim is to strengthen the work we have begun this year on increasing our training offer, redesigning audit processes and looking for further opportunities and data sources that can strengthen our assurance models.

We will be launching our Trust wide campaign entitled 'Why MCA?' in the autumn of 2025, to celebrate 20 years of the Act and redouble our efforts to ensure that the fundamentals of MCA are strengthened across the organisation.

## **11.14 MHA and MCA Priorities for 2025-2026**

- Continue to review and progress the actions and workplan identified following the internal MHA/MCA Legislation service Review.
- Support CSU's and teams across the Trust to continue to meet 80% compliance at all levels of MCA Mandatory Training.
- Continue to develop evidenced processes to ensure that LTHT assessment of Capacity meets statutory requirements and is led and informed by the voice of the patient/child.
- Continue to embed the LSAB and LSCP key priorities and city-wide work streams into the LTHT approach around MCA and MHA agendas.
- Continue to work collaboratively with all CSUs to understand their challenges around MCA and MHA legislation and how the MCA/MHA Legislation team can support to make MCA and MHA Legislation more effective, meaningful and improve compliance with process.
- The LTHT MCA/MHA Team will support the wider Trust work in the development



of the new LTHT Mental Health Strategy.

- To work in partnership with our partners in readiness for the new MHA and any elements which may have an accelerated implementation timescale.

## **12. Conclusion**

Whilst Safeguarding, Prevent, Mental Capacity and Mental Health agendas continue to be a challenging area for all health agencies and multi-agency partners, the Trust continues to actively respond and contribute to regional and national developments. This Annual Report demonstrates that safeguarding vulnerable people remains a significant priority for the Trust and offers assurance that the annual work programme has been delivered, and the Trust continues to meet its statutory duties as well as proactively developing safeguarding provision and implementing learning from adverse events into frontline practice.

However, we recognise there is much more to achieve and to this end the development and delivery of the future priorities will help ensure that the Trust is fully engaged in the effective prevention of and response to safeguarding concerns.

The underpinning message, however, remains the same in that safeguarding is everyone's business irrespective of role or position. It is everyone's responsibility to safeguard and protect the most vulnerable adults and children in our society. The child and adult at risk must remain at the centre and be the motivation for our actions.

## Appendix 1. Definitions

**Safeguarding:** The Care Quality Commission (CQC) state; ‘Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to high-quality health and social care’ (CQC, 2016).

**Safeguarding Children:** A child is defined within the Children Act 1989 as - “an individual who has not reached their 18th birthday”.

The fact that a child may:

- live independently
- are a parent themselves
- are in custody
- are a member of the armed forces

does not change their entitlement to protection under the Children Act 1989. This is important because young people aged 16 and 17 years with safeguarding needs access ‘adult’ services in the Trust and are seen and treated by adult trained staff who may not acknowledge this entitlement.

**Safeguarding Adults:** An adult is an individual aged 18 years or over.

The Care Act 2014 defines an ‘adult at risk’ as:

An adult who has care and support needs (whether the needs are being met or not). Is experiencing, or at risk of, abuse or neglect; and as a result of those care and support needs, is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

**Named Professionals:** All LTHT staff have a statutory responsibility to safeguard and protect those who access our care regardless of their position in the Trust. However, Named Safeguarding Professionals have specific roles and responsibilities for safeguarding children and adults, as described in the Intercollegiate Safeguarding Competencies for Adults (2018) and Children (2019).

NHS providers must identify a Named Doctor and a Named Nurse for Safeguarding Children and Young People (and a Named Midwife, if the organisation provides maternity services). Named Professionals provide expert advice, support to Trust employees, and promote good practice within their organisation (Children Act 1989/2004; Care Act 2014). The Trust is assured that all Named Safeguarding Professional roles are fulfilled and in post.

## **Appendix 2. Missing Persons Annual Data Report**

### **1. Summary**

The purpose of this report is to provide the Safeguarding Governance Group with key safety and quality data which describes the safety of patients preserved under the Management of Missing Patients Procedure (MISPERS).

Data in this report is provided for the period of 1st April 2024 to 31st March 2025. The Professional Practice Standards & Safety (PPSS) Team holds responsibility for the Missing Patients Procedure and data collection. The PPSS Team will present an annual report and a quarterly data summary to the Safeguarding, Learning Disabilities and Autism Governance Group.

This report provides detailed information on the referral of at risk missing/absconding patients to West Yorkshire (WY) Police and Yorkshire Ambulance Services (YAS). This is measured against the criteria within the procedure.

### **2. Background**

Leeds Teaching Hospitals Trust (LTHT) has a duty of care towards the safety of its patients and works collaboratively with West Yorkshire Police (WYP) and Yorkshire Ambulance Service (YAS), outlining the process to identify which patients are at risk of potential harm if they went missing. The Management of Missing Adult Patients and Safeguarding Missing or Abducted Child Procedures have been designed to protect patients and highlights the fundamental processes involved in risk assessment, escalation of potentially vulnerable patients, an introduction of alert systems and the key responsibilities of LTHT and police personnel.

There is a requirement from the Safeguarding, Learning Disabilities and Autism Governance Group to record the number of missing/absconding patients from LTHT. This includes monitoring the Datix incident reporting system and analysing data from WYP on all the reported cases. The term MISPERS used within this report is the terminology used by WYP. The data from WYP, security call logs and Datix reports are reviewed monthly by the PPSS team.

Following a 2022 YAS audit identifying LTHT as having the highest number of inappropriate MISPERS referrals, a revised referral flowchart was co-developed with input from YAS and West Yorkshire Police. The new flowchart, aligned with key safeguarding procedures, addresses previous gaps in risk assessment and inter-agency consistency. It integrates the risk assessment directly into the process to reduce paperwork and improve clinical usability. This updated approach has been in place since February 2024.

### **3. Monitoring Arrangements**

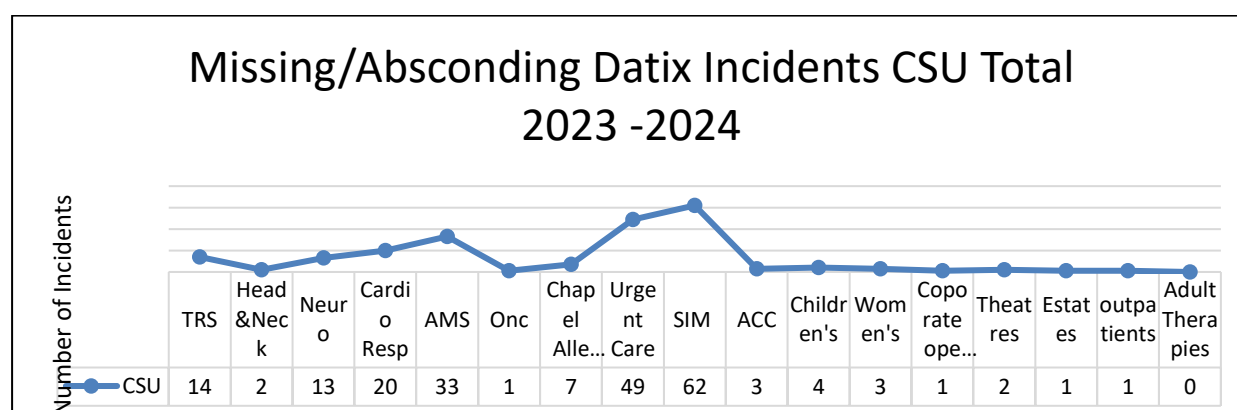
Adherence to the 'LTHT Management of Missing Adult Patients Procedure' will be monitored by the Safeguarding Governance Group and PPSS team. Referrals made for all missing/absconding incidents will be examined and analysed through the Datix reporting system, police referral logs and security call logs. The PPSS team is responsible for reviewing Datix to assess the effectiveness of the procedure. The PPSS team will also liaise with WYP to analyse data on missing persons monthly to monitor LTHT performance and identify gaps.

#### 4. Reporting - Annual Data April 2024-March 2025

There were 216 missing/absconding incidents reported on the Datix reporting system from April 2024 to March 2025. This is in line with previous reporting financial year (n= 218 incidents recorded).

Of the 216 incidents reported on Datix, four incidents regarded a young person or a child, and the remainder were involving adults. Figure 1 (below) highlights the total number of reported missing/absconding incidents on Datix by Clinical Service Unit (CSU) in 2024-2025. It is evidenced from Figure 1 that the Specialty & Integrated Medicine (SIM) and Urgent Care (UC) CSUs reported the highest number of missing persons; this trend is observed in previous reporting periods and is most likely due to the patient groups admitted within these specialities. The Abdominal Medicine and Surgery (AMS) CSU had the third highest reported numbers this financial year. As recommended in the previous MISPERs report, the PPSS Team will continue to conduct continuous Datix reports analysis and review to identify incidents that have been reported more than once.

**Figure 1: Missing/Absconding Datix reported incidents by CSU, April 2024 - March 2025**



A review of all incident reports on Datix provided information regarding to which personnel the ward escalated the MISPER incident to and what support was sought to help locate the patient (Figure 2). This included the Clinical Site Matron (CSM), WYP, Security, and YAS, or further referral for psychiatric review or Mental Health section. Those requiring psych review/MHA section were patients who were lacking capacity at the time of absconding thus requiring further interventions from peripheral teams.

**Figure 2: Missing/Absconding Patients escalated personnel (April 2023 - March 2025)**

Task	2023-2024	2024-2025	% Difference
CSM Informed	126	129	+2.4%

Police Called	86	104	+20.9%
Psych RV/Section/Dementia/Confusion	53	102	+92.5%
Security Contacted	111	109	-1.8%
999/YAS	39	46	+20%
Total number of incidents	218	216	-1.0%

It is evident from Figure 2 that there has been an overall increase in the number of patients with mental health conditions absconding/missing (+92.5%). Figure 2 also highlights an increase in incidents that required further input from police (+20.9%) and YAS (+20%), this could suggest that the Trust teams are becoming more descriptive with the content of the Datix reports. Data provided by WYP would support this as the Datix data is significantly closer to the WYP date when compared to last year. This should continue to improve with the new procedure as it outlines the criteria needed for police and YAS involvement.

**Figure 3: Missing/Absconding Datix outcomes reported (April 2023 - March 2025)**

Criteria	2023-24	2024-25	% Difference
Located/returned/ brought back	104	150	+44.2%
Not required to return/ reported as do not wish to return	41	62	+51.2%
Not found/ Outcome unknown	69	3	-95.7%

Datix incident reports were further analysed to identify how many patients were “located/returned/ brought back”, “not required to return/ reported as do not wish to return” and “Not found/ Outcome unknown”. As displayed in Figure 3 above, the number of incidents with an unknown outcome has decreased by 95.7%. The data for this information is generated from the investigation section of the relevant Datix form and it is dependent on staff completing a full review of the Datix incident, that is mandatory for completion since previous financial year.

The LTHT security team was asked to provide additional data on the number of patients they had logged as located and returned. The security team logged 457 calls regarding missing or absconding patients. Of these calls they reported that 32% (146) of these patients were located and returned to their ward/department; this is a 6% decrease from the previous year. 68% (311) of the patients were not located and returned by the security team, a 3% increase from the previous year. Insufficient data exists to compare how many of these were escalated to police, refused to return, or were medically fit for discharge.

The most contemporary data received from police in April 2024 (figure 4) reviews the previous two financial years (from April 2023 to March 2025). Figure 4 is sourced from WYP and details the number of calls reported which were accepted.

**Figure 4: Number of Accepted Calls to West Yorkshire Police from LTHT (April 2023-March 2025)**

Hospitals	2023-2024	2024-2025	+/- Difference	+/- %
St. James' University Hospital	67	113	+46	+68.7%
Leeds General Infirmary	46	48	+2	+4.3%
Seacroft Hospital	3	5	+2	+66.7%
Chapel Allerton Hospital	1	1	0	N/A
Wharfedale General Hospital	0	0	0	N/A
<b>LTHT Total</b>	<b>117</b>	<b>167</b>	<b>+50</b>	<b>+5.6%</b>

All calls to the WYP go through the eligibility criteria and this is based on the information provided by LTHT staff reporting the incident. If the supplementing information meets the police criteria, the reported cases will be accepted for investigation. Calls to WYP that were subsequently declined due to being inappropriate have been excluded from the figures. Therefore, the total number of calls to WYP may have been much higher than the reported data (Figure 4). When comparing the data for 2024-2025 against 2023-24 there is an increase of 5.6% in the number of accepted cases. As mentioned above, there has been an increase in both reports indicating police involvement (shown in Figure 2) and the calls to WYP. Figure 2 also shows an increase in the number of absconding incidents involving patients with cognitive impairments or mental health concerns.

These patients would meet the police criteria for response which could explain the increase in calls logged by police. This represents a positive development in staff appropriately identifying high-risk individuals and compliance with the MISPERs procedure. However, while adherence to protocol is critical, there remains a clear need for further preventative action. Efforts should focus on reducing the likelihood of such incidents occurring in the first place through strengthened risk assessment processes, enhanced patient monitoring, and targeted interventions for vulnerable individuals.

It is important to highlight that WYP only record calls that they actively respond to. As a result, calls deemed inappropriate for police response are not logged in their system. This is supported by details in Datix reports, where some entries note that although the police were contacted, they declined further involvement. Two key issues contribute to this: staff referring patients who do not meet the criteria for police response, and 999 call handlers either failing to dispatch police for appropriate cases or instructing staff to contact YAS instead.

The MISPERs policy was developed in collaboration with WYP and includes specific criteria that must be met for police involvement. WYP have clearly stated that they will only respond to incidents where these criteria are fulfilled, and the patient's location is unknown. Despite this, there have been instances where call handlers redirect staff to YAS for cases that do meet the police response criteria.

YAS, however, will only attend if the patient's location is known and urgent medical attention is required. As such, they frequently decline to respond when redirected from the police. Further work is required to strengthen communication and understanding between WYP call handlers and healthcare staff. Improving this collaboration is essential to ensure appropriate and timely responses to missing patient incidents and to reduce delays in managing high-risk situations.

Figure 5 below illustrates the comparison made between Datix reports, security call logs and referrals to WYP. When comparing the reporting of incidents between the sources, it is evident that LTHT is underreporting as the security call logs are at a higher rate when compared to Datix reports from CSUs, except for peripheral sites.

While the overall number of Datix reports has remained relatively consistent compared to the previous year, the proportion of incidents recorded in Datix relative to security logs has decreased from 49% to 47%. This suggests that fewer incidents are being formally reported through Datix despite being logged by security. Additionally, calls to security have increased significantly, rising by 44.2%. This growing discrepancy may reflect underreporting by staff or a need for further training and reinforcement around incident reporting protocols.

WYP data included "high" risk patient calls in accordance with the "Management of Missing Adult Patient Procedure". Every missing/absconding incident must be reported on Datix as per the procedure, therefore expecting that LTHT Datix would show more reporting of incidents with the inclusion of low and medium risk patients. The situation has deteriorated compared to last year. As shown in Figure 5, all three locations reported more calls in police data than were recorded in Datix. This discrepancy may indicate a lack of staff understanding or adherence to the MISPERs reporting process.

**Figure 5: Missing/Absconding Patients Comparison Data - April 2024 - March 2025**

LTHT Sites	SJUH			LGI			Peripheral Sites		
Data Source	WYP Data	Datix	Security call logs	WYP Data	Datix	Security call logs	WYP Data	Datix	Security call logs
12-month Total	157	113	333	52	48	124	7	5	0

## 5. Summary of Actions Being Taken

A new flowchart has now been in place for just over a year. There are some issues noted when asking police to attend calls with call handlers stating that they will not dispatch officers or advising staff to contact YAS instead. Some training is needed for staff to ensure appropriate patients are referred to WYP and communication with call handlers highlights the relevant immediate risks of the patient. Some communication is also needed with WYP to revisit agreements made in the creation of the flow chart and ensure call handlers are aware of these agreements. LTHT will work to reduce the number of missing people by integrating missing people to the Enhanced Care working group. The group will identify preventive improvement strategies alongside



the enhanced care risk assessment tool and procedure.

The Professional Practice Standards & Safety Team will continue to:

- Liaise with WYP for quarterly data on total number of incidents reported.
- Liaise with WYP and YAS for future shared learning on themes identified by them and for LTHT to action to further improve the robustness of the current flowchart.
- Liaise with LTHT Security team to review data on the number of calls received and the outcome.
- Continue to analyse data from Datix, security and police.
- Liaise with the communications team, Head of Nursing and Matron groups to reinforce reporting of missing/absconded patient incidents on Datix through email and forums.
- Encourage education around the use of adding a note on PPM+ on every missing incident.
- Monitor Datix reporting system on a monthly basis to review incidents reported.
- Share data at the Safeguarding, Learning Disabilities and Autism Governance Group.
- Continue to deliver missing patients teaching session at Introduction to Professional Practice (IPP).
- Continue to encourage staff to complete the outcomes section on Datix so every report will include whether the patient has been located and returned or not located and not returned.
- Hold responsibility for the procedure review. The procedure is due for review in April 2026.

## **6. Priorities for 2025-2026**

- To consider providing training for call handlers to ensure appropriate patients referred to WYP.
- To strengthen communication and understanding between WYP call handlers and health care staff.
- To explore the benefits of adding a risk of absconding section on the Nursing Specialist Assessment so this can be completed on admission for patient and at-risk patients can be identified earlier.
- Dedicated focused work on recurring incidents through strengthened risk assessment processes, enhanced patient monitoring, and targeted interventions for vulnerable individuals.
- To review education and training in potential to add MISPERs as priority training on training interface as a two-yearly training module.
- Professional practice team will review the Datix form to include mandatory feeds for improved and expanded data collection.

Yasmin Walsh  
Senior Sister  
Professional Practice Standards and Safety Team  
April 2025