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SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE SUMMARY

REPORT TO THE HEALTHCARE GOVERNANCE COMMITTEE

HELD ON 21 OCTOBER 2013

Subject:	Annual Safeguarding Adults Report
Supporting Executive:	Professor Hilary Chapman, Chief Nurse / Chief Operating Officer
Author:	Christina Herbert, Lead Nurse Older People and Vulnerable Adults
Status[1]	N

PURPOSE OF THE REPORT:

- To inform the Healthcare Governance Committee of the current arrangements for safeguarding adults at Sheffield Teaching Hospitals NHS Foundation Trust (STHFT)
- To demonstrate key achievements to safeguard vulnerable adults over the last 12 months
- To identify the key priorities for 2013-14 to improve the processes, policies and audits, training and assurance in order to better safeguard vulnerable adults

KEY POINTS:

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

IMPLICATIONS

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

RECOMMENDATION(S):

- The Healthcare Governance Committee are asked to note the contents of this report.

APPROVAL PROCESS:

Meeting	**Date**	**Approved**
Trust Executive Group	14 August 2013	
Healthcare Governance Committee	21 October 2013	

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

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

APRIL 2012- MARCH 2013

1. INTRODUCTION

Safeguarding vulnerable adults has remained high on the national agenda for both health and social care organisations particularly with regard to both the Mid Staffordshire Inquiry and the Winterbourne View (2012) Inquiry. Following the publication of the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (2013) there is a renewed focus on improving standards of care within all organisations and ensuring that the safeguarding and protection of adults at risk from abuse and harm is everyone's business.

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

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 addressing domestic abuse, substance misuse, nutrition, tissue viability, embedding the principles of the Mental Capacity Act (MCA), privacy and dignity and mental health including Dementia.

2. DEFINITION

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

3. STRATEGIC CONTEXT

The Trust has a duty to comply with national and local policy, in particular, guidance contained in 'No Secrets' (DH 2000), Safeguarding Adults (ADSS 2005), South Yorkshire's Adult Protection Procedures (2007), and 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, and the Safeguarding Vulnerable Groups Act 2006.
In lieu of the absence of an update of the No Secrets guidance, the Department of Health published a set of standards for health services which provide up to date guidance on safeguarding adult practice (Safeguarding Adults DH 2011).

Key Priorities

- To contribute a Safeguarding Adults Strategy to the Central Nursing Directorate 5 Year Strategy.

3.1 Safeguarding Adults Team

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

Key achievements 2012-2013

- The STHFT adult safeguarding team has been enhanced by the appointment of a 0.6 WTE Mental Capacity Practice Development Facilitator on a temporary contract until September 2013. This post is funded by the Local Authority to provide expert training and advice around mental capacity/ best interest decision making and to support staff to embed the principles of the MCA into practice.

- This appointment has added to the capacity of the safeguarding team and ensured that STHFT's approach to safeguarding and caring for vulnerable adults both in the acute setting and in the community is strengthened.
- From September 2013 the post will be retained as a 0.4 WTE permanent post funded by the Learning and Development Department.
- Processes for distribution of workload across the safeguarding adults team have been developed by; introducing weekly matrix meetings to allocate and discuss cases, introducing a safeguarding adults dedicated e-mail address, and the development of a database to record and monitor safeguarding advice calls, enquiries and requests for information. This helps to ensure prompt prioritised response and equitable access to expert advice and support across the organisation and has been further strengthened by the introduction of a duty rota for responding to advice calls during core hours.

Key priorities 2013-2014

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

4. POLICIES AND PROCEDURES

All agencies across South Yorkshire work within the framework of **the South Yorkshire Adult Protection Procedures (SYAPP) (2007).** 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 to be updated in 2013 overseen by the SASP. STHFT will be actively contributing to this review.

The Deputy Chief Nurse completed an internal review of the procedures for volunteers and celebrities visiting the trust in the light of the 'Savile' allegations in 2012. The review highlighted how STHFT has robust arrangements in place surrounding the recruitment, training, monitoring and support of volunteers within the Trust.

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

1. Concerns identified as a coincidence to a patient's treatment by STHFT – i.e. those arising as a result of a third party act or omission (for example a domiciliary or care home setting).

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

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

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

Following a review of the hospital social work provision and the decision to withdraw the general social work team from July 2013, the specialist hospital social workers will have limited capacity to screen safeguarding concerns generated within STHFT. As an interim solution to address this, the STHFT adult safeguarding team has proposed a pilot process whereby all safeguarding adult's alerts generated within the Trust, will be forwarded to the STHFT Adult Safeguarding Team following initial screening by the Named referrers. Where the thresholds for adult safeguarding have been met, referrals will be forwarded to the Local Authority Safeguarding Adult Access Team by the STHFT Adult Safeguarding team. This pilot is due to commence from 1st July 2013 and will assess capacity, capability and resource implications within the STHFT Safeguarding Team.

Key achievements 2012-2013

The Named Nurse for Adult Safeguarding contributed to the development of a Trust wide Policy for the Management of Patients Whose Behaviour Challenges the Service. This includes guidance on the use of and management of restraint. The Policy links to the City wide Prevention and Management of the Use of Restraint, Framework for Good Practice (2011) which has been adopted by STHFT.

Key Priorities 2013-2014

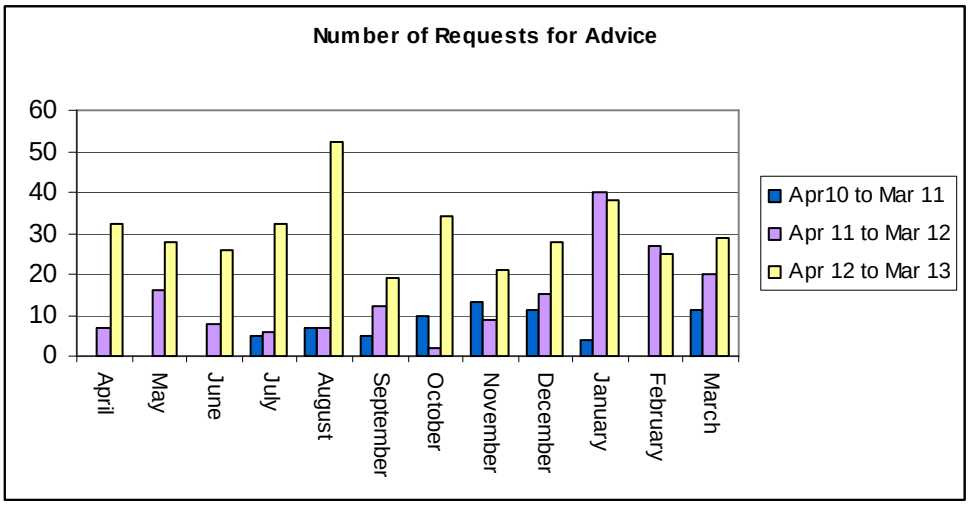
- To contribute to the re write of the South Yorkshire Adult Protection Procedures
- To undertake an audit of complaints and SUIs to identify whether safeguarding concerns are being correctly recognised via the complaints review and risk grading process and by the SUI process.
- To pilot the revised safeguarding adults referral process and evaluate the impact on the STHFT safeguarding team.
- To agree and disseminate a robust process for the referral of adult safeguarding concerns generated from within STHFT
- To ensure Named Referrers have the skills to recognise the various forms of abuse and screen alerts appropriately.

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

The following table shows the year on year rise in contacts with the Safeguarding Adults Team for advice and support from both within the Trust and also from outside agencies.
These contacts often require further information to be sought and/or investigation to be undertaken by the Safeguarding Adults Team.

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

Number of requests to Safeguarding Adults Team for advice



Totals

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

What this data is unable to reflect is the impact on the workload of the Safeguarding Adults Team and the time required to respond to the requests for support generated by each individual contact.

Key achievements 2012-2013

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

Key priorities for 2013-2014

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

6. INCIDENTS/SAFEGUARDING ALERTS AND REFERRALS

Alerts

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 local authority Adult Safeguarding Office and has highlighted some discrepancies between Datix and safeguarding referrals to social care.

Key achievements 2012-2013

- There were a total of 161 reported formal alerts noted on Datix from April 2012 – March 2013.

Key priorities for 2013-2014

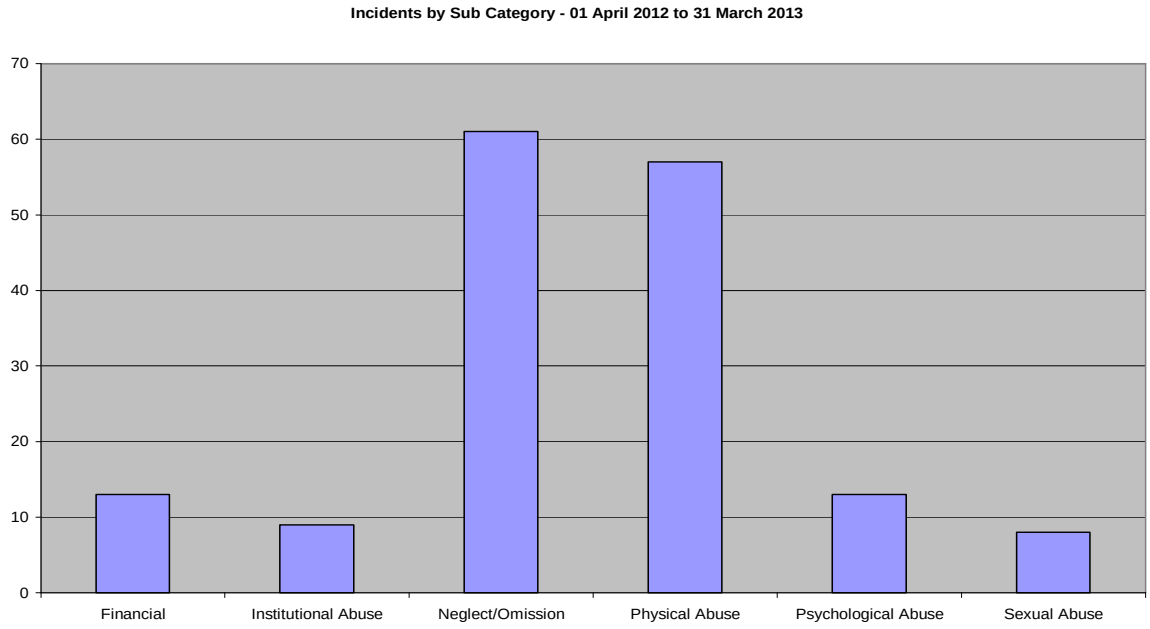
- To increase the number of alerts reported, taking the opportunity to highlight via the Safeguarding Leads meeting, situations where appropriate alerts are being missed.
- To gather data from similar sized organisations to STHFT in order to benchmark our own performance.

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

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

It not clear as to why there has been a fall in the number of safeguarding alerts during this year following the previous year on year rise in alerts being recorded.
It is possible that there have been fewer safeguarding alerts raised in 2012-13, or that the Named Referrers have become more skilled at screening the concerns out of the safeguarding process at the initial stage of the alerts being raised.
However there is also the possibility that safeguarding alerts have not been recorded on Datix as per Trust Policy**.**

6.2 Table 4 - Types of Abuse



Neglect or omission and physical abuse have been the main categories for the allegations of abuse recorded in 2012 / 13 which is consistent with previous years.

6.3 Referrals

Referrals to Sheffield Adult Access Team April 2012 to March 2013	**112**
Referrals to Sheffield Adult Access Team April 2011 to March 2012	**136**

It is also unclear as to why the number of referrals has decreased over the past year.

One possible explanation is that following training, the Named Referrers are more proficient and skilled in screening out the safeguarding alerts that do not require progression to a safeguarding referral but can be managed via a different and more appropriate route e.g. complaints process.

Key achievements 2012-2013

- Referrer training has been provided to 116 senior staff from nursing and therapy services.

Priorities for 2013-2014

- To undertake an audit of those referrals recorded on Datix.
- To review and refine the STHFT referral process following the withdrawal of the hospital general social work team.

6.4 Investigations

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

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

Individual Management reviews (IMRs) into serious case reviews and domestic homicide reviews require an advanced level of investigative and analytical skills. An IMR is an internal investigation report by an agency that have provided services to the victim, perpetrator or other relevant family members. The purpose of the IMR is to look openly and critically at the involvement of the individual agency in order to identify both good practice and where there may have been inadequacies, to review organisational policy and procedure and to make recommendations for future action.

Issues of identifying appropriate individuals, to undertake IMRs to the required standard, including ensuring that the IMR authors are appropriately trained and able to maintain competence needs further consideration.

Key Achievements 2012-2013

- The Named Nurse for Adult Safeguarding attended specialist training in undertaking IMRs, provided by the Local Authority Adult Safeguarding Team.

Key Priority for 2013-2014

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

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

The Deprivation of Liberty Safeguards (DOLS), introduced in the Mental Capacity Act (MCA) (2005), (enacted April 2009) provide a framework for approving the deprivation of liberty for people who are in a care home or hospital who lack capacity to consent to treatment or care, that in their own best interests, can only be provided in circumstances that amount to a deprivation of their liberty.

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

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.

A Managing Authority must apply in writing to the supervisory body for a standard authorisation to deprive a person of their liberty in the relevant hospital or care home.

An urgent authorisation may be given by a Managing Authority for a period of up to seven days giving the Managing Authority lawful authority to deprive a person of their liberty in a hospital or care home while the standard deprivation of liberty authorisation process is undertaken by the Supervisory Body.

DOLS applications are assessed by a Best Interest Assessor from the Supervisory Body to establish whether a deprivation of liberty is occurring or going to occur and whether the deprivation of liberty is in the best interest of the person to be deprived of their liberty.
The assessment process requires six assessments to be conducted before the Supervisory Body can give an authorisation. These include an age assessment, mental capacity assessment, eligibility assessment and best interest assessment.

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 these 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 Deprivation of Liberty Safeguards.

7.1 The following tables detail the current available data on the number of DOLS applications made by STH during the period from April 2012 – March 2013:

DOLS Applications	Total	Granted	Not Granted	Assessed as not appropriate
APRIL 2011-JAN 2012	42	29	7	6
APRIL 2012-MARCH 2013	51	24	14	13

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

7.2 The following tables detail the current available data on the number of IMCA referrals made by STH during the period from April 2012 – March 2013:

Referrals to the IMCA Service APRIL 2012-MARCH 2013	Q1	Q2	Q3	Q4	TOTAL
	15	15	15	16	61

The data from the IMCA service indicates that there were 61 referrals made linked to 57 clients. Some clients therefore had more than one referral. The referrals related to change of accommodation, serious medical treatment and the Deprivation of Liberty safeguards assessments. All of the clients were in Sheffield Teaching Hospitals at the time of referral.

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

Key Achievements 2012-2013

- A fixed term MCA Practice Development Facilitator post was recruited to, to embed the principles of the Mental Capacity Act and Deprivation of Liberty safeguards in practice. The post is commissioned and funded by the Sheffield Safeguarding Adults Office and includes a responsibility for training and development across all health organisations in Sheffield.
- A guidance toolkit and exemplar of good practice in assessing and recording mental capacity has been devised and made available on the Trust MCA intranet site.
- A rolling programme of training in MCA Assessment, DOLS and Best Interest Decision Making has been ongoing since September 2012. Uptake of the training has exceeded expectation and additional training dates to meet the demand have been arranged.

Key Priorities for 2013-2014

- To ensure mental capacity assessments and best interest decisions are being made and documented according to the legal requirements as stated in the Mental Capacity Act (2005).
- To continue to provide training and to support staff in undertaking mental capacity assessments and best interest decisions.

- The MCA Practice Development Facilitator is to undertake a small scale trust wide audit of mental capacity assessments and best interest decisions from July to August 2013.
- To ascertain if correct procedures for assessing and documenting mental capacity are being adhered to
- To ascertain if best interest decisions are clearly documented in the care record.
- To identify training needs.

8. DOMESTIC ABUSE

The recognition and support of victims of domestic abuse is a key issue for all agencies.
In collaboration with colleagues from Safeguarding Children and Young People, Emergency Care, Obstetrics and Gynaecology Directorates, work has taken place to review how as a Trust we can liaise with other agencies to protect victims of Domestic Abuse (DA).

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

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

8.1 Independent Domestic Violence Advocacy Service (IDVA)

The IDVA Service is managed by Vida Sheffield (formerly known as Sheffield Domestic Abuse Forum) and works primarily with women and occasionally men who are at the highest levels of risk from domestic abuse in the city .The service helps victims of domestic abuse to take steps to reduce their risk levels and to hold perpetrators to account through the Police, Probation and legal or other remedies.

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

Since 2010 health based IDVAS had been hosted within Jessop Wing maternity services, to provide early support to pregnant women, as domestic abuse often starts or escalates during pregnancy and is a major health risk for mothers and unborn babies. The IDVAs were also hosted within the A&E Department at the Northern General Hospital and provided in reach into the GUM Clinic. However, following the review of domestic abuse services the IDVA service will no longer have staff based within STHFT.

IDVAS will in future provide in-reach into the Jessop Wing, A&E Department at the Northern General Hospital and into the GUM Clinic. To monitor the impact of this change in service, it will be necessary to compare the IDVA referral rates from 2011-12 with the referrals for 2012 – 13 from STHFT in liaison with the IDVA service.

8.2 Multi Agency Risk Assessment Conference (MARAC)

The MARAC process is a dynamic process which takes a multi agency approach within a single meeting to combine up to date risk assessment information regarding victims of domestic abuse with a comprehensive assessment of the victims needs.

MARAC meetings are held in Sheffield on a fortnightly basis and are attended by key staff from STHFT.

Key achievements 2012-2013

- 100% Attendance at MARAC
- A Domestic Abuse and Sexual Violence study day involving key speakers from outside agencies was organised by the Lead Nurse for Older People/Vulnerable Adults and hosted by STHFT in November 2012

Key priorities for 2013-2014

- 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 work with Human Resources to develop guidance for line managers to support staff who may be victims of domestic abuse.

9. DOMESTIC HOMICIDE REVIEWS

Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004) and came into force on 13th April 2011.
This requires a local multi-agency review of care provision and services provided to both the victim and the alleged perpetrator when a domestic homicide occurs and is carried out alongside legal / criminal proceedings. The purpose of the DHR therefore, is not to assign blame or responsibility but to learn lessons and to improve policies and practice at a local and national level.
The lead responsibility for determining which domestic homicides meet the criteria for review under the DHR process lies with the Community Safety Partnership (CSP) which in Sheffield, is the Safer and Sustainable Communities Partnership (SSCP). They will coordinate DHRs, select members of the review panel and commission an independent author to compile the report.
The process is similar to the existing Serious Case Review process carried out following the death of a child or vulnerable adult where any organisation identified as having had contact with the victim is required to produce an Individual Management review (IMR). 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 STH is that the workload is unpredictable i.e. Sheffield has had between 0-5 domestic homicides per year, in recent years. The requirement to participate in SI Lessons Learned Reviews is an additional workload for the safeguarding team with no supplementary funding.

9.1 STHFT Involvement in the DHR process

Since June 2011 STHFT has participated in three full DHRs and two SI Lessons Learned Reviews. Unfortunately there was a further domestic homicide in June 2013 for which the SSCP is currently commissioning a DHR in which STHFT will be required to participate.
STHFT is represented on the DHR or SI Review Panels by the Deputy Chief Nurse or Lead Nurse for Older People/Vulnerable Adults in his absence.

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

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

Adult C DHR May 2012

Adult C's body was discovered on Friday 18th May 2012. A post mortem concluded that Adult C died of multiple stab wounds. Adult CS, the son of Adult C, was charged with the murder of his mother.

An IMR was requested in accordance with Sheffield Safer and Sustainable Communities Partnership's procedure for conducting a multi agency Domestic Homicide Review and was undertaken by the Lead Nurse for Older People and Vulnerable Adults.

STHFT had contact with Adult C for medical treatment from 2001 – 2012.
Adult CS had had a small number of contacts with services at STHFT for minor ailments.

Whilst accessing services at STHFT, Adult C was not as far as the IMR author could ascertain, asked about domestic violence and abuse as part of her clinical assessment. STHFT currently has a system of selective enquiry in relation to domestic abuse rather than a system to routinely enquire about abuse and violence in all its services.

As Adult C did not articulate any apparent warning signs which suggested to staff that she was currently, or had ever, previously been in a violent relationship and was seeking help, so staff were appropriately applying selective enquiry..

The overview report was published in December 2012.

Recommendations

1. To update the current safeguarding vulnerable adults training needs analysis to reflect the need for specific staff groups to acquire domestic abuse awareness.

2. To develop a variety of methods to ensure domestic abuse awareness is widely disseminated across appropriate staff groups in accordance with the safeguarding vulnerable adults training needs analysis.

Adult B Serious Incident (SI) October 2012

The review of the SI which took place in October 2012 was undertaken jointly by the Named Nurse, Safeguarding Children with support from the Lead Nurse for Older People/Vulnerable Adults. A précis of this review is included in the Annual report for Safeguarding Children.

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

Adult D DHR February 2013

The Lead Nurse for Older People and Vulnerable Adults has written an IMR for this Domestic Homicide Review. As this review is still ongoing, further information about the outcome of the review and any recommendations for the Trust will be reported in the annual report for 2014/15.

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

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

On 21st February 2103 the police were called to a stabbing on Blackstock Road in Gleadless and found Adult D lying in the road suffering multiple stab wounds. She was taken by ambulance to A&E and pronounced dead at 12.44pm.

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

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

The recommendations made by the IMR author are as follows:

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

The overview report and recommendations for all agencies will be reported on in the annual report for 2014/15.

Adult Z DHR conducted by Safer Rotherham Partnership June 2013

STHFT was requested to submit an IMR for the period of time in which care was provided to Adult Z.

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

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

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

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

Adult E DHR

A further DHR has been commissioned following the murder of a young woman in Sheffield in June 2013. STHFT has had contact with both the victim and the perpetrator in this case and will be required to submit an IMR.

Key Achievements 2012-2013

- The IMRs from STHFT were submitted to the independent overview authors in a timely manner according to the agreed timescales.
- STHFT has completed all actions assigned to the Trust arising from the recommendations from the previous DHRs.
- The Lead Nurse for Older People/ Vulnerable Adults attended a DHR training day provided by the Home Office.

Key priorities 2012 -2013

- 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's and the alleged perpetrator's contact with STHFT services.
- To ensure recommendations are implemented and progress reported via the Sheffield Domestic Abuse Partnership.

10. VULNERABLE ADULTS PANEL

The Vulnerable Adults Panel has been developed with the intention of creating a routine system that improves the way the Sheffield health and social care system responds to and manages the risks posed by and to Vulnerable adults at risk who:

- Make frequent avoidable use of emergency and crisis services

And/or

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

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

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

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

Key achievements 2012-2013

- The Named Nurse for adult safeguarding is representing the interests of the Trust on the vulnerable adult's panel.
- A system of identification and referral of the high frequency service users has been developed.

Key priorities for 2013-2014

- To develop a robust system for implementing recommendations and actions from the vulnerable adults panel.

11. SAFEGUARDING ADULTS STRUCTURES AND PROCESSES

11.1 External

Sheffield Adults Safeguarding Partnership (SASP) is a partnership between a number of agencies responsible for protecting vulnerable adults at risk of harm.
The SASP has both an Executive Board and an Operational Group chaired by Sue Fiennes, Independent Chair, and is responsible for developing interagency standards and monitoring performance against these standards.

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

Sub groups of the SASP Operational Group are the Policy and Practice Review Group (PPRG) and the Sheffield Adult Safeguarding Education and Development Group
(SASED) both of which are attended by the Named Nurses for adult safeguarding.

SASP has agreed to undertake a Governance Review of its current arrangements during 2013/14 and the Trust will participate in this review as a member of the partnership.

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

Key achievements 2012-2013

- 100% Attendance at SASP

Key priorities for 2013-2014

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

Table 1: Summary of STHFT attendance at SASP Meetings

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

11.2 Internal

Safeguarding Leads Meetings

This meeting is held bi-monthly as an opportunity to brief the senior key individuals (mostly the Deputy Nurse Directors) 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 supports shared learning from case discussion.
It is a vehicle for sharing learning from case reviews, Serious Case Reviews and Domestic Homicide Reviews and for allocating duties and monitoring any associated action plans.

Key achievements 2012-2013

- Six Safeguarding Leads Meetings have been held, where Care Group representatives are informed about citywide and Trust issues and strategies regarding safeguarding adults.
- The group is a forum for signing off and disseminating policies and procedures relating to safeguarding adults and children.

Key priorities for 2013-2014

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

12. SERIOUS CASE REVIEWS (SCR)

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

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

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

A Serious Case Review requires agencies involved in the care of the vulnerable adult to undertaken an Individual Management Review (IMR) to analyse their involvement with the case in order to make recommendations for future action. A Serious Case Review has an independent author to scrutinise the IMRs and produce the final overview report and recommendations.

To undertake an IMR requires dedicated time out and a commitment from the IMR author to complete and submit the IMR to meet the required deadlines.
The capacity of the STHFT safeguarding team is limited, therefore it may in the future be necessary to delegate and support the responsibility for undertaking an IMR to an appropriate senior member of staff from another directorate or department.

12.1 Adult E11

A Serious Case Review was commissioned by Nottinghamshire Safeguarding Adult Board in February 2012 in respect of Adult E11. Despite living out of area, Adult E11 had a longstanding history of service provision from STHFT and previously from Lodge Moor Hospital.

An IMR of the Trust's involvement in provision of services to Adult E11 was undertaken by the Named Nurse for Adult Safeguarding supervised by the Lead Nurse for Older People/Vulnerable Adults who also represented STHFT on the Nottinghamshire SCR Panel.

No recommendations for STHFT were identified by the IMR author.

The overview report has been "signed off" by the Nottinghamshire Board recently and will be forwarded to the Chair of the Sheffield City Board in due course.

An acknowledgement of the contribution made by both the STHFT Lead Nurse and Named Nurse for Adult Safeguarding was e-mailed from the Nottinghamshire Safeguarding Adults Board Manager, to the STHFT Chief Nurse.

12.2 Adult B

A Serious Case Review was commissioned by the Sheffield Adult Safeguarding Board in March 2012 and the terms of references distributed in April 2012. Adult B died in a house fire which started as a result of Adult B setting fire to her chair whilst smoking. STHFT had provided both acute and community services to Adult B therefore an IMR was undertaken by the Named Nurse for Adult Safeguarding.

This review did not find any evidence of unmet need that could have been fulfilled by services provided by STHFT however, there were some areas identified where communication between services could have been more robust.

Recommendations

The author of the IMR made the following recommendations to improve practice:

That STHFT

1. Introduces a process whereby when a referral to another service is made, the referrer should confirm that the referral has been received by the intended recipient.

2. Reviews and updates the guideline used when STHFT staff are unable to gain access to patients in their own home to ensure it includes advice in relation to working with uncooperative families. This updated guideline will then be circulated to appropriate staff.

3. Works with South Yorkshire Fire and Rescue service to raise general awareness of the fire safety referral pathway and specifically inform STHFT staff working in Community Nursing, Accident and Emergency, Respiratory Medicine and the Burns Unit/Dressing Clinic about this pathway.

4. Promotes access to Stop Smoking training, to include raising awareness of the physical dangers of smoking particularly for people who lack insight for their own safety and how to develop care plans to manage these risks.

Key achievements 2012-2013

- The IMRs for Adult E11 and for Adult B were submitted to the independent overview authors according to the agreed timescales.
- The Nottinghamshire SCR Review Panel members commended the STHFT IMR authors for the high standard of the IMR submitted.
- An acknowledgement of the contribution made by both the STHFT Lead Nurse and Named Nurse for Adult Safeguarding was e-mailed from the Nottinghamshire Safeguarding Adults Board Manager, to the STHFT Chief Nurse.
- The recommendations for Adult B have been implemented.

Key Priorities 2013-14

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

13. CASE REVIEWS

There has been one new Case Review commissioned by Sheffield Adult Safeguarding Board in February 2012 where STHFT has had some involvement. Case reviews are similar to Serious Case Reviews but without an independent author. This role is fulfilled by the Local Authority Adult Safeguarding Office.

The Lead Nurse for Older People/Vulnerable Adults completed an IMR which was submitted in June 2012.

The Overview Report has not yet been signed off or recommendations agreed. The delay in the publication of the Overview Report appears to be due to the complexities of this case and the volume of information submitted to the Overview Author by the agencies involved.

13.1 Adult case AY

AY was a vulnerable young man with extensive and complex needs. He would appear to lack capacity to make his own decisions and was completely reliant on his family to provide all cares necessary for him to fulfil his activities of daily living.

Concerns were raised by NHS Sheffield regarding the clinical care and support provided to AY over a period of time from 2005 to 2011 following allegations of ill treatment made against his family.

The case review was commissioned in order to allow a thorough and impartial review of the individual agencies involvement and multi agency working in order to establish if there were lessons to be learned. This included a review of the effectiveness of procedures and whether they have been adequately followed by the range of agencies involved.

AY was known to a number of different specialities and consultants within Sheffield Teaching Hospitals NHS Foundation Trust.

The care provided to AY spanned children's services at the Sheffield Children's Hospital NHSFT, and adult services both at STHFT and the Sheffield Health and Social Care NHS Foundation Trust Joint Learning Disability service.
Issues of poor communication and handover were identified during the course of the Case Review relating to the transition process from children's to adult services.
STHFT now has in place a policy to support the transition of young people into adult services.

There are 34 recorded contacts with AY at/by STHFT, which include 24 attendances at A&E from August 2002 until the last contact in June 2011.

Overall it appears that the medical and multi disciplinary management of AY whilst receiving care at STHFT was good.

The IMR author could not identify any specific recommendations for STHFT. Recommendations for all agencies may be suggested once the overview report has been published.

Key achievements 2012-2013

- The Named Nurse for Adult Safeguarding attended specialist training in undertaking IMRs, provided by the Local Authority Adult Safeguarding Team.

Key priorities for 2013-2014

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

14. PREVENT

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

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

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

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

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

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

Healthcare organisations need to ensure that staff:

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

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

The Prevent Lead for STHFT is the Chief Nurse/ Chief Operating Officer.

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

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

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

Key achievements 2012-2013

- 93 staff have undergone the Health WRAP training

Key priorities for 2013-2014

- To develop a Training Needs Analysis for Prevent
- To increase the number of accredited Health WRAP trainers
- To continue to offer Health WRAP training
- To develop a policy and referral pathway for Prevent

15. ASSURANCE/GOVERNANCE

15.1 Internal

Key achievements 2012-2013

Audits

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

The overall aim of the audit was to provide a review in respect of Safeguarding Vulnerable Adults awareness within the Trust.

The objectives were:

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

Data was collected using online survey software, SurveyMonkey®. This questionnaire was developed in line with Trust policies relating to Safeguarding and Whistle Blowing.

Conclusions

The audit results appear mainly positive and demonstrate progress in both staff awareness of safeguarding and in staff accessing training. However, 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.

There is good awareness of the STHFT Safeguarding Adults Policy however more needs to be done to raise awareness of the South Yorkshire Procedures to ensure these can be applied in practice and used as a resource to guide staff in making safeguarding decisions.
Further work needs to be done to identify leads within each directorate or speciality to ensure that staff have a local contact person to approach for safeguarding advice and support.

Recommendations

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

- To ensure Safeguarding Leads have had training and support for their role.

Key priorities for 2013-2014

- To ensure the recommendations from the Safeguarding Adults audit are implemented.
- Each Clinical and Corporate Directorate is required to write a 5 year strategy. The Safeguarding Adults Team is contributing to the Safeguarding Adults element of the strategy for Central Nursing.

15.2 External

- STHFT has submitted its annual provider declaration to NHS Sheffield in March 2013.
- The Sheffield Adult Safeguarding Partnership Performance Checklist monitors performance by partners against key SASP performance indicators.

Key achievements 2012-2013

Care Quality Commission inspectors visited the Northern General Hospital in December 2012 to ensure that people who use our services were protected from abuse. Visits to adult clinical areas, including an unannounced inspection and discussions with staff and patients took place. Structures, policies and procedures, and staff training, were reviewed. The CQC inspection report published in February 2013 indicated that the Trust was compliant with the standard for caring for people safely and protecting them from harm.

Key priorities for 2013-2014

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

16. EDUCATION AND TRAINING

Staff training and development

Safeguarding Adults training is provided by the Adult Safeguarding Team at STHFT which includes Basic Awareness, Referrer Training, Vulnerable Adults Risk Management Model (VARMM), training for staff at Corporate Induction and the availability of an appropriate E-learning module.

A Safeguarding Adults awareness leaflet for volunteer staff is distributed via the volunteer induction programme and via the volunteer coordinators.

Attendance at training and safeguarding updates by both acute and community based staff is recorded and monitored by the STHFT Safeguarding Office.

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

Key achievements for 2012-2013 are shown in the following table

Central Training Provided by the Adult Safeguarding Team	Numbers trained 2012/2013
Safeguarding Adults Basic Awareness	234
Safeguarding Adults Update	80
Safeguarding Adults E-Learning	34
Safeguarding Adults Referrer Training	116
Vulnerable Adults Risk Management Model(VARMM)	39
MCA/ Best Interest/DOLS	195
PREVENT	93

Key priorities for 2013-2014

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

17. CONCLUSION

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

The full integration of the Primary and Community Care Directorate has increased the level of activity for the STHFT Adult Safeguarding Team both in providing support and advice to community staff in the recognition and reporting of safeguarding concerns and in the provision of safeguarding training. It has however also brought some valuable resource, knowledge and expertise into the Trust.

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

The STHFT Adult Safeguarding team will be monitoring closely the resource required to undertake this additional work and continually looking for internal solutions.

This report has detailed the data collected and the main areas of activity during 2012-13 and has summarised the key priorities for 2013-14.

18. REFERENCES

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Serious Case Review (Winterbourne View) (Flynn 2012) www.southglos.uk/wv

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Appendix 1

Key Achievements for Adult Safeguarding at STHFT 2012-13

	Key priorities identified in the 2012-2013 Annual Report	**Progress/ achievements**
STHFT Involvement in the DHR process	1. To participate in the current DHR which was commissioned following a Domestic Homicide which occurred in May 2012 ensuring that the Trust submits a timely, accurate and comprehensive IMR in respect of the victim's and the alleged perpetrator's contact with STHFT services. 2. To ensure recommendations from this and any subsequent DHRs are implemented and progress reported via the Sheffield Domestic Abuse Coordination Team (DACT).	1. The IMRs from STHFT were submitted to the independent overview authors in a timely manner according to the agreed timescales. 2. STH has completed all actions assigned to the Trust arising from the recommendations from the previous DHRs. The Lead Nurse for Older People/ Vulnerable Adults attended a DHR training day provided by the Home Office
Safeguarding Adults Team	1. To continue to offer training advice and support to STHFT staff in respect of the care provided to vulnerable people. 2. To maintain an excellent attendance record at the delegated safeguarding meetings and sub groups. 3. To develop robust systems and processes for delegation of workload across the team to ensure all safeguarding concerns are addressed in a timely manner.	1. The Mental Capacity Practice Development Facilitator has provided expert training and advice around mental capacity/ best interest decision making and support for staff to embed the principles of the MCA into practice. 2. The team has achieved 100% attendance at safeguarding meetings. 3. Processes for delegation of workload across the safeguarding adults team have been developed by; the introduction of weekly matrix meetings to allocate and discuss cases, the introduction of a safeguarding adults dedicated e-mail address, the development of a database to record and monitor safeguarding advice calls, enquiries and requests for information

Domestic Abuse	1. To continue to ensure 100% attendance by STHFT at MARAC. 2. 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. 3. To ensure 100% attendance at the SDAP Strategic Planning Group 4. To work with Human Resources to develop guidance for line managers to support staff who may be victims of domestic abuse.	1. 100% attendance at MARAC has been achieved. 2. All actions from MARAC have been completed as per requirements 3. 100% attendance has been achieved at Domestic Abuse Strategic Meetings 4. A flowchart for managers has been developed which will be made available once ratified.
<u>Policies and Procedures</u>	1. To undertake an audit of complaints to identify whether safeguarding concerns are being correctly recognised via the complaints review and risk grading process. 2. To contribute to and agree a trust wide policy on restraint with reference to the city wide guidance on restraint.	1. This action has not been achieved and has been identified as a priority for 2013-14 2. The Named Nurse for Adult Safeguarding contributed to the development of a Trust wide Policy for the Management of Patients Whose Behaviour Challenges the Service. This includes guidance on the use of and management of restraint
Incidents/ Safeguarding Alerts and Referrals **Referrals**	1. To increase the number of alerts reported, taking the opportunity to highlight via the Safeguarding Leads meeting, situations where appropriate alerts are being missed. 2. To further develop the system of data collection and recording of safeguarding adults referrals made by STHFT	1. There has been a fall in the number of safeguarding alerts during this year following the previous year on year rise in alerts being recorded. It is possible that there have been fewer safeguarding alerts raised in 2012-13, or that the Named Referrers have become more skilled at screening the concerns out of the safeguarding process. 2. The current system relies on the information recorded on Datix cross referencing with the referrals recorded on the local authority Care First system.

Investigations	1. To identify senior key individuals from within the Trust who have the skills to lead on safeguarding investigations and IMRs. 2. To provide specialist training for key staff in undertaking IMRs.	1. This action has not been completed and has been identified as a priority for 2013-14. 2. The Named Nurse for Adult Safeguarding attended specialist training in undertaking IMRS
Mental Capacity Act (2005) and Deprivation of Liberty Safeguards	1. To recruit to and support a fixed term MCA Development Facilitator post to embed the principles of the Mental Capacity Act and Deprivation of Liberty safeguards in practice. The post is commissioned and funded by the Sheffield Safeguarding Adults Office and will include a responsibility for training and development. 2. To ensure mental capacity assessments and best decisions are being made and documented according to the legal requirements as stated in the Mental Capacity Act (2005). 3. To provide training and to support staff in undertaking mental capacity assessments and best interest decisions. 4. To re-audit from January to March 2013 to review whether the recommendations have led to improvements.	1. The STHFT adult safeguarding team has been enhanced by the appointment of a 0.6 WTE Mental Capacity Practice Development Facilitator to provide expert training and advice around mental capacity/ best interest decision making and to support staff to embed the principles of the MCA into practice. 2. A guidance toolkit and exemplar of good practice in assessing and recording mental capacity has been devised and made available on the Trust MCA intranet site. 3. A rolling programme of training in MCA Assessment , DOLS and Best Interest Decision Making has been ongoing since September 2012. Uptake of the training has exceeded expectation and additional training dates to meet the demand have been arranged. 4. An audit of mental capacity assessments and best interest decisions has been registered to be undertaken from July to August 2013.
Vulnerable Adults Panel	1. To develop a system of identification and referral for vulnerable adults accessing services at STHFT which links to the identification by A&E staff of the most frequent and often inappropriate attendees at A&E. 2. To develop a system for implementing recommendations and actions from the vulnerable adults panel.	1. A system of identification and referral of the most frequent and often inappropriate attendees at A&E has been developed. 2. This action requires further consideration in 2013-14

Vulnerable Adults Risk Management Model (VARMM	1. To provide awareness and training for staff in the identification of patients who may be appropriate for referral into the VARMM process	1. Training has been provided to 30 members of staff in 2012-13
Safeguarding Adults Structures and Processes	1. To continue to ensure 100% attendance by STHFT at SASP Board and associated meetings.	1. 100% attendance at SASP Board has been achieved.
Safeguarding Leads Meetings	1. To continue to ensure that information, strategies and plans for safeguarding adults both citywide and within the Trust are shared and formed at the Safeguarding Leads meetings.	1. Six Safeguarding Leads Meetings have been held, where Care Group representatives are informed about citywide and Trust issues and strategies regarding safeguarding adults
Serious Case Reviews (SCR)	1. To participate in any SCRs involving STHFT as required. 2. To submit well written, comprehensive IMR s in a timely manner. 3. To ensure that recommendations from SCRs are implemented and monitored via the Safeguarding Leads Group. 4. To ensure that action plans are updated and progress reported to the Sheffield Safeguarding Adults Partnership (SASP) Board as requested	1. A Serious Case Review (Adult B) was commissioned by the Sheffield Adult Safeguarding Board in March 2012. A Serious Case Review (Adult E11) was commissioned by Nottinghamshire Safeguarding Adult Board in February 2012. 2. An IMR for Adult B was undertaken by the Named Nurse for Adult Safeguarding. An IMR of the Trust's involvement in provision of services to Adult E11 was undertaken by the Named Nurse for Adult Safeguarding supervised by the Lead Nurse for Older People/Vulnerable Adults The IMRs for Adult E11 and for Adult B were submitted to the independent overview authors according to the agreed timescales. 3. The actions for Adult B have been implemented. There were no recommendations or actions for STHFT resulting from Adult E11 4. Progress against all actions has been reported to the SASP Board as requested.

Case Reviews	1. To complete and submit well written, comprehensive IMRs in a timely manner. 2. To implement the actions identified for STHFT from the recommendations from case reviews. 3. To identify key senior members of staff from across the Trust and to support them to develop the skills and knowledge required to take on the role of IMR author.	1. The AY Case Review IMR was submitted to the independent overview author according to the agreed timescales. 2. No specific actions for STHFT were identified by the IMR author for AY. 3. The Named Nurse for Adult Safeguarding attended specialist training in undertaking IMRS, provided by the Local Authority Adult Safeguarding Team
Governance/ Assurance **Internal** **External**	1. To develop an audit tool and undertake a re- audit of safeguarding awareness across both acute and community staff in October 2012. 2. To provide MCA/ best interest decision making support and training where required 3. To ensure recommendations arising from the SASP Performance Checker are completed within the agreed timescales.	1. An internal audit relating to adult safeguarding knowledge and awareness of clinical staff was undertaken in March 2013. The results were disseminated via the safeguarding Leads Group . 2. The Mental Capacity Practice Development Facilitator has provided expert training and advice around mental capacity/ best interest decision making 3. Requests for evidence of assurance from commissioners, partner agencies and quality monitoring organisations have been completed within the agreed timescales.
Education and Training	1. To publicise the Training Needs Analysis and ensure that Directorates and Departments are aware of the training requirements of all their staff. 2. To provide referrer training to heads of Therapy Services and other allied health services and to senior staff within the Community Care Directorate, to enable them to identify safeguarding concerns, in order where necessary, to make appropriate referrals into safeguarding	1. A Safeguarding Adults TNA is available on the Learning and Development Intranet site. Safeguarding awareness is provided at Corporate Induction. 2. Safeguarding Adults training is provided by the Adult Safeguarding Team at STHFT which includes Basic Awareness, Referrer Training , Vulnerable Adults Risk Management Model (VARMM).

	procedures. 3. To provide further training for STH staff on completing and accurately recording mental capacity assessments and best interest decision making. 4. Contribute to the city wide working group developing multi agency training on restraint. 5. To provide awareness sessions for health staff on the Government's PREVENT strategy. 6. To capture the training and updates provided to the Primary and Community Care Directorate.	3. Face to face MCA and best interest decision making, training is available for staff plus there is the availability of an E-learning module. 4. The Named Nurse for Adult Safeguarding represents STHFT on the city wide working group for restraint. 5. 93 staff have undergone the PREVENT Awareness training. This includes the Primary and Community Services Senior Management Team. 6. Safeguarding Adults training has been provided to staff from the Primary and Community Services directorate as requested and recorded on the Safeguarding Adults training database.