SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST **D**

EXECUTIVE SUMMARY

REPORT TO THE HEALTHCARE GOVERNANCE COMMITTEE MEETING

HELD ON 20 OCTOBER 2014

Subject:	Annual Safeguarding Adults Report
Supporting Executive Member:	Professor Hilary Chapman, Chief Nurse
Author:	Christina Herbert, Lead Nurse Older People and Vulnerable Adults Una Cunningham, Nurse Director, Head & Neck
Status[1]	N

PURPOSE OF THE REPORT:

- To inform the Trust Executive Group and Healthcare Governance Committee of the current arrangements for safeguarding adults including people with learning disabilities at Sheffield Teaching Hospitals NHS Foundation Trust (STHFT)
- To demonstrate key achievements to safeguard vulnerable adults over the last 12 months
- To identify the key priorities for 2014-15 to improve the processes, policies and audits, training and assurance in order to better safeguard vulnerable adults

KEY POINTS:

- Responsibilities to the Sheffield Adult Safeguarding Board (SASB), Sheffield Adult Safeguarding Partnership (SASP) and Learning Disabilities Partnership Board
- Management structure and named professionals
- Policies and procedures
- External reviews and audits
- Education and training

IMPLICATIONS

AIM OF THE STHFT CORPORATE STRATEGY 2012-2017		**TICK AS APPROPRIATE**
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	✓
5	Deliver Excellent Research, Education & Innovation	✓

RECOMMENDATION(S):

The Trust Executive Group and Healthcare Governance Committee are asked to note the contents of this report.

APPROVAL PROCESS:

Meeting	**Date**	**Approved**
Trust Executive Group	8 October 2014	
Healthcare Governance Committee	20 October 2014	

[1] Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

[2] Against the three pillars (aims) of the STH Corporate Strategy 2008-2012

SAFEGUARDING VULNERABLE ADULTS AT SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST ANNUAL REPORT

APRIL 2013- MARCH 2014

1. INTRODUCTION

Safeguarding and the protection of vulnerable adults at risk from abuse and harm is everyone's business.

Safeguarding vulnerable adults has remained high on the national agenda for both health and social care organisations particularly with regard to both the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013) and the Winterbourne View Inquiry (Flynn, 2012). Following the publication of the Francis Report and the subsequent Government response, Hard Truths, The journey to putting patients first (DH 2014), there is a renewed focus on cultural change to protect patients and to improve standards of care within all organisations, improving transparency and ensuring a duty of candour.

The Trust, as a member of both the Sheffield Adult Safeguarding Partnership (SASP), the Sheffield Adult Safeguarding Board (SASB), and the Learning Disabilities Partnership Board, continues to work closely with the statutory and voluntary agencies across Sheffield to discharge it's responsibilities as an NHS provider for the safeguarding of vulnerable people and people with a learning disability.

Wider Trust initiatives to safeguard patients and staff include work streams on issues such as transition of children and young people with complex needs into adult services, meeting the needs of patients with a learning disability, identifying and supporting victims of domestic abuse, substance misuse, forced marriage and female genital mutilation (FGM), Prevent, nutrition, falls, tissue viability, embedding the principles of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DOLS), privacy and dignity and mental health including dementia.

2. DEFINITION

In relation to safeguarding adults, a vulnerable adult or what is now widely referred to as an adult at risk of harm, is defined by No Secrets (Department of Health 2000) as "anyone aged 18 years or over, who is or may be in need of community care services by reason of mental or other disability, age or illness, and who is unable to take care of him or herself or protect him or herself against significant harm or exploitation". (Department of Health, 2000, p8.)

3. STRATEGIC CONTEXT

The Trust has a duty to comply with national and local policy, in particular, guidance contained in 'No Secrets' (Department of Health 2000), Safeguarding Adults (ADSS 2005), South Yorkshire Safeguarding Adults Procedures (2014), and to ensure that the human rights of vulnerable people are upheld in accordance with the Human Rights Act (Great Britain,1998), Mental Capacity Act (Great Britain, 2005) and Deprivation of Liberty Safeguards (Great Britain, 2008), and the Safeguarding Vulnerable Groups Act (Great Britain, 2006).

In lieu of an update of the No Secrets guidance, the Department of Health published a set of standards for health services which provide complementary guidance on safeguarding adult practice (Department of Health, 2011a, b, c, d).

Key Priorities

To support STHFT staff to become familiar with and to utilise the updated web based South Yorkshire Safeguarding Adults Procedures, providing feedback on the ease of use to the Sheffield Adult Safeguarding Office.

3.1 Safeguarding Adults Team

Led by the Chief Nurse and supported by the Deputy Chief Nurse, safeguarding adults at risk is a high priority for the Trust.

The Adult Safeguarding team consists of the Lead Nurse for Vulnerable Adults, Named Nurse, Mental Capacity Act (MCA) Practice Development Facilitator and Safeguarding Support Secretary.

Key achievements 2013-2014

- The STHFT adult safeguarding team has been able to secure funding from the Learning and Development department to employ the Mental Capacity Act Practice Development Facilitator for two days a week on a permanent basis. The Local Authority have also provided an additional one and a half days temporary funding towards the post until March 2015 in order to ensure the post holder can effectively provide expert training and advice around mental capacity/ best interest decision making and support staff to embed the principles of the MCA /Deprivation of Liberty (DOLS) into practice.
- The Safeguarding Adults team has continued to offer prompt prioritised responses to requests for expert advice and support across the organisation during core hours.

Key priorities 2014-2015

- To continue to offer training, advice and support to STHFT staff in respect of all aspects of safeguarding vulnerable people.
- To continue to train and support staff to apply the principles of the Mental Capacity Act and Deprivation of Liberty safeguards in day to day practice.
- To maintain an excellent attendance record at the delegated safeguarding/vulnerable adults meetings and sub groups.

4. POLICIES AND PROCEDURES

All agencies across South Yorkshire work within the framework of the South Yorkshire Safeguarding Adults Board Procedures (2014)**.** These procedures provide guidance to professionals and the public on the identification of abuse and processes to follow to report suspected abuse.

Issues around safeguarding at STHFT would seem to fit in to two main categories:

1. Concerns about a vulnerable person identified by or disclosed to STHFT staff during a period of treatment i.e. those arising as a result of a third party act or omission (for example a domiciliary or care home setting).

2. Concerns arising as a result of an act or omission in care by STHFT. Increasingly, these concerns are initially raised through the Trust's complaints and or serious incident processes.

Agreement was reached via the former multi agency policy and practice review group (PPRG) to standardise the response of various organisations to the management of complaints where there are potential safeguarding adults concerns identified within the complaint.

Patient Partnership Team staff members have been given additional training to enable them to identify any potential safeguarding concerns when undertaking the initial risk grading of a complaint. Any safeguarding concerns identified are forwarded to the Adult Safeguarding Team for review and further action if required.

Following a review of the hospital social work provision, the general social work team was withdrawn from STHFT in July 2013, leaving only a small team of specialist social workers in situ. The specialist hospital social workers have limited capacity to screen and investigate safeguarding concerns generated within or relating to STHFT. As an interim solution to address this, the STHFT Adult Safeguarding Team piloted a process whereby all safeguarding adult alerts generated within the acute

Trust within core hours, are forwarded to the STHFT Adult Safeguarding Team following initial screening by a senior manager such as a Matron, known as the Named Referrers. Where the thresholds for adult safeguarding have been met, referrals are forwarded to the Local Authority Safeguarding Adult Access Team by the STHFT Adult Safeguarding Team. The pilot was successful in respect of screening out those concerns that do not require a referral into safeguarding procedures, redirecting them to more appropriate processes and thereby ensuring that only true safeguarding concerns are forwarded to the local authority for investigation.

Now that the process of screening referrals has been established by the STHFT Adult Safeguarding Team, it is not envisaged that the hospital social work team having relinquished this role have the capacity to accept this responsibility back. Additionally, where there are safeguarding concerns raised about care provision at STHFT, the local authority social workers and team managers contact the STHFT Adult Safeguarding Team to provide information to contribute to the local authority led safeguarding strategy meeting and investigation.

These processes, which would previously have been the responsibility of the social work department, have created an additional pressure on the workload of the Lead Nurse and Named Nurse.

Safeguarding concerns generated by staff in the Community Care Group continue to be raised directly with the Local Authority Safeguarding Adult Access Team.

Key achievements 2013-2014

- The Lead Nurse and Named Nurse for Adult Safeguarding contributed to the review and revision of the South Yorkshire Safeguarding Adults Procedures.
- A robust process for the referral of adult safeguarding concerns generated from within STHFT has been put into practice.
- A number of senior staff have undertaken specific safeguarding training to equip them with the skills to understand the thresholds for referral into safeguarding adults procedures and to screen alerts appropriately.

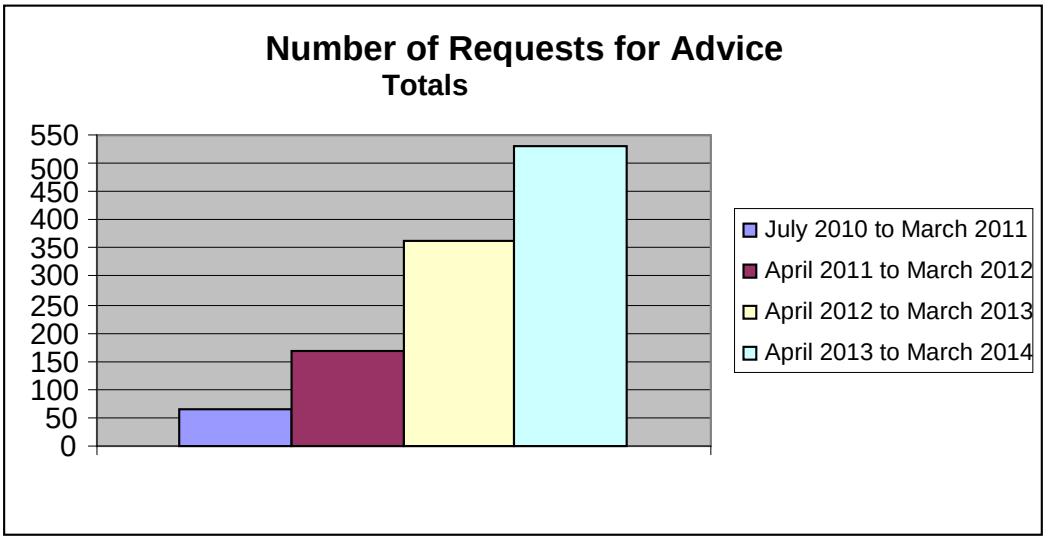
Key Priorities 2014-2015

- To undertake an audit of the quality of the safeguarding adults alerts generated from within STHFT, to identify whether they are appropriate and contain sufficient information for a decision to be made about whether they should be screened into safeguarding procedures.
- To audit the origin of safeguarding alerts generated within STHFT to identify areas that may be under reporting safeguarding concerns.
- To identify whether as a result of these audits further training is required.

5. CONTACTS WITH STHFT SAFEGUARDING ADULTS TEAM FOR ADVICE AND SUPPORT

The following table shows the year on year rise in recorded contacts with the Adult Safeguarding Team for advice and support from both within the Trust and also from outside agencies.

Graph 1 - Number of requests to STHFT Adult Safeguarding Team for advice



July 2010-March 2011	=	**66**
April 2011-March 2012	=	**169**
April 2012-March 2013	=	**364**
April 2013-March 2014	=	**529**

There is no data available prior to July 2010. Data collection was instigated by the Lead Nurse for Older People / Vulnerable Adults on commencement of her post in July 2010.

Whilst this data reflects the number of requests received, it does not demonstrate the increasing complexity of the safeguarding concerns being identified by health staff which have a consequential impact on the workload of the Adult Safeguarding Team and the time commitments required when supporting staff to address the concerns being raised.

These contacts will often require further information to be sought and/or investigation to be undertaken by the Adult Safeguarding Team e.g. review of case notes, information gathering from STHFT staff or from outside agencies, liaison with other agencies, collating of information into written reports, attendance at strategy or best interest meetings, Vulnerable Adults Risk Management Model (VARMM) meetings, or case conferences.

Key achievements 2013-2014

- The STHFT Adult Safeguarding Team has seen an increase in the number of contacts for advice and support. This may be due to the impact of training and awareness provided by the Safeguarding Adults Team along with positive feedback from the support offered**.**
- A rota system has been implemented to ensure that a member of the Safeguarding Adults Team is available to offer advice and support during core hours 9-5 Monday to Friday**.**

Key priorities for 2014-2015

- To continue to respond to requests for advice in a timely manner to ensure staff are supported and vulnerable adults are kept safe.

6. INCIDENTS/SAFEGUARDING ALERTS AND REFERRALS

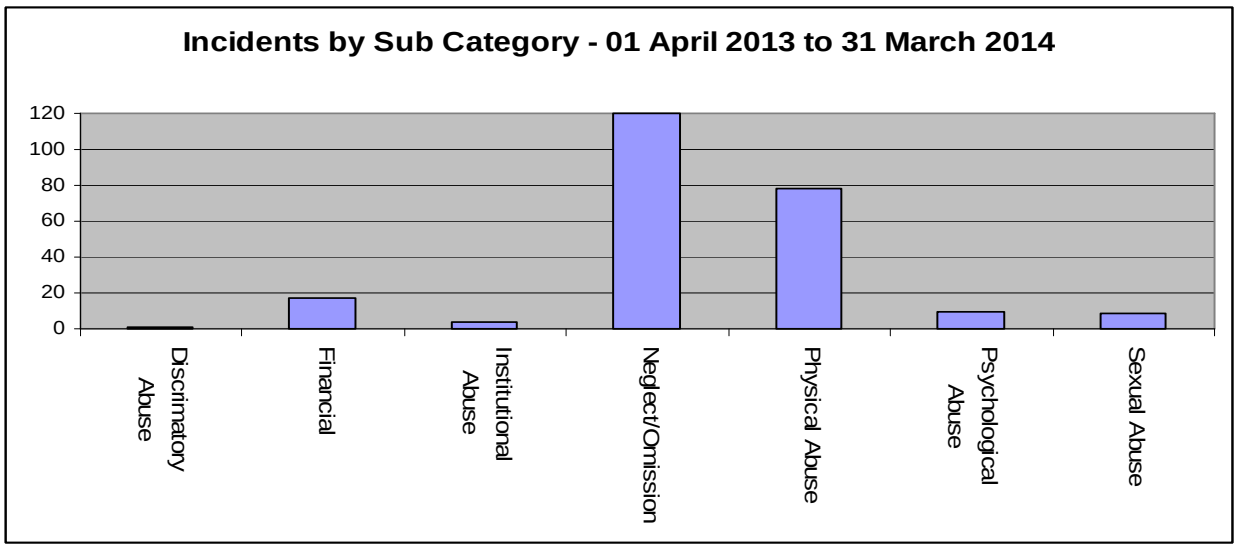
Alerts and Referrals

The STHFT Datix system records the number of safeguarding adults alerts made in the various departments across the Trust. The system does not allow for identification of how many of those alerts are subsequently generated into formal safeguarding referrals. Information regarding the number of referrals which have been forwarded to social care has to be requested from the Sheffield Adult Safeguarding Office and has highlighted some discrepancies between Datix and safeguarding referrals to social care.

6.1 Table 3 - Yearly summary of adult safeguarding alerts recorded on DATIX

2008-9	2009-10	2010-11	2011-12	2012-13	2013-14
7	74	137	202	161	239

6.2 Graph 2 - Types of Abuse



Neglect/ acts of omission and physical abuse have been the main categories for the allegations of abuse recorded in 2013 / 14 which is consistent with previous years.

6.3 Table 4 - Referrals from STHFT recorded on the Local Authority Care First System

April 2011 - March 2012	April 2012 to March 2013	April 2013-March 2014
136	112	73

It is not clear as to why there has been a fall in the number of safeguarding referrals during this year.

It is possible that there have been fewer safeguarding alerts raised in 2013-14 or that following training, the Named Referrers are more proficient and skilled in screening out the safeguarding alerts that do not require progression to a safeguarding referral but can be managed via a different and more appropriate route e.g. complaints process.

However there is also the possibility that safeguarding alerts/referrals have not been recorded on the Datix and Adult Access systems appropriately.

Key achievements 2013-2014

- There were a total of 239 reported formal alerts noted on Datix from April 2013 – March 2014, an increase from the previous year.

Key priorities for 2014-2015

- To increase the number of alerts reported, taking the opportunity to highlight via the Safeguarding Leads meeting, situations where appropriate alerts are being missed.
- To gather data from similar sized organisations to STHFT in order to benchmark our own performance.

Key achievements 2013-2014

- Referrer training has been provided to 117 senior staff from nursing and therapy services.
- The STHFT referral process has been reviewed and refined following the withdrawal of the hospital general social work team

Priorities for 2014-2015

- To undertake an audit of alerts recorded on Datix to compare with the number of referrals recorded on the Local Authority Care First System to ensure referrals are being submitted appropriately.

6.3 Investigations

Safeguarding concerns are investigated at different levels; the majority are investigated at the service level, principally involving the teams providing the service to the patient. Internal safeguarding investigations form part of a wider investigation under Adult Safeguarding Procedures coordinated and led by Social Care.

The Sheffield Safeguarding Adults Office are keen to encourage health organisations to take the lead in coordinating and managing safeguarding investigations particularly where health issues or health agencies are the alleged primary focus of concern.

Some investigations such as Individual Management Reviews (IMRs) into Serious Case Reviews where vulnerable adults have suffered serious harm despite being known to services, and Domestic Homicide Reviews (DHR) where individuals have been killed as a direct or indirect consequence of domestic abuse, require an advanced level of investigative, analytical and report writing skills.

An IMR is an internal investigation report by an agency that has provided services to the victim, and/or perpetrator or other relevant family members. The purpose of the IMR is to look openly and critically at the involvement of the individual agency in order to identify both good practice and where there may have been shortcomings, to review organisational policy and procedure and to make recommendations for future action.

As the number of DHRs is increasing, issues of identifying appropriate individuals to undertake IMRs to the required standard, including ensuring that the IMR authors are appropriately trained and able to maintain competence, needs further consideration and resourcing.

Key Achievements 2013-2014

- The STHFT Safeguarding Adults and Children teams have submitted three IMRS in respect of DHRs during 2013-2014

Key Priority for 2014-2015

To identify further senior key individuals from within the Trust who have the skills to lead on safeguarding investigations and IMRs and to ensure they have the correct training and support.

7. MENTAL CAPACITY ACT (2005) AND DEPRIVATION OF LIBERTY SAFEGUARDS

The Mental Capacity Act (2005) (MCA) which came into force in October 2007 provides a statutory framework for acting and making decisions on behalf of individuals who lack the mental capacity to do so for themselves.

The Deprivation of Liberty Safeguards (DOLS) were introduced in April 2009 focussing on some of the most vulnerable people in our society, and provide a legal basis for detention in care homes or hospitals for care and treatment that is deemed in their best interests and may amount to a deprivation of their liberty.

To practice within the law and avoid any unlawful actions or deprivations of liberty it is important that staff within the Trust understand the legal authority for detention and treatment of patients who lack the capacity to consent to the arrangements.

The DOLS legislation provides detailed requirements about when and how deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty.

An urgent authorisation may be given by a Managing Authority (hospital or care home) for a period of up to seven days in order to deprive a person of their liberty in a hospital or care home to lawfully provide treatment in that person's best interest. The Managing Authority must at the same time apply to the supervisory body (in Sheffield this is the Local Authority) for a standard authorisation to deprive a person of their liberty in the relevant hospital or care home, using a standard form.

The urgent authorisation is only valid for 7 days pending assessments for a standard authorisation, these assessments are commissioned by the supervisory body.

A Best Interest Assessor from the supervisory body will establish whether a deprivation of liberty is occurring or likely to occur and whether the deprivation of liberty is in the best interest of the person.

The Independent Mental Capacity Advocacy Service (IMCA) supports people who lack capacity to make decisions where there is no other person e.g. relative, friend or carer to advocate on that person's behalf. An IMCA must be involved in those situations where there are decisions to be made regarding serious medical treatment or a long term change of accommodation. IMCAs also have specific roles in relation to the DOLS.

On the 19th March 2014, the Supreme Court handed down its judgement in the case of "P v Cheshire West and Chester Council" and 'P and Q v Surrey County Council'. The judgement made explicit the factors that constitute a deprivation of liberty and the requirement for all organisations to work in accordance with that precedent.

The implications of the judgement for STHFT is that it is likely that a much greater number of inpatients who lack capacity to consent to their arrangements will need to be subject to a DOLS authorisation or a detention under the Mental Health Act, to ensure they are lawfully and appropriately deprived of their liberty in their best interest. This will include patients who are being treated in intermediate care facilities.

The Trust (the Managing Authority) needs to work in close collaboration with local authority colleagues (the Supervisory Body) to ensure local processes are robust and efficient with regard to the authorisation of DOLS safeguards.

7.1 The following table details the current available data on the number of DOLS applications made by STH during the period from April 2011 – March 2014:

Table 5. DOLS applications requested by STH from April 2011 to March 2014

	April 2011 - March 2012	April 2012 to March 2013	April 2013-March 2014
Total Applications Requested	**42**	**51**	**56**
Granted	**29**	**24**	**16**
Not Granted	**7**	**14**	**22**
Assessed as not appropriate	**6**	**13**	**18**

The refusal to grant a DOLS application may result from one of the six assessment requirements not being met. Those applications assessed as not appropriate may occur where the patient is assessed to have mental capacity or has regained capacity since the DOLS application was submitted.

7.2 The following table details the current available data on the number of IMCA referrals made by STH during the period from April 2012 – March 2014:

Table 6. Referrals to the IMCA Service April 2012 -March 2014

April 2012 to March 2013	April 2013-March 2014
61	**70**

The data received from the IMCA service indicate that there were 70 referrals made from April 2013 to March 2014, some of which may have been made regarding the same client as was the case in previous years. The referrals related to change of accommodation, serious medical treatment, Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders and to the Deprivation of Liberty safeguards assessments. All of the clients were patients of STHFT at the time of referral.

This data was not collected for the 2011-12 annual report therefore the 2012-13 data is the benchmark for subsequent years. It was anticipated that the provision of MCA training from October 2012 would lead to an increase in awareness of the need to involve an IMCA and in turn will result in an increase in referrals.

The increase has been minimal which raises a concern that IMCAs may not be being involved as often as they should be to advocate for patients who lack capacity. The MCA Practice Development Facilitator meets with the IMCA service on a 3 monthly basis in order to work together to resolve any issues and improve practice within STHFT.

7.3 MCA Audit

The MCA Practice Development Facilitator undertook a small scale Trust wide audit of mental capacity assessments and best interest decisions from July to August 2013 to ascertain if correct procedures for assessing and documenting mental capacity and best interest decisions are being adhered to and to identify any additional training needs.

A sample of inpatients from units that were most likely to include patients with capacity issues and a general sample taken from patients across the Trust with a learning disability was selected. From this sample 22 patients were identified as fitting the criteria.

The audit revealed a general lack of knowledge and understanding about the requirements of the act and where there was some understanding the processes used were not robust enough to withstand scrutiny and fulfil the requirements of the act. There was little evidence of capacity assessments or best interests decisions being made in a manner which complied with the MCA Code of Practice.

- An action plan was devised and implemented to raise the profile of the MCA and increase the number of training sessions, to address general compliance with the MCA decision making process and to highlight the issues of applying the principles of the MCA to DNACPR orders.
- A further audit regarding compliance with the MCA will be undertaken in September 2014.
- An audit of DNACPR orders is proposed for January to March 2015 to identify both good practice and areas where there is a requirement for further training and awareness.

7.4 Training

Table 7. The numbers of staff trained by the MCA Practice Development Facilitator

Mental Capacity Act	Assessing MCA and Best Interest	Deprivation of Liberty Safeguards (DOLS)	Consent and the MCA	TOTAL
204	**47**	**70**	**16**	**337**

MCA basic awareness has also been delivered at Corporate Induction up until April 2014 but following a review of corporate induction is now no longer included.
MCA is also referred to in the Safeguarding Adults basic awareness training.

Key Achievements 2013-2014

- A guidance toolkit and exemplar of good practice in assessing and recording mental capacity has been devised and made available on the Trust MCA intranet site.
- A rolling programme of training on; MCA, capacity assessment and best interest decision making and Deprivation of Liberty Safeguards has been ongoing since September 2012. Uptake of the training has exceeded expectation and additional training dates to meet the demand have been added.

Key Priorities for 2014-2015

- To implement the action plan to address compliance with the Supreme Court judgement on DOLS.
- A further audit around compliance with the MCA will be undertaken in September 2014.
- To ensure mental capacity assessments and best interest decisions are being made and documented according to the legal requirements as stated in the Mental Capacity Act (2005).
- To continue to provide training and to support staff in undertaking mental capacity assessments and best interest decisions.

8. DOMESTIC ABUSE

The recognition and support of victims of domestic abuse (DA) is a key issue for all agencies.

There have also been known instances where staff members at STHFT have been victims of domestic abuse and forced marriage.

A comprehensive review of DA services in Sheffield was undertaken by the head of the Sheffield Drugs and Alcohol/ Domestic Abuse Co-ordination Team (DACT) and a new strategy published to take services forward. Membership of the strategic and operational groups were also re-examined by the review. STHFT is represented on the Strategic Board by the Deputy Chief Nurse. The Lead Nurse for Older People and Vulnerable Adults represents the Trust on the Domestic Abuse Provider Consultation Group and the Domestic Homicide Review Sub Group.

NICE public health guidance 50 was published in February 2014 (NICE, 2014) and aims to help identify, prevent and reduce domestic violence and abuse. The guidance is for health and social care commissioners, specialist domestic violence and abuse staff and others whose work may bring them into contact with people who experience or perpetrate domestic violence and abuse. The guidance includes signposting to support to address honour based violence and forced marriage.

The recommendations cover the broad spectrum of domestic violence and abuse, including violence perpetrated on men, on those in same-sex relationships and on young people.

Those recommendations with relevance to STHFT have been identified by the Lead Nurse for Vulnerable Adults and an action plan formulated to address any gaps, however many of the recommendations have already been implemented at STHFT.

8.1 Independent Domestic Violence Advocacy Service (IDVAS)

The Independent Domestic Violence Advisors (IDVAs) work primarily with women and occasionally men who are at the highest levels of risk from domestic abuse in the city. The service helps victims of domestic abuse to take steps to reduce their risk levels and to hold perpetrators to account through the Police, Probation and legal or other remedies.

The IDVAs are able to refer directly to and provide information on the high risk victims of domestic abuse at the Multi Agency Risk Assessment Conference (MARAC).

From 2010 health based IDVAs were hosted within Jessop Wing maternity services, to provide early support to pregnant women identified as being at risk from domestic abuse or violence, as domestic abuse often starts or escalates during pregnancy and is a major health risk for mothers and unborn babies. The IDVAs were also hosted within the A&E Department at the Northern General Hospital and provided in reach into the Genito-Urinary Medicine (GUM) Clinic. However, following the city wide review of domestic abuse services the IDVAS no longer has staff based within STHFT.

A Domestic Abuse Pathway Coordinator from the Domestic Abuse Outreach Service now provides support to STHFT Staff to identify high risk victims via the completion of the Domestic Abuse Stalking, Harassment and Honour Based Violence (DASH) risk assessment tool.

There were 64 referrals to the IDVAS from STHFT during 2013-14.

8.2 Multi Agency Risk Assessment Conference (MARAC)

The MARAC is a Police-led dynamic process which takes a collaborative multi agency approach within a single case review style meeting to combine up to date risk assessment information regarding both victims and perpetrators of domestic abuse, with a comprehensive assessment of the victim's needs and action planning to prevent further harm. Referrals into the MARAC process are made via the DASH risk assessment tool.

Due to the increase in high risk referrals to the MARAC process, MARAC meetings are currently held in Sheffield three times per month and are attended by a small group of key staff from STHFT safeguarding children and adults teams, maternity services and A&E.

Key achievements 2013-2014

- 100% Attendance at MARAC
- The Lead Nurse for Vulnerable Adults worked with Human Resources to develop guidance for line managers to support staff who may be victims of domestic abuse. This guidance is available on the Domestic Abuse Intranet site.
- A Domestic Abuse Policy has been written and is awaiting ratification. Once agreed it will be available on the STHFT Domestic Abuse Intranet site.

Key priorities for 2014-2015

- To continue to ensure 100% attendance by STHFT at MARAC.
- To ensure 100% attendance at the Domestic Abuse Strategic Board.
- To ensure 100% attendance at the Domestic Homicide Review Sub Group.
- To ensure 100% attendance at the Domestic Abuse Provider Consultation Group.
- To ensure actions identified for STHFT are completed in a timely manner and reported back to the MARAC coordinator for inclusion in the MARAC minutes.
- To ensure learning from involvement in the MARAC process is integrated into practice via the Safeguarding Leads meetings and through inclusion in safeguarding adults and domestic abuse training and awareness sessions.
- To ensure the recommendations from the NICE Public Health Guidance are implemented in a timely manner.

9. DOMESTIC HOMICIDE REVIEWS

DHRs were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004a) and came into force on 13th April 2011 (Domestic Violence, Crime and Victims Act 2004b (Commencement No. 14) Order 2011)

This requires a local multi-agency review of care provision and services provided to both the victim and the alleged perpetrator when a domestic homicide occurs and is carried out alongside legal / criminal proceedings. The purpose of the DHR therefore, is not to assign blame or responsibility but to learn lessons and to improve policies and practice at a local and national level.

The lead responsibility for determining which domestic homicides meet the criteria for review under the DHR process lies with the Community Safety Partnership (CSP) which in Sheffield, is the Safer and Sustainable Communities Partnership (SSCP). They will coordinate DHRs, select members of the review panel and commission an independent author to compile the report.
The process is similar to the existing Serious Case Review process carried out following the death of a child or vulnerable adult where any organisation identified as having had contact with the victim is required to produce an Individual Management Review (IMR).

IMR authors are required to attend IMR author briefings as required and directed by the DHR Overview author.

The IMR is signed off at Executive Board level and submitted for further scrutiny by the DHR panel and Overview Author before ultimate inclusion in the overview report compiled by the independent author.

The final DHR report is forwarded to the Home Office for review and the Trust has a statutory duty to participate in this process.

Where a domestic homicide does not meet the criteria for a full DHR, but there has been some association with domestic violence, good practice would be to commission a Serious Incident (SI) Lessons Learned Review which follows the same methodology as a DHR. There is still the requirement to produce an IMR however the overview report is authored locally by a member of the SSCP. There is no requirement for the overview report from a SI Lessons Learned Review to be submitted to the Home Office.

The implication for STHFT is that the workload associated with DHRs is unpredictable i.e. Sheffield has had between 0-5 domestic homicides per year, in recent years. Although there is no statutory obligation to do so, STHFT will continue to lead by example and work in partnership with other agencies to participate in SI Lessons Learned Reviews as required.

9.1 STHFT Involvement in the DHR process

Since June 2011 STHFT has participated in five full DHRs and two SI Lessons Learned Reviews in Sheffield, and two DHRs from Rotherham where the victims and/or perpetrators had received services from STHFT. Two of the five DHRs from Sheffield are still in the process of being completed.
STHFT is represented on the DHR or SI Review Panels by the Deputy Chief Nurse or Lead Nurse for Older People/Vulnerable Adults in his absence.

The Domestic Abuse Strategic Board has set up a Domestic Homicide and Serious Incident Review sub group to be responsible for overseeing the progress of Domestic Homicide Reviews and DA Serious Incident Reviews and the implementation of action plans on behalf of the Board. The Lead Nurse for Older People/Vulnerable Adults represents STHFT on this group.

The Independent Management Reviews (IMRs) of the Trust's involvement in the provision of services to both the victims and the alleged perpetrators of all the DHRs and SIs have been undertaken by the Lead Nurse for Older People/Vulnerable Adults and the Named Doctor and Named Nurse for Safeguarding Children.

Recommendations to improve practice were identified by both the IMR authors and the independent DHR/SI overview authors for the respective reviews.

Adult D DHR February 2013

The Lead Nurse for Older People and Vulnerable Adults has written an IMR for this Domestic Homicide Review. The overview report is published on the Sheffield First internet site, so the information below is already in the public domain.

Adult D was a Bulgarian national with leave to remain in the UK. She met her partner Adult DX, also a Bulgarian national in Wales and they moved to Derbyshire and then Sheffield. Adult D first became known to STHFT when she was transferred from Derby Hospitals to the Jessop Wing in December 2010 in early labour at 27 weeks gestation and gave birth to her son. It was communicated from Derby Hospitals that there was a history of domestic violence.

The family then moved from Derbyshire to Sheffield. Adult D had also accessed services at STHFT following a fracture to her arm in September 2012 which is now believed to have been the result of a domestic assault by Adult DX.

On 21st February 2013 the police were called to a stabbing on Blackstock Road in Gleadless and found Adult D lying in the road with multiple stab wounds. She was taken by ambulance to A&E and pronounced dead at 12.44pm.

Adult DX has been convicted of the murder of Adult D.

The IMR for Adult D was undertaken by the Lead Nurse for Older People and Vulnerable Adults and submitted in July 2013.

The recommendations made by the IMR author are as follows:

- For Neonatal Intensive Care Unit staff to have arrangements in place to safely facilitate selective enquiry with a parent or parents where there are concerns about or a known history of domestic abuse.
- For Minor Injuries Unit, Accident and Emergency and Fracture Clinic staff to consider late presentation of an injury with an unconvincing explanation as to the cause, as a trigger for selective enquiry into Domestic Abuse.

The Overview author made an additional recommendation:

All Sheffield Foundation Trusts and GP practices to implement National Institute for Health and Care Excellence (NICE) Public Health Guidance: 'Domestic violence and abuse : how social care, health services and those they work with can identify, prevent and reduce domestic violence and abuse'.

All the actions for this DHR are being implemented and are nearly complete.

Adult Z DHR conducted by Safer Rotherham Partnership June 2013

STHFT was requested to submit an IMR for the period of time in which care was provided to Adult Z. The information provided below was released into the public domain during the trial of Adult Z's husband.

In December 2011 Adult Z was transferred from the General Intensive Care Unit at Rotherham District General Hospital to the Critical Care Unit at the Northern General Hospital for airway and burns management after sustaining burns to her face, upper chest and airway.
The burns had been inflicted following a domestic argument. Due to the effects of the inhalation burns, Adult Z deteriorated rapidly and died as a result of multiple organ failure.
Adult Z's husband was arrested and has subsequently been convicted of her murder.

The IMR for Adult Z was undertaken by the Lead Nurse for Older People and Vulnerable Adults and submitted in June 2013.

The following recommendation for STHFT was requested by the overview author:

- A protocol should be considered to assist health staff to recognise where significant injuries sustained as a result of a suspected assault need to be escalated to the Police.

The A&E department at STHFT has developed a guideline for when patients attend following an assault. This will need to be updated to meet the requirement of the DHR recommendation.

Adult E DHR

Adult E was a young woman in Sheffield who was murdered by her ex boyfriend in June 2013. STHFT had had contact with both the victim and the perpetrator in this case and was required to submit an IMR.
The IMR was written and submitted by the Named Doctor for Children and Young People. The overview report has not yet been published, so the summary of this case has been omitted at this time. However the standard of care provided to Adult E by STHHFT was good and in one service exemplary.

The following recommendations for STHFT were identified by the IMR author:

- That A&E guidance is produced which covers the indications for and consent to perform pregnancy tests.

- That a robust pathway for referrals to Sheffield Children's Social Care and Sexual exploitation service from GUM is formulated.

- That the information systems used by GUM and Sexual Health Sheffield are reviewed now the service is integrated.

- That Sexual Health Sheffield review markers for high risk behaviour and update staff and systems as necessary

Adult F DHR

On 22nd February 2014 Police were called to a house in the Fulwood area of Sheffield where a 92 year old lady had been found deceased. Police subsequently arrested her daughter on suspicion of murder.
A DHR has been commissioned and STHFT are required to complete and submit an IMR in respect of provision of services to the victim from November 2013 to February2014.
The Named Nurse for Safeguarding Adults will be writing the IMR supported by the Lead Nurse for Vulnerable Adults.
The chronology for the involvement of STHFT has been submitted and the IMR is in the process of being written as per the Terms of Reference.

Adult G DHR

On the afternoon of Tuesday the 4th March 2014 police were called to a private rented property in Firth Park where the body of Adult G was discovered.

A DHR has been commissioned which requires STHFT to complete and submit an IMR in relation to contact with the victim and the alleged perpetrator.

As there were young children in the family and contact with maternity services at STHFT, the Named Professional for Safeguarding Children and Young People will be writing the IMR as per the Terms of Reference, supported by the Lead Nurse for Children and Young People and the Lead Nurse for Vulnerable Adults.

Key Achievements 2013-2014

- All previous IMRs from STHFT were submitted to the independent overview authors in a timely manner according to the agreed timescales.
- All actions assigned to the Trust arising from the recommendations from the previous DHRs are either completed or are within the timescales for completion.
- Updates for the recommendations and action plans have been submitted to the Domestic Abuse Coordination Team (DACT) within the agreed timescales as requested.

Key priorities 2014 -2015

- To ensure the IMRs for the current DHRs are submitted in accordance with the Terms of Reference.
- To ensure attendance at the Domestic Homicide and Serious Incident Review Subgroup
- To participate in any future DHRs and SI Lessons Learned reviews ensuring that the Trust submits a timely, accurate and comprehensive IMR in respect of the victim and the alleged perpetrator contact with STHFT services.
- To ensure recommendations are implemented and progress reported via the DACT.

10. FEMALE GENITAL MUTILATION (FGM)

In February 2014 government ministers met with charities and stakeholders to sign a declaration to stop the practice of FGM.
FGM has no justification as a procedure; it is illegal and is child abuse (Home Office 2014).

From April 2014 NHS hospitals are required to record:

- If a patient has had FGM
- If there is a family history of FGM
- If an FGM related procedure has been carried out on a woman - (deinfibulation).

By September 2014, all acute hospitals must report this data centrally to the Department of Health on a monthly basis.

This is the first stage of a wider ranging programme of work in development to improve the way in which the NHS will respond to the health needs of girls and women who have suffered FGM and actively support prevention.
The Deputy Chief Nurse is organising a task and finish group to look at how STHFT identifies and reports incidences of FGM.

Key priorities 2014 -2015

- To educate staff regarding the need to systematically collect data about FGM and the process for reporting FGM
- To establish a process to gather information about patients who have had FGM and submit this information to the Department of Health

11. VULNERABLE ADULTS PANEL

The Vulnerable Adults Panel endeavours to provide a routine system to improve the way the Sheffield health and social care services respond to and manage the risks posed by and to Vulnerable adults at risk who:

- Make frequent avoidable use of emergency and crisis services

And/or

- Do not clearly meet the eligibility criteria of any particular service and as a result are not having their needs met leading to high risk to the individual and/or others.

Many of these vulnerable adults will be regular users of services provided by STHFT e.g. A&E, Minor Injury Unit, GP Collaborative, etc.

The Vulnerable Adults Panel consists of representatives from key agencies who meet fortnightly to discuss a multi agency approach to supporting those vulnerable adults referred to the panel ensuring that vulnerable adults at high risk receive a coordinated and effective service.

The panel also aims to identify common themes that could improve the service to this client group and make recommendations for service improvement.

Key achievements 2013-2014

- The Named Nurse for adult safeguarding represents the interests of the Trust on the Vulnerable Adults Panel.
- A system of identification and referral of the high frequency service users has been developed with the A&E Department.

Key priorities for 2014-2015

- To develop a robust system for implementing recommendations and actions from the Vulnerable Adults Panel.

12. LEARNING DISABILITIES

The care of people with learning disabilities continues to remain high on the national and local agenda. In 2013 the landmark report 'Confidential Inquiry into premature deaths of people with learning disabilities' (CIPOLD) (Department of Health, 2013a) was published and this continues to drive the direction for improving the care given to adults with learning disabilities.

12.1 Data

The following table details the current data on the number of adults with learning disabilities who have accessed STHFT during the period April 2010 – March 2014.

Table 8. Adults with learning disabilities who have accessed STHFT during the period April 2010 – March 2014

	2010/2011	2011/2012	2012/2013	2013/2014
In-patient admissions	**1205**	**614**	**867**	**940**
Individual patient count/number admissions	**437**	**470**	**617**	**693**
Out-patient attendances	**1419**	**3587**	**5194**	**5324**
Individual patient count/number outpatient attendances	**900**	**1931**	**2365**	**2598**

Consistent with previous years, specialities that have a significant number of people with learning disabilities attending outpatients are diabetes, audiology medicine, ENT, neurology and ophthalmology. There has been a significant reduction in obstetric attendances.

With regard to inpatients, there has been a significant increase in admissions to general medical specialties. Directorates which continue to admit a significant number of adults with learning disabilities are Respiratory Medicine (although the number is lower this year) and Gastroenterology.

As part of this year's data collection, it has been identified that there have been 404 attendances of people with learning disabilities at A&E; this is an increase from 260 attendances in 2012-2013. The number of patient's attending A&E has increased from 174 in 2012-2013 to 242 in 2013-2014. In this year's report we are able to identify the individuals who have attended A&E on two or more occasions. So whilst we have had 242 patients with a learning disability attending A&E, we have had 2 patients attending on 48 occasions and 44 patients attending on 5 occasions or more. This data was not collected for the 2012-2013 annual report but will be used as a benchmark for subsequent years.

To further explore these data, Sheffield Clinical Commissioning Group have commissioned Sheffield Health & Social Care NHS Foundation Trust through the Community Learning Disability Team and Sheffield Mencap's Sharing Caring Project to undertake a piece of work aimed at reducing the number of people with learning disabilities who frequently use hospital services for emergency care or an unplanned admission.

The purpose of this project is to work with identified patients and their supporters to understand why this has happened and if any help can be offered to prevent attendances or admissions. This work will also explore and identify pathways and any unidentified health needs which may contribute to frequent admissions. This project will also explore the use of 'Hospital Passports' as a health tool that will enable their health needs to be met. Consideration will also be given to referring individual patients to the Vulnerable Adults Panel where the measures outlined above fail to reduce frequent attendance at A&E.

Key Achievements 2013-2014

- In 2013 the Trust participated in the first Joint Health and Social Care Learning Disability Self-Assessment Framework. This is a single delivery monitoring tool that supports Clinical Commissioning Groups and Local Authorities in assuring NHS England, the Department of Health and the Association of Directors of Adult Services that the Yorkshire & Humber region is addressing the key priorities for people with learning disabilities. These include the NHS Outcomes Framework 2013-2014 (Department of Health, 2013b), other key levers for improving the health and social services for people with learning disabilities and a progress report on Six Lives (Department of Health, 2013c).

  In 2013 the Yorkshire & Humber region received regional group validation, with an action plan to deliver change, rather than as in previous years whereby there was an agreed score for each city. The assessment identified that there was good support and equal treatment in the acute hospitals in Sheffield for people with learning disabilities. However more work was needed across the region with complying with the Mental Capacity Act and significant improvement was required from GPs informing other health services that someone has a learning disability. This action plan will direct the work of the Improving Health Group which the Trust is a member of.

- Continued partnership working with Sheffield Health & Social Care NHS Foundation Trust, Sheffield City Council, NHS Sheffield Commissioning Group and Service User Groups to improve the care of people with learning disabilities.

- An audiologist received an Advancing Healthcare Award 'Runner up in the Health Education Allied Health Professions Patients' Forum Award for outstanding achievement in this field'. This was for her support within Audiology clinics for people with learning disabilities.

- Continued examples of reasonable adjustments throughout the Trust to support the care of patients with learning disabilities. Particular areas of excellence are:

  - Ophthalmology where staff carry out domiciliary visits and have set up a 'Best Interest' clinic for people with learning disabilities and dementia.
  - Specialist Dentistry at Heeley Clinic.
  - Midwifery & Gynaecology who have implemented system wide reasonable adjustments.
  - Weston Park Radiography Department.

Key Priorities 2014-2015

NHS Outcomes Framework 2014/15

The NHS Outcomes Framework (2013) forms an essential part of the health and care system. This framework provides a national overview of how well the NHS is performing, and is the primary accountability mechanism for the NHS. The framework is structured around 5 domains and within domain 1 'Preventing people from dying prematurely'; work is ongoing to develop a learning disability indicator to reduce deaths in people under 60 with learning disabilities, with an estimated live date of 2014/2015.

This specific indicator on reducing premature mortality in people with learning disabilities will act as a critical driver to focus the work which will follow from the CIPOLD recommendations. To work towards achieving this indicator will require a range of actions across the whole healthcare system, however Emerson et al (2014) have identified through their recent research undertaken in Sheffield that it is possible to achieve a sustained reduction in mortality rates and a sustained increase in life expectancy for people with learning disabilities. However there is currently little evidence that the gap in this area between people with learning disabilities and the general population is closing.

To address these health inequalities there will need to be a focus on providing appropriate and effective health care. Fundamental to this at STH will be the need to ensure that we are removing barriers to access, making reasonable adjustments and fully applying the Mental Capacity Act.

NHS England have suggested that they will carry out case note reviews of hospital deaths from 2015 to improve the evidence base in relation to this indicator.

Monitor Compliance Framework- Governance Indicators

The Trust is required to report against the Monitor Compliance Framework, which identifies six criteria for meeting the needs of people with a learning disability based on recommendations set out in Health Care for All (Michael, 2008).

The table below provides 6 key questions that Monitor asks, and the Trust's proposed response, together with the evidence to support these responses.

Table 9. Key Questions asked by Monitor and the Responses from STHFT

Criteria	Requirement	Compliant	Evidence
1	The Trust has a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients.		PatientCentre flagging system. Equality, diversity and human rights strategy. Learning disability link staff. Admission/discharge algorithms.
2	The Trust provides readily available and comprehensible information to patients with learning disabilities about treatment options, complaints procedures and appointments.		Intranet resource includes- Easy read library Easy read complaints leaflet
3	The Trust has protocols in place to provide suitable support for family/carers that support patients with learning disabilities.		Learning Disabilities Nursing Care Guideline (ncg 113)
4	The Trust has protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff		E learning GMC LD E learning LD E learning Hidden Impairments PROUD values used within appraisal process. 'Prepare to Care' course includes LD presentation. 'Well-being study days'
5	The Trust has protocols in place to encourage representation of people with learning disabilities and their family/carers.		Disability user groups within the Trust. Trust has volunteers with learning disabilities. Nurse Director represents the Trust on Partnership Board, Improving Health Group and Complex Needs Group. ND has done presentations at Carer forums and listened to their views/concerns.

6	The Trust has protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports.		Learning Disability Annual Report for Board of Directors.

In assessing the Trust against these indicators, the development and approval of a Carers strategy is required to achieve criteria 3. To achieve criteria 6 further work is required to audit practices and a bid has been submitted to the Sheffield Hospitals Charity, for them to consider funding a survey to audit the care provided to adults with learning disabilities.

13. SAFEGUARDING ADULTS STRUCTURES AND PROCESSES

13.1 LEARNING DISABILITY External

The city wide Improving Health Group (IHG) is a multi agency senior level meeting for, developing and reviewing policies and procedures used in service provision in supporting people with learning disabilities in Sheffield.

STHFT is represented on the IHG by the Nurse Director for Head and Neck Services who is the Trust operational lead for learning disabilities.

A Learning Disabilities Partnership Board meeting is held monthly in the city, to give a voice to service users and carers and to support them to understand and where possible to influence service provision across the city. The Board meeting is co-chaired between a service user and a senior officer from Sheffield City Council. Other representatives include statutory, voluntary and support agencies and health. STHFT is represented on alternate months by the Lead Nurse for Vulnerable Adults and the Deputy Nurse Director for Head and Neck Services.

Key achievements 2013-2014

- Epilepsy project
- Postural care training programme developed and delivered
- Hearing Assessment project
- Weigh Ahead project
- Breast screening-improved training resources
- Sexual Health Strategy for Adults with a Learning Disability

Key priorities for 2014-2015

- Progressing the recommendations proposed in the CIPOLD report
- Review the priority work of the Improving Health Group and Partnership Board to meet the learning disability agenda.
- To review the use of DNACPR orders.
- Further work on the use of the Mental Capacity Act within the health service.

13.2 Safeguarding Adults External

The Sheffield Adults Safeguarding Partnership (SASP) is a partnership between a number of agencies responsible for protecting vulnerable adults at risk of harm.

The SASP has both an Executive Board and an Operational Group both chaired by Sue Fiennes, Independent Chair, and is responsible for developing interagency standards and monitoring performance against these standards.

STHFT continues to be represented at Board level by the Chief Nurse. The Trust is represented on the Operational Group by the Lead Nurse for Older People and Vulnerable Adults.

Sub groups of the SASP Operational Group include the Sheffield Adult Safeguarding Education and Development Group (SASED) and the former Policy and Practice Review Group (PPRG). Both these sub groups are attended by the Named Nurse for Adult Safeguarding.

SASP has agreed to undertake a Governance Review of the effectiveness of its current sub groups during 2014/15 and the Trust will participate in this review as a member of the partnership.

There are also regional Yorkshire and Humber adult safeguarding meetings which are attended by the Lead Nurse for Older People/Vulnerable Adults.

Key achievements 2013-2014

- 100% Attendance at SASP

Key priorities for 2014-2015

- To continue to ensure 100% attendance by STHFT at SASP and associated meetings
- To contribute to the SASP Governance Review, supporting the implementation of the agreed actions

Table 10. Summary of STHFT attendance at SASP Meetings

SASP Meeting/Sub Group	STH Attendance for 2012/2013
Sheffield Adult Safeguarding Board	100% (4 of 4)
Sheffield Adult Safeguarding Partnership (SASP) Operational Group	100% (4 of 4)
SASP Policy and Practice Review Group (PPRG)	100% (2 of 2)

13.3 Internal

Safeguarding Leads Meetings

This bi-monthly meeting is an opportunity to brief the senior key individuals (mostly the Deputy Nurse Directors and governance leads) for each care group on safeguarding related matters for both children and adults. This allows issues to be addressed at a local level, gaps to be identified in service or training provision and information to be cascaded across the Trust.
It is a forum for sharing learning from complaints and safeguarding investigations, Case Reviews, SCRs and DHRs and for allocating responsibilities and monitoring any associated action plans.

Key achievements 2013-2014

- Six Safeguarding Leads Meetings have been held, where care group representatives are informed about national, citywide and Trust issues and new developments regarding safeguarding vulnerable people.
- The group is a forum for the approval of and dissemination of policies and procedures relating to safeguarding vulnerable adults and children.

Key priorities for 2014-2015

- To continue to ensure that information, strategies and plans for safeguarding adults both citywide and within the Trust are developed and shared at the Safeguarding Leads meetings.

14. SERIOUS CASE REVIEWS (SCR)

Serious Case Reviews are held following the death of, or serious harm to, a vulnerable adult if abuse or neglect is suspected as a significant factor.

The aims of Serious Case Reviews are not to apportion blame but to:

- Establish whether there are lessons to be learned from the case about the way in which professionals and agencies work together to safeguard vulnerable people.
- To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.
- To improve inter-agency working to better safeguard vulnerable people.

A Serious Case Review requires agencies involved in the care of the vulnerable adult to undertake an IMR to analyse their involvement with the case in order to make recommendations for future action. A Serious Case Review has an independent author to scrutinise the IMRs and produce the final overview report and recommendations.
To undertake an IMR requires dedicated time and a commitment from the IMR author to complete and submit the IMR to meet the required deadlines.

Key achievements 2014-15

- There have been no new SCRs in 2013-14 which have required participation from STHFT.

Key Priorities 2014-15

- To participate in any SCRs involving STHFT as required.
- To submit well written, comprehensive IMRs in a timely manner if required.
- To ensure that recommendations from any SCRs are implemented and monitored via the Safeguarding Leads Group.
- To ensure that action plans are updated and progress reported to the Sheffield Safeguarding Adults Partnership Board as requested.

15. CASE REVIEWS

Case reviews are similar to SCRs but without an independent author. This role is fulfilled by the Sheffield Adult Safeguarding Office.

Key achievements 2013-2014

- There have been no new case reviews in 2013-14 which have required participation from STHFT.
- The Named Nurse for Adult Safeguarding attended specialist training in undertaking IMRs, provided by the Sheffield Adult Safeguarding Team.

Key priorities for 2014-2015

- To complete and submit well written, comprehensive IMRs in a timely manner if required.
- To implement the actions identified for STHFT from the recommendations from any case reviews.
- To identify key senior members of staff from across the Trust and to support them to develop the skills and knowledge required to take on the role of IMR author.

16. PREVENT

CONTEST (HM Government, 2011a) is the UK's counter-terrorism strategy that aims to reduce the risk from terrorism.
It is made up of four work streams:

Protect
Prepare
Pursue
The fourth **P is Prevent** – this aims to stop people becoming terrorists or supporting terrorism by supporting and protecting people who might be susceptible to radicalisation.

The Prevent Strategy (HM Government, 2011b) was published in June 2011 with the aim of preventing people supporting terrorism or becoming terrorists themselves.

Prevent is about protecting people and is therefore fundamental to our duty of care. The emphasis is on supporting vulnerable individuals whether patients or staff.

Health care staff are well placed to recognise those who may be vulnerable and therefore susceptible to radicalisation and recruitment into terrorist organisations with the process akin to the Safeguarding Model, which protects vulnerable adults.

Health care professionals may meet and treat people who are vulnerable to radicalisation.

Healthcare organisations need to ensure that staff:

- Are able to recognise the exploitation of individuals being drawn towards terrorist related activity.
- Are aware of the escalation processes and support in place that enable them to discuss their concerns.
- Receive training and information about the organisational policies, procedures and processes in place through which they can raise concerns and discuss sensitive/ controversial issues.
- Are aware of the Prevent contacts within their organisation.

Prevent is now firmly embedded within the NHS Standard Contract for 2013-14 which states that providers of healthcare must include in its policies and procedures a programme to deliver Health WRAP (Workshops to Raise Awareness of Prevent) and resource the delivery of the training programme with accredited trainers. Only accredited trainers are authorised to provide Prevent training.

The provider is also required to appoint a Prevent Lead.

The Executive Prevent Lead for STHFT is the Chief Nurse.

The Lead Nurse for Older People/ Vulnerable Adults is the Prevent operational link for STHFT and represents the Trust at the city wide and regional Prevent meetings.

The Lead Nurse is also the only active accredited Prevent WRAP trainer for the Trust and delivers the Health WRAP training to targeted staff groups on a monthly basis.

Training figures are required to be forwarded to the Regional Prevent Lead on a monthly basis for submission to the Department of Health and are also shared with the CCG.

Key achievements 2013-2014

- 93 staff have undergone the Health WRAP training during 2013-14.
- Basic Prevent awareness is included in the Safeguarding presentation to new starters to the Trust at Corporate Induction.

Key priorities for 2014-2015

- To increase the number of accredited Health WRAP trainers.
- To continue to offer Health WRAP training.
- To develop local guidance and information and a clear referral pathway for Prevent concerns.

17. ASSURANCE/GOVERNANCE

17.1 Internal

Key achievements 2013-2014

Audits

- An internal audit relating to adult safeguarding knowledge and awareness of clinical staff was undertaken in March 2013.

The overall aim of the audit was to provide a review in respect of safeguarding vulnerable adults awareness within the Trust.

The objectives were:

- To ensure that all clinical staff are able to identify and report concerns of abuse and neglect.
- To ascertain whether people know where to access information advice and support.
- To ensure safeguarding leads have received specific training and support for their role.

Data was collected using online survey software, SurveyMonkey®. The questionnaire was developed in line with Trust policies relating to Safeguarding Vulnerable Adults and the Raising Concerns at Work Policy and Procedure.

Audit Conclusions

The audit results were positive and demonstrate progress in both staff awareness of safeguarding and in staff accessing training. However, there is a need to address the knowledge gap for those staff who have not had a safeguarding adults update within the last three years.

There is good awareness of the STHFT Safeguarding Adults Policy however more needs to be done to raise awareness of the South Yorkshire Procedures, particularly now that these have been updated, to ensure that these can be applied in practice and used as a resource to guide staff in making safeguarding decisions.

Further work needs to be done to identify leads within each directorate or speciality to provide staff with access to a local contact person to approach for safeguarding advice and support.

Recommendations

- Provide training to staff who have not had a safeguarding adults update in the last three years.
- Address the gaps in knowledge about the follow up of patients who Did Not Attend and No Access visits with service leads.
- Identify safeguarding leads for each directorate / service area and ensure frontline staff are informed about these leads.
- Provide targeted training to staff groups where a need has been identified.
- To ensure safeguarding leads have had training and support for their role.

Key priorities for 2014-2015

- To ensure the recommendations from the safeguarding adults audit are addressed.
- The Safeguarding Adults Team is contributing to the safeguarding element of the Central Nursing business plans.

17.2 External

- The Sheffield Adult Safeguarding Partnership Performance Checklist monitors performance by partners against key SASP performance indicators.

Key achievements 2013-2014
The STHFT Adult Safeguarding Team has provided evidence to the SASP Performance Checklist in a timely manner as requested.

Key priorities for 2014-2015

- To ensure that requests for evidence of assurance from commissioners and quality monitoring organisations are completed within the agreed timescales.

18. EDUCATION AND TRAINING

Staff training and development

Safeguarding adults training is provided by the Adult Safeguarding Team at STHFT which includes basic awareness, referrer training, Vulnerable Adults Risk Management Model (VARMM), Prevent, training for staff at corporate induction and volunteer induction and the availability of an appropriate E-learning module.

A safeguarding adults awareness leaflet for volunteer staff is distributed via the volunteer induction programme and via the volunteer coordinators.
Attendance at training and safeguarding updates by both acute and community based staff is recorded and monitored by the STHFT Safeguarding Office.

Safeguarding adults awareness is also provided at central induction and by local departments and directorates within STHFT as part of their mandatory training updates.
Staff can also access multi agency training provided by the Local Authority.

Individual directorates do not routinely inform the STHFT Safeguarding team of the numbers of staff who have received safeguarding adults updates as part of the departmental mandatory training therefore it is not currently possible to monitor performance against the STHFT Safeguarding Adults Training Needs Analysis .

It is anticipated that the Personal Achievement and Learning Management System (PALMS) will allow for this information to be obtained in the future.

Key achievements for 2013-2014 are shown in the following table

- The STHFT Safeguarding Adults Training Needs Analysis and supporting electronic Staff Record (ESR) competencies were updated in December 2013 and launched in March 2014 with support from the Learning and Development Department.
- The table below shows Safeguarding /Vulnerable Adults Training provided by the STHFT Safeguarding Team

Table 11. Safeguarding /Vulnerable Adults Training provided by the STHFT Safeguarding Team

Training by Topic	Numbers of staff trained 2013/2014
Safeguarding adults basic awareness	242
Safeguarding adults update	95
Safeguarding adults e-learning	299
Safeguarding adults 'referrer' training	157
Vulnerable Adults Risk Management Model (VARMM)	144
MCA/Best Interest/DOLS	279
PREVENT	90
Domestic abuse awareness (facilitated by VIDA Sheffield)	85
MCA e-learning	186
Safeguarding Awareness at Corporate Induction	1271
Volunteer induction	
TOTAL	**2848**

Key priorities for 2014-2015

- To provide additional training to heads of Therapy Services and other allied health services and to senior staff within the Primary and Community Care Directorate, to enable them to identify safeguarding concerns, in order where necessary, to make appropriate alerts into safeguarding procedures.
- To develop a podcast for safeguarding adults which can be used to provide safeguarding refresher awareness and at corporate induction to signpost to further training and support.
- To provide further training for STH staff on completing and accurately recording mental capacity assessments and best interest decision making.
- To provide awareness sessions for health staff on the Government's PREVENT strategy
- Contribute to the city wide working group developing multi agency training on restraint.

19. CONCLUSION

There has been significant further progress made during the year on embedding the safeguarding structure and increasing awareness in the organisation, evidence that this is happening is shown by the year on year increase in contacts with the STHFT Adult Safeguarding Team for advice.

The contribution of the MCA Practice Development Facilitator post has strengthened the team's skills and knowledge base with regard to MCA/DOLS and best interest decision making and has provided much needed training in this area of practice. However, the work of the STHFT Adult Safeguarding team continues to grow with significant work streams having been added in the last two years, specifically the PREVENT agenda and the DHR/SI processes.

This report has detailed the data collected and the main areas of activity and achievement during 2013-14 and has summarised the key priorities for 2014-15.

20. REFERENCES

CARE QUALITY COMMISSION (2010) *Our Safeguarding Protocol*.

DEPARTMENT OF HEALTH (2000). *No Secrets: Guidance on developing and implementing multi-agency policies to protect vulnerable adults from abuse*. London. The Stationery Office

DEPARTMENT OF HEALTH (2011a) *Safeguarding Adults: The role of health services.* Published to DH website, in electronic PDF format only. http://www.dh.gov.uk/publications

DEPARTMENT OF HEALTH (2011b) *Safeguarding Adults: The role of Health Service Managers and their Boards* Published to DH website, in electronic PDF format only.. http://www.dh.gov.uk/publications

DEPARTMENT OF HEALTH (2011c) *Safeguarding Adults: The role of Health Service Practitioners* Published to DH website, in electronic PDF format only.. http://www.dh.gov.uk/publications

DEPARTMENT OF HEALTH (2011d) *Safeguarding Adults: The role of NHS Commissioners* Published to DH website, in electronic PDF format only. . http://www.dh.gov.uk/publications

DEPARTMENT OF HEALTH (2013a). *Government response to the Confidential Inquiry into premature deaths of people with learning disabilities*. www.gov.uk/dh.

DEPARTMENT OF HEALTH (2013b). The NHS Outcomes Framework 2013/2014. www.gov.uk/dh

DEPARTMENT OF HEALTH (2013c). Six Lives: progress report on healthcare for people with learning disabilities.www.gov.uk/dh

DEPARTMENT OF HEALTH (2014). Hard Truths. The Journey to Putting Patients First. The Stationery Office

EMERSON E, GLOVER G, HATTON C AND WOLSTENHOLME, J. (2014). *Trends in age-standardised mortality rates and life expectancy of people with learning disabilities in Sheffield over a 33-year period*. Learning Disability Review. Vol 19. NO.2, pp90-95

FLYNN M (2012) *Serious Case Review* (Winterbourne View) www.southglos.uk/wv

FRANCIS R (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* The Stationery Office

GREAT BRITAIN (1998) *Human Rights Act 1998* (c.42) London. The Stationery Office http://www.legislation.gov.uk/ukpga/1998/42/contents/enacted?view=plain

GREAT BRITAIN (2004a) *Domestic Violence, Crime and Victims Act 2004* (Commencement No. 14) Order 2011 No. 1008 (C. 41) London. The Stationery Office.http://www.legislation.gov.uk/uksi/2011/1008/article/1/made

GREAT BRITAIN (2004b) Domestic Violence Crimes and Victims Act (2004). 2004 (c.28) Part1 Domestic Homicide Reviews Section 9. London. The Stationery Office http://www.legislation.gov.uk/ukpga/2004/28/contents

GREAT BRITAIN (2005) *Mental Capacity Act 2005* (c. 9) London. The Stationery Office http://www.legislation.gov.uk/ukpga/2005/9

GREAT BRITAIN (2006) *Safeguarding Vulnerable Groups Act 2006* (c.47) http://www.legislation.gov.uk/ukpga/2006/47/contents

GREAT BRITAIN (2007) *Mental Capacity Act Code of Practice 2007* London. The Stationery Office

GREAT BRITAIN (2008) *Mental Capacity Act 2005: Deprivation of Liberty Safeguards* – code of practice to supplement the main Mental Capacity Act 2005 Code of Practice (2008). London. The Stationery Office

HESLOP P et al (2013). *Confidential Inquiry into Premature Deaths of People with Learning Disabilities*. (CIPOLD). Learning Disability Observatory. Norah Fry Research Centre.

HM GOVERNMENT (2011a) *CONTEST: The United Kingdom's strategy for countering terrorism*. www.homeoffice.gov.uk/publications/counter-terrorism/counter-terrorism-strategy

HM GOVERNMENT (2011b) *Prevent Strategy* www.homeoffice.gov.uk/publications/counter-terrorism/prevent/prevent-strategy

HOME OFFICE (2011) *Multi –agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*. (http://homeoffice.gov.uk/crie/violence-against-women-girls/domestic-homicide-reviews/.

HOME OFFICE, (2014b) *Female Genital Mutilation : Multi agency practice guidelines*. P. 40 www.gov.uk/fgm

MICHAEL. J. (2008). Health care for All.www.nationalarchives.gov.uk

NICE (2014) *NICE Public Health Guidance 50-Domestic violence and abuse; how health services, social care and the organisations they work with can respond effectively*. http://www.nice.org.uk/nicemedia/live/14384/66668/66668.pdf

SHEFFIELD LOCAL AUTHORITY EXECUTIVE MANAGEMENT TEAM (2011) *Domestic Homicide Review. Draft Report*.

SHEFFIELD CITY COUNCIL AND NHS SHEFFIELD (2011).*Prevention and Management of the use of Restraint. Framework for Good Practice.*

ASSOCIATION OF DIRECTORS OF SOCIAL SERVICES (ADSS) (2005) *Safeguarding Adults. A National Framework of Standards for good practice and outcomes in adult protection work*.. Safeguarding Adults Network.

SOUTH YORKSHIRE SAFEGUARDING ADULTS BOARD (2014). South Yorkshire's Adult Protection Procedures *Safeguarding Adults*. http://www.proceduresonline.com/southyorks/sab/

This annual report will be posted on the Safeguarding Adults intranet site, Safeguarding Patients.

Appendix 1

Key Achievements for Adult Safeguarding at STHFT 2013-14

	Key priorities identified in the 2012-2013 Annual Report	Progress/ achievements
STHFT Involvement in the DHR process	1. To ensure attendance at the DHR and Serious Incident Review Subgroup 2. To participate in any future DHRs and SI Lessons Learned reviews ensuring that the Trust submits a timely, accurate and comprehensive IMR in respect of the victim's and the alleged perpetrator's contact with STHFT services. 3. To ensure recommendations are implemented and progress reported via the Domestic Abuse Coordination Team (DACT).	1. The Trust has achieved 100% attendance. 2. The IMRs from STHFT were submitted to the independent overview authors in a timely manner according to the agreed timescales. 3. Updates on the progress of action plans have been provided to the DACT in a timely manner as requested.
Adult Safeguarding Team	1. To maintain an excellent attendance record at the delegated safeguarding meetings and sub groups. 2. To continue to respond to requests for advice in a timely manner to ensure staff are supported and vulnerable adults are kept safe.	1. The team has achieved 100% attendance at safeguarding meetings. 2. Safeguarding cases are allocated and discussed at the weekly team matrix meetings. Advice calls are responded to within 24 hours wherever possible.
Domestic Abuse	1. To continue to ensure 100% attendance by STHFT at MARAC. 2. To ensure 100% attendance at the Domestic Abuse Strategic Board. 3. To ensure 100% attendance at the Domestic Homicide Review Sub Group. 4. To ensure 100% attendance at the Domestic	1. STHFT was unable to provide representation at the MARAC on one occasion during 2013 due to the increased frequency of the meetings. 2. 100% attendance at DA Strategic Board has been achieved 3. 100% attendance at the DHR sub group has been achieved 4. 100% attendance at the DA provider

	Abuse Provider Consultation Group. 5. To ensure actions identified for STHFT are completed in a timely manner and reported back to the MARAC coordinator for inclusion in the MARAC minutes. 6. To work with Human Resources to develop guidance for line managers to support staff who may be victims of domestic abuse	Consultation Group has been achieved 5. All actions from MARAC have been completed as per requirements 6. A flowchart signposting staff to support and advice is available on the STHFT intranet
Policies and Procedures	1. To contribute to the re write of the South Yorkshire Adult Protection Procedures 2. To undertake an audit of complaints and SIs to identify whether safeguarding concerns are being correctly recognised via the complaints review and risk grading process and by the SI process. 3. To pilot the revised safeguarding adults referral process and evaluate the impact on the STHFT safeguarding team. 4. To agree and disseminate a robust process for the referral of adult safeguarding concerns generated from within STHFT. 5. To ensure Named Referrers have the skills to recognise the various forms of abuse and screen alerts appropriately.	1. The Lead Nurse and Named Nurse contributed to the re write of the South Yorkshire Adult Protection procedures. 2. This piece of work has not been completed following agreement from the CCG about how safeguarding concerns are identified via the SI process. 3. The process for safeguarding adults referrals has been piloted and is now embedded into practice. 4. The Four Steps referral flowchart and the Safeguarding Adults Alert Form have been updated to reflect the new process. 5. Referrer training has been provided by the STHFT Adult Safeguarding Team

Incidents/ Safeguarding Alerts and Referrals **Referrals**	1. To increase the number of alerts reported, taking the opportunity to highlight via the Safeguarding Leads meeting, situations where appropriate alerts are being missed. 2. To increase the number of alerts reported, taking the opportunity to highlight via the Safeguarding Leads meeting, situations where appropriate alerts are being missed. 3. To gather data from similar sized organisations to STHFT in order to benchmark our own performance 4. To undertake an audit of those referrals recorded on Datix	1. There has been a fall in the number of safeguarding alerts during this year following the previous year on year rise in alerts being recorded. It is possible that there have been fewer safeguarding alerts raised in 2012-13, or that the Named Referrers have become more skilled at screening the concerns out of the safeguarding process. 2. The current system of recording alerts relies on the information recorded on Datix cross referencing with the referrals recorded on the local authority Care First system. 3. This action has not been completed and will be a priority for 2014-15 4. This action has not been completed and will be reviewed as an action for 2014-15
<u>Investigations</u>	1. To identify senior key individuals from within the Trust who have the skills to lead on safeguarding investigations and IMRs. 2. To provide specialist training for key staff in undertaking IMRs.	1. This action has not been completed and will be reviewed as an action for 2014-15 2. The Named Nurse for Adult Safeguarding attended specialist training in undertaking IMRS
<u>Mental Capacity Act (2005) and Deprivation of Liberty Safeguards</u>	1. To ensure mental capacity assessments and best interest decisions are being made and documented according to the legal requirements as stated in the Mental Capacity Act (2005). 2. To continue to provide training and to support staff in undertaking mental capacity assessments and best interest decisions.	1. The STHFT Mental Capacity Practice Development Facilitator has provided expert training and advice around mental capacity/DOLS and best interest decision making. 2. A guidance toolkit and exemplar of good practice in assessing and recording mental capacity has been devised and

	3. The MCA Practice Development Facilitator is to undertake a small scale trust wide audit of mental capacity assessments and best interest decisions from July to August 2013.To ascertain if correct procedures for assessing and documenting mental capacity are being adhered to and to ascertain if best interest decisions are clearly documented in the care record. 4. To identify training needs.	made available on the Trust MCA intranet site. 3. An audit of mental capacity assessments and best interest decisions was undertaken from July to August 2013. Results evidenced poor standards of documentation to evidence compliance with the MCA. 4. A rolling programme of training in MCA Assessment , DOLS and best interest decision making has been ongoing since September 2012
Vulnerable Adults Panel(VAP)	1. To develop a robust system for implementing recommendations and actions from the vulnerable adults panel.	1. A system of identification and referral of the most frequent and often inappropriate attendees at A&E has been developed. STHFT is represented at the VAP by the Named Nurse for Safeguarding Adults
Vulnerable Adults Risk Management Model (VARMM	1. To provide awareness and training for staff in the identification of patients who may be appropriate for referral into the VARMM process	1. A rolling programme of training has been provided to STHFT who require it during 2013-14
PREVENT	1. To develop a Training Needs Analysis (TNA) for Prevent 2. To increase the number of accredited Health WRAP trainers 3. To continue to offer Health WRAP training 4. To develop a policy and referral pathway for Prevent	1. Prevent is included in the TNA for Safeguarding Adults. 2. This action has not been completed and will be a priority for 2014-15 3. Health WRAP training has been provided to A&E staff at their mandatory training updates 4. A Prevent policy is available on the STFHT Intranet site

Safeguarding Adults Structures and Processes	1. To continue to ensure 100% attendance by STHFT at SASP and associated meetings 2. To contribute to the SASP Governance Review, supporting the implementation of the agreed actions	1. 100% attendance at SASP Board has been achieved. 2. The STHFT Adult Safeguarding Team contributed to the SASP Governance Review .There were no specific actions for STHFT.
Safeguarding Leads Meetings	1. To continue to ensure that information, strategies and plans for safeguarding adults both citywide and within the Trust are shared and developed at the Safeguarding Leads meetings.	1. Six Safeguarding Leads Meetings have been held, where Care Group representatives are informed about citywide and Trust issues and strategies regarding safeguarding adults
Serious Case Reviews (SCR)	1. To participate in any SCRs involving STHFT as required. 2. To submit well written, comprehensive IMRs in a timely manner. 3. To ensure that recommendations from SCRs are implemented and monitored via the Safeguarding Leads Group. 4. To ensure that action plans are updated and progress reported to the Sheffield Safeguarding Adults Partnership Board as requested.	1. There have been no Serious Case Reviews commissioned during 2013-14.
Case Reviews	1. To complete and submit well written, comprehensive IMRs in a timely manner. 2. To implement the actions identified for STHFT from the recommendations from case reviews. 3. To identify key senior members of staff from across the Trust and to support them to develop the skills and knowledge required to take on the role of IMR author.	1. There have been no Case Reviews commissioned during 2013-14. 2. The Named Nurse for Adult Safeguarding attended specialist training in undertaking IMRS, provided by the Local Authority Adult Safeguarding Team.

Governance/ Assurance	1. To ensure the recommendations from the safeguarding adults audit are implemented. 2. Each Clinical and Corporate Directorate is required to write a 5 year strategy. The Safeguarding Adults Team is contributing to the Safeguarding Adults element of the strategy for Central Nursing. 3. To ensure that requests for evidence of assurance from commissioners, partner agencies and quality monitoring organisations are completed within the agreed timescales.	1. The results of the internal audit completed in March 2013 were disseminated via the safeguarding Leads Group. Recommendations for further training and awareness have been acted upon. The safeguarding TNA has been updated with support from Learning & Development to identify which staff groups require which level of training. 2. The Lead Nurse has contributed to the Central Nursing strategy which includes Safeguarding Adults 3. Requests for evidence of assurance from commissioners, partner agencies and quality monitoring organisations have been completed within the agreed timescales.
Education and Training	1. To continue to offer training, advice and support to STHFT staff in respect of all aspects of safeguarding vulnerable people. 2. To continue to train and support staff to apply the principles of the Mental Capacity Act in day to day practice. 3. To provide further training for STH staff on completing and accurately recording mental capacity assessments and best interest decision making.	1. A programme of safeguarding adults training has been provided to staff from across the Trust and including the Primary and Community Services directorate as requested and recorded on the safeguarding adults training database. Safeguarding awareness is provided at Corporate Induction. 2/3.The Mental Capacity Practice Development Facilitator has provided expert training and advice around mental capacity/ best interest decision making and support for staff to embed the principles of the MCA into practice

	4. To provide referrer training to heads of Therapy Services and other allied health services and to senior staff within the Primary and Community Care Directorate, to enable them to identify safeguarding concerns, in order where necessary, to make appropriate referrals into safeguarding procedures.	4. Referrer training has been provided to senior staff within STHFT.
	5. To develop podcasts for safeguarding adults which can be used to provide safeguarding refresher awareness and at corporate induction to signpost to further training and support.	5. This piece of work has not been completed and will be considered for 2104-15.
	6. To provide awareness sessions for health staff on the Government's PREVENT strategy	6. Staff in the A&E department have received Prevent training as part of their mandatory training updates.
	7. Contribute to the city wide working group developing multi agency training on restraint.	7. The MCA Practice Development Facilitator represents STHFT on the city wide working group for restraint