F

SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE SUMMARY

REPORT TO THE HEALTHCARE GOVERNANCE COMMITTEE

HELD ON 24 SEPTEMBER 2012

Subject:	Annual Safeguarding Adults Report
Supporting TEG Member:	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 2012-13 to improve the processes, policies and audits, training and assurance for adult safeguarding.

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	✓
	CQC Outcome	7 Safeguarding people who use services from abuse

RECOMMENDATION(S):

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

APPROVAL PROCESS:

Meeting	Presented	Approved	Date
Trust Executive Group	CN/COO		12 September 2012
Healthcare Governance Committee	CN/COO		24 September 2012

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

Safeguarding Vulnerable Adults at Sheffield Teaching Hospitals NHS Foundation Trust, Annual Report

April 2011- March 2012

1. Introduction

Safeguarding vulnerable adults has remained high on the national agenda for both health and social care organisations. There is a continued focus on improving standards within all organisations to safeguard and protect vulnerable adults from abuse.
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 as an NHS Provider for the safeguarding of vulnerable people.

Wider Trust initiatives to safeguard patients include work streams on issues such as transition of children with complex needs into adult services, learning disabilities, domestic abuse, substance misuse, nutrition, tissue viability, Mental Capacity Act, privacy and dignity, mental health including Dementia etc.

2. Definition

The term 'vulnerable adult' refers to any person 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)

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 long awaited 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).

3.1 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). 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. The process is similar to the existing Serious Case Review process carried out following the death of a child or vulnerable adult. The purpose is not to assign blame or responsibility but to learn lessons and to improve policies and practice at a local and national level. This provision came into force on 13th April 2011.

The lead responsibility for co-ordinating DHRs lies with the Community Safety Partnership (CSP). In Sheffield this is the Safer and Sustainable Communities Partnership. They will initiate DHRs and select members of the review panel. The panel will then carry out the review as an independent body. The Trust has a statutory duty to participate in this process.

The implication for STH is that the requirement for DHRs is an additional workload with no supplementary funding. The workload is also unpredictable – Sheffield has had from 0-5 domestic homicides per year, in recent years.

STHFT Involvement in the DHR process

Following a domestic homicide in Sheffield in June 2011, STHFT was represented on the DHR Review Panel by the Deputy Chief Nurse.

An Independent Management Review (IMR) of the Trust's involvement in provision of services to both the victim and the alleged perpetrator was undertaken by the Lead Nurse for Older People/Vulnerable Adults.

The IMR forms part of the Domestic Homicide Review overview report, compiled by an independent author.

The IMR from STHFT was submitted to the independent overview author in a timely manner according to the agreed timescales.
Recommendations to improve practice were identified by both the IMR author and the independent DHR overview author
Monitoring of actions from the DHR is undertaken by the DHR panel.

Key Achievements 2011-2012

- STH has completed all actions assigned to the Trust arising from the recommendations from the DHR.
- The DHR was forwarded to the Home Office Domestic Homicide Review Quality Assurance Panel which commented that the review from Sheffield was of an excellent standard and that it would be published as an example of good practice on the Home Office website.
- The Quality Assurance Panel recognised the contribution of the other agencies involved and commented that the approach to the review was open and transparent and it was clear that partners in Sheffield were willing to be self-critical in their analysis.

Key priorities 2012 -2013

- 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.
- To ensure recommendations from this and any subsequent DHRs are implemented and progress reported via the Sheffield Domestic Abuse Partnership.

4. Safeguarding Adults Team

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

Key achievements 2011-2012

The STHFT adult safeguarding team has been enhanced by the successful transfer of the adult safeguarding adviser from Community Provider Services to the post of Named Nurse for adult safeguarding. 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.

Job descriptions, roles and responsibilities for the adult safeguarding team have been revised to reflect the requirements of the service and to ensure that the operational aspects of safeguarding vulnerable adults are delegated to the most appropriate member of staff.

Key priorities 2012-2013

To continue to offer training. advice and support to STHFT staff in respect of the care provided to vulnerable people.

To maintain an excellent attendance record at the delegated safeguarding meetings and sub groups.

To develop robust systems and processes for delegation of workload across the team to ensure all safeguarding concerns are addressed in a timely manner.

5. Policies and Procedures

All agencies across South Yorkshire work within the guidance of **the South Yorkshire Adult Protection Procedures (SYAPP).** 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 reviewed in 2012 overseen by the SASP. STHFT will be expected to contribute to this review.

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 (often a domiciliary or care home setting).

2. Concerns arising as a result of an act or omission in care by STHFT. Many of 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.

The Trust was represented on this task and finish group by the Lead Nurse for Older People and by representatives from Patient Partnership.

As a result, Patient Partnership staff now forward to the Adult Safeguarding Team for review, any potential safeguarding concerns identified when undertaking the initial risk grading of a complaint.

Key achievements 2011-2012

- The Trust Safeguarding Adults policy has been reviewed and updated to combine the acute hospital safeguarding procedures and responsibilities with those of the community care group.
- A guidance document has been agreed for the provision of adult safeguarding supervision for staff working with vulnerable adults who may be challenging or creating additional stresses to care staff.

Key Priorities 2012-2013

- To undertake an audit of complaints to identify whether safeguarding concerns are being correctly recognised via the complaints review and risk grading process.
- To contribute to and agree a trust wide policy on restraint with reference to the city wide guidance on restraint.

5.1 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 how many safeguarding referrals 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 2011-2012

- There were a total of 202 reported formal alerts noted on Datix from April 2011 – March 2012. This is an increase of 68% on the previous year suggesting that staff are becoming more aware of safeguarding concerns and are more confident in making a safeguarding alert or referral.
- There were 170 contacts with the STH adult safeguarding team for advice and support from within the Trust and from external agencies. These requests often require some further information to be sought and / or investigation undertaken by the safeguarding adults' team. What these data are unable to reflect is the impact on the workload of the safeguarding adult team generated by each individual contact.

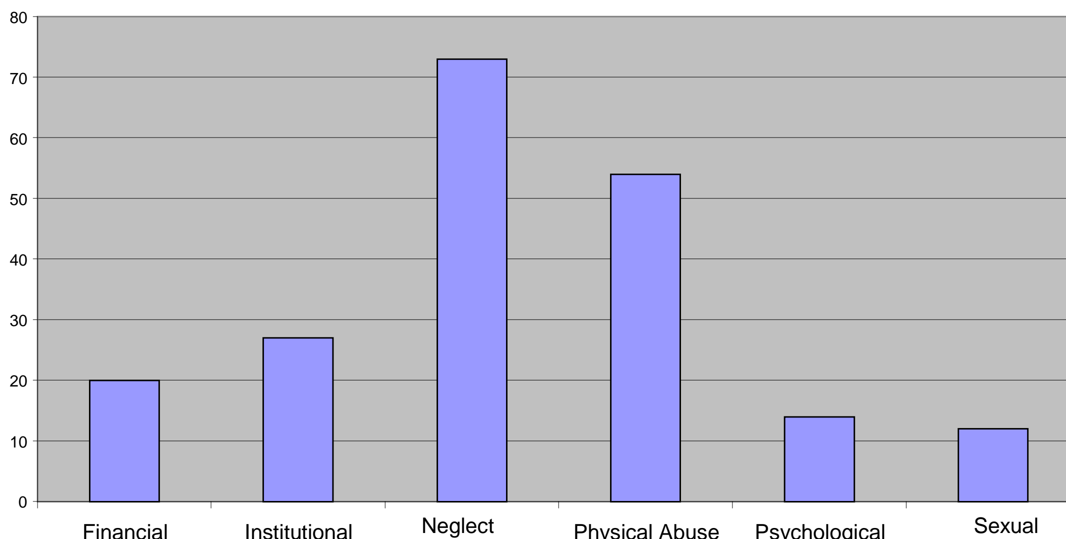
Key priorities for 2012-2013

- To increase the number of alerts reported, taking the opportunity to highlight via the Safeguarding Leads meeting, situations where appropriate alerts are being missed.

5.2 Table 3 - Yearly summary of safeguarding alerts recorded on DATIX

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

Table 4 - Types of Abuse



Neglect or omission and physical abuse have been the main categories for the allegations of abuse.

5.4 Referrals

STHFT referrals to Sheffield Adult Safeguarding Office from 01.04.2011 to 31.03.2012	**Comments**
136	The Sheffield Safeguarding Adults Office is unable to clarify whether this total includes referrals generated from the Community Care Group which makes it difficult to ascertain if there has been an increase in referrals from STH acute services

Key achievements 2011-2012

- A '4 Steps to raising a Safeguarding Alert' flowchart is available on the Intranet. The aim of this flow chart is to explain and simplify the process for staff responsible for raising an alert and those responsible for making referrals.
- An additional 4 Steps flow chart has been developed to specifically signpost community based staff to the appropriate referral process.
- Guidance on the thresholds for referral into adult safeguarding has been circulated to the SUI panel and to the Patient Partnership team for reference.

Key Priority for 2012-2013

- To further develop the system of data collection and recording of safeguarding adults referrals made by STHFT.

5.5 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.

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

Key Priority for 2012-2013

- To identify senior key individuals from within the Trust who have the skills to lead on safeguarding investigations and IMRs.
- To provide specialist training for key staff in undertaking IMRs.

5.6 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.

The following table details the current available data on the number of DOLS applications made by STH during the period from April 2011 – January 2012.

TOTAL DOLS APPLICATIONS APRIL 2011-JAN 2012	STANDARD AUTHORISATIONS GRANTED	URGENT REQUESTS ASSESSED AS BEING APPROPRIATE	URGENT REQUESTS ASSESSED AS NOT APPROPRIATE	URGENT ONLY REQUIRED AS PATIENT REGAINED CAPACITY
42	71%	17%	10%	2%

Key Achievements 2011-2012

The Adult Safeguarding Team undertook a small scale trust wide audit of mental capacity assessments and best interest decisions:

- 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.

The audit forms were collated by Clinical Effectiveness. The findings showed that mental capacity assessments are being carried out across the Trust but are not being documented as per the recognised 2 stage capacity test. This is required to provide assurance that the Mental Capacity Act Code of Practice is being adhered to.

Best Interest meetings are being held but best interest decisions are not being documented as such and the overall decision maker is not clearly identified.

Recommendations are as follows:

1. To make an exemplar of good practice in recording a mental capacity assessment available on the Trust MCA intranet site.
2. To provide MCA /best interest awareness as part of the Safeguarding Adults Basic Awareness Training and the newly qualified staff induction programme.
3. To re-audit from January to March 2013 to review whether the recommendations have led to improvements.

Key Priorities for 2012-2013

- 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).

- To provide training and to support staff in undertaking mental capacity assessments and best interest decisions.

- 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.

- To re-audit from January to March 2013 to review whether the recommendations have led to improvements.

5.7 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.

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

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.

Health based IDVAS have 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.

IDVAS were introduced to the A&E Department at the Northern General Hospital in August 2011 and are currently providing 3 sessions per week.

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

Multi Agency Risk Assessment Conference

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 2011-2012

- 100% Attendance at MARAC
- The coding box for Domestic Abuse has been moved to the 'Special Cases' section of the A&E card. This generates an alert on the front of the A&E record with the code Dom V to alert staff to previous DA concerns. The changes have been made to both the hard copy record and the electronic system.
- The Nursing Care Guideline for Domestic Abuse has been updated to reflect current practice.

Domestic Abuse Meetings	STH Attendance for 2011/12
MARAC	100% (22 of 22)
Sheffield Domestic Abuse Partnership (SDAP) Strategic Planning Group	83% (5 of 6)

Key priorities for 2012-2013

- To continue to ensure 100% attendance by STHFT at MARAC.
- To ensure 100% attendance at the SDAP Strategic Planning 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.

5.8 Vulnerable Adults Panel

There are a number of vulnerable individuals in the city who are well known to a variety of agencies, often with chaotic lifestyles but who do not necessarily meet the criteria for referral to specialist services for support. These people are often referred to as 'frequent fliers' and will access services inappropriately and repeatedly, diverting limited resources away from those who may be in greater need, whilst not adequately addressing the needs of the individual.
Many of these vulnerable adults will be regular users of services provided by STHFT e.g. A&E, minor injuries, 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 adults referred into the panel with the aim of reducing the inappropriate use of essential services, by meeting the needs of these individuals.

Key achievements 2011-2012

- The Named Nurse for adult safeguarding is representing the interests of the Trust on the vulnerable adult's panel.

Key priorities for 2012-2013

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

6. Safeguarding Adults Structures and Processes

6.1 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.

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

Key achievements 2011-2012

- 100% Attendance at SASP.

Key priorities for 2012-2013

- To continue to ensure 100% attendance by STHFT at SASP and associated meetings.

Table 1: Summary of STHFT attendance at SASP Meetings

SASP Meeting/Sub Group	STH Attendance for 2010/2011
Sheffield Adult Safeguarding Board	100% (4 of 4)
Sheffield Adult Safeguarding Partnership (SASP) Operational Group	100% (4 of 4)
SASP Policy and Practice Implementation Group (PPIG)	100% (4 of 4)
Sheffield Adults Safeguarding Education and Development Group (SASED)	100% (4 of 4)

6.2 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 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 and monitoring any associated action plans.

Key achievements 2011-2012

- Six Safeguarding Leads Meetings have been held, where Care Group representatives are informed on 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 2012-2013

- 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.

7. 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 STH 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.

7.1 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.

No recommendations for STHFT were identified by the IMR author.

The overview report has not yet been completed.

7.2 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. STHFT had provided services for the individual concerned therefore an IMR will be undertaken by the Named Nurse for Adult Safeguarding.

Key achievements 2011-2012

- The IMR for the Nottinghamshire SCR was submitted to the independent overview author in a timely manner according to the agreed timescales.
- The Nottinghamshire SCR Review Panel has commended the IMR authors for the high standard of the IMR submitted.

Key Priorities 2012-13

- 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.

8. 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 Adult Safeguarding Office.

Adult case AY involved a patient who suffered harm whilst in the care of his family. AY has a long history of contact with services at STHFT.
The Lead Nurse for Older People/Vulnerable Adults has completed an IMR which was submitted in June 2012.

Adult case RE involved a patient with necrotising fasciitis and an IMR was submitted by STHFT in November 2010.
The final report was signed off by the SASP Board and the recommendations and action plans circulated in March 2012.

Key achievements 2011-2012

A key theme from SCRs and SASP has been the assessment and monitoring of the implementation of the recommendations from SCRs and how these have been embedded in to practice to improve patient care.
In response to the recommendations and action plans from the above Case Reviews and SCRs the following actions are in progress:

- An audit of compliance with Mental Capacity Assessments and best interest decision making was registered with the Clinical Effectiveness Unit and undertaken between September 2011 and January 2012.

Key priorities for 2012-2013

- 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.

9. Assurance/Governance

Internal

Key achievements 2011-2012

Audits

- An internal audit relating to adult safeguarding in the acute setting was completed and a report published in June 2011. A C grading was allocated indicating the presence of medium risks/internal control weaknesses. Four recommendations were raised and action taken on all of these.
- In December 2011 the recommendations were reviewed by the internal audit team and an A Grading was awarded, which indicates that all recommendations have been implemented.
- The Lead Nurse for Older People and Vulnerable Adults has provided evidence to assure the Care Quality Commission CQC Provider Compliance Assessment (PCA) Outcome 7 - Safeguarding.
- The Primary and Community Care Directorate undertook a re-audit of safeguarding awareness in October 2011 to compare with the audit undertaken in 2010.

  The objectives were:
  - to highlight gaps in knowledge
  - to identify adherence to policies, procedures and guidance
  - to inform design of training and awareness to meet the needs of staff.

  A total of 115 completed questionnaires were received of the 300 disseminated; a response rate of 38.3%, an increase from the 27% response rate in 2010.

Results

- On the whole the audit identified some improvement in knowledge of Safeguarding Adults policy and procedure compared to the previous year's audit.

- There was some improvement in the number of staff who would complete an incident form to report any allegation of abuse.

- The audit demonstrates that some staff lack understanding about time and decision specific mental capacity assessments.

Recommendations

- The next safeguarding adults audit will be a combined acute and primary and community care audit.

- Staff to receive additional support and training in understanding embedding MCA/ Best Interest decision making in practice.

Key priorities for 2012-2013

- To develop an audit tool and undertake a re- audit of safeguarding awareness across both acute and community staff in October 2012.
- To provide MCA/ best interest decision making support and training where required

<u>External</u>

The SASP has developed a Performance Checklist as part of the Dashboard against which performance by partners against key SASP performance indicators will be monitored.

Key achievements 2011-2012

- The SASP Performance Checklist was completed and submitted to the Safeguarding Adults Office in December 2011 as requested.
- STH is currently graded as green or amber for the actions identified. Work is underway to ensure remaining actions will be completed within the agreed timescales.

Key priorities for 2012-2013

- To ensure recommendations arising from the SASP Performance Checker are completed within the agreed timescales.

10. <u>Education and Training</u>

Staff training and development

Key achievements 2011-2012

- The Lead Nurse for Older People and Vulnerable Adults has established an in house Safeguarding Adults Basic Awareness training programme in STHFT which includes training for staff at Corporate Induction and the availability of an appropriate E-learning module.
- A Training Needs Analysis was updated in January 2012 which incorporates a newly adopted set of national competencies for staff working with vulnerable adults.
- A Safeguarding Adults awareness leaflet for volunteer staff has been published and distributed via the volunteer induction programme and via the volunteer coordinators.
- Attendance at training is recorded and monitored by the STHFT Safeguarding Office.

- An evaluation of the current basic awareness training has been undertaken with support from the Clinical Effectiveness department. The initial findings suggest that staff who have completed the training have a good basic knowledge of how to recognise and report adult abuse.
- The Lead Nurse and Named Nurse attended the Department of Health PREVENT anti terrorism training for trainer's course with a view to disseminating the learning across the organisation.

Key priorities for 2012-2013

- To publicise the Training Needs Analysis and ensure that Directorates and Departments are aware of the training requirements of all their staff.
- 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 procedures.
- Contribute to the city wide working group developing multi agency training on restraint.
- 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.
- To capture the training and updates provided to the Primary and Community Care Directorate.

11. Conclusion

There has been a great deal of progress 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. The integration of the Primary and Community Care Directorate has increased the level of activity for the Adult Safeguarding Team to include support and advice for staff in the recognition and reporting of safeguarding concerns in the community. The capacity of the Adult safeguarding team has been increased by the addition of the 1.5 WTE Named Nurse posts. This additional resource has strengthened the skills and knowledge base within the team and the ability to respond to the increased numbers of safeguarding concerns and work streams.

This report has detailed the data collected and the main areas of activity during 2011-12 and has summarised the key priorities for 2012-13.

12. 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.

Care Quality Commission (2010) **Our Safeguarding Protocol**. CQC

Department of Health (2011) **Statement of Government policy on adult safeguarding Health guidance for managers, commissioners and nurses**. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124882

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

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

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

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

Department of Health (2011**) Safeguarding Adults and the Role of Health Services. Analysis of the Impact on Equality**. Published to DH website, in electronic PDF format only.. http://www.dh.gov.uk/publications

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

Home Office (2011) **Call to End Violence Against Women and Girls** .Cabinet Office. www.homeoffice.gov.uk/vawg

Home Office (2011) **Call to End Violence Against Women and Girls Action Plan**. Cabinet Office . www.homeoffice.gov.uk/vawg

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

Safeguarding Adults. **South Yorkshire's Adult Protection Procedures** (2007)

Sheffield Local Authority Executive Management Team (2011) **Domestic Homicide Review. Draft Report.**

Annual Report to be posted on Safeguarding Adults intranet site, Safeguarding Patients

Appendix 1

Key Achievements for Adult Safeguarding 2011-12

	Key priorities identified in the 2011-2012 Annual Report	Progress/ achievements
STHFT Involvement in the DHR process	• Participate in this and any other DHR which occur during 2011/12 ensuring that the Trust submits a timely, accurate comprehensive Independent Management Review (IMR) in respect of the victim's and the alleged perpetrator's contact with STHFT services.	The IMR from STHFT was submitted to the independent overview author in a timely manner according to the agreed timescales. • STH has completed all actions assigned to the Trust arising from the recommendations from the DHR. • The DHR was forwarded to the Home Office Domestic Homicide Review Quality Assurance Panel which commented that the review was of an excellent standard and that they would like to publish it as an example of good practice on the Home Office website. • The Quality Assurance Panel recognised the contribution of the other agencies involved and commented that the approach to the review was open and transparent and it was clear that partners in Sheffield were willing to be self-critical in their analysis
Violence Against Women and Girls	• The Lead Nurse for Older People and Vulnerable Adults will represent the Trust at city wide action planning meetings which will now link into the Domestic Abuse Partnership Strategic Planning Group and ensure that the implications from the city wide meetings are implemented within STHFT.	The Lead Nurse for Older People/ Vulnerable adults and the Nurse Director/ Head of Midwifery ensured representation at all the Domestic Abuse Partnership Strategic Planning Group meetings.

Policies and Procedures	To ratify a joint policy for adult safeguarding integrating STHFT and Community Care Group adult safeguarding roles and responsibilities .	• The Trust Safeguarding Adults policy has been reviewed to combine the acute hospital safeguarding procedures and responsibilities with those of the community care group. • A guidance document has been agreed for the provision of adult safeguarding supervision for staff working with vulnerable adults who may be challenging or creating additional stresses to care staff.
Referrals	1. To review the referral process and provide clear guidelines on which cases should be referred to safeguarding. 2. To identify the appropriate level of reporting in circumstances where the safeguarding concern or incident relates to the care provided by STHFT.	• Work has been undertaken to inform Patient Partnership regarding referring potential safeguarding issues from complaints • Thresholds guidance sent to Andrew Scott for dissemination to the Serious Untoward Incident panel • 4 Steps for making a referral has been developed for community staff
Investigations	• To further discuss and agree on the roles and responsibilities of health staff in leading safeguarding investigations where other agencies may also be involved.	Discussed at Safeguarding Leads and with the Local Authority Adult Safeguarding Lead. At this point in time there has been no agreement reached.
Domestic Abuse	• To continue to ensure 100% attendance by STHFT at MARAC. • To review how information obtained from MARAC can be utilised within the Trust to identify the high risk victims of domestic abuse. • To provide representation at the SDAP Operational Group.	• 100% Attendance at MARAC • 83% attendance at the SDAP Strategic Planning Group. • It has been agreed that the SDAP Operational Group does not require representation from health. • The coding box for Domestic Abuse has been moved to the 'Special Cases' section of the A&E card. This generates an alert on the front of the A&E card with the code Dom V to alert staff to

		previous DA concerns. The changes have been made to both the hard copy and the electronic system. • The Nursing Care Guideline for Domestic Abuse has been updated to reflect current practice.
Vulnerable Adults Risk Management Model (VARMM	To provide awareness and training for staff in the identification of patients who may be appropriate for referral into the VARMM process	VARMM awareness is included in all safeguarding adults basic awareness training. VARMM information and paperwork is available on the Trust Safeguarding Patients Intranet site.
Safeguarding Adults Structures and Processes	To continue to ensure 100% attendance by STHFT at SASP Board and associated meetings.	100% Attendance at SASP Board
Safeguarding Leads Meetings	• 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.	Six Safeguarding Leads Meetings have been held where safeguarding updates have been provided and agreement reached on polices and procedures presented to the group.
Serious Case Reviews (SCR)	• To develop a method of reviewing service improvement as a result of action planning from case reviews and SCRs	An audit of MCA compliance was undertaken as follow up to a recommendation from a SCR.
Governance/ Assurance Internal/ External	• To complete the PCA for CQC Outcome 7: Safeguarding. • Further agreement needs to be reached on the Safeguarding Adults Governance Framework to ensure this complies with the requirements of the SASP Annual Safeguarding Governance Check. • A clear structure of internal reporting needs to be agreed to ensure information is cascaded to the appropriate forums to inform and provide assurance to the Trust Board.	• An internal audit relating to adult safeguarding was completed and a report published in June 2011 with an allocated C grading indicating the presence of medium risks/internal control weaknesses. Four recommendations were raised and action taken on all of these. • In December 2011 the recommendations were reviewed by the internal audit team and an A Grading was awarded, which indicates that all recommendations have been

		implemented. • The Lead Nurse for Older People and Vulnerable Adults has provided evidence to assure the Care Quality Commission CQC Provider Compliance Assessment (PCA) Outcome 7 - Safeguarding.
Staff training and development	• To publicise the Training Needs Analysis and ensure that Directorates and Departments are aware of the training their staff require. • To undertake an evaluation of the current basic awareness training in relation to relevance and effectiveness in informing and enabling staff to complete safeguarding alerts and referrals. • Contribute to the city wide approach to developing further training programmes overseen by the Sheffield Adult Safeguarding Education and Development Group (SASED) • Contribute to the city wide working group developing multi agency training on restraint. • Ensure volunteers receive appropriate safeguarding adults training.	• The training needs analysis is available on the Intranet and via the Central News Update. • An evaluation of the basic awareness training was undertaken and the training programme updated as a result of the feedback obtained. • The Named Nurse for adult safeguarding attends the SASED. • The Named Nurse attends the working group on restraint and has contributed to the development of the 'Policy for the Management of Patients whose Behaviour Challenges the Service' • A leaflet for volunteers has been developed and disseminated via the volunteer coordinator.
Incidents/Safeguarding Alerts	To increase the number of alerts reported, taking the opportunity to highlight via the Safeguarding Leads meeting, situations where appropriate alerts are frequently missed	• A database of safeguarding adult's referrals has been established to enable monitoring of sources of referrals, identify any gaps and facilitate a future audit of the appropriateness of referrals.