SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

D

EXECUTIVE SUMMARY

REPORT TO THE HEALTHCARE GOVERNANCE COMMITTEE

HELD ON 27 NOVEMBER 2017

Subject:	Annual Safeguarding Adults Report
Supporting TEG Member:	Professor Hilary Chapman, Chief Nurse
Author:	Christina Herbert, Lead Nurse Safeguarding Adults
Status	D & A

PURPOSE OF THE REPORT:

- To inform the Trust Executive Group and the Board of Directors via the 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 adults at risk of abuse or neglect over the last 12 months.
- To identify the key priorities for 2017-18 to improve the processes, policies and audits, training and assurance in order to better safeguard adults at risk.

KEY POINTS:

The report;

- Outlines the responsibilities to the Sheffield Adult Safeguarding Board (SASB), Sheffield Adult Safeguarding Partnership (SASP) and Learning Disabilities Partnership Board.
- Highlights the management structure and named professionals.
- Describes relevant policies and procedures.
- Details the external reviews and audits involving the Trust.
- Identifies how progress with education and training is monitored.

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 debate and approve the contents of this report.

APPROVAL PROCESS:

Meeting	**Date**	**Approved**
Trust Executive Group	01 November 2017	
Healthcare Governance Committee	27 November 2017	

Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate

SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST (STHFT)
SAFEGUARDING ADULTS AT RISK
ANNUAL REPORT APRIL 2016 - MARCH 2017

CONTENTS

1.0 INTRODUCTION

Living a life free from abuse or neglect is a fundamental right of every individual. Where abuse or neglect does take place, it needs to be dealt with swiftly, effectively and in a way that is proportionate to the areas of concern.

Safeguards against poor practice, abuse, neglect and exploitation need to be an integral part in the delivery of care and support of patients, their families and the wider community.
Safeguarding is a multi- agency approach to promoting good practice in:

- Recognising those who may be at risk of abuse and neglect
- Ensuring systems and processes are in place to ensure vulnerable people are kept safe
- Responding to concerns in a timely manner
- Learning from allegations of abuse or neglect to prevent risks to other adults at risk

During 2016-17 the Trust has strengthened the internal arrangements to safeguard our most vulnerable patients by continuing to educate staff and to embed a culture that makes safeguarding central to the delivery of safe and effective patient care.

This report summarises the activities of the Adult Safeguarding Team and demonstrates to the Board of Directors and to external agencies how Sheffield Teaching Hospitals NHSFT discharges its statutory duties in relation to:

- Safeguarding Adults under Section 14 of the Care Act 2014
- The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009.
- The Counter Terrorism and Security Act 2015, Prevent Duty 2015
- The Modern Slavery Act 2015

This report covers all the activities that fall under the umbrella of safeguarding adults which is now much broader than purely Safeguarding Adults. To help structure the report it has been split into the following sections, all of which we are assessed and monitored against;

- Strategic Context
- Policy and Procedures
- Safeguarding Adults Structures and Processes
- Governance Arrangements
- Multi- Agency Working and Responding to Concerns
- Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DOLs)
- Domestic Abuse
- Domestic Homicide Reviews (DHR)
- Modern Slavery and Human Trafficking (MS&HT)
- Female Genital Mutilation (FGM)
- Vulnerable Adults Panel (VAP)
- Safeguarding Adults Reviews (SARs)
- Recruitment and Employment Practice
- Safeguarding Adults Education and Training
- Counter Terrorism and Security Act (2015) and the Prevent Duty
- Learning Disabilities (LD)

Each section then contains as appropriate:

- An overview of the national and local context
- An update on activity during 2016-17 including progress made in strengthening practice and outcomes
- Assurance that the Trust is meeting its statutory obligations and the required national standards
- An overview of any significant gaps or risks and the actions being taken to mitigate these.
- Key achievements for 2016 -17 and key priorities for 2017 -18.

2.0 STRATEGIC CONTEXT

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

Safeguarding adults has remained high on the national agenda for both health and social care following a series of inquiries and reports including Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013) and the Winterbourne View Inquiry (Flynn, 2012), the Saville Enquiry (Lampard 2014) and the child sexual exploitation cases across the country but particularly in Rotherham (Jay, 2014). 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. In addition, following the recent terror attacks in London and Manchester, there is also an increased focus on the risk of radicalisation of vulnerable people leading them to joining extremist groups or terrorist organisations.

The Trust, as a member of both the Sheffield Adult Safeguarding Partnership (SASP), the Sheffield Adult Safeguarding Board (SASB), the Learning Disabilities Partnership Board and the Domestic Abuse Strategic Board, continues to work closely with the statutory and voluntary agencies across Sheffield to discharge its responsibilities as an NHS provider for the safeguarding of vulnerable people who may be at risk of abuse or exploitation.

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, modern slavery and human trafficking, embedding the principles of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DOLS), privacy and dignity and mental health including dementia.

2.1 Statutory Framework and National Policy Drivers

The Trust has a duty to abide by legislation, national and local policy in relation to safeguarding adults at risk of abuse or neglect.

Safeguarding adults processes also need to ensure that the human rights of vulnerable people are upheld in accordance with the Human Rights Act (1998), Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2008), and the Safeguarding Vulnerable Groups Act (2006), Domestic Violence, Crimes and Victims Act (2004), Counter-Terrorism and Security Act (2015), Sexual Offences Act (2003), Modern Slavery Act (2015), Hate Crime under the Criminal Justice Act (2003) section 146, Female Genital Mutilation Act (2003).

2.2 The Care Act (2014)

The Care Act (2014) came into force on the 1st April 2015. Chapter 14 of The Care Act (2014) provides organisations with distinct legislative requirements to comply with in order to safeguard adults at risk of abuse and neglect. This has superseded the previous guidance contained in 'No Secrets' (Department of Health 2000) and Safeguarding Adults (ADSS 2005).

There are additional categories of adult abuse to consider including self- neglect, domestic abuse, Prevent, Female Genital Mutilation (FGM), Forced Marriage and Honour Based Violence, Sexual Exploitation, Modern Slavery and Human Trafficking and Hate Crime.

2.3 Six Key Principles

Safeguarding Adults is underpinned by the following Six Key Principles:

1. Empowerment – People being supported and encouraged to make their own decisions and provide informed consent

2. Prevention – It is better to take action before harm occurs.

3. Proportionality – The least intrusive response appropriate to the risk presented should be implemented.

4. Protection – Support and representation for those in greatest need.

5. Partnership – Local solutions through services working with their communities.

6. Accountability – Accountability and transparency in delivering safeguarding.

2.4 The Three Point Test

The Care Act 2014 has determined a set of criteria to be met when applying the safeguarding duties to an adult at risk, in respect of what is referred to as the Three Point Test:

1. The adult has needs for care and support (whether or not the local authority is meeting any of those needs) and;

2. is experiencing, or at risk of, abuse or neglect; and

3. 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.

2.5 Making Safeguarding Personal

The Care Act has made changes to the way safeguarding adults is approached and managed including a requirement for 'Making Safeguarding Personal', which in essence gives the adult at risk much greater involvement in any decisions made to safeguard them, taking into consideration their wishes, feelings and desired outcomes.

Where an adult at risk would have substantial difficulty in engaging with and understanding the safeguarding process, the local authority has to provide an advocate to support them.

2.6 Safeguarding Adults Board

The Care Act requires all local authorities to have in place a Safeguarding Adults Board (SAB) to provide strategic leadership and oversight of adult safeguarding across the locality. The SAB must assure itself that local safeguarding arrangements and partners act to protect adults at risk of abuse or neglect. Sheffield already has an established SAB.

3.0 POLICIES AND PROCEDURES

3.1 South Yorkshire Safeguarding Adults Procedures

All agencies across South Yorkshire work within the framework of the South Yorkshire Safeguarding Adults Board Procedures (2015)**.** These procedures provide guidance to professionals and the public on the identification of abuse and processes to follow to report suspected abuse.

The procedures are available via the STHFT Staff Intranet page Safeguarding Patients.

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

1. Concerns about an adult at risk 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, a domestic abuse situation).

2. Concerns arising as a result of an alleged act of poor care or omission in care by STHFT. The STHFT Safeguarding Team may be asked to investigate these concerns under Safeguarding procedures either following a request from the Local Authority or internally via the Trust's complaints and or serious incident processes.

Patient Partnership team staff members have been provided with a flowchart to support and 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.

All safeguarding adult concerns generated within the acute Trust within core hours, should be forwarded to the STHFT Adult Safeguarding Team following initial screening by a senior manager such as a Matron. Where the thresholds for adult safeguarding have been met i.e. the Three Point Test (p3), the STHFT Safeguarding Adults Team forward the concerns to the Local Authority Safeguarding Adult Access Team. This process facilitates the successful screening out of those concerns that do not require a referral into safeguarding procedures, redirecting them to more appropriate processes or services and thereby ensuring that only true safeguarding concerns are forwarded to the local authority for investigation.

Safeguarding concerns generated by STHFT staff working in the community continue to be raised directly with the Local Authority Safeguarding Adult Access Team. This is because community staff may need to address a safeguarding concern whilst they are in the patient's home to ensure their and the patient's safety and so make immediate contact with Adult Access by telephone rather than completing a concern form.
Adult Access is also a source of 'out of hours' advice when the STHFT Adult Safeguarding team are not available.

Key achievements 2016-2017

- The Safeguarding Adults team have continued to provide training to senior staff to equip them to understand both the safeguarding adult's procedures, the thresholds for referral into those procedures, and the knowledge to screen alerts appropriately.
- An audit of the origin of safeguarding concerns generated within STHFT has been undertaken and any areas of under reporting identified. This information has been fed back to Safeguarding Leads for review within their particular Care Groups.

Key Priorities 2017-2018

- To undertake an audit of safeguarding adults concern forms generated from within STHFT, to identify whether they contain sufficient information for a decision to be made about whether they meet the threshold for screening into safeguarding procedures.
- To address under reporting of safeguarding concerns with the relevant safeguarding leads, and to provide additional training and support to staff in those areas.

4.0 SAFEGUARDING ADULTS STRUCTURES AND PROCESSES

4.1 Safeguarding Adults External

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

The SASP complies with the requirements of the Care Act (2014) and has both an Executive Board and an Operational Board which are responsible for developing interagency standards and monitoring performance against these standards. The Boards are chaired by an Independent Chair Jane Haywood.
STHFT continues to be represented at Executive Board level by the Chief Nurse. The Trust is represented on the Operational Board by the Lead Nurse for Safeguarding Adults.

Sub groups of the SAB are convened as task and finish groups to oversee specific service developments or to implement changes to policy and practice as required.

There are also regional Yorkshire and Humber adult safeguarding meetings which are attended by the Lead Nurse for Safeguarding Adults

Key achievements 2016-2017

- 100% Attendance at SASP Executive and Operational Board meetings

Key priorities for 2017-2018

- To continue to ensure 100% attendance by STHFT at SASP and associated meetings
- To contribute to the implementation of the Sheffield Adult Safeguarding Partnership Business Plan and Strategy for 2017-18, supporting the implementation of actions towards the agreed outcomes.

5.0 GOVERNANCE ARRANGEMENTS

5.1 Internal

CQC Inspection report 2016

The Care Quality Commission (CQC) expects that all NHS Trusts have "*reliable systems, processes and practices in place to keep people safe and safeguarded from abuse".* This translates into a requirement that;

> 'arrangements are in place to safeguard adults from abuse that reflect relevant legislation and local requirements, and that staff understand their responsibilities and adhere to safeguarding policies and procedures' (CQC, 2015).

Safeguarding Adults was an integral element of the STHFT CQC inspection report published in June 2016.
All areas inspected were grade as 'Good' for the 'Safe' key question. There were no recommendations or actions for Safeguarding Adults.

Summary Findings

The trust had appropriate systems and procedures in place to keep patients safe, including safeguarding and infection control.

Safeguarding

- The trust had appropriate safeguarding policies and procedures in place for both adult and children.
- The policies and procedures were supported by staff training. We found 86% of staff had received level 1 children's safeguarding training, 65% had received level 2 and 58% had received level 3 training against a trust target of 90%. A total of 85% of staff had received level 1 safeguarding vulnerable adults training and 75% level 2. Safeguarding leads were aware of the areas that had low compliance with training, such as the Emergency Department, and gave examples of action to improve compliance.
- The trust had a safeguarding committee which reported to the healthcare governance committee, a sub-committee of the board.
- The executive lead for safeguarding both adults and children was the Chief Nurse. The Deputy Chief Nurse had operational responsibility for safeguarding.
- There was a lead nurse for children and young people, lead nurse for safeguarding adults, named midwife and named doctor. In addition, each care group had a safeguarding lead who attended the safeguarding committee.

- A specialist team of ten whole time equivalent midwives worked to deliver a 24-hour service providing care and support for women with more complex social needs. The team performed daily maternity ward rounds and discussed new cases, ensuring all women within their caseload had a named midwife from the vulnerability team.
- Midwives were identified by a recent CQC review for looked after children, as high referrers for the Family Common Assessment Framework (FCAF) and to the local Multi Agency Support Teams (MAST) to elicit early support.
- The recent Care Quality Commission review of health services in safeguarding and looked after children services in Sheffield, noted "excellent examples of strong paediatric liaison", and good liaison with Children and Young People Mental Health Service (CAMHS) within the Emergency Department. However, they noted a city-wide reliance on telephone calls for referral concerns rather than written follow up information. The trust had a strong focus on safeguarding, for example in the Emergency Department a 'Pathway for Vulnerable Young People' had been developed in partnership with an external stakeholder. This had been highly commended at the National Children and Young People Awards.
- The trust had implemented an action plan in place in response to the Savile Inquiry.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Most staff had a clear understanding of consent, mental capacity and deprivation of liberty safeguards.
- The trust has a Specialist Advisor for Mental Capacity Act and Deprivation of Liberty Safeguards who is responsible for guiding, training and supporting staff with all matters related to the Mental Capacity Act and Deprivation of Liberty.

The trust's Deprivation of Liberty Safeguards (DoLS) policy was overdue for review from October, this has now been reviewed and updated.

Key Achievements

The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards Policy was ratified in March 2017 and is accessible via the STHFT Intranet.

Safeguarding Leads Meetings

The Safeguarding Leads meeting is held quarterly, chaired by the Deputy Chief Nurse and is an opportunity to brief the Safeguarding Leads, 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, Serious Case Reviews (SCR) and Domestic Homicide Reviews (DHR) and for allocating responsibilities and monitoring any associated action plans.

The group also approves and disseminates policies and procedures relating to safeguarding adults and children.

Key achievements 2016-2017

- Four Safeguarding Leads Meetings were held in 2016-17

Key priorities for 2017-2018

- 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.

5.2 External

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

- The Clinical Commissioning Group (CCG) requires providers of services to submit a Provider Safeguarding Annual Assurance Assessment Tool which is based on six domains – Policy and Procedures, Governance, Multi-agency working, Recruitment, Training and Prevent.

This document has been developed by the Department of Health and draws on existing standards & inspection frameworks including the Care Quality Commission (CQC) Essential Standards for Quality & Safety, Association of Directors of Social Services (ADASS) Standards for Adult Protection (ADASS 2005) & the NHS Outcomes Framework. It has been adapted for the members of the NHS England South Yorkshire and Bassetlaw Area Team and Provider organisations within individual CCG boundaries. The tool reflects the essential standards contained in NHS Sheffield CCG Safeguarding Policy 2014.

The Assessment Tool was submitted in July 2016. The Trust have discussed this assessment with the CCG following its submission.

The Sheffield Safeguarding Children Board Section 11 Audit for Safeguarding Children also required assurances for Safeguarding Adults. The audit was submitted in January 2017. There have been no recommendations or actions for STHFT.

Key achievements 2016-2017

- The STHFT Adult Safeguarding Team has provided evidence to the SASP Performance Checklist in a timely manner as requested.
- The CCG Provider Safeguarding Annual Assurance Assessment Tool was submitted in July 2016.
- The CCG Section 11 Audit was submitted in January 2017.

Key priorities for 2017-2018

- To ensure that requests for evidence of assurance from commissioners and quality monitoring organisations are completed within the specified timescales and any resulting recommendations or actions are addressed promptly.
- Recommendations and actions from the Section 11 Audit and the CCG Assessment Tool will be reported in the 2017-18 Annual Report

5.3 Learning Disability External

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 by 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 Safeguarding Adults and the Deputy Nurse Director for Head and Neck Services.

Key priorities for 2017-2018

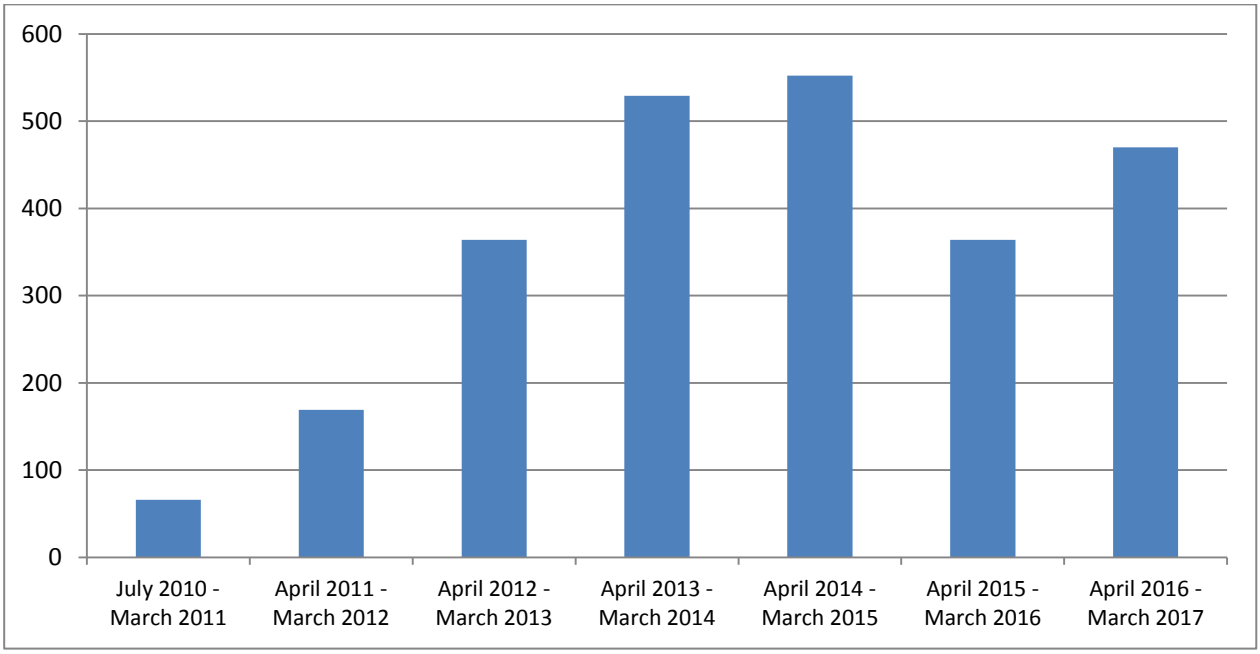
- Further work on the use of the Mental Capacity Act and Best Interest Decision Making for patients with a Learning Disability

6.0 MULTI-AGENCY WORKING AND RESPONDING TO CONCERNS

6.1 Contacts with STHFT Safeguarding Adults Team for Advice and Support

The following graph and table shows the 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 recorded contacts with the STHFT Safeguarding Adults Team



		Totals
July 2010-March 2011	=	**66**
April 2011-March 2012	=	**169**
April 2012-March 2013	=	**364**
April 2013-March 2014	=	**529**
April 2014- March 2015	=	**552**
April 2015 – March 2016	=	**364**
April 2016 – March 2017	=	**470**

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

Whilst these data reflect the number of advice requests recorded, they do not demonstrate the increasing complexity of the safeguarding concerns being identified by health staff. This has 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. Many of these contacts will require further information to be sought and/or an enquiry into alleged abuse to be undertaken by the Adult Safeguarding Team.

The Care Act (2014) requires the local authority as the lead agency for safeguarding adults to carry out safeguarding enquiries into allegations of abuse or neglect, **or to request others to undertake enquiries.**

Where a safeguarding concern involves STHFT either as a service provider to the adult at risk, or where STHFT is the alleged source of harm, the Adult Safeguarding Team will be required to undertake an enquiry as part of the safeguarding process.

Safeguarding enquiries involve extensive review of case notes and analysis of the care provided, review and interpretation of x-ray reports, blood results, the effects of medications given or omitted etc. Information is gathered from STHFT staff or teams e.g., ward staff, Tissue Viability, Medicines Management as well as via liaison with other agencies both within Sheffield and out of area. Expert advice may need to be sought from medical consultants and/or Clinical Nurse Specialists.
The information obtained is required to be collated into a timeline and a written report produced with analysis of the findings, recommendations and action plans. Where safeguarding procedures progress the Safeguarding Adults Team may also be required to attend Safeguarding planning or best interest meetings, Self Neglect Risk Management Model (SNRMM) meeting, or Safeguarding Outcomes Meeting.
The Adult Safeguarding Team carried out 94 of these complex enquiries between April 2016 and March 2017 in addition to the contacts for advice and support.

The Safeguarding Team Secretary manages contacts and / or messages for the Safeguarding Team whether by telephone or email and redirects them to the appropriate person to respond.

There have been 1105 telephone contacts to the Adult Safeguarding Team recorded by the Safeguarding Team Secretary during 2016-2017.

Table 1 - Yearly summary of safeguarding adult's activity 2016-17

	Advice and Support Contacts	Safeguarding Enquiries Undertaken	Planning Meetings Attended	Outcomes Meetings Attended	Self-Neglect Risk Management Meetings Attended	Telephone contacts recorded
2015-16	**364**	**85**	**6**	**2**	**5**	**1218**
2016-17	**470**	**94**	**9**	**7**	**2**	**1105**

Key achievements 2016-2017

1. 94 Safeguarding enquiries were undertaken by the Adult Safeguarding Team in line with the requirements of the Care Act 2014
2. 1105 telephone contacts were recorded by the Safeguarding Secretary which indicates that staff are identifying safeguarding concerns and are seeking advice in a timely manner. This reflects positively on the awareness of safeguarding across the Trust.

Key priorities for 2017-18

- To continue to respond to requests for advice in a timely manner to ensure adults at risk are kept safe and staff are supported to manage complex cases.

6.2 Incidents/Safeguarding Concerns Raised and Referred to Social Care

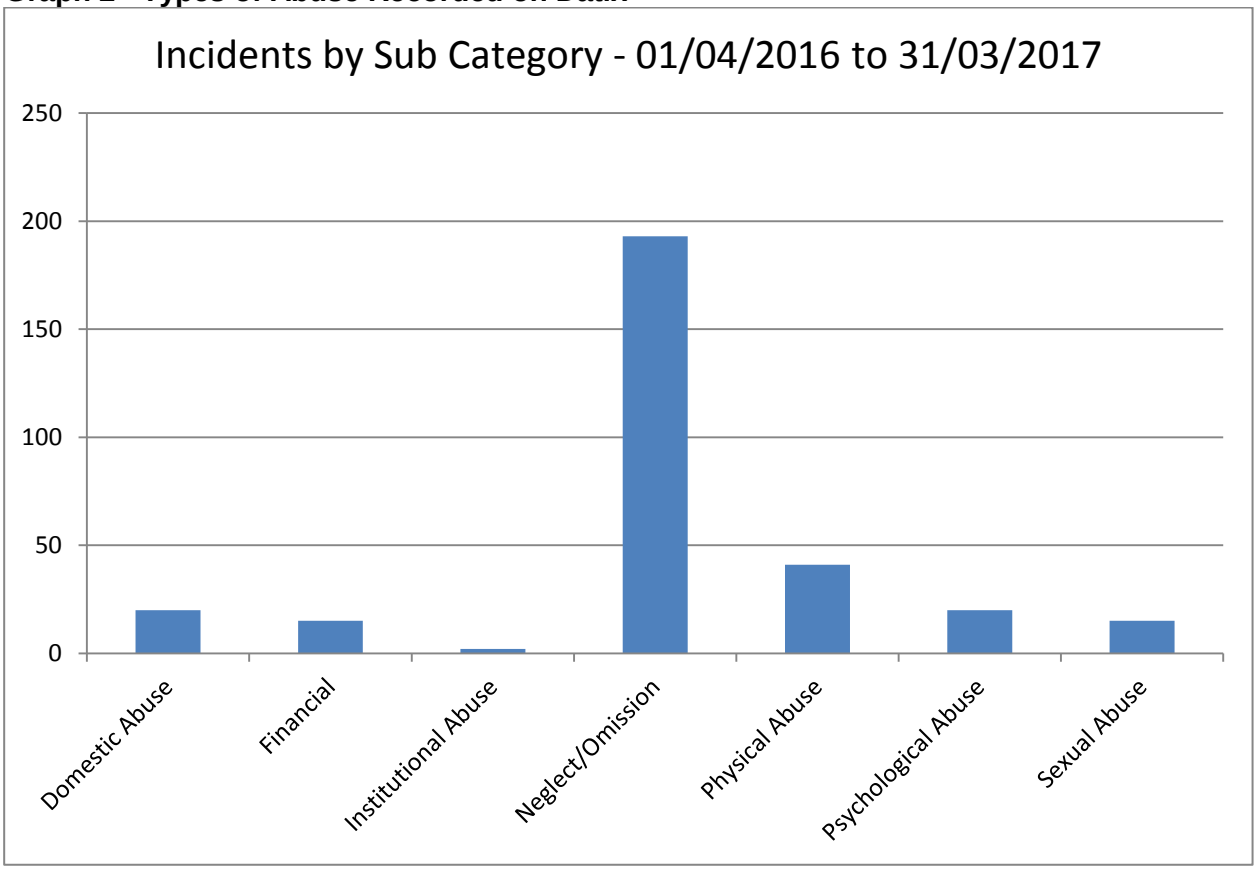
Alerts and Referrals

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. Work has been undertaken with the IT department to develop electronic recording of safeguarding concerns on both Lorenzo and SystmOne which allows safeguarding concerns or alerts to be forwarded electronically and therefore provides more robust audit data.

Table 2 - Yearly summary of adult safeguarding alerts recorded on DATIX

2008-9	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
7	**74**	**137**	**202**	**161**	**239**	**217**	**265**	**306**

Graph 2 - Types of Abuse Recorded on Datix



Neglect/ acts of omission and physical abuse continue to be the highest categories of abuse recorded which is consistent with the pattern in previous years.

Table 3 – Safeguarding Concerns raised by STHFT as recorded on the Local Authority Care First System

April 2011 - March 2012	April 2012 - March 2013	April 2013 - March 2014	April 2014 - March 2015	April 2015 - March 2016	April 2016 – March 2017
136	**112**	**73**	**207**	**276**	**335**

The Local Authority has a number of concerns recorded under the generic term 'health' where the source of the concern is not identifiable as a specific agency, therefore the figures may not be truly reflective of the concerns generated from STHFT.

Table 4 – Safeguarding Concern Forms forwarded to Adult Access following initial screening by the STHFT Safeguarding Adults team 2016-2017

Concern Forms Received by STHFT Safeguarding Team	July 2013 to March 2014	April 2014 to March 2015	April 2015 to March 2016	April 2016 – March 2017
Screened in to the Local Authority Adult Access	65	121	162	215
Screened out	39	24	69	37
TOTAL	**104**	**145**	**231**	**252**

The data for 2013 -14 is incomplete as the process began in July 2013. The benchmark for the numbers of concerns received by the STHFT Safeguarding Team will therefore be taken from 2014-15.

The table demonstrates a year on year increase in the number of concern forms being received and screened by the STHFT Safeguarding Team.
It also evidences those concerns that met the threshold for submission to the Local Authority Adult Access Team and those that were screened out as inappropriate referrals or not meeting the threshold for safeguarding adults procedures.

Key achievements 2016-2017

- The number of safeguarding concern forms received by the STHFT Safeguarding Adults Team has increased year on year and indicates that staff are recognising abuse and neglect and are taking steps to raise concerns using the appropriate pathways.

Key priorities for 2017-2018

- To increase the number of appropriate concerns reported, taking the opportunity to highlight via the Safeguarding Leads meeting, situations where appropriate concerns may be being missed.
- To review the reasons for screening out concerns raised and to provide training and support to staff to reduce the number of inappropriate concerns received.

6.3 Safeguarding Enquiries (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 enquiries form part of a wider investigation under adult safeguarding procedures which, until the Care Act 2014 came into force, have been co-ordinated and led by Social Care as part of their statutory duty.

The Care Act now requires the local authority to undertake a safeguarding 'enquiry' or to ensure an enquiry happens, therefore the enquiry can be delegated to another organisation where appropriate.

The Sheffield Safeguarding Adults Board (SAB) is keen to encourage health organisations to take the lead in coordinating and managing safeguarding enquiries particularly where health issues or health agencies are the alleged primary focus of concern.

Other essential investigations such as Individual Management Reviews (IMRs) into Safeguarding Adults Reviews (SARs) where adults at risk 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 person(s) alleged to have caused harm 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. The IMR forms part of an overview report, written by an Independent Author. The overview report is scrutinised by the SAB in the case of a SAR, or the Home Office in respect of DHRs.

Key Achievements 2016-2017

- The Safeguarding Adults Practice Development Facilitator and the Safeguarding Adults Adviser have attended IMR author training.

Key Priority for 2017-2018

- To respond to requests for safeguarding enquiries and DHR IMRs in a timely manner.

7.0 MENTAL CAPACITY ACT (2005) AND DEPRIVATION OF LIBERTY SAFEGUARDS(DOLS) (2009)

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.

7.1 Deprivation of Liberty Safeguards (DOLS)

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 detaining an individual in a care home or hospital in order to provide care and treatment that is agreed to be in their best interest, where that individual is unable to consent to the detention (deprivation of 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.

7.2 The Acid Test

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 which became known as the Acid Test i.e.

1. Is the person under constant supervision and control?
2. Is the person free to leave?

If the answer to 1 is yes and the answer to 2 is no, a deprivation of liberty is occurring.

The implications of the judgement for STHFT is that a far 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 being lawfully and appropriately deprived of their liberty in their best interest and have access to appeal against the detention. This includes patients who are being treated in intermediate care facilities.

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

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

The Trust (the Managing Authority) works closely with local authority colleagues (the Supervisory Body) to ensure local processes are robust and efficient with regard to the authorisation of DOLS safeguards.

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 refusal to grant a DOLS application may result from one of six assessment requirements not being met. Those applications assessed as not appropriate may occur where for example, the patient is assessed to have mental capacity or has regained capacity since the DOLS application was submitted. Those referrals withdrawn include those cases which meet the criteria for detention under the Mental Health Act rather than the Mental Capacity Act DOLS.

In April 2014, NHS England published the guidance: Mental Capacity Act 2005 'A guide for Clinical Commissioning Groups (CCGs) and other commissioners of healthcare services on commissioning for compliance'. NHSE (2014)

The guidance sets out how CCGs and other commissioners should discharge their duty to ensure legislation, guidance and policy relating to the MCA are delivered by service providers thereby assuring CCGs and NHS England that the rights of patients are being recognised & protected.

CCGs and NHS England require assurance that the services they commission are being delivered in a way that respects and upholds the rights of individual patients. Failure to provide care within the framework could be deemed to be unlawful. Whilst the provider organisation is primarily responsible, the commissioner could also be found to be equally liable.

7.3 Deprivation of Liberty (DOLs) Applications

The following table details the current available data on the number of DOLS applications made by STH during the period from April 2011 – March 2017:

Table 5 - DOLS applications requested by STH from April 2011 to March 2017

	April 2011 to March 2012	April 2012 to March 2013	April 2013 to March 2014	April 2014 to March 2015	April 2015 to March 2016	April 2016 to March 2017
Total Applications Requested	**42**	**51**	**56**	**167**	**454**	**346**
Granted	**29**	**24**	**16**	**29**	**14**	**5**
Not Granted	**7**	**14**	**22**	**10**	**6**	**3**
Assessed as not appropriate	**6**	**13**	**18**	**128**		
Withdrawn				**47**	**387**	**223**

Note: Due to the pressure on local authorities, many assessments are not being completed within the set timescales, this is why we are unable to provide the required data. It is impossible for STH to distinguish between those not granted or those that have never been assessed.

The Cheshire West judgement has had an impact on the increase in the number of DOLS applications made by STHFT. This demonstrates an improvement in the identification of patients who may require a DOL.

The increase in applications has however impacted substantially on the capacity of the Supervisory Body, (Local Authority) to assess and authorise the applications.

The data for 2016 -17 may not be accurate as up until December 2015 the 'granted' paperwork was sent by the Local Authority directly to the relevant ward. It was then the responsibility of the ward to inform the STHFT Legal Department, however this did not always happen. The Legal Department is in the process of following up outstanding outcomes. This also will have an impact on the data for applications granted.

From late December 2015 all correspondence and paper work has been sent electronically between the Local Authority and Legal Services. Any relevant documents are now distributed electronically to the ward and also sent from the Local Authority by post.

The MCA Specialist Advisor continues to provide training and support to staff to undertake mental capacity assessments and submit DOLS applications in respect of authorising the legal detention of patients who lack capacity to consent to being in hospital or intermediate care facilities for the purposes of receiving necessary care, treatments or rehabilitation in their best interest.

7.4 Independent Mental Capacity Advocacy Service (IMCA)

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.

The MCA Specialist Advisor meets with the IMCA service on a 3 monthly basis in order to work together to resolve any issues and improve practice within STHFT.

7.5 MCA/DOLS Training

Table 6 – The numbers of staff who have attended training provided by the MCA Specialist Advisor

Year	2013-14	2014-15	2015-16	2016-17	TOTAL
Mental Capacity Act	204	670	211	100	1185
Assessing Mental Capacity and Best Interest	47	208	111	63	429
Deprivation of Liberty Safeguards (DOLS)	70	195	88	47	400
Consent and the MCA	16	Not provided	13	Provided within other sessions	29
Assessing Capacity Master Classes			44	16	60
Best Interest Decision Making Master Classes			37	8	45
TOTAL Number of Staff Trained by MCA PDF	337	1073	423	234	2148

Consent and the MCA training is no longer delivered as standalone training but is incorporated into the other training sessions. MCA basic awareness was delivered at Corporate Induction up until April 2014 but following a review of the mandatory training topics by the Trust, MCA is now no longer included. However, MCA is referred to in all Safeguarding Adults Basic Awareness training delivered by the Safeguarding team and bespoke training is provided on a needs basis to targeted staff groups supported by the MCA toolkits and guidance documents.

The overview of the Mental Capacity Act is now an e-learning package available on PALMS, staff must complete this before they are able to book onto the Mental Capacity Assessment and Best Interests Decision Training.

The MCA Specialist Advisor is now providing a 2 hour master class for Assessment of Capacity and Best Interests Decision Making, this is aimed at staff who have completed the assessing capacity and best interests decision making module and is designed to build confidence and deal with live cases in order to improve practice.

7.6 Restraints

A Group of representatives from the key organisations in Sheffield meet on a 6 weekly basis to share good practice and information on developments in the area of restrictive practices and restraint. The MCA Specialist Advisor is a member of this group which aims to develop a city wide approach to restraint.
The city wide Framework for Restrictive Practice is now complete and was launched in February 2017. The document was discussed and circulated to attendees of the Dementia Care Group and is available on the STHFT Intranet. The document will be referenced in the updated STHFT Policy for the Management of Patients whose Behaviour Challenges the Service (Adults) and in the MCA Policy.

Key Achievements 2016-2017

- Advice and support to manage complex cases where patients lack capacity has been offered in a timely manner by the MCA Specialist Advisor.
- A guidance toolkit and exemplar of good practice in assessing and recording mental capacity has been devised and is made available to staff on completion of the assessment of capacity and best interests module.
- A rolling programme of training on; MCA (e-learning), mental capacity assessment and best interest decision making and Deprivation of Liberty Safeguards has been on-going since September 2012. Uptake of the training has exceeded expectation and additional training dates to meet the demand have been added.
- A training needs analysis has been completed in collaboration with the Learning and Development Department.

Key Priorities for 2017-2018

- 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 train and support staff to apply the principles of the Mental Capacity Act and Deprivation of Liberty safeguards in day to day practice.
- To undertake an audit of the quality of mental capacity assessments
- To undertake a survey of staff's knowledge and skill around the assessment of capacity

8.0 DOMESTIC ABUSE/ VIOLENCE

The recognition and support of victims of domestic abuse (DA), forced marriage and honour based violence is a key issue for all agencies.

8.1 Domestic Abuse

Domestic Abuse is defined as:
'Any incident of controlling or threatening behaviour, violence or abuse between those aged 16 years and over who are or have been intimate partners of family members'.

The Association of Chief Police Officers (ACPO) categorise the risk of domestic abuse as the following;

Standard - no significant current indicators of risk of harm.
Medium - there are identifiable indicators of risk of harm. The offender has the potential to cause harm but is unlikely to do so unless there is a change in circumstances, for example,

failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse.
High - there are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

In order to assist with assessing the level of risk the Domestic Abuse, a Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was introduced which includes a DASH risk assessment tool.

Forced marriage and so called 'Honour' based violence are a violation against human rights and are a high priority area of the national and local violence against women and girls agenda. It is, primarily an issue for young women and girls aged between 13 and 30 years, although evidence collated by the Foreign and Commonwealth Office indicates that 15% of the victims are male.
It is estimated that between 5000 and 8000 cases of forced marriage are reported per year

8.2 Arranged Marriage

In arranged marriages, the families of both spouses take a leading role in arranging the marriage but the choice whether or not to accept the arrangement remains with the prospective spouses.

8.3 Forced Marriage

Forced marriage is a marriage conducted without the valid consent of one or both parties, where some element of duress is a factor.

The 1948 Universal Declaration of Human Rights (OHCHR 1948) regards Forced Marriage as a form of human rights abuse, since it violates the principle of freedom and autonomy of individuals, Article 16.2

The Declaration stipulates that marriage should take place between spouses of 'full age' and with the 'free and full' consent of both parties.

Forced marriage 'is also a form of child/domestic abuse and should be treated as such. According to the UN Convention on the Rights of the Child (CRC) Article1 (OHCHR 1999), a child is defined as 'every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier'

Forced marriage affects people from many communities and cultures. Cases should be addressed using existing structures, policies and procedures designed to safeguard children, adults with support needs and victims of domestic abuse, working in partnership with other agencies.

STHFT has policies and procedures in place to escalate concerns to safeguarding adults and children and /or domestic abuse services where a service user or staff member is alleged to be at risk of forced marriage.

8.4 'Honour' Based Violence (HBV)

'Honour' based violence occurs when perpetrators believe a relative or other individual has shamed or damaged a family's or community's 'honour' or reputation (known in some communities as izzat), and that the only way to redeem the damaged 'honour' is to punish and/or kill the individual.

'Honour' based violence is a term that is widely used to describe this sort of abuse however it is often referred to as so called 'honour' based violence because the concept of 'honour' is used by perpetrators to make excuses for their abuse. There is a very strong link between 'honour' based violence, forced marriage and domestic abuse. Examples of damaged honour are:

- Defying parental authority
- Becoming overly westernised in style (e.g. clothing, make up, behaviour, attitudes, etc.)

- Having sex/relationships/pregnancies outside marriage
- Using drugs, alcohol, cigarettes
- Gossip – family honour can be damaged by unfounded or untrue gossip or rumours
- Interfaith or intercommunity relationships
- Leaving a spouse or seeking a divorce

Forms of 'honour' based violence can include, but are not limited to:

- Being disowned or ostracised by the community
- Physical abuse of the victim by family members including spouse and in laws
- Restriction of freedom or loss of independence – being "policed" by family members
- Isolation from wider family or community, e.g. stopped from seeing friends
- Forced marriage
- Murder

Internalisation of guilt or shame by the victim can cause internal conflict for them, and not wanting to cause further shame can result in self harm and suicide attempts.

There have been known instances where staff members at STH have been victims and or perpetrators of domestic abuse and forced marriage.

DA services in Sheffield are led and coordinated by the Drugs and Alcohol/ Domestic Abuse Co-ordination Team (DACT). STHFT is represented on the Domestic Abuse Strategic Board by the Deputy Chief Nurse. The Lead Nurse for Safeguarding Adults represents the Trust on the Domestic Abuse Provider Consultation Group and the Domestic Homicide Review Sub Group.

8.5 Domestic Abuse Training

A programme of Domestic Violence and Abuse Awareness training has been facilitated at STHFT by the Sheffield Independent Domestic Violence Advocacy Service as part of their contractual agreement with Action Housing to provide multi agency training across Sheffield.

8.6 Domestic Abuse Helpline

The Sheffield Domestic Abuse Helpline is available for advice and support to both the victims of domestic abuse and to professionals.

8.7 Independent Domestic Violence Advocacy Service (IDVAS)

The Independent Domestic Violence Advocates (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.

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).

High risk victims of domestic abuse are referred to the MARAC following completion of the Domestic Abuse Stalking, Harassment and Honour Based Violence (DASH) risk assessment tool. A DASH Risk Assessor from the Domestic Abuse Outreach Service is available to support STHFT staff to identify and refer high risk domestic abuse victims and to complete the DASH.

Honour Based Violence cases are discussed with relevant agencies and professionals on a need to know basis at the end of each MARAC. STHFT has not been required to attend the HBV discussions to date.

8.8 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 with intermittent additional catch up meetings and are attended by a small group of key staff from the STHFT safeguarding children and adults teams, maternity services and the Emergency Department (ED) in rotation.
The Safeguarding Adults Team has attended 29% (11/38) of the MARACs held in 2016-17 as part of the rotation.

8.9 Referrals to Domestic Abuse services

Table 7 - The following table demonstrates where referrals to domestic abuse services have been generated from within STHFT.

DA Referrals 2016-17	ED	Midwifery Services	GUM
MARAC High Risk	28	8	3
Medium /standard risk services	180	37	4

Key achievements 2016-2017

- 100% Attendance by STHFT at MARAC and completion of actions for STHFT.
- 100% attendance at the Domestic Abuse Strategic Board.
- 100% attendance at the Domestic Homicide Review Sub Group.
- 100% attendance at the Domestic Abuse Provider Consultation Group.
- A STHFT Domestic Abuse policy has been written to support the management of staff victims of Domestic Violence and abuse.

Key priorities for 2017-2018

- 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.

9.0 DOMESTIC HOMICIDE REVIEWS (DHRs)

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) under the remit of the DACT. 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 process carried out following the death of a child or 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 requested 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 nine domestic homicides since 2011. 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 six full DHRs and three SI Lessons Learned Reviews in Sheffield, plus two DHRs from Rotherham where the victims and/or perpetrators had received services from STHFT.
STHFT is represented on the DHR or SI Review Panels by the Deputy Chief Nurse or Lead Nurse for Safeguarding Adults in his/her 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 Safeguarding 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 and Named Professionals for Safeguarding Adults, the Named Doctor and Named Professional for Safeguarding Children and a Senior Nurse working within the Central Nursing Directorate.

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

Quarterly submissions to the DACT are required by organisations to evidence progress against the recommendations from DHRs. Data to inform the quarterly submissions is gathered and collated by the Lead Nurse Safeguarding Adults.

Adult JS Serious Incident

On 20.08.2016 Adult JS was brought to the Emergency Department at the Northern General Hospital by emergency ambulance after being beaten about the face and head with a hammer, allegedly by his son.
He had sustained significant injuries to his head and face and was transferred to neuro surgery at the Royal Hallamshire Hospital where he underwent life- saving surgery.
He remained in the neuro critical care unit until being transferred to the neuro rehabilitation ward, Osborne 4. He was discharged home with neuro rehabilitation follow up, on the 18.10.2016.

The Lead Nurse for Safeguarding Adults produced an IMR relating to the Trust's involvement in the provision of services to both the victim and the alleged perpetrator before and after the incident. The IMR was submitted to the SI Panel in January 2017.

Key Achievements 2016-2017

- The IMR for Adult JS was completed and submitted within the required timescale.
- 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 2017-2018

- To ensure the IMRs for future DHRs or SIs 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.

10.0 MODERN SLAVERY AND HUMAN TRAFFICKING

The Modern Slavery Act 2015 describes modern slavery as 'a brutal form of organised crime in which people are treated as commodities and exploited for criminal gain'.

The term 'Modern Slavery' was first introduced into the UK to encompass all offences previously referred to as slavery, sexual exploitation, human trafficking, forced labour and domestic servitude.

In the UK the scale of this hidden crime is significant. The Home Office estimates that in 2013, the number of potential victims in the UK was between 10,000 –13,000 including not only victims trafficked into the UK, but British adults and children too. (Home Office 2014)

Human trafficking is the movement of a person from one place to another, using methods of deception, coercion, the abuse of power or of someone's vulnerability and for the purposes of exploitation.

Traffickers and slave masters use whatever means they have to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment. (National Crime Agency [NCA] (2014). It is possible for a person to be a victim of trafficking even if their consent has been given to being moved. Human trafficking may occur across international borders or take place within one country.

According to the NCA (2014), there are three main elements:

- The movement: recruitment, transportation, transfer, harbouring or receipt of people;
- The control: threat, use of force, coercion, abduction, fraud, deception, abuse of power or vulnerability, or the giving of payments or benefits to a person in control of the victim;

- The purpose: exploitation of a person, which includes prostitution and other sexual exploitation, forced labour, slavery or similar practices, and the removal of organs.

As is often the case with other types of exploitation, victims of modern slavery report being assaulted or threatened with violence.

Young girls are often raped, beaten, passed from abuser to abuser and sexually exploited for profit. Vulnerable men are tricked into long hours of hard labour and may be locked away in poor quality and overcrowded accommodation e.g. cold sheds or rundown caravans. Victims are made to work in fields, factories, and on fishing vessels. Women are forced into prostitution, and children systematically exploited. Domestic workers are imprisoned and made to work all hours of the day and night for little or no pay. (Home Office 2014)
Victims are often unable or unwilling to report their circumstances to the police or to safeguarding agencies for fear of reprisals or due to social or cultural barriers. Victims may not always see themselves as victims and may not be recognised as victims by those they come into contact with.

A Detective Sergeant from South Yorkshire Police Modern Slavery Unit delivered a presentation to the Sheffield Safeguarding Adults Operational Board in February 2017 to raise the profile of Modern Slavery and Human Trafficking.

The CCG has suggested it will be including a key performance indicator regarding modern slavery in its monitoring of provider safeguarding activity for 2017-18

Key Achievements 2016-17

The Lead Nurse for Safeguarding Adults participated in a multi-agency meeting in January 2017 led by the CCG, to discuss the feasibility of a partnership arrangement within Sheffield to drive forward the city's response to Modern Slavery and Human trafficking. This proposal was discussed at a Safeguarding Adults Operational Board meeting and it was agreed that Modern Slavery and Human Trafficking should be aligned to existing safeguarding procedures and therefore does not require a separate arrangement currently.

As a result of this the Lead Nurse for Safeguarding Adults devised a Modern Slavery and Human Trafficking (MS&HT) Action Plan to raise the profile of MS&HT within STHFT. The action plan includes dissemination of information and literature to staff and the inclusion of a section on MS&HT in both the Children and Adults Safeguarding Policies. Safeguarding training will also include an awareness of MS&HT and the agreed referral pathways.

Key Priorities 2017-18

- To complete the actions identified in the MS&HT action plan within the agreed timescales.
- To ensure staff are aware of how to spot the signs of MS&HT and how to support victims.

11.0 FEMALE GENITAL MUTILATION (FGM)

FGM, also called "female genital cutting", comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non- medical reasons.

Procedures are usually carried out on young girls sometime between infancy and age 15, occasionally in adulthood.

The practice is most common in the western, eastern and north eastern regions of Africa, in some countries in Asia and the Middle East, and among migrants from these areas. In Africa more than 3 million girls have been estimated to be at risk of FGM annually.

More than 125 million girls and women alive today have undergone FGM in the 29 countries in Africa and Middle East where it is concentrated. (HSCIC 2014)

FGM has no justification as a procedure, therefore in February 2014 government ministers met with charities and stakeholders to sign a declaration to stop the practice of FGM.

FGM has been a specific criminal offence since 1985, under the Prohibition of Female Circumcision Act (1985), which was replaced by the Female Genital Mutilation Act (2003) (in England, Wales and Northern Ireland) carrying a maximum penalty of 14 years imprisonment.

FGM is a form of child abuse (Home Office 2014) and must be reported via the appropriate safeguarding children procedures.

11.1 FGM Prevalence Dataset

The Female Genital Mutilation Prevalence Dataset (HSCIC 2014) is a quarterly return of data from acute hospital providers in England. It is an aggregated return of the incidence of FGM including women who have been previously identified and are currently being treated (for FGM related or non FGM related conditions) and newly identified women within the reporting period. It has been a mandated collection from 1 September 2014.

The data is collated by the STHFT Safeguarding Secretary onto a standard proforma which is uploaded onto the Health and Social Care Information Centre (HSCIC) website address to be submitted to meet the quarterly deadline.

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.

Key Achievements 2016-2017

- Data has been submitted to the Health and Social Care Information Centre to meet the required deadlines.

11.2 FGM Cases Identified by staff working at Sheffield Teaching Hospitals NHS Foundation Trust.

2015-16	2016-17
163	154

154 new cases have been identified in 2016-17 by STHFT Staff mainly working with patients attending Obstetrics and Gynaecology and Sexual Health Sheffield.

STHFT published a Trust Policy on FGM in 2016 which reflects both national and local guidance.

Key priorities 2017-2018

- To continue to educate appropriate staff regarding the need to systematically collect data about FGM and the process for reporting FGM
- To ensure the process to gather information about patients who have had FGM for submission to the HSCIC is robust and complied with.
- To implement any future actions or recommendations from the Department of Health or the Safeguarding Adults or Children's Board's in Sheffield in response to the data being submitted.

12.0 VULNERABLE ADULTS PANEL (VAP)

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 adults at risk who:

- Make frequent avoidable use of emergency and crisis services
- Demonstrate challenging behaviours towards professionals

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 adults will be regular users of services provided by STHFT e.g. ED, Minor Injury Unit, GP Collaborative, etc.

The Vulnerable Adults Panel consists of representatives from key agencies who meet bi monthly to discuss a multi-agency approach to supporting those adults referred to the panel ensuring that 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 2016-2017

- The Lead Nurse for Safeguarding Adults represents the interests of the Trust on the Vulnerable Adults Panel and ensures actions for STHFT are enacted as agreed by the panel.
- A system of identification and referral of the high frequency service users has been developed with the ED.
- STHFT has made a number of referrals to the Vulnerable Adults Panel which has led to direct action being taken by other agencies to support the individuals and in some cases to contain the behaviour of the individuals via the criminal justice system.

Key priorities for 2017-2018

- To ensure actions are carried out and information regarding individuals discussed at the Vulnerable Adults Panel is disseminated and acted on appropriately within STHFT on a need to know basis.

13.0 SAFEGUARDING ADULTS REVIEWS (SARS)

Safeguarding Adults Reviews, previously known as Serious Case Reviews (SCRs) are held following the death of, or serious harm to, an adult if abuse or neglect is suspected as a significant factor.

The aims of SARs 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 adults at risk.
- 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 SAR requires agencies involved in the care of the adult at risk to undertake an IMR to analyse their involvement with the case in order to make recommendations for future action. A Safeguarding Adults 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.

Adult H (Nottinghamshire Serious Incident)

Adult H was a 22 year old woman from Nottinghamshire who was transferred from Doncaster Royal Infirmary to the Burns Unit at the Northern General Hospital in August 2015 after being found at home by her family in a neglected state and with severe burns indicative of urine burns.
After an extended period in hospital Adult H returned home with a significant package of care.

A SAR was commissioned by Nottinghamshire Safeguarding Adults Board in August 2016, following the principles of the Serious Incident Learning Process (SILP).
The STHFT Safeguarding Adults Adviser authored an IMR relating to the care provided to Adult H by STHFT.

There were no recommendations or actions identified for STHFT.

Key achievements 2016-2017

- The IMR for the SILP was submitted to the Overview Author within the required timescales.
- The Lead Nurse for Safeguarding Adults and the Safeguarding Adults Adviser attended the IMR author learning events chaired by the Overview Author as required.

Key Priorities 2017-2018

- To participate in any SARs involving STHFT as required.
- To submit well written, comprehensive IMRs in a timely manner if required.
- To ensure that recommendations from any SARs 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.

13.1 Case Reviews

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

Key achievements 2016-2017

- There have been no new case reviews in 2016-2017

Key priorities for 2017-2018

- 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.

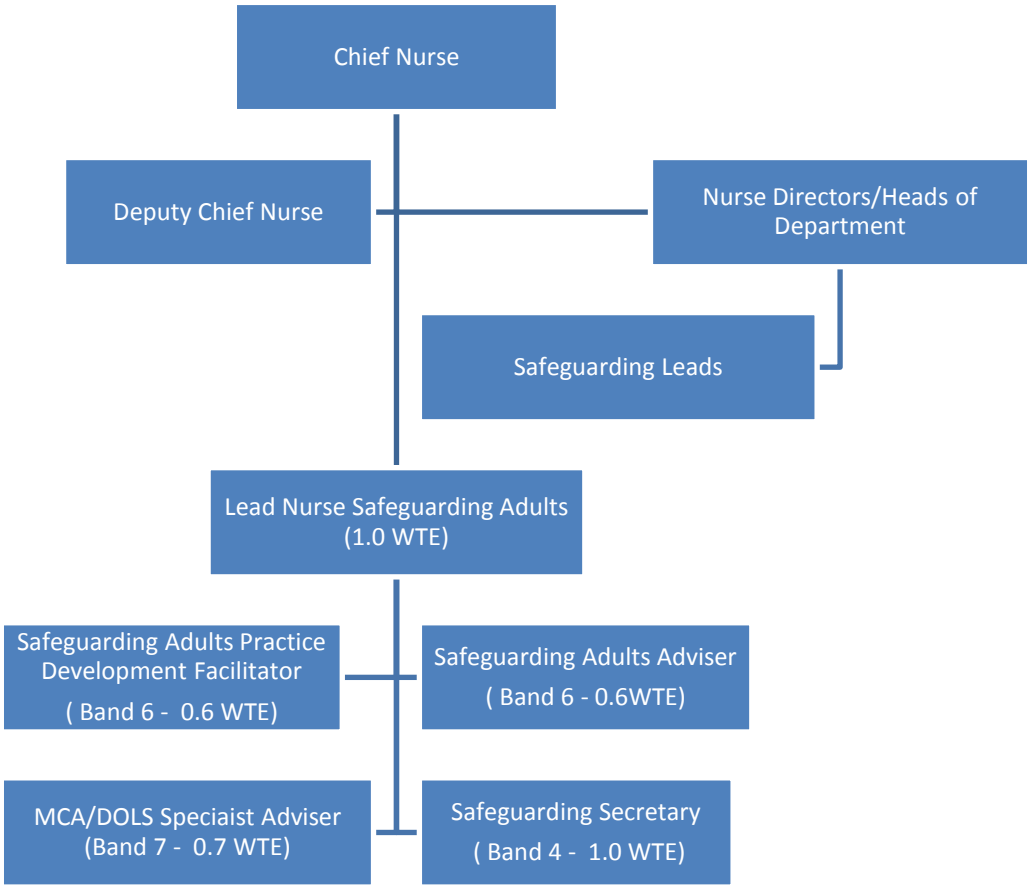
14.0 STHFT SAFEGUARDING TEAM

14.1 Safeguarding Adults Team

Led by the Chief Nurse and supported by the Deputy Chief Nurse, safeguarding is a high priority for the trust.

As the various key themes and categories of safeguarding emerge and the policy and governance arrangements are developed around these categories at both local and national level, there is a need to more closely integrate adults and children's safeguarding practice.
The safeguarding adults team works in close collaboration with the safeguarding children team.

Safeguarding Adults Lines of Accountability to the Board of Directors at STHFT



Key achievements 2016-2017

The following areas have been addressed jointly during 2016-17:

- Collaboration in the development of training materials and delivery of training.
- The development of electronic safeguarding referral forms on Lorenzo and the provision of face to face awareness sessions for front line staff.
- Attendance at a Safeguarding Team Time Out day in March 2017 to agree joint objectives for 2017-18.
- Agreement of a work plan for 2017-18 which includes the development of a Safeguarding Strategy for the Trust.

Key priorities 2017-2018

- To continue to work collaboratively to ensure vulnerable people are kept safe from abuse and neglect.
- To continue to work collaboratively to ensure the objectives identified in the work plan are achieved within the agreed timescales.
- To develop a Safeguarding Strategy to give a clear steer on the direction of travel for Safeguarding at STHFT over the next 5 years
- To collate the various assurance processes into a governance framework to support the monitoring of safeguarding activity and performance

15.0 SAFEGUARDING ADULTS EDUCATION AND TRAINING

15.1 Staff Training and Development

Safeguarding adults training provided by the Adult Safeguarding Team at STHFT includes the following topics, safeguarding basic awareness, Self Neglect Risk Management Model (SNRMM), MCA/DoLS, Prevent, Modern Slavery and Human Trafficking, Female Genital Mutilation and Domestic Abuse. Safeguarding awareness sessions are delivered at corporate induction and Trust central mandatory training days, supported by safeguarding adults awareness leaflets for both staff and volunteers. E-learning modules for some topic areas are accessible through the Personal Achievement and Learning Management System (PALMS).
Attendance at training and safeguarding updates by both acute and community based staff is recorded and monitored on PALMS.
The PALMS system allows monitoring of performance against the STHFT Safeguarding Adults Training Needs Analysis (TNA).

Safeguarding adults awareness is also provided by Clinical Educators in local departments and directorates within STHFT as part of their mandatory training updates. The Safeguarding Adults Practice Development Facilitator has provided updated training materials to the Clinical Educators to try to provide consistency and accuracy of the information. Staff can also access multi agency training provided by the Local Authority.

The STHFT Safeguarding adults Training Needs Analysis (TNA) was updated in March 2015 to reflect the Skills for Health UK Core Skills Training Framework (2014) and the Bournemouth University National Competence Framework for Safeguarding Adults, Bournemouth University and Learn to Care (2010).

Key achievements 2016-2017
The table below shows Safeguarding /Adults at Risk Training provided by the STHFT Safeguarding Team

Table 8 - Safeguarding Training provided by the STHFT Safeguarding Team

Training by Topic	Numbers of staff trained 2015/2016	2016 -17
Safeguarding adults basic awareness (including MCA and Prevent)	324	282
Safeguarding adults update	25	Not delivered as included in Mandatory Training updates
Safeguarding adults refresher training	272	Not delivered as included in Mandatory Training updates
Self- Neglect Risk Management Model (SNRMM)	118	Not delivered due to a review of the SNRMM Process
MCA/Best Interest/DOLS	423	210
Workshops to Raise Awareness of PREVENT (WRAP)	154	167
Domestic abuse awareness (facilitated by IDVAS)	79	135
Safeguarding Awareness at Corporate Induction	1395	1600
Central Mandatory Induction (Level 1)	1997	531
Volunteer Induction	300	241 (April 16-Jan 17)
TOTAL	**5087**	**3166**

NB From January 2017 Volunteers now receive mandatory training via the Central Mandatory Induction Programme

Key priorities for 2017-2018

- To update the TNA to reflect the competencies for health care staff as identified in the NHSE Intercollegiate Document for Safeguarding Adults (awaiting publication) and the Prevent Training and Competencies Framework (NHSE 2015 Updated November 2016).
- To provide Safeguarding update training materials to clinical educators/training leads across the Trust to ensure key messages and a consistent approach.
- To provide additional training to heads of Therapy Services and other allied health services and to senior staff within the Combined Community and Acute Directorate, to enable them to identify safeguarding concerns, in order where necessary, to raise concerns under 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 both guidance on and multi agency training on restraint and restrictive practices.

16.0 COUNTER TERRORISM AND PREVENT

16.1 Counter Terrorism and Security Act (2015) and the Prevent Duty

On 29 August 2014, the independent Joint Terrorism Analysis Centre (JTAC) raised the UK national terrorist threat level from SUBSTANTIAL to SEVERE, indicating terrorist attack on the UK "highly likely". The Government recognised a need to legislate in order to reduce the threat to the UK from terrorism and violent extremists. The Counter Terrorism and Security Act 2015 (CT&S Act 2015) came into force on 1st July 2015.

Section 26 of the Act places a duty on specified authorities (specified in Section 6 of the Act and including NHS Foundation Trusts) , whilst carrying out their functions, to have "due regard to the need to prevent people from being drawn into terrorism". The Act also states that authorities subject to the provisions must have regard to the Prevent Duty Guidance: For England and Wales (HM Government 2015).

Nearly 600 people from the UK who are of interest to the security services are thought to have travelled to Syria and the surrounding region since the start of the conflict there, and the security services estimate that around half of those have returned to the UK. In the context of this heightened threat to our national security, the provisions in this Act will strengthen the legal powers and capabilities of law enforcement and intelligence agencies to disrupt terrorism and prevent individuals from being radicalised in the first instance.

The UK has a strategy for countering terrorism: CONTEST. The aim of CONTEST is to reduce the risk to the UK and its interests overseas from terrorism, so that people can go about their lives freely and with confidence. The strategy is made up of four work streams:

Protect – protecting our borders, infrastructure and citizens
Prepare –having emergency preparedness plans and business continuity plans in place
Pursue – pursuing those known to have links to terrorism
Prevent –this aims to stop people becoming terrorists or supporting terrorism by identifying and safeguarding people who might be susceptible to radicalisation.

The *Prevent* strategy has three specific strategic objectives:

1. To respond to the ideological challenge of terrorism and the threat we face from those who promote it;
2. To prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support; and
3. To work with sectors and institutions where there are risks of radicalisation that we need to address.

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 adults at risk. Prevent is now firmly embedded within the NHS Standard Contract for 2015-16 and the contract requires providers to appoint a Prevent Lead.

The Executive Prevent Lead for STHFT is the Chief Nurse and the Lead Nurse for Safeguarding Adults is the Prevent operational link for STHFT and represents the Trust at the city wide and regional Prevent meetings.

The contract also requires providers of healthcare to include in its policies and procedures a programme to deliver WRAP, (Workshops to Raise Awareness of Prevent), fully resourced with accredited trainers.

A Prevent Training and Competencies Framework (NHS England 2015) has been developed in order to ensure a consistent approach to training and provide parity between the expectations to safeguard both children and adults with care and support needs. The Trust has a small number of accredited Prevent WRAP trainers for the Trust who deliver the WRAP training to targeted staff groups.

Training figures are required to be forwarded to the Regional Prevent Lead on a quarterly basis for submission to the Department of Health and are also shared with the Clinical Commissioning Group (CCG). The CCG also requires provider organisations to provide assurances in relation to their Prevent responsibilities via the Safeguarding Annual Assurance Self-assessment Tool.

16.2 CHANNEL

Sections 36 to 41of the CT&S Act 2015 sets out the duty on local authorities and partners of local safeguarding panels, to provide support for people vulnerable to being drawn into terrorism. In England and Wales this duty is the CHANNEL programme.

The CHANNEL programme focuses on providing early intervention and support to people who are identified as being vulnerable to being drawn into any form of terrorism. The programme uses a multi-agency approach to protect vulnerable people by:
a. identifying individuals at risk;
b. assessing the nature and extent of that risk; and
c. developing the most appropriate support plan for the individuals concerned.

CHANNEL is about ensuring that vulnerable children, young people and adults of any faith, ethnicity or background receive support before their vulnerabilities are exploited by those that would want them to embrace terrorism, and before they become involved in criminal terrorist related activity (pre criminal space).

16.3 CHANNEL Panel

Section 37(5) of the CT&S Act 2015 requires multi agency CHANNEL panels to be convened and chaired by the responsible local authority. Members of the panel must include the police for the relevant local authority area, and may also include representatives from other agencies including the NHS and Social workers.

Whilst the CHANNEL provisions in Chapter 2 of Part 5 of the CT&S Act 2015 are counter-terrorism measures, it is imperative that CHANNEL referrals are considered by the local authority and panel partners alongside their work to safeguard vulnerable children, young people and adults and to protect them from harm. Key links should be established with social services and other panel partners to ensure that an individual receives the most appropriate support available.

In Sheffield the CHANNEL Panel meetings are held following the end of the Vulnerable Adults Panel. STHFT is represented on the Sheffield CHANNEL Panel by the Lead Nurse for Adult Safeguarding.

16.4 Gold and Silver Meetings

Prevent Gold strategic meetings and Prevent Silver operational meetings have been established in Sheffield. The Lead Nurse for Safeguarding Adults represents STHFT at the Silver meetings.

Key achievements 2016-2017

- 148 staff have undergone the WRAP training during 2016-2017 (426 staff in total have received WRAP).
- Basic Prevent awareness is included in the Safeguarding presentation to new starters to the Trust at corporate induction and at Trust mandatory training.
- The Safeguarding Practice Development Adviser and the Safeguarding Adults Adviser attended the WRAP version 3 training for trainers and are accredited by the Home Office to provide the WRAP 3.
- Targeted staff groups have received WRAP training to date i.e. ED, Human Resources, Medical Personnel, Community Dental Services, some community nursing teams and Chaplains.

Key priorities for 2017-2018

- To agree and execute a Prevent WRAP delivery plan for the Trust
- To increase the number of accredited WRAP 3 trainers by training Clinical Educators.
- To increase the number of staff who have attended the WRAP 3 training in line with the Prevent Duty.
- To develop further resources to support awareness of how to recognise individuals at risk of radicalisation and counterterrorism initiatives.
- To ensure 100% attendance at the CHANNEL Panel as appropriate
- To ensure 100% attendance at the Prevent SILVER meeting.

17.0 LEARNING DISABILITIES

People with learning disabilities often face significant disadvantages in terms of their health and wellbeing. These can include shorter than average life expectancy, higher rates of avoidable or preventable ill health, unequal access to or low uptake of services and poorer outcomes in relation to the wider determinants of health and wellbeing such as employment or independent living. (Department of Health, 2013a).The Sheffield Joint Strategic Needs Assessment (2016) states that there is local evidence to show disproportionate prevalence and poorer outcomes from preventable and case sensitive long term conditions with people with learning disabilities, further work on health action plans is taking place to address this, primarily exploring why many people with learning disability may not attend health screening at the general Practice.

17.1 Data

The Learning Disabilities Observatory 2015 (2016) highlight that there is no definitive record of the number of people with learning disabilities in England as no government department collects comprehensive information on the presence of learning disabilities in the population and it is not

recorded in the decennial census of the United Kingdom population. Therefore the data depends on combining information collected by government departments on the presence of learning disabilities among people using particular services, overall predictions for England and the results of epidemiological research.

The Learning Observatory 2015 (2016) estimates that in 2015, 2.16% of the English adult population have a learning disability. However there are many people who are not known to or do not use specialist services who may have a 'learning disability'.

STHFT use the Sheffield Case Register –a voluntary register held by Sheffield Health and Social Care Trust of people with learning disabilities (all ages) who meet a minimum set of criteria- to gather information about which services adults with a learning disability use. This information is downloaded into the Trust patient administration system, Lorenzo and therefore once the details of a person with learning disability are entered, an alert highlights that the person has a learning disability.

In April 2016 there were 3910 patients who have a learning disability alert in our system, this has increased to 4,074 in April 2017.

From these data we can monitor attendances at STH and the alert allows us to identify patients with a learning disability and therefore we can make reasonable adjustments where appropriate.

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 2017.

Table 9 - Adults with learning disabilities who have accessed STHFT during the period April 2010 – March 2017

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/2017
In-patient admissions	**1205**	**614**	**867**	**940**	**930**	**1079**	**1219**
Individual patient /number who have been admitted	**437**	**470**	**617**	**693**	**703**	**757**	**827**
Out-patient attendances	**1419**	**3587**	**5194**	**5324**	**5562**	**5738**	**6400**
Individual patient /number who attended outpatient	**900**	**1931**	**2365**	**2598**	**2727**	**2768**	**3011**

Consistent with previous years, specialities that have a significant number of adults with learning disabilities attending outpatients are diabetes, audiology medicine, ED -where there has been a significant increase in attendances, ENT although attendances are lower this year, hearing services, neurology, ophthalmology and orthopaedics.

There has also been a significant rise in attendances to Cardiology and Neurology clinics.

Table 10 – Services that have shown a significant change in the number of admissions of Adults with a learning disability during April 2016-March 2017.

Clinical Services	2015-2016		2016-2017		
	Number of admissions	Patient count	Number of admissions	Patient count	Trend
Care of the elderly	16	15	35	28	↑
Chest medicine	85	60	137	80	↑
Infectious Diseases	20	12	45	23	↑
Oral Surgery	44	44	62	61	↑
Urology	81	38	56	31	↓

Specialities which continue to have a significant number of admissions of adults with learning disabilities during the last year are general medicine (this includes diabetes and endocrinology), gastroenterology and chest medicine (this includes Cystic Fibrosis Unit, Respiratory Care and PPH).

Overall, there has been a rise in in-patient admissions along with an increased level of attendances in outpatient services. This is in keeping with the increased prevalence of people with learning disabilities who live in Sheffield.

Over the past year, there has been a significant increase in the number of attendances by adults with learning disabilities at the Emergency Department at STHFT. The following table details this increase.

Table 11 - Adults with learning disabilities that have accessed STHFT Emergency Department during the period April 2014 – March 2017

	2014/2015	2015/2016	2016/2017
A&E Attendances	**766**	**1199**	**1251**

Over the last few years, we have had people with learning disability who have visited the department frequently, in 2014-2015 we had 3 adults who visited the department on 15 occasions each, the data we had for 2015 -2016 showed that we have had 4 adults with learning disability attending on more than 15 occasions. There has been an improvement in this data with only one patient attending the department more than 15 times, this person visited the department on 23 occasions, and this patient was the highest attender in 2015/16 too with 28 visits.

This information, including names of individuals is shared with the ED for them to explore further, the Clinical Director reviews all regular attenders and formulates plans of care, including liaising with GPs and other services.

According to the Learning Disabilities Observatory (2016) expenditure on residential care, home care, other long term community support, and to a lesser extent nursing care, was recorded as lower in 2014/15 then 2013/14, however supported accommodation was slightly higher. This may be a factor which has impacted on the changes to admissions and attendances.

It has also been suggested that a number of these people visiting hospital are also requiring mental health input which has not always been available, it is hoped that the service we can provide to

these people will improve and frequent attenders will be reduced due to the impact of the mental health liaison nurses providing more input in and out of hours in ED.

In 2016 to 2017, we have had 60 adults attending the ED on five or more occasions.

Table 12 - Adults with a learning disability who have accessed STHFT Emergency Department during the period April 2013 - March 2017 on 5 or more occasions

	2013/2014	2014/2015	2015/2016	2016/2017
Number of Patients who have Attended ED on 5 or more occasions	**44**	**48**	**64**	**60**

Updates 2016-2017

Offering Opportunities

In last year's report we highlighted plans to work with Mencap representatives to organise a partnership project with them, offering opportunities for their members to learn about being a hospital volunteer. Unfortunately this was not progressed and now Mecap are prioritising a project across the city region called "Building Better Opportunities – Sheffield City Region" (BBO SCR). BBO SCR is an integrated, person-centred employment service for people with physical and mental health conditions, learning disabilities and complex needs. It is based on Individual Placement Support, a "place then train" approach that is shown to be twice as effective as traditional approaches. Mencap and Gateway have focused on this activity rather than volunteer opportunities for its members.

However the Trust remains committed to supporting adults with learning disabilities to become volunteers and although we currently do not have any volunteers with a learning disability, we will continue to explore opportunities with Mencap and Gateway members to become Hospital Volunteers in the future. For example there are plans to recruit volunteers to work on the Clothing for Patients Scheme, this is a scheme whereby clothes are given to the Trust and then provided to patients who have none, to enable them to be discharged in clothing rather than pyjamas thus supporting a person's dignity. We have agreed to meet again in the Autumn when Mencap and Gateway feel they will have more capacity to engage with this initiative.

In addition we feel it would also be important and may be more appropriate for the Trust to link into Building Better Opportunities directly and explore what STHFT can offer in both work and volunteer based placements.

Accessible Information Standard

The Accessible Information Standard (AIS) was mandated in July 2015 and as such Trusts were expected to abide by the new standard in full by July 2016.

All organisations that provide NHS or adult social care are required to follow the new standard, including NHS Trusts and Foundation Trusts and GP practices. As part of the accessible information standard, organisations must do four things:

- Ask people if they have any information or communication needs and find out how to meet their needs. Record those needs clearly and in a set way.
- Highlight or 'flag' the person's file or notes so it is clear that they have information or communication needs and how those needs should be met.

- Share information about people's information and communication needs with other providers of NHS and adult social care, when they have consent or permission to do so.
- Take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it.

This Trust is now making some progress with regards to this process, including providing relevant training and engagement with patients with communication difficulties.

Process: the functionality of Lorenzo has now been adapted to enable the process of recording and flagging the relevant communication need(s) and we are hopeful that this will ensure that patients receive the most appropriate information at every point that they are in contact or in receipt of treatment from the Trust. The Lorenzo Team have produced a user guide for this function which is currently being tested to ensure it meets the requirements of the AIS. It is envisaged that this will fully meet all of the indicators within the standard for recording and alerts.

Training: a blended learning package is currently being developed that incorporates the national e-Learning modules for the AIS, Lorenzo/clinical systems training and face to face training to discuss the specifics surrounding sensory disability and learning disability/Autism/Mental Health and the impact this has upon the ability to communicate.

In addition individuals can identify their own training needs in relation to AIS, by providing Clinical Systems (Lorenzo), Disability and Communication Awareness as standalone subjects and then creating an intervention that meets their needs and enables them to be compliant to the requirements of the AIS. It is hoped that this will be fully available by the end of the year.

17.2 Learning Disability Mortality Review (LeDeR) (2016-2017)

Since the 1990s there have been a number of reports and case studies that have consistently highlighted that in England, people with learning disabilities die younger than people without learning disabilities.

Recent calculations by Public Health England, using data drawn from the Clinical Practice Research Database, indicate that more than three times the number of people with learning disabilities in England die each year than would be expected from general population mortality rates after allowing for their age and gender profile. (Glover et al. 2016). A large proportion of such deaths are considered to be avoidable through the provision of good quality health and social care.

In November 2016 the Learning Disabilities Mortality Review (LeDeR) was launched with the overall aim to drive improvement in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities in this population.

It aims do this primarily by supporting local agencies to conduct reviews of the deaths of people with learning disabilities and to take account of the learning that comes from these reviews in order to improve their service provision. It will also contribute to national and international evidence about mortality in people with learning disabilities.

Other objectives of the LeDeR programme are:

- To influence practice change at individual, professional, clinician and allied health professional levels, such that it will contribute to improving service provision for people with learning disabilities and their families.

- To influence change in policy and service provision at national level with Government, NHS England, Public Health England and the Local Government Association, such that it will contribute to improving service provision for people with learning disabilities and their families.

- To support commissioning and service redesign by helping commissioners understand opportunities to improve service delivery, reduce variation and learn from best practice.

- To encourage a move towards equality of treatment and parity of esteem for people with learning disabilities and help tackle the systemic contributors to the health and access inequalities they face.

The LeDeR Programme will support reviews of deaths of people with learning disabilities aged 4 upwards who are registered with a GP in England at the time of their death.

There have been concerns raised locally about professionals' capacity to undertake reviews of deaths; currently Sheffield has 8 trained reviewers. The local Area contact has stated that Sheffield will be taking a proportionate approach to the reviews, with each death receiving an initial review and only those meeting the required threshold receiving a full multi-agency review.

Public Health England have calculated the expected number of deaths in each region, taking into account as far as possible, the age/sex population data for each region, and data about people with learning disabilities on GP Quality and Outcomes Framework (QOF) registers, and national age/sex specific death rates for people with learning disabilities from the Clinical Practice Research Database and this was approximated at 2,300 in England

The Sheffield Case Register data from 1975 to 2016 shows a collective death total of 1702, an average of 42 deaths per year. From commencement of the LeDeR Programme on 1 November 2016 to 18 April 2017 there have been 31 death notifications.

Within STHFT the process adopted has been that the Medical Examiner's Office and the Nurse Director Lead for Learning Disabilities are sending an initial review of the death to the LeDeR Programme of anyone who they believe has a learning disability according to the programmes criteria, is flagged on Lorenzo as having a learning disability (determined by being on Sheffield case register) or has 'learning disability' documented in the notes.

Since November Sheffield Teaching Hospital has notified the programme of 18 deaths that have been identified through Lorenzo, but also other deaths that the Medical Examiner has determined appropriate to be referred to the programme.

The eligibility of referrals will be reviewed by the Local Area Contact.

The Governance of our process is through the Trust Mortality & Morbidity Steering Group.

Key Achievements 2016-2017

<u>Patient Feedback</u>

The following three quotes relate to feedback received from the Trust regarding the care of people with a learning disability at the Trust:

"We support a man, who has a severe learning disability and Autism, he attended theatre admissions, prior to that great detail had been put in to his support plan, to support him and adapt to his complex support needs, My own career supporting people with learning disabilities spans many years and I have frequently supported people with learning disabilities to be admitted to hospital, this experience so recently has been the most positive by far, everything that could be done to support him has been adapted, changed to whatever has been required, communication has been clear and precise and given with kindness and respect, his dignity has been maintained at all times"

'As an adult who has Asperger syndrome they could not have done enough for me, you have all been kind, supportive and understanding, for this thank you very much'.

" Two members of staff in particular deserve specific mention due to their kindness and patience with the patient's autism and subsequent difficulties in handling the experience of a busy, full ward of sick people, quite apart from the professionalism demonstrated in treating someone who was quite

beside herself with pain and fear for her own health. The staff in question went above and beyond the call of duty in the small hours of the morning to ensure that this lady with learning disabilities and complex needs was as comfortable as possible and understood fully what was going on in terms of her treatment, especially during periods when we were waiting for further assessment."

In regard to the complaints that have been received last year there have been 19 identified (four from the same family) from patients/carers with a learning disability. The data does have to be treated with some caution as not everyone will disclose that they have a disability and also although there is a field to record this on datix this is not routinely completed. Complaints co-ordinators have been reminded about the importance of completing this field. There will also a number of complaints/concerns raised that will have been resolved informally.

The themes were:

- 4 related to transition and the Trust acknowledges that there is a piece of work to do to improve the transition of patient's from Children's services to adult services
- 8 had elements regarding care and the appropriateness of the care
- 2 were around carers and how they were supported on the wards and during treatment
- All complaints had concerns about communication and some had issues with reasonable adjustment.

Carers

Sheffield City Council, in collaboration with their partners, has developed a Carers Strategy for the city. The Trust are required to respond to this by developing an action plan, to support this Carers Strategy. A steering group had been established, involving carers, to identify the actions which needed to be taken within the Trust. In order to take the actions forward, representatives from all the care groups across the Trust had been invited to attend the working group.

Carers Strategy Principles

- Access at the right time to the right type of information and advice for them, their family and the person they care for
- Understand their rights and have access to an assessment
- Have a voice for themselves and the person they care for
- Have regular and sufficient breaks
- Continue to learn and develop, train or work (if they wish to)
- Look after their own health

This is very important for carers of adults with learning disability as it has been stated by the Learning Disability Observatory (2016) that overall family carers of adults with learning disability reported lower levels of satisfaction with the support received than other family carers.

The actions that the Carers Steering Group are supporting include:

- Carer's survey; this has commenced and will be undertaken for a year, the feedback will be reported throughout the year to the steering group to influence ongoing actions.
- Guidelines for staff
- Lanyard Project; a process for identifying carers
- Review the 'All about me' booklet
- Involvement with Carers Week, this included extended visiting times and information stalls
- Close partnership working with the Carers Centre, Sheffield Young Carers

17.3 Sheffield Mental Health & Learning Disability Delivery Board

Sheffield has agreed the establishment of the Transformation Programme Board under which Delivery Boards will operate. The Trust is a member of the Sheffield Mental Health & Learning

Disability Delivery Board, which may fall under the remit of Accountable Care Partnership in the future.

The Transformation Board will consider whole system problems and will discuss these openly and without regard to organisational boundaries. These open discussions will be about the rigorous delivery and the implementation of agreed transformational initiatives. There are likely to be 4 to 6 initiatives that will be delegated to the Delivery Board to oversee and ensure completion within a given time-scale (likely to be a commissioning & financial cycle of one year.)
The Delivery Boards will:

- Provide clinical and professional leadership across all involved organisations
- Develop credible and jointly agreed plans covering the projects/programmes of work agreed by the Transformation Board
- Be a place for robust and open discussion around the joint delivery of the agreed initiatives
- Apply a standardised approach to problem solving
- Produce and submit highlight & exception reports to the Transformation Programme Board

Key Priorities 2016-2017

Delivering high quality end of life care

Health inequalities for people with a learning disability also extend into palliative and end of life care. In May 2016 the Care Quality Commission (CQC) published a thematic review into inequalities in end of life care. The review identified that 'people from certain groups in society sometimes experience poorer quality care at the end of their lives because providers do not always understand or fully consider their needs'. It identified people who have a learning disability as one such group. The Confidential Inquiry into Premature Deaths of People with a Learning Disability (CIPOLD) (Department of Health, 2013) found that for many people with a learning disability, who were dying, end of life care was not coordinated and the support for the person and their families could have been improved. It also identified that people with a learning disability were less likely to have access to specialist palliative care services and opioid analgesia than a comparison group of people without a learning disability.

Other research carried out by the NHS National End of Life care programme (2011) has suggested that hospice, palliative care and end of life care professionals report limited contact with people with learning disabilities and lack confidence in working with this group and understanding their needs.

As a consequence of these inequalities a 'top tips' guidance has been developed by NHS England in association with the Palliative care For People with Learning Disabilities Network. This guide aims to support clinicians to reduce inequalities focusing on 'The Ambitions for Palliative and End of Life Care' (2015).

Progress on this will be monitored through the 'End of Life Care Group' which is looking at improving the end of life care that patients receive in the Trust.

Individualised care

People with learning disabilities use our services for a wide range of physical conditions. Care of people with learning disabilities who are admitted to hospital or community services may be complicated in many ways. They may have limited mental capacity to understand what is happening around them or why. They may be confused or frightened by unfamiliar surroundings, or simply not understand what they are being asked to do. Staff may not always recognise that people have learning disabilities and therefore are not good at judging the extent to which patients understand information and may mistake incomprehension for a lack of cooperation. There may be uncertainty of capacity and a lack of understanding of the legal requirements for proxy decision making if they cannot make their own decisions.

We are addressing these issues through a series of discrete projects and through the Learning

Disability Link Network and Matrons. Specific examples include improvements in care planning through the Trust Care Planning Project, the use of the hospital passport to aid communication, and greater involvement of carers through the work of the Trust's Carers Working Party.

17.4 Compliance Framework- Governance Indicators

Up until the end of March 2016, the Trust had been required to report against the Monitor Compliance Framework, which identified six criteria for meeting the needs of people with a learning disability based on recommendations set out in Health Care for All (Michael, 2008).

However from April 2016, Monitor became part of NHS Improvement (NHSI) and the Learning Disability Governance indicators were not included in the 'Single Oversight framework'. We have recently been informed that there will be new NHSI provider service improvements standards published in Autumn for organisations that provide care to people with learning disabilities as part of this framework. These will cover 4 standards with 16 underpinning deliverables.

The standards will cover:

- Workforce
- Reasonable Adjustments to access services
- Improve inclusion and engagement
- Specialist LD Provider performance improvement

Clearly, the first three will apply to the Trust, whilst the last one will mainly apply to SHSC and SCH.

18.0 CONCLUSION

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

The MCA Specialist Adviser has provided valuable training to increase staff skills and knowledge with regard to MCA/DOLS and best interest decision making.

The work of the STHFT Adult Safeguarding team continues to grow with significant work streams having been added in the last three years, specifically relating to the PREVENT agenda, Modern Slavery and Human Trafficking, and FGM data collection.

There are further challenges with regard to implementing the Prevent Duty 2015.

The Care Act – duty to carry out enquiries has had a significant impact on the workload of the Safeguarding Team and it is anticipated that this will continue to be a core part of the safeguarding team's routine business

This report has detailed the data collected and the main areas of activity and achievement during 2016-2017 and has summarised the key priorities for 2017-2018.

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

19.0 REFERENCES

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.

BOURNEMOUTH UNIVERSITY AND LEARN TO CARE (2010) *National Competence Framework for Safeguarding Adults.*
http://www.scie.org.uk/publications/guides/guide45/files/Bournemouth.pdf

Care Act 2014 (c.14) – London. The Stationery Office.
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

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

Care Quality Commission (2016). Sheffield Teaching Hospital NHS Foundation Trust Quality Report.
http://www.cqc.org.uk/provider/RHQ

CARE QUALITY COMMISSION (2016) 'A different ending Addressing inequalities in end of life care (www.cqc. org.uk/sites/default/files/20160505%20CQC_EOLC_OVERVIEW_FINAL_3.pdf)
Care Quality Commission, A different ending, our review looking at end of life care (2016) (www.cqc.org. uk/news/stories/different-ending-our-review-looking-end-life-care-published)

Counter-Terrorism and Security Act 2015 – London.The Stationery Office.
www.legislation.gov.uk/ukpga/2015/6/contents/enacted

Criminal Justice Act 2003 – London. The Stationary Office.
http://www.legislation.gov.uk/ukpga/2003/44/contents

CQC NHS Acute Hospitals: Provider Handbook, Revised March 2015.

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 (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 2014/2015. www.gov.uk/dh

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

DEPARTMENT OF HEALTH (2014) Care and Support Statutory Guidance.https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf

DEPARTMENT OF HEALTH (2015) Identifying and supporting victims of modern slavery Guidance for health staff
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/480631/slavery_guidance.pdf

Domestic Abuse, Stalking, Harassment and Honour Based Violence (DASH) Risk Assessment
http://nww.sth.nhs.uk/STHcontDocs/STH_CGP/SafeguardingPatients/DASHandMARACreferralForm.docx

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
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

EMMERSON E.. Health status and health risks of 'hidden majority' of adults with intellectual disability. Intellectual & Developmental Disabilities. 2011: 49:155-65.

Female Genital Mutilation Act 2003
http://www.legislation.gov.uk/ukpga/2003/31/contents

FLYNN M (2012) *Serious Case Review* (Winterbourne View)
http://www.southglos.gov.uk/news/serious-case-review-winterbourne-view/

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

HEALTH AND SOCIAL CARE INFORMATION CENTRE (HSCIC) 2014 *Female Genital Mutilation (FGM)* September 2014, experimental statistics
www.hscic.gov.uk
enquiries@hscic.gov.uk

HEALTH AND SOCIAL CARE INFORMATION CENTRE (HSCIC) 2014 Female Genital Mutilation Datasets October 2014
http://www.hscic.gov.uk/fgm

HESLOP, P et al (2013). *Confidential Inquiry into Premature Deaths of People with Learning Disabilities*. (CIPOLD). Learning Disability Observatory. Norah Fry Research Centre.
http://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf

HM GOVERNMENT (2015) Channel Guidance: Protecting vulnerable people from being drawn into terrorism. Statutory guidance for Channel panel members and partners of local panels
https://www.gov.uk/government/publications/channel-guidance

HM GOVERNMENT (2015) Revised Prevent Duty Guidance: for England and Wales. Guidance for specified authorities in England and Wales on the duty in the Counter-Terrorism and Security Act 2015 to have due regard to the need to prevent people from being drawn into terrorism. Updated March 2016
https://www.gov.uk/government/publications/prevent-duty-guidance

HM GOVERNMENT (2011a) *CONTEST: The United Kingdom's strategy for countering terrorism*. Counter –terrorism strategy (CONTEST) – Publications – GOV.UK
https://www.gov.uk/government/collections/contest

HM GOVERNMENT (2011b) *Prevent Strategy*
https://www.gov.uk/government/publications/prevent-strategy-2011

HOME OFFICE (2014) Modern Slavery Strategy
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/383764/Modern_Slavery_Strategy_FINAL_DEC2015.pdf

HOME OFFICE (2016) *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

HOME OFFICE, (2016*) Multi- agency Statutory Guidance on Female Genital Mutilation.*
https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation

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

JAY, A (OBE)(2014) *Independent Enquiry into Child Sexual Exploitation in Rotherham 1997-2013*. Rotherham Council.
http://www.rotherham.gov.uk/downloads/file/1407/independent_inquiry_cse_in_rotherham

LAMPARD, K, MARSDEN, E. (2015) *Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile* . Department of Health.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/407209/KL_lessons_learned_report_FINAL.pdf

LEARNING DISABILITIES OBSERVATORY. (2016) People with learning disabilities in England 2015: Main Report http://www.improvinghealthandlives.org.uk/publications/313925/PeoplewithLearningDisabilitiesinEngland_2015

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

Mental Capacity Act Code of Practice 2007 London. The Stationery Office
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

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

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

Modern Slavery Act 2015
http://www.legislation.gov.uk/ukpga/2015/30/contents/enacted

National Crime Agency (2014) NCA Strategic Assessment. The Nature and Scale of Human Trafficking in 2014.
http://www.nationalcrimeagency.gov.uk/publications/656-nca-strategic-assessment-the-nature-and-scale-of-human-trafficking-in-2014/file

NHS England (2014*) Mental Capacity Act 2005 'A guide for Clinical Commissioning Groups (CCGs) and other commissioners of healthcare services on commissioning for compliance'.* (April 2014)
http://www.england.nhs.uk/wp-content/uploads/2014/09/guide-for-clinical-commissioning.pdf

NHS England (2015) *Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document. NHS England - V1 DRAFT December 2015*

NHS England (2015) A*ccessible.Information.Standard*. www.england.nhs.uk/accessibleinfo

NHS England (2015)– *Prevent Training and Competencies Framework (Feb* 2015) Updated November 2016
http://www.lewishamccg.nhs.uk/news-publications/Policies/Documents/Prevent%20training%20and%20competencies%20framework.pdf

NHSImprovement.(2016) Single Oversight Framework Consultation.
https://improvement.nhs.uk/resources/have-your-say-single-oversight-framework-consultation/

NHS NATIONAL END OF LIFE PROGRAMME (2011) The route to success in end of life care – achieving quality for people with learning disabilities (http://webarchive.nationalarchives.gov.uk/20130718121912/http:/www.endoflifecare.nhs.uk/search-resources/resources-search/publications/imported-publications/the-route-tosuccess-in-end-of-life-care-achieving-quality-for-people-with-learning-disabilities.aspx)

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

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

SHEFFIELD JOINT STRATEGIC NEEDS ASSESSMENT (2016). https://www.sheffield.gov.uk/content/dam/sheffield/docs/social-care/social-care-policies-and-plans/JSNA%202013%20Report.pdf

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

SHEFFIELD CITY COUNCIL AND NHS SHEFFIELD (2015).*Prevention and Management of the use of Restraint. Framework for Good Practice.* https://shsc.nhs.uk/wp-content/uploads/2016/07/Prevention-and-Management-of-the-use-of-Restraint-Framework-for-Good-Practice-Sheffield-Adult-Safeguarding-Board.pdf

SKILLS FOR HEALTH (2014) *UK Core Skills Training Framework . Subject Guide Version 1.2 (September 2014). Subject 9: Safeguarding Adults* *http://www.skillsforhealth.org.uk/services/item/146-core-skills-training-framework*

SOUTH YORKSHIRE SAFEGUARDING ADULTS BOARD (2015) . *South Yorkshire's Adult Protection Procedures Safeguarding Adults.* http://www.proceduresonline.com/southyorks/sab/

THE AMBITIONS FOR PALLIATIVE AND END OF LIFE CARE (2015) http:endoflifecareambitions.org.uk/wp-content/uploads/2015/09/ambitions-for-Palliative-and-End-of-life-Care. pdf

20.0 Appendix 1

Progress against Priorities for Adult Safeguarding 2016-17			
Section from Annual Report	**Key priorities**	**Comments**	**Progress (RAG)**
Strategic Context **2.6 -** Safeguarding Adults Board	1. To support STHFT staff to become familiar with the Care Act 2014 and to adopt and use the updated South Yorkshire Safeguarding Adults Procedures. 2. To provide Care Act and Safeguarding Adults updates in all Safeguarding Adults training and at Safeguarding Leads Meetings and Safeguarding Mandatory Updates.	The Flowchart to support staff to make a referral to adult safeguarding procedures was updated to reflect the requirements of the update South Yorkshire Safeguarding Adults Procedures All safeguarding adults mandatory training is Care Act compliant and regularly reviewed to include updates as required. Updates are shared at the STHFT Safeguarding Leads meeting for further dissemination across the Trust.	GREEN
Policy and Procedures **3.1 –** South Yorkshire Safeguarding Adults Procedures	1. To undertake an audit of the quality of the safeguarding adults concerns 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. 2. To audit the origin of safeguarding concerns generated within STHFT to identify areas that may be under reporting safeguarding concerns. 3. To identify whether as a result of these audits further training is required.	1. This action has not been completed and will be added to the work plan for Safeguarding Adults for 2017-18. 2. This action has been commenced and results are to be shared at the quarterly Safeguarding Leads meetings 3. Further training will be targeted to areas identified as under reporting safeguarding concerns.	AMBER
Safeguarding Adults Structures and Processes **4.1 –** Safeguarding Adult External	1. To continue to ensure 100% attendance by STHFT at Sheffield Adult Safeguarding Partnership (SASP) and associated meetings 2. To contribute to the implementation of the Sheffield Adult Safeguarding Partnership Business Plan and Strategy for 2016-17, supporting the implementation of actions towards the agreed outcomes.	1. 100% attendance at SASP Executive and Operational Board meetings 2. STHFT contributed to the consultation and agreement to the SASP Business Plan and Strategy as requested.	GREEN

Governance Arrangements **5.1 –** Internal	Two medium risk actions were noted in relation to the internal Safeguarding Adults Audit 1. The need to develop ways of working that take a whole systems approach to safeguarding and allow the Trust to respond to key risks and responsibilities that are shared across both the adult and child safeguarding agendas. 2. Development of the governance framework to ensure the Healthcare Governance Committee receives formal and timely assurance on adult safeguarding activity. At present there is an operational forum for safeguarding without clear lines of reporting and accountability.	1. The Deputy Chief Nurse, Lead Nurse for Safeguarding Adults and Lead Nurse for Children and Young People met to delegate roles and responsibilities and to agree on shared objectives. 2. Safeguarding Adults has a clear Governance framework and evidence of compliance with requests for assurance and performance measures. The Safeguarding Leads meeting was reviewed in 2016 and is now a joint adults and children meeting Chaired by the Deputy Chief Nurse. The terms of reference and membership were refreshed. Formal minutes are agreed and disseminated amongst the Safeguarding Leads. Actions identified are reported on monitored via the Safeguarding Leads meeting.	GREEN
5.2 – Survey Monkey Audit of Safeguarding Adults Awareness	1. Safeguarding Leads will receive specific training and support for their role. 2. There is clearly a need to address the knowledge gap for those staff who have not had a Safeguarding Adults update within the last three years. 3. Further work needs to be done to identify leads within each directorate or speciality to ensure that staff have a local contact person to approach for safeguarding advice and support.	1. Safeguarding Leads are provided with information and support via the Safeguarding Leads meeting and through attending training for safeguarding and MCA/DOLS related topics. 2. PALMS data assists with identifying compliance with mandatory training. The STHFT Safeguarding team have provided face to face updates at Trust Central Mandatory safeguarding updates 3. Safeguarding Leads have been identified for all care groups and an updated list is available on the Safeguarding Patients Intranet site.	GREEN
5.3 – Safeguarding Leads Meeting	1. 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.	1. Internal and external safeguarding information and plans have been discussed and shared at the Safeguarding Leads meetings held in 2016-17	GREEN

5.4 – External	1. To ensure that requests for evidence of assurance from commissioners and quality monitoring organisations are completed within the specified timescales. 2. Prevent training and awareness will be addressed via a Training Needs Analysis (TNA) and delivery strategy in collaboration with the Learning and Development Department to achieve compliance with the Prevent Duty	1. All requests for evidence of assurance have been submitted to the agreed timescales. 2. Prevent Training has been delivered as per the existing training plan and in line with the Safeguarding Adults TNA Further work is being undertaken in 2017-18 to further develop and update the Prevent TNA and Trust wide training strategy.	AMBER
5.5 – Learning Disability External	1. Further work on the use of the Mental Capacity Act and Best Interest Decision Making for patients with a Learning Disability 2. Review of the use of the Hospital Passport	1. The MCA Specialist Adviser has produced and updated MCA / Best Interest checklists and guidance documents. The MCA Specialist Adviser has worked with individual practitioners and departments to support the care of patients with a learning disability who lack capacity to make their own decisions. 2. The review of the Hospital Passport was a request from the Learning Disability Customer Forum however the Hospital Passport is a MENCAP document therefore has not been reviewed. The use of the Hospital Passport is encouraged and staff are advised to refer to it when providing care to patients with a learning disability. The document can be accessed via the Learning Disability intranet site.	GREEN
Multi Agency Working and responding to concerns **6.1 –** Contracts with STHFT Safeguarding Adults Team for advice and support	1. To continue to respond to requests for advice in a timely manner to ensure adults at risk are kept safe and staff are supported to manage complex cases.	The Adult Safeguarding Team has continued to offer advice and support to STH staff, acute and community, and to requests from external agencies. The team has responded to requests for information to contribute to safeguarding enquiries attending planning and outcomes meetings and producing written reports as required	GREEN

6.2 – Incidents/ Safeguarding concerns raised and referred to Social Care	1. To increase the number of concerns reported, taking the opportunity to highlight via the Safeguarding Leads meeting, situations where appropriate concerns may be being missed. 2. To gather data on safeguarding alerts from similar sized organisations to STHFT in order to benchmark STHFT performance against peer Trusts. This has been difficult to achieve in 2015-16 due to lack of responses from Safeguarding leads in other Trusts.	1. This piece of work has been developed for reporting to the Safeguarding Leads meetings from 2017-18. 2. Engagement from other organisations has been difficult to achieve due to the diversity of services therefore this has not been completed. Following further discussion, it has been concluded that this would not provide an accurate benchmark due to the differences in the demographic make- up of the populations that individual Trusts provide services to.	AMBER
6.3 – Safeguarding Enquiries (investigations)	1. To respond to requests for safeguarding enquiries and DHR IMRs in a timely manner. 2. The Safeguarding Adults Practice Development Facilitator and the Safeguarding Adults Adviser will be required to attend IMR author training as this becomes available.	1. The safeguarding team has responded to requests for information to contribute to safeguarding enquiry, attending planning and outcomes meetings and producing written reports as required. IMRs were written in response to a DHR and a SAR. 2. The Practice Development Facilitator and the Safeguarding Adults Adviser have both attended IMR author training.	GREEN
Mental Capacity and DOLs **7.5 –** Restraints	1. To implement the Framework for Restrictive Practices across STHFT.	1. The city wide Framework for Restrictive Practices was launched in February 2017 and was discussed and circulated to attendees of the Dementia Care Group on 10.02.2017. This document is available on the STHFT Intranet and will be referenced in the updated STHFT Policy for the Management of Patients whose Behaviour Challenges the Service (Adults) and in the MCA Policy.	GREEN
7.6 – MCA/DOLs Training	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 train and support staff to apply the principles of the Mental Capacity Act and Deprivation of Liberty safeguards in day to day practice. 3. To develop an MCA/DOLS Training Needs Analysis and training	1. An audit of MCA assessments was undertaken from Jan – March 2017 with support from the Clinical Effectiveness Dept. The results have been circulated to the Safeguarding Leads and will be shared at the Safeguarding Leads meeting and with the Medical Director as Chair of the Mental Health Committee. 2. A rolling programme of training on; MCA,	GREEN

	strategy in collaboration with the Learning and Development department.	mental capacity assessment and best interest decision making and Deprivation of Liberty Safeguards has been on- going since September 2012 3. A Job –Specific Essential TNA for Mental Capacity and DoLs, Mental Health Act and Restrictive Practice and Intervention was published in July 2016.	
Domestic Abuse **8.7 –** Multi Agency Risk Assessment Conference (MARAC)	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 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 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. 7. To develop a domestic abuse Policy and guidance to support the management of staff victims of Domestic Violence and abuse.	1. 100% Attendance at MARAC and completion of actions for STHFT. 2. 100% attendance at the Domestic Abuse Strategic Board. 3. 100% attendance at the Domestic Homicide Review Sub Group. 4. 100%attendance at the Domestic Abuse Provider Consultation Group. 5. Work has been undertaken with HR to develop a policy to support staff who are victims of Domestic Abuse 6. Learning Briefs are circulated to staff via the Safeguarding Leads meetings. Anonymised high risk domestic abuse case studies are discussed during safeguarding children and adults safeguarding training. 7. A Policy to support staff members who are victims of domestic abuse has been produced and agreed and will be available on the Intranet once ratified.	GREEN

Domestic Homicide Review **9.1 –** STHFT Involvement in the DHR Process	1. To ensure the IMRs for future DHRs are submitted in accordance with the Terms of Reference. 2. To ensure attendance at the Domestic Homicide and Serious Incident Review Subgroup 3. 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. 4. To ensure recommendations are implemented and progress reported via the DACT.	1. An IMR for Adult JS was submitted in January 2017 in accordance with the Terms of Reference 2. The Lead Nurse for Safeguarding Adults has attended the quarterly DHR Sub Group Meetings 3. The IMR for Adult JS was submitted within the agreed timescale. 4. Updates on progress and actions against recommendations for STHFT have been submitted to the DACT as required and discussed at the DHR sun groups meetings.	GREEN
Female Genital Mutilation (FGM) **10.2 –** FGM Cases Identified	1. To educate appropriate staff regarding the need to systematically collect data about FGM and the process for reporting FGM To ensure the process to gather information about patients who have had FGM for submission to the HSCIC is robust and complied with. 2. To implement any future actions or recommendations from the Department of Health or the Safeguarding Adults or Children's Board's in Sheffield in response to the data being submitted.	1. FGM data is collected from obstetrics and gynaecology and Sexual Health Sheffield. Women are offered support on an individual basis by Obstetrics and & Gynaecology and safeguarding children procedures are followed where necessary. 2. Data is submitted to the Health and Social Care Information Centre as requested and to meet the required deadlines.	GREEN
Vulnerable Adults Panel (VAP) **11.0 -** VAP	1. To develop a robust system for implementing recommendations and actions from the Vulnerable Adults Panel. 2. To ensure actions are carried out and information regarding individuals discussed at the Vulnerable Adults Panel is disseminated and acted on appropriately within STHFT on a need to know basis.	1. A system of identification and referral of the most frequent attendees at the ED has been developed. 2. STHFT is represented on the VAP by the Lead Nurse for Safeguarding Adults who is responsible for disseminating recommendations and actions	GREEN

Safeguarding Adults Reviews (SARS) **12.0 –** SARS	1. To participate in any SARs involving STHFT as required. 2. To submit well written, comprehensive IMRs in a timely manner if required. 3. To ensure that recommendations from any SARs 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. STHFT Participated in a Nottinghamshire Adult Serious Incident Learning Process. 2. An IMR was submitted within the required timescale. 3. There were no recommendations for STHFT 4. There are current actions for STHFT with regard to SARS.	GREEN
Case Reviews **12.1 –** Case Reviews	1. To complete and submit well written, comprehensive IMRs in a timely manner if required. 2. To implement the actions identified for STHFT from the recommendations from any case reviews. 3. The Safeguarding Adults Practice Development Facilitator and the Safeguarding Adults Adviser will be required to attend IMR author training as this becomes available.	1. There are no current case reviews for safeguarding adults 2. There are no outstanding actions for STHFT from previous case reviews 3. The Safeguarding Adults Practice Development Facilitator and the Safeguarding Adults Adviser attended IMR author training in 2016.	GREEN
Recruitment and Employment Practice **13.1 –** Safeguarding Adults Team	1. To continue to offer training, expert specialist advice and support to STHFT staff in respect of all aspects of safeguarding adults. 2. 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. 3. To develop a Training Needs Analysis for MCA/DOLS in collaboration with Learning and Development. 4. To maintain an excellent attendance record at the delegated safeguarding/vulnerable adults meetings and sub group	1. The STHFT Safeguarding Adults team provides a rolling programme of safeguarding adults training covering all aspects of safeguarding. 2. The MCA Specialist Adviser provides a rolling programme of training on; MCA, mental capacity assessment and best interest decision making and Deprivation of Liberty Safeguards 3. A Job –Specific Essential TNA for Mental Capacity and DoLs, Mental Health Act and Restrictive Practice and Intervention was published in July 2016. 4. 100% attendance at the associated safeguarding/vulnerable adults meetings has been achieved	GREEN
Safeguarding Adults Education and Training	1. To provide Safeguarding update training materials to clinical educators/training leads across the Trust to ensure key messages and a consistent approach.	1. The Safeguarding Adults Practice Development Facilitator has linked with Clinical Educators to provide lesson plans and resources with current safeguarding	GREEN

14.1 – Staff Training and Development	2. To provide additional training to heads of Therapy Services and other allied health services and to senior staff within the Combined Community and Acute Directorate, to enable them to identify safeguarding concerns, in order where necessary, to raise concerns under safeguarding procedures. 3. 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. 4. To provide further training for STH staff on completing and accurately recording mental capacity assessments and best interest decision making. 5. To provide awareness sessions for health staff on the Government's Prevent strategy 6. Contribute to the city wide working group developing both guidance on and multi- agency training on restraint and restrictive practices.	information, policies and procedures. 2. Safeguarding Adults training is offered and provided as a bespoke training to specific staff groups as requested or as a need is identified. This action is on-going. Heads of service do also attend safeguarding training accessed via PALMS. 3. A 'podcast' for safeguarding basic awareness (level1) is almost completed and will be circulated for use as an aid to mandatory training and corporate induction. 4. The MCA Specialist Adviser provides a rolling programme of training on; MCA, mental capacity assessment and best interest decision making and Deprivation of Liberty Safeguards 5. Prevent basic awareness is included in all safeguarding adults and children training as well as at trust corporate induction and mandatory training. 6. The MCA Specialist Adviser sits on the city wide restraints working group and has contributed to the development of the Framework for Restrictive Practices.	
Counter Terrorism and Prevent **15.4 –** Gold and Silver Meetings	1. To increase the number of accredited WRAP 3 trainers. 2. To increase the number of staff who have attended the WRAP 3 training in line with the Prevent Duty. 3. To develop further resources to support awareness of how to recognise individuals at risk of radicalisation and counterterrorism initiatives. 4. To ensure 100% attendance at the Channel Panel as appropriate 5. To ensure 100% attendance at the Prevent Silver meeting.	1. The safeguarding adults and children team have been trained to facilitate the WRAP training as have a number of Clinical Educators. 3. Prevent Training has been delivered as per the existing training plan and in line with the Safeguarding Adults TNA 2. Further work is being undertaken in 2017-18 to further develop and update the Prevent TNA and Trust wide training strategy. Prevent basic awareness is included in all safeguarding adults and children training as well as at trust corporate induction and mandatory training 3. 100% attendance at Channel Panel 4. 100% attendance at Prevent Silver meetings	AMBER