Board of Directors **Trust Quality & Performance Committee**	Guy's and St Thomas' NHS Foundation Trust
Safeguarding Adults Annual Report 2017 - 2018	**11th April 2018**

This paper is for:		Sponsor:	Dame Eileen Sills, DBE	
Decision		Author:	Mala Karasu, Head of Safeguarding Adults	
Discussion		Reviewed by:		
Noting	✓	CEO*		
Information		ED*	✓	
		Board Committee*	✓	Quality & Performance Committee
		TME*		
		Other*		Sarah Wilding, Deputy Chief Nurse

* *Specify*

1. Summary

- The referrals to safeguarding adults from the acute and community services have continued to rise (22% for acute and 9% for community) over the last year demonstrating increased awareness of safeguarding vulnerable adults and the need to report concerns of abuse or neglect as a statutory duty. There is evidence to support good practice of early identification and appropriate referral of safeguarding concerns to the safeguarding adults team.

- Deprivation of Liberty Safeguards (DoLS) applications have increased by 74% from the previous year through increased staff awareness of the DoLS requirements and case finding by the safeguarding team. Focused work has been undertaken to support wards that have had fewer referrals submitted by the safeguarding team having weekly ward visits proactively case finding patients.

- Safeguarding adults training compliance is 82.39% which is below the 85% compliance rate set by the Clinical Commissioning Groups. Additional teaching sessions and an e-learning package have been live since February 2017 to increase compliance. There is a Prevent training programme available to staff who have been profiled for the appropriate level of Prevent training. WRAP 3 Prevent training is reportable and is also below the agreed compliance rate of 85% at 65.42%. Extra training is being provided and an e-learning package is due to be uploaded onto the Trust Intranet site for staff to use.

- Dementia screening compliance only reached the target compliance rate of 90% in one quarter. The team has continued to support the wards and clinical teams in a number of ways and the DaD team and Committee are looking at a number of actions to improve the screening compliance, including a teaching session at SIOH on the reasons for screening.

- A key priority for the Trust is to provide high quality care for people with a learning disability (LD). There is a Learning Disability Strategy which is a three year plan to further develop services delivered to people with LD. Progress to date includes the development of a flagging system to identify patients with LD while in hospital, identification of a suitable e-learning package to raise LD awareness within the organisation

and the development of a communication resource. The focus for 18/19 will be to ensure that departments have suitable accessible information for the population and transition processes.

- The governance for mental health services within the Trust has been strengthened with the formation of the Mental Health Board chaired by the Deputy Chief Nurse and supported by seven sub-groups. A new Mental Health Lead has started in the Trust with strategic and operational responsibilities for the development of mental health services.

2. Request to the Quality and Performance Committee

The Committee is asked to consider the contents of this report and raise any issues of concern or outline any specific action they request.

3. Safeguarding Adults Activity

3.1 Safeguarding Adults Referrals (Acute Services)

3.1.1 Numbers of referrals received from the acute services over the last year is shown in the table below.

2017 - 2018	Q1	Q2	Q3	Q4	Total referrals in 2017-2018	Total referrals in 2016-2017	% increase
Number of referrals	292	258	362	385	1297	1055	22.94%

3.1.2 Safeguarding adult's referrals from the acute services to the team have continued to rise each quarter and shows a 22.9% increase when compared to the previous year. Staff awareness of when to raise an alert was good as noted from the recent safeguarding adult's reality rounds undertaken on the Guy's Hospital site.

3.2 Safeguarding Adults Referrals (Community Services)

3.2.1 Numbers of referrals received from community services identified in table below.

2017 - 2018	Q1	Q2	Q3	Q4	Total referrals in 2017-2018	Total referrals in 2016-2017	% increase
Total referrals	92	109	120	111	432	396	9.09%

3.2.2 Referrals from the community have also increased with a 9% increase from the previous year. Staff awareness of when to raise a safeguarding adults referral also showed a positive result from a Reality Round undertaken in the community. Staff are more confident in asking for advice from the team and escalating concerns early and appropriately.

3.2.3 Referrals from the community remain complex and often required a multi-agency approach to resolving some of the issues. To support staff with early advice and early escalation with complex cases, an Adult Safeguarding Review meeting has been set up where community frontline staff can bring and discuss complex cases with the safeguarding adults team and escalated appropriately. A Community Reality Round also demonstrated that staff understood what to do when they had a safeguarding concern.

3.3 Referral Types

3.3.1

2017-2018	Q1		Q2		Q3		Q4	
	A	C	A	C	A	C	A	C
Domestic abuse	16	0	17	2	18	3	21	3
Financial abuse	32	4	17	3	30	3	28	2
Psychological and/or verbal	26	2	16	7	11	6	15	4
Physical abuse	21	6	20	10	24	13	25	8
Sexual abuse	8	0	5	2	4	1	4	0
Organisational abuse	3	0	2	0	2	2	4	0
Neglect	68	37	67	49	103	50	115	54
Care Management	117	41	111	35	168	41	172	40
Modern Slavery	1	0	1	0	0	0	0	0
Prevent	0	2	2	1	2	1	1	0
Total	**292**	**92**	**258**	**109**	**362**	**120**	**385**	**111**

3.2.2 The table above demonstrates the categories of abuse that patients were referred for over the last year. Neglect by others was the highest category of alleged abuse reported over the last year. This category includes incidents such as development of pressure ulcers, delayed or missed visits to patients, omissions of care by formal and informal carers etc.

3.2.3 The second most common category of potential abuse reported was physical abuse. Physical abuse of vulnerable people by strangers, partners, children and carers. Another feature of this type of abuse is self-harm. Once the team has assessed the patient who has suffered abuse the team would provide initial advice and agree and document any safeguarding plan for their stay in hospital if required. The vulnerable adult is then then referred onto other appropriate specialist services such as Social services, the Homeless Team and the Alcohol team with the patient's consent. For patients who lack capacity referrals to other appropriate services were made in the patient's best interest.

3.2.4 Just under half of the referrals were for further support from social care for the person involved and did not trigger a safeguarding response. Self-neglect is a concern that falls within this category, where patients often only required a referral to social services for a reassessment of their care needs in the community. However, the team scrutinises such cases to ensure that there are no safeguarding reasons for the self-neglect such as financial abuse or neglect by others. Another example of self-neglect, particularly in the community setting, is where patients refuse care that is essential for their health and wellbeing. Nurses in particular find refusals very disempowering and feel responsible for the situation. The safeguarding team has worked with the clinical teams and advised the use of the Mental Capacity Act to ascertain capacity for the patient to refuse care together with other strategies of using friends and family to engage with the patient, providing written information for the patient to understand the issues, respecting the wishes of patients with capacity to refuse care and advising the patient to call the care teams when they need assistance and equipping them with the contact details to do so.

3.3 Referral Breakdown by Age

3.3.1 The referrals as per the table below have demonstrated that older people are more vulnerable to being abused due to many of them having care and support needs that make it difficult for them to protect themselves against neglect or abuse. Safeguarding adults training addresses vulnerabilities and how patients can be supported to report any concerns that they have through information giving on how to raise a safeguarding concern. Safeguarding adults and dementia care training have been focused on the older person's wards so staff are vigilant to any concerns their patients have.

3.3.2 Ages of People Referred to Safeguarding Adults

Age	Q1	Q2	Q3	Q4
17-30	24	40	49	52
31-50	58	39	69	43
51-70	95	106	121	147
Over 70	203	179	238	248
Not Specified	1	2	1	3
Under 17 age	3	1	4	3

3.3.3 Referrals for patients under the age of 17 were received from adult wards where patients of 16 and 17 years of age are sometimes admitted to. These referrals were discussed and referred to the Children Safeguarding team. There is often joint working between both teams especially where there are vulnerable adults involved in the care of this child.

4.0 Safeguarding Adults and Prevent Training

4.1 Safeguarding Adults training comprises of two levels of training, Basic Awareness at Level 1 for non- clinical staff and Level 2 for all clinical and non-clinical staff with patient contact. The Trust is required to maintain a training compliance level of 85% at all times. The table below shows training compliance at the end of February 2018 which was below the 85% required. Staff turnover has been the main reason for not reaching the level of compliance required. The number of staff requiring to be trained had increased over the year and there was a significant number of staff leaving the Trust with new staff starting. This has resulted in the slow progress made with reaching the target compliance rate as shown in the table below.

Safeguarding Training Level 2	CCG Target	Total number to train	Acute compliance		Community Adults compliance		Children Acute and community compliance		Overall Trust compliance
Level 2 in Feb 2018	85%	9272	5776	81.42%	518	90.40%	1345	83.80%	82.39%
Level 2 in Feb 2017	85%	8838	5119	75.87%	456	82.91%	1233	80.01%	77.03%

4.1.1 All staff who were non-compliant were written to, to ask them to book onto a session or to undertake the e-learning package that was made available for staff since March 2017. Additional sessions including bespoke training were provided to increase the compliance rate. The trainers will continue to provide additional sessions with all new starter now using the e-learning package. An e-learning package is also being developed for Safeguarding Adults Level 1 training which will be ready for use in the new financial year.

4.2 Prevent Training

4.2.1 The Trust is required to provide two levels of training for staff; Level 1 Basic Awareness of Prevent (BAPT) for all non-clinical staff and WRAP 3 (Level 2) training for all clinical staff. Currently Level 1 training is provided at corporate induction and as bespoke sessions. WRAP 3 training is provided as classroom sessions for new starters and three yearly updates for clinical staff.

4.2.2 Prevent training started to be monitored on WIRED (the Trust training recording system) since 22nd March 2016. Level 1 Prevent training is provided at corporate induction as a face to face session and via an e-learning package for non- clinical staff. Bespoke face to face Level 1 training sessions have been provided to non-clinical staff who do not have easy access to computers such as domestic and food services staff. The table below shows the compliance with training.

PREVENT Training Level 1	Total number of staff profiled	Total numbers of staff compliant	% compliant
Level 1 in Feb 2018	5982	5046	84.35%
Level 1 in Feb 2017	5530	3902	70.56%

4.2.3 The challenge with reaching the target compliance of 85% has been staff turnover which reduces the number trained and further increases the numbers that have to be trained. Also not all non-clinical staff have access to computers and are able to access the training online and so require face to face sessions. Despite these challenges Level 1 Prevent training is on the trajectory to achieving 85% compliance by 31st March 2018.

4.2.4 WRAP 3 training is very prescriptive and developed by the Home Office and delivered by organisational trainers as a face to face session. WRAP 3 training have been provided in the Trust since February 2015 and the number of staff profiled to undertake this training was limited to specialist teams including A&E ,community adult services and the safeguarding team. In 2016 the Trust reviewed its Prevent policy and delivery plan and profiled all clinical staff to receive WRAP 3 training with a training plan. The training compliance set by the Home Office is 85% to be achieved by March 31st 2018. The Trust is not on the trajectory to achieving this target. Trust Prevent training compliance was reviewed by Southwark Clinical Commissioning Group and an action plan was set by the safeguarding adult's team in an attempt to achieve the required compliance. Southwark CCG was reassured that the Trust has a robust training programme and has tried to achieve the required compliance despite the challenges highlighted.

4.2.5 An e-learning package for WRAP 3 has just been made available to all provider trusts by the Home Office and will soon be available on the Trust training site. There is also an e-learning programme of WRAP 3 addressing the needs of Mental Health Trusts which will be made available to staff. These e-learning packages when set up on the Trust Intranet will help to improve the training compliance.

4.2.6 The tables below detail the training figures over the last 2 years and the change in numbers of staff who require WRAP 3 training. Quarter 3 saw a significant increase in staff numbers which in turn influences compliance figures.

PREVENT Training Level 2	Q1	Q2	Q3	Q4
Total number of staff profiled	**8612**	**8721**	**9016**	**8997**
Total numbers of staff compliant	**4482**	**4773**	**5371**	**5886**
% compliant	**52.04%**	**54.73%**	**59.57%**	**65.42%**

PREVENT Training Level 2	Total number of staff profiled	Total numbers of staff compliant	% compliant
Level 2 in Feb 2018	8997	5886	65.42%
Level 2 in Feb 2017	8562	3927	45.87%

5.0 Mental capacity Act 2005 (MHA) and Deprivation of Liberty Safeguards (DoLS)

5.1 The Mental Capacity Act 2005 is a legal framework to support people who cannot make decisions about themselves. In hospital this applies to how all care and treatment is provided to patients who lack capacity and supporting them to make decisions about their discharge arrangements. The safeguarding adult's team with the Clinical Lead for MCA have been working continuously towards embedding the principles of the MCA within practice across the Trust.

5.1.2 A mental capacity assessment recording form is now available for all staff to use on E-noting. A recent small audit of the use of this form showed evidence that staff were using this form when a formal capacity assessment for significant decisions such as a serious medical intervention or a change of accommodation was needed. It was recognised that there was a need for continuous awareness raising regarding the use of

the recording form to ensure that all clinical staff were aware of it as it provides structure and consistency to recording the outcome of capacity assessments.

5.1.3 The Safeguarding Adults Link Practitioner Programme is now into its second year with more staff becoming aware of the course. The safeguarding team has reviewed the course and it is now provided over a three month period instead of six months to allow for more staff to undergo this training. Post course evaluation has been very positive.

5.1.4 Reality Rounds undertaken in late 2017 in the community directorate and across Guy's Hospital wards showed that staff generally had a good idea of the MCA but needed more support with identifying when a deprivation of liberty was occurring in hospital and for the community staff to have an understanding when a community deprivation of liberty was occurring.

5.1.5 In early February 2018 the safeguarding team undertook a case notes audit looking at how clinical staff used the MCA when caring for patients who lacked capacity to make decisions about being in hospital and about their care and treatment. The audit showed that the MCA was used appropriately, with capacity assessments being recorded, best interest decisions being made and referrals being made to the safeguarding adult's team for a Deprivation of Liberty Safeguards assessment. Areas of improvement included ascertaining if the patient had made arrangements for incapacity, recording that the patient and carer were informed when a DoLS was applied for, clear identification of the decision maker and raising the awareness of the E-noting capacity recording form so all clinicians will use the recording form for recording capacity.

5.1.6 The safeguarding adult's team was successful at the Dragon's Den challenge and was awarded funds to plan and print desk top MCA and Safeguarding Adults calendars for staff. Each of the calendar pages have a key message for staff to act as an aide memoire. The calendars were printed and distributed to all clinical areas in early January 2018.

5.2 <u>Deprivation of Liberty Safeguards (DoLS)</u>

5.2.1 This legislation applies to people who are admitted to hospitals and care homes and who are not able to consent to the admission. A person is said to be deprived of their liberty if the person cannot consent to be accommodated in hospital to receive care and treatment in their best interest, are under continuous supervision and control and are not free to leave. The DoLS is the legal process whereby patients can be deprived of their liberty in their best interest. A separate process applies for people who are deprived of their liberty in their own homes or in supported living.

5.2.2 There were 658 referrals received for a DoLS over the last year of which 433 applications were made. The remaining referrals where either closed because the patient regained capacity to consent, discharged or were referred to the psychiatric liaison services for an assessment under the Mental Health Act 1983. The table below shows a breakdown of how the referrals for DoLS were processed.

5.2.3 DoLS Referrals for the last year

DoLS	2017-18	2016-17	2015-16
Referrals	658	377	229
Application	433	181	127
Granted	126	61	49
Not granted	31	17	14
Not assessed	276	103	64

5.2.4 276 patients were not assessed by the local authority within the 14 day period and the patients either had regained their capacity or were discharged. The assessments by the local authorities are delayed due to the sheer volume of referrals to the local authorities, which is a national problem.

5.2.6 Following the Policing and Crime Act 2017 which came into force on Monday 3 April 2017, the Coroners and Justice Act 2009 was amended so that people subject to authorisations under DoLS will no longer be considered to be ‘otherwise in state detention’ for the purposes of Section 1 of the Coroners and Justice Act 2009. This meant that coroners will no longer be under a duty to investigate a death solely because a DoLS

authorisation was in place. Such deaths will only be reported to the coroner if the cause of death is unknown, or where there are concerns that the death was violent or unnatural.

5.2.7 The table below shows a breakdown of DoLS application over the four quarters of the year. Whilst the referrals for DoLS have significantly risen, there is still room for improvement as statistically you would expect more patients to be deprived of their liberty. To aid the process of identifying those patients who are being deprived of their liberty, the safeguarding adult's team is making ward visits to and case finding through length of stay data to identify patients.

DoLS	Q1	Q2	Q3	Q4	Total
DoLS referral from ward	146	166	174	172	658
Application	87	99	126	121	433
Granted	26	30	39	31	126
Not granted	2	4	9	16	31
Not assessed	59	65	78	74	276

5.2.8 The DoLS legislation has been subject to heavy criticism since its inception. The House of Lords Select Committee on the Mental Capacity Act in 2014 found that the DoLS were "frequently not used when they should be, leaving individuals without the safeguards Parliament intended" and care providers "vulnerable to legal challenge". It concluded that "the legislation is not fit for purpose" and proposed its replacement. In 2014 a decision of the Supreme Court (commonly referred to as "*Cheshire West*") gave a significantly wider interpretation of deprivation of liberty than had been previously applied in the health and social care context. This increased considerably the number of people who needed to be recognised as being deprived of liberty and requiring safeguards. The Law Commission was commissioned to review the DoLS and consider how the law should protect people who need to be deprived of their liberty in order to receive care or treatment and lack the capacity to consent to this. Article 5 of the European Convention on Human Rights ("ECHR") guarantees the right to personal liberty and provides that no-one should be deprived of liberty in an arbitrary fashion. If a person is deprived of liberty then certain safeguards must be provided, including entitlement to

bring legal proceedings to challenge the deprivation of liberty. Such situations also engage an individual's right to private and family life under Article 8 of the ECHR.

5.2.9 The Law Commission published its final report on 13th March 2017. The report recommended that the DoLS should be repealed and a new scheme introduced called Liberty Protection Safeguards. A draft Bill accompanied the report containing the recommendations which include amendments to other parts of the MCA to provide increased protection for people whose rights to respect for their private and family life and their home under Article 8 of the ECHR are at risk, whether or not they risk being deprived of their liberty. A new Code of Practice was also recommended.

5.2.10 On 14th March 2018 the Government responded to the Law Commission Report to replace the DoLS in its current state. It agreed in principle that the current DoLS system should be replaced as a matter of pressing urgency. The Government has accepted nearly all of the recommendations of the report but did not clearly state when the Liberty Protection Safeguards will be implemented. However, it also stated that before the introduction of any new system, it will need to consider carefully the detail of the proposals carefully and ensure that the design of the new system fits with the conditions of the sector, taking into account the future direction of health and social care. On timescale for implementation it has stated that it can be expected that legislation to implement the new model when Parliamentary time allows.

6.0 Mental Health Act 1983 (MHA)

6.1 Over the last year there were 350 patients detained under the MHA 1983 admitted to the Trust compared to 173 the previous year. The table below shows a breakdown of the different sections that were used to admit patients with mental health illness to the Trust during the four quarters of the year.

6.2 There has been over 100% increase in patients detained under the MHA compared to the previous year. One of the reasons for the increase can be attributed to the lack of mental health beds for patients to be transferred to. As a result patients are detained to the Trust until a bed becomes available. There are ongoing discussions with South London & Maudsley Trust about this issue. An added complication is that a high number of patients

detained in the Trust are patients who are resident outside of our local boroughs and so the bed availability has to be negotiated with individual boroughs.

Mental Health act 1983	Q1	Q2	Q3	Q4	Total	2016-17
Detained under s5(2)	**16**	**28**	**30**	**30**	**104**	**53**
Detained under s2	**32**	**28**	**52**	**65**	**177**	**102**
Patient detained under s3	**0**	**0**	**2**	**3**	**5**	**2**
Section 136	**14**	**12**	**16**	**11**	**53**	**6**
Treatment under (s17)	**0**	**3**	**2**	**5**	**10**	**9**
CTO Recall	**0**	**0**	**1**	**0**	**1**	**0**
Detained under s41	**0**	**0**	**0**	**0**	**0**	**1**
Total	**62**	**71**	**103**	**114**	**350**	**173**

6.3 There has been a significant increase in patients being brought into A&E under a section 136 by the Police. This may be a result of the guidance, Mental Health Crisis Care – London's section 136 pathway and health based place of safety specifications (December 2016), that A&E departments can now be used as a place of safety if a designated specialist bed is not available. Most patients are assessed in A&E and diverted to specialist units if required and where available. Since December 2017 the detention time for a section 136 was reduced from 76 hours to 24 hours with a possibility of a 12 hour extension if clinically required. This also may have resulted in patients being detained to the Trust sooner whilst waiting for an assessment or an appropriate specialist bed.

6.4 The governance for Mental Health was reviewed and a new structure (Appendix 1) is now in place. There is a new Mental Health Board which is chaired by the Deputy Chief Nurse and supported by a number of sub groups, some of which may well be short lived once their project is completed. The Mental Health Board will update the Safeguarding Adults Operational Group and reports directly into the Vulnerable Persons Assurance Committee.

6.5 The new Mental Health Lead has commenced her role in the Trust and providing advice and support to staff and the sub groups. The Lead also chairs the Supporting Positive Behaviour sub group.

7.0 Allegations and Safeguarding Incidents

7.1 Allegations

7.1.1 There were thirteen allegations involving adult services over the last year that were investigated with five being in the last quarter. Several of the allegations related to incidents that had occurred outside of the organisation.

7.2 Safeguarding Adults Referrals

7.2.1 There were 36 safeguarding referrals made against Trust services in the last year. The concerns raised were mainly around Trust acquired pressure ulcers, fall with fracture and omissions of care. Seven cases have been substantiated to date.

Complex Cases	Q1	Q2	Q3	Q4
Total Number of Cases	13	7	8	8

7.2.2 All safeguarding incidents attributed to the Trust were fully investigated and lessons learnt shared with the individual teams. Appropriate cases have been presented at the Safeguarding Adults Operational Group meeting and lessons learnt shared to a wider group of staff.

8.0 Internal management reviews/serious case reviews/domestic homicide reviews

8.1 The Southwark Safeguarding Adults Board (SSAB) had commissioned a Safeguarding Adults Review (SAR) into the death of a resident of Southwark who died as a result of a fire at her home. This lady was known to many services and had lived a chaotic life. The SAR panel met and decided that a review would be required

as it was not evident that the MCA 2005 was used appropriately to support this lady when difficult decisions had to be made about treatment and care. A SAR panel meeting was held and the individual management reviews were discussed and emerging themes were identified. A learning event was held on 13th July 2017 for a wider audience of operational staff. Lessons learnt and good practice were identified. A further learning event is being planned.

8.2 There has been a Domestic Homicide Review undertaken by Bexley Local Authority following the death of a young woman in December 2016. The victim was referred to Reach, one of the two Trust specialist domestic abuse services that had supported the victim for a period of six weeks in 2014. The victim then had not approached Reach for further support until shortly before her death. A panel meeting was held on 19th July where all the individual management reviews of the agencies involved were discussed and emerging themes as learning points were identified. The final report has been compiled with two recommendations for the Trust. A publication date has not been agreed.

8.3 Southwark SAR panel met on 27th June 2017 to discuss a case involving Trust services and to agree if this case fulfilled the criteria for a SAR multiagency investigation. It involved a patient with oncology care needs who was discharged home. There was no evidence that the patient had been seen by the community nursing service following receipt of a referral for follow-up care. The patient failed to attend a follow-up hospital appointment and when followed-up, it was found that the patient had died at home. The SAR Panel decided that this case did not meet the threshold for a SAR investigation and should follow the Serious Incident process.

8.4 A DHR was undertaken by Bolton Local Authority following the death of a lady in 2013 who attend a cardiology clinic in the Trust. The review has been completed and was published on 29th September 2017. The review included a recommendation for the Trust which was for the Trust to raise the awareness of clinicians of their role in offering locally available support to people who disclose domestic abuse through safeguarding adults training. An offer of a referral to a specialist DV service to patients who disclose domestic abuse is covered in safeguarding adults training and is also highlighted in the safeguarding pocket guide.

8.5 Lambeth Safeguarding Adults Board's (LSAB) Safeguarding Adults Review (SAR) sub group met to look at a number of Serious Incidents (SI) reported by the Trust. The aim of the meeting was to identify if any of the SIs met the Lambeth's threshold for a SAR. None of the SIs were considered as meeting the threshold for a SAR.

9.0 Other relevant points for the Board to consider

9.1 Local Authority Feedback- Lambeth

9.1.1 LSAB held a Board Development day on 27th February 2018 to review the progress made with safeguarding adults within Lambeth and to look at developments for the coming year. Among themes discussed included an external review of the LSAB, further work on DoLS and MCA, improving information sharing, prevention and keeping people safe and enabling people in the community to assess risk.

9.1.2 The LSAB had commissioned a task and finish group to look at safeguarding adults thresholds to ensure that the right cases are being reported via safeguarding adults. This also looked at the alignment of SIs reported by the Trust with safeguarding to ensure that there was oversight by the local authority of any safeguarding adults concerns raised within the Trust. A similar piece of work is being undertaken by NHS England and the Safeguarding Adults Provider Network. The Trust has been involved in both pieces of work.

9.1.3 Multi-agency work has been underway in accordance with the three strategic priorities of the LSAB; prevention, representation and promotion, communication and involvement. With regards to prevention the strategic aim is to receive a reduced number of safeguarding adults concerns relating to abuse and neglect in family life through demonstrable effectiveness of adult safeguarding enquiries in reducing risks in private and family life. The Quality and Performance subgroup presented a report to the LSAB in October 2017 on the number of adult safeguarding concerns relating to abuse and neglect in family life and made a number of recommendations as to how this might be reduced.

9.1.4 Under representation, work has been carried out to achieve the aim that the Board will have assurance that recognising and acting on safeguarding concerns happens for people with care and support needs from all communities. Making safeguarding personal takes into account issues of diversity and difference. An audit of equality data was collated as part of the safeguarding adults work by all providers was undertaken to establish a baseline. A report was submitted to the LSAB in October 2017 outlining the minimum equalities data set for safeguarding which will include age, disability, ethnicity, religion, gender and sexual orientation. The safeguarding adult's referral form in the Trust currently does not include information on disability, religion or sexual orientation. The safeguarding adult's team will be working with IT in the New Year to look at how the additional information may be collated when the safeguarding referral is completed.

9.1.5 Under promotion, communication and involvement the provider agencies and Lambeth Local Authority have been working together to evidence that those with care and support needs in Lambeth know how to recognise and act on risks of abuse and neglect and are doing so. The Community Reference Group developed a safeguarding adult's awareness survey as part of this work which was distributed widely and data collection was commenced in November 2017. The survey monkey closed on February 2018 and the Trust has taken part in this survey during the targeted week for all provider agencies. The findings of the survey will be presented to the LSAB in April 2018.

9.2 <u>Local Authority Feedback- Southwark</u>

9.2.1 The Joint Southwark Safeguarding Children Board (SSCB) and SSAB independent chair left the post mid-2017. The SSAB meeting chair role have been undertaken by the Vice Chair and Interim Chief Nurse of the Clinical Commissioning Group since September 2017. The SSAB reviewed its priorities for 2018/2019 which included SSAB development and governance, knife crime, managing risk and learning from SARs. These priorities were agreed and signed off.

9.2.2 The Trust completed the safeguarding adult's self-assessment tool as required of all partners of the SSAB. A challenge event was held on 26th February 2018 where each organisation presented on three areas that it is doing well and three areas of weakness. This was an interactive session where organisations were able to

challenge each other and seek assurance. The event was successful and a number of issues experienced by all organisations will be considered for development by the sub-groups.

9.2.3 A joint SSCB and SSAB meeting was held on 14th November 2017 that looked at the Domestic Abuse Strategy for Southwark. An interactive session took place looking at the progress and next steps of three aspects of the strategy namely prevention and awareness, early identification and support and enforcement. There was rich discussion and recommendations from the group was collated to be shared and inform actions for year three of the strategy.

10.0 Audits

10.1 The safeguarding adult's team undertook two Reality Round audits to look at staff understanding of the principles of safeguarding adults and the MCA and DoLS. One audit was conducted on the wards at Guy's Hospital and the other audit was conducted in the community. Both audit results were positive and areas of improvement included knowledge of DoLS in the hospital and the community, knowledge and use of the communication box and knowledge and use of the Hospital Passport. The action plans from the audits will be included in the safeguarding adults work plan for 2018-2019.

10.2 The team also undertook a case notes audit looking at how the MCA was implemented when care was delivered to people with dementia or learning disability. The results demonstrated that staff did capacity tests where needed and documented them appropriately. Best interest meetings/discussions were held when required and the results recorded in the patients records. The patients were correctly referred to the safeguarding adult's team for a DoLS assessment and application. Areas for improvement included ascertaining if the patient had made arrangements for incapacity, recording in E-notes that the patient and their carer were informed and explained the DoLS application and for a best interest recording form to be agreed and uploaded onto E-Notes for all staff to use to achieve consistency in the recoding of best interest decisions.

10.3 Routine monitoring

10.3.1 The team continued to monitor the following without any exceptions or concerns to report on:

- Ethnicity breakdown for referrals
- Breakdown of referrals by boroughs
- Number of patients admitted with dementia
- Number of patients with falls and fractures who have dementia
- Alerts raised with the Patient Advice and Liaison Service
- Clinical incidents involving adults at risk

11.0 Achievements

11.1 The team was successful in winning the Dragon's Den event and have produced safeguarding and MCA calendars for staff use to try and raise the awareness of both subjects. The calendars were distributed early January 2018.

11.2 An e-learning package for Level 1 safeguarding adults training has been completed and will be ready for use by staff in April 2018.

11.3 A short version of the Dementia Care Update course has been developed which staff can now access and do not have to undertake the full day training for their three year update.

12.0 Dementia and Delirium (DaD)

12.1 Dementia and Delirium (DaD) Referrals

12.1.1 Overall there has been an increase of 10% in referrals to the DaD team when compared with the previous year with a total of 1259 referrals. This may be partly due to staff awareness of the DaD team and the support they offer and partly due to the fact that delirium is better recognised by staff and early referrals are made.

One of the common reasons for a referral is challenging behaviour and non-compliance with treatment presented by the patient with delirium. The DaD CNSs support the teams to identify any causes of delirium and to treat the cause. They also support staff with strategies to engage with the patient such as reminiscence or activities. The table below shows the referrals received for all four quarters of the year.

2017-18	Q1	Q2	Q3	Q4	TOTAL	2016-17
Delirium	**183**	**195**	**180**	**194**	**752**	**770**
Dementia	**86**	**130**	**131**	**160**	**507**	**367**
Total	**269**	**325**	**311**	**354**	**1259**	**1137**

12.2 Dementia Screening

12.2.1 All patients above the age of 70 admitted through emergency services should be screened for memory problems in accordance with the National Dementia Strategy. Those with a positive score will be referred to their GP on discharge who will then make an onward referral to a local memory service. The benefit of the screening is three-fold; it highlights patients who have potential memory issues or may have a delirium which would require investigation and treatment; it captures patients who already have a confirmed dementia diagnosis to allow for care to be planned accordingly and for patients to be able to plan for later life with an early diagnosis of dementia.

12.2.2 It has been a challenging year for the DaD team to get the screening compliance rate to 90% or more each quarter. Quarter 4 compliance was 79.4%. The DaD CNSs have continuously supported staff on the wards with daily email and ward contacts together with bespoke training sessions for staff on the ward with teaching on how to undertake screening.

12.2.3 The steady decline in the dementia screening figures this year could be attributed to a number of reasons. A lack of ownership for the screening activity from health care staff as it is everyone's responsibility which means no one is taking responsibility to ensure it is completed on time. Some nurses do not view the screening process as a priority and therefore screening is sometimes completed after 72hours according to their

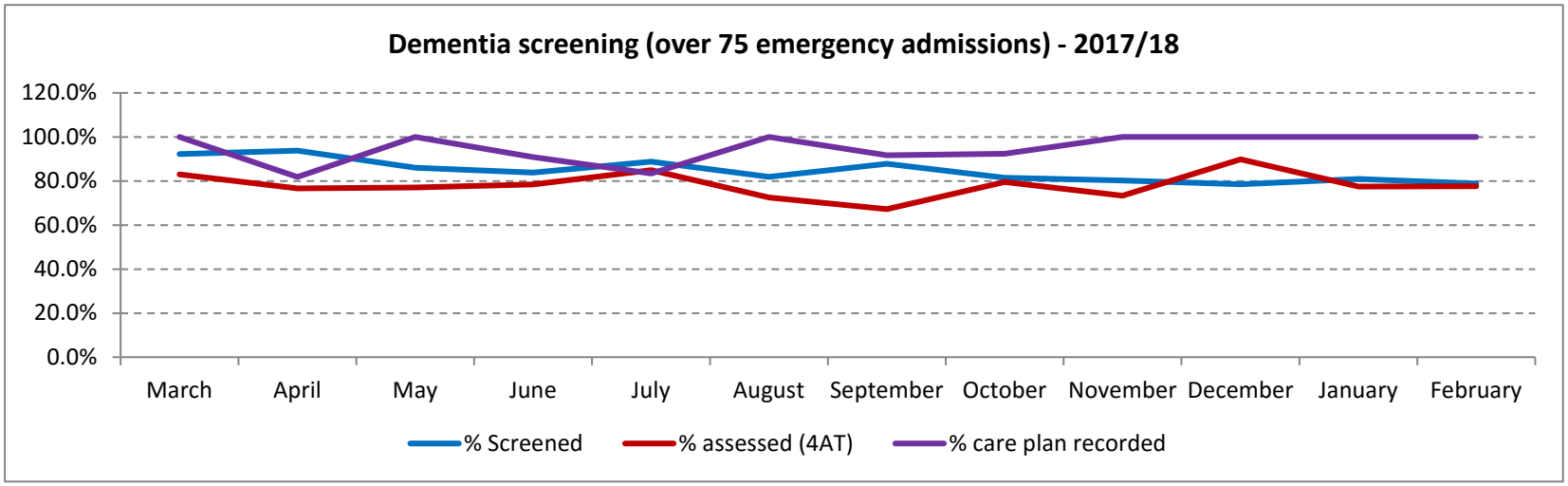
capacity. Some staff have expressed that they do not see the relevance of the screening. Other reasons relate to holiday periods, new intake of junior doctors in August and staff migration.

12.2.4 There have been several ongoing actions to promote compliance with dementia screening. The Clinical Lead has worked with junior doctors to ensure they are aware of the memory screening and how to complete it. The DaD CNSs have continuously challenged current practice and ongoing beliefs that staff may hold around the importance of the screening process. The DaD CNSs have continued to drive a change in ward culture by offering reminder sessions to staff on the wards on the significance of dementia screening to a patient's care and how and when to complete a dementia screen. The DaD CNSs have also carried out dementia screening on the wards on patients who are at risk of breaching the screening target to support staff. Following the low compliance figures of the last quarter, wards who have had consistently low compliance have had teaching from the DaD CNSs. They have also continued to work closely with the Acute Admission Ward (AAW) which has had the greatest number of eligible admissions, a quick patient turn around and thus at a high risk of breaches.

12.2.5 In addition to the above, the DaD CNSs have continued to identify new inpatients requiring a dementia assessment and reminded staff daily via email of those patients with outstanding dementia screens. These additional reminders were focused on those patients who had breached, or were close to breaching the 72 hour window within which they should be screened. Wards have also been reminded to have plans in place to ensure that the screening was completed during periods when there were less staff around such as the weekends and bank holidays to avoid a drop in screening compliance. The table and graph below show the screening compliance for the last year.

12.2.6 Dementia Screening data 2017 – 2018

	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Emergency patients over 75	194	177	172	186	187	149	189	189	197	242	231	203
Screened	179	166	148	156	166	122	166	154	158	190	187	160
% Screened	**92.3%**	**93.8%**	**86.0%**	**83.9%**	**88.8%**	**81.9%**	**87.8%**	**81.5%**	**80.2%**	**78.5%**	**81.0%**	**78.8%**
Patients needing 4AT assessment	53	60	48	51	53	40	61	49	60	59	62	49
Patients assessed	44	46	37	40	45	29	41	39	44	53	48	38
% assessed (4AT)	**83.0%**	**76.7%**	**77.1%**	**78.4%**	**84.9%**	**72.5%**	**67.2%**	**79.6%**	**73.3%**	**89.8%**	**77.4%**	**77.6%**
Patients needing onward care plan	5	11	7	11	12	9	12	13	8	23	23	15
Patients with care plan recorded	5	9	7	10	10	9	11	12	8	23	23	15
% care plan recorded	**100.0%**	**81.8%**	**100.0%**	**90.9%**	**83.3%**	**100.0%**	**91.7%**	**92.3%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**



12.3 Dementia Training

12.3.1 Dementia Level 1: All staff new to the Trust complete a one hour dementia awareness session, featuring Barbara's Story Episode 1, as part of their corporate or junior doctor induction.

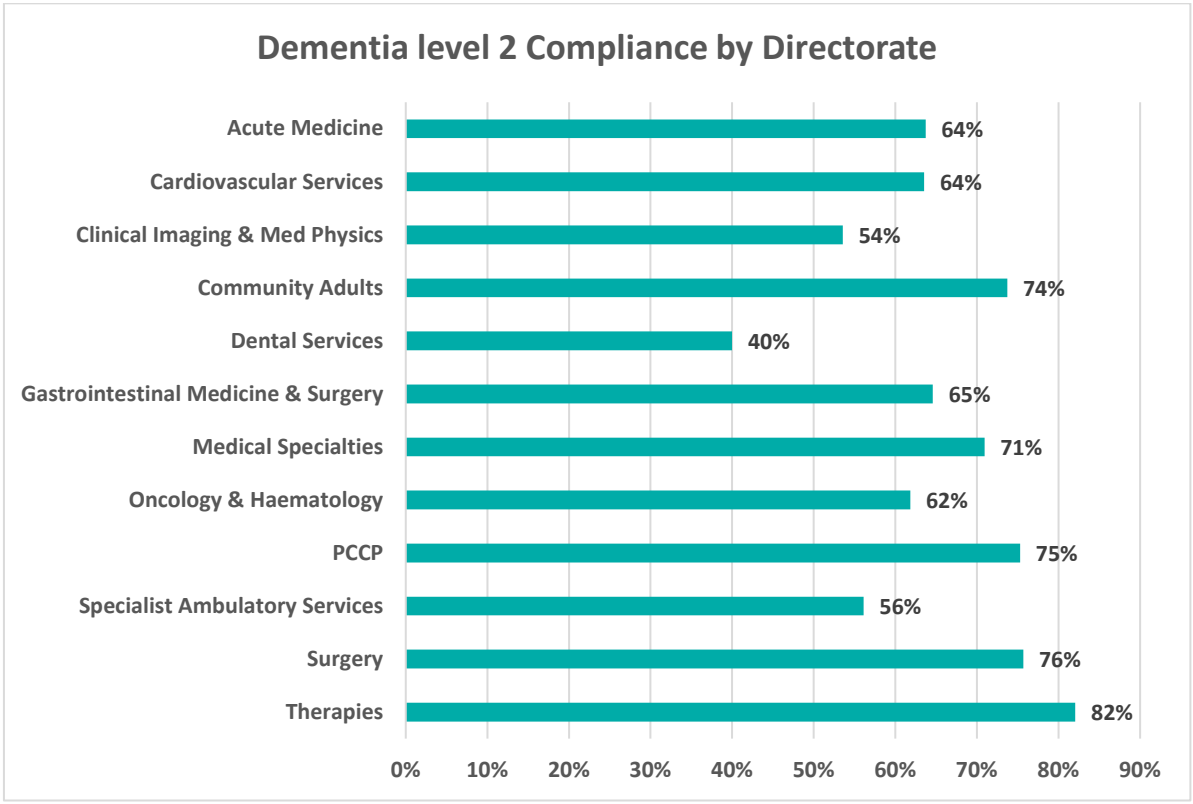
12.3.2 Dementia Level 2 training as a study day has been delivered in the Trust since 2010 and has evolved with changes in evidence based dementia practice, research, national dementia strategies from the Department of Health, RCN, various charities, and competencies within the Dementia Core Skills Framework. There has been traditional emphasis on training acute nurses from 2011-2014/5 in line with CCG's and respective CQUIN mandate. Following on, our priority has been to embed knowledge and skill in dementia care into practice over a wide remit in outpatient and inpatient settings with the support of the DaD team where required. In addition, new staff profiled for this training have received and continue to receive this training as mandatory to their learning portfolio. We set about incrementally increasing denominators to profile new staff such as community district nurses, support workers, healthcare assistants, occupational therapists, and physiotherapists to attend this training as mandatory to their training portfolio.

12.3.4 Currently there are 2,266 staff profiled on WIRED with 1,588 compliant and 68.7% compliance as of 27th February 2018. At present all other clinical areas apart from the OPU has averaged 65% or above over the last 12 months. The tables below show current and previous year training compliance and the quarterly breakdown of the training data.

Dementia Training Level 2	Q1	Q2	Q3	Q4
Total number of staff profiled	2242	2235	2256	2266
Total numbers of staff compliant	1375	1516	1542	1588
% compliant	61.33%	67.83%	68.35%	68.7%

Dementia Training Level 2	Total number of staff profiled	Total numbers of staff compliant	% compliant
Level 2 in Feb 2018	2266	1588	68.7%
Level 2 in Feb 2017	2176	1185	54.46%

12.3.5 The graph below shows the current compliance of all profiled directorates for Dementia Level 2.



12.3.6 In addition to the Dementia Level 2 training day, individual clinical areas were also offered bespoke short training or reminder sessions. These sessions were provided by the two DaD CNSs.

12.3.7 A short version of the Dementia Care Update course has been developed which staff can now access and do not have to undertake the full day training for their three year update. A short version of the Level 2 dementia training has been planned for the Consultants' mandatory training day.

12.4 Carer's Surveys

12.4.1 Over the year there has been a steady decline in the number of carer's surveys completed by carers. Many of the next of kin for patients with dementia were not the patient's main carer and therefore opted not to complete the survey as they did not feel able to answer all the questions. Most carers tend to visit after hours or weekends when the DaD CNSs are not around to complete the surveys. Staff on the wards have often been unable to go through the surveys with carers due to capacity and workload issues. Taking into account the above findings over the year the DaD team have implemented a number of strategies to help to improve compliance including:

- Carer surveys have been attached to the 'this is me' document and on some wards, it is placed in a visible area above the patient's bed. This way it acts as a prompt for staff to remind carers to complete surveys during visiting times
- The dementia champions have been challenged with the responsibility to ensure carers are sought out on the ward and surveys are completed
- A designated folder/area is available for blank and completed forms on most wards
- The DaD CNSs continue to allocate specific time to go to the wards to meet with carers and complete the surveys.
- A postal system which involved sending the surveys to carers and including a self-addressed envelope.
- Telephone surveys.

12.4.2 The telephone surveys and the postal survey have proven to be good methods of getting carer feedback. A total of 15 surveys were completed and analysed.

12.4.3 There were many positive comments obtained from the surveys which included outstanding care and the patient not wanting to leave the ward, staff being excellent in terms of engagement with patient and family, recognition of work pressures on staff and staff being described as angels. The ward areas that were particularly praised were George Perkins, Anne Ward, Sarah Swift ward, Somerset ward and Acute Admissions and A&E wards.

12.4.4 Other comments included lack of communication with carers, over reliance on carers, inflexible visiting times and staff not often being visible to talk to. Other responses included the following:

- 8/15 of the respondents stated that they were asked to complete a 'This is Me' document and 6/15 respondents said that a 'This is Me' document was already available at the bedside.
- 12/15 respondents reported that they did not receive a dementia carer information pack
- 9/15 commented that they were not asked if they wished to discuss the care of their relative with a dementia specialist nurse

12.4.5 The carer passport was developed to build in reasonable adjustments for people with dementia which includes flexible visiting and supporting the carer to be involved with the care of the person with dementia as much as they wished to. Inflexible visiting times may be due to the carer passport not being used by staff. This may have been attributed to the period where changes were being made to the carer passport and a new passport was in the process of being re-launched. During this period the DaD CNSs did not actively promote the passport. The new passport has now been launched and the DaD committee and champions have been supporting the dissemination of the passport to the wards. It is also being reinforced during dementia training. There is an up-to-date version of the carer passport and a carer's agreement on the DaD GTI page and the carer's hub which is on the GTI page. The carer passport usage will be monitored and its awareness continuously raised over this financial year.

12.4.6 The DaD CNS' continue to promote their availability to speak to carers and they are easily contacted through the referral process, phone, bleep or email. Staff are reminded on e-noting to offer carer's the opportunity to speak to a DaD CNS. More recently the DaD CNS contact details have been made available for staff to display on their ward areas. This is to empower relatives to request for DaD CNS support should the need arise. This message is re-iterated during DaD teaching sessions.

12.5 Activity Boxes

12.5.1 55 Activity boxes were purchased through the Friends of Guy's and St. Thomas' NHS Foundation Trust Charity funding and distributed across the community and acute services. The boxes have been well received by the wards and used to engage and occupy patients with dementia or a learning disability. The Dementia trainer is also spending some time each week on the wards working with patients to support staff and show them how the items in the box can be used.

12.6 Dementia Friendly Environment

12.6.1 The DaD Committee has been working closely with Essentia staff looking at making the environment dementia friendly. The agreed changes to the environment are as follows:

Signage: Work is ongoing around the Trust to ensure all toilet and bathroom doors have the dementia friendly signage. Work is estimated to be completed in early 2018.

Toilet roll holders and hand towel dispensers: Work began in January 2017 has been delayed by negotiations to secure a better deal from suppliers. The new toilet roll holders and hand towel dispenses will be black with dementia-friendly signage. Some areas do already have the dementia-friendly toilet roll and hand towel holders in place. This work is ongoing.

Toilet seats: Toilet seats will be a colour distinct to the surrounding area to be easily visible. There is ongoing research and negotiation by Essentia to secure the best deal for purchase of toilet seats. Some areas like the Older Persons Unit do already have the dementia-friendly toilet seats in place.

Toilet paper: It was decided after consideration that toilet paper would remain white and not a contrasting colour. The white will contrast with the toilet roll holders. Additionally a reasonable quote for good quality colour toilet paper was not achieved.

Hearing loops: This is under the leadership of the Equality and Diversity department to ensure hearing loops are available in the necessary areas. It was agreed at the DaD Committee that hearing loops would be available in the Communication Boxes on all wards.

Grab rails in showers: It was agreed that additional grab rails were not to be placed in showers at present and the initial focus would be make sure that all the flooring in bathrooms were non-slip. Measuring equipment has been purchased and the suppliers have trained members of the Health and Safety team on how to test floor performance (re non-slip performance).

Clocks and Signage on wards: A bid for the clocks went to Friends of Guy's and St. Thomas' NHS Foundation Trust in July 2017 and was successful. 32 clocks (8 per ward in 2 wards) is being trialled and will be evaluated this year.

Non-shiny floors: The housekeeping team have been exploring the procurement of an alternative polish that is a sheen finish rather than high gloss. Additionally the deep cleaning project team are aware of this issue and are also trialling different methods to combat a shiny floor.

12.7 Delirium Studies and Improvement Work

12.7.1 Dr Peter Sommerville, Darsi Fellow, undertook a project to improve delirium management on wards within Guy's and St Thomas' Trust. Starting his study in the haematology/oncology directorate he analysed some of the challenges and short comings of delirium management. Following this a Delirium Community of Practice was created, a Delirium-5 challenge was devised (to address delirium within 5 hours of recognition) and has begun work with IT on a new e-noting delirium documentation page. The DaD CNS and wider DaD Committee have been involved for comment and advice throughout this work on delirium. Peter has also involved a wide selection of staff (The Community of Practice, Ward sisters/matrons) etc. to best understand the needs of the whole hospital with regards to delirium management. The CAM and Delirium 5 toolkit is now available on e-noting. The usage of this will be audited in 2018-2019.

12.7.2 Dr Jennifer Rossdale has completed a study across a number of wards (Acute Admissions Ward, Albert, Alexandra, Anne, GI Unit, Nightingale) looking into the use of Neuroleptics in the management of delirium. This audit has highlighted the shortcomings within delirium documentation with regards to decision to prescribe medication (for delirium management) and instructions post prescription. The delirium bundle was revised and updated.

13.0 Learning Disability (LD)

13.1 LD Referrals

LD Referrals	Q1	Q2	Q3	Q4	TOTAL	2016-17
Acute	82	74	88	81	325	250
Community	36	54	71	59	220	160
Total	118	128	159	140	545	410

13.1.1 The table above shows the referrals and notifications made to the safeguarding adult's team in the last year. There has been a 32.9% increase in the referrals and notifications to the LD CNS which made it quite a challenging year for the service. A significant number of the referrals were for support with patients undergoing procedures at the Trust who often require several visits to desensitise the patient before they are ready to have the procedure. Additional support has been sought from the safeguarding adult's team with the increase in referrals.

13.1.2 In addition to the above the LD CNS visits each patient referred to the service offering management advice, supporting the staff with consent issues, supporting the carer and advising on reasonable adjustments. One of the challenges faced by staff is challenging behaviour by the patient where the LD CNS has been able to advice on different strategies to reduce the number of episodes of aggressive behaviour through personalised care and understanding the needs of the patient.

13.2 The Trust's Learning Disability Strategy, developed in partnership with a local service user group, was launched in June 2017 during Learning Disability Awareness week. In line with Mencap's Getting It Right Charter, GSTT has identified the following key objectives:

- Identification of the LD patient population in hospital
- A skilled workforce that is supported by high quality evidence based specialist health services
- Partnership working with patients and carers ensuring co-production of personalised and adjusted care and support to patients and their carers to achieve best outcomes
- A seamless pathway for children with learning disabilities to transition to adult services
- All information to be made accessible for patients with learning disabilities
- Robust partnership agreements between health, social care and the third sector to ensure that people with learning disabilities and their carers receive seamless, safe care.

13.3 The Trust's Learning Disability Strategy Group developed a three year action plan to take forward these objectives. Progress to date includes the development of a flagging system to identify patients with LD while in hospital, identification of a suitable e-learning package to raise LD awareness within the organisation and the development of a communication resource. The focus for 18/19 will be to ensure that departments have suitable accessible information for the population and transition processes.

13.4 The Trust is committed to undertaking a review of all deaths of people with LD in accordance with the LeDeR (Learning Disability Mortality Review. It is also linked to the Trust Mortality Review where a Structured Judgement Review is undertaken if the person has a diagnosis of LD and there is information sharing between the two processes. The programme has developed a review process which trained reviewers must follow. Data is then collated and anonymised information about the deaths in this population shared so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements. GSTT has thirteen trained reviewers all of whom have now been involved in at least one review. Initial national findings suggest that learning disability awareness and carer involvement are key components of ensuring positive care pathways and these are reflected in our learning disability strategy objectives.

13.5 The LeDeR process for the allocation of reviewers, managing the reviews and sharing of learning from the reviews has now been devolved to local area teams. The local CCGs have the responsibility of allocating the reviewers, providing scrutiny for the reports and ensuring that learning from the reviews are shared widely. SSAB and LSAB have now commissioned local LeDeR steering groups made up of leads from the local providers to implement the LeDeR death review process in their areas.

13.6 The devolution of the LeDeR process has resource implications for the Trust which has the largest number of reviewers locally. Following the devolution, each reviewer who on completion of the initial review recommends a multi-agency review will be responsible for co-ordinating and completing the multi-agency review which would involve seeking information from all involved agencies, analysing the data and reporting back the learning with recommendations. Undertaking a multi-agency review is time intensive and may take a reviewer a longer time than the stipulated four months to complete the review as this will be done in addition to their professional role. It also requires co-operation from all agencies in a timely manner. This has been discussed with the local area lead for Southwark.

13.7 LD week was celebrated between 19th and 25th June 2017 and there were events held on the acute sites and the community. The Community LD team went out to visit staff in community service venues and hand out the LD information packs. There was a real interest in caring for people with LD and the team have received many requests for awareness training.

14.0 Assurance Statement

14.1 The Quality and Performance Committee is to be assured that, over the last year the Trust has adhered to its statutory duties in safeguarding the welfare of adults at risk through early recognition, responding to and reporting concerns of abuse of adults at risk and achieving its safeguarding adults training target. The Trust will continue to question the extent to which the safeguarding of adults at risk and the Mental Capacity Act 2005 are embedded within the organisation, including ensuring increased access to mandatory training.

14.2 All safeguarding adults and related policies and procedures are being or have been reviewed and updated in accordance with national and local guidance.

14.3 The Trust is working in partnership with its local Safeguarding Adults Boards to ensure that vulnerable people are supported to live safe lives through the exercising of choice and autonomy. Information is shared appropriately and in accordance with multi-agency agreements to safeguarding the rights of adults at risk.

14.3 Increased safeguarding adults training sessions including bespoke sessions are being offered to staff to reach the CCG agreed compliance target of 85%. An e-learning training package is now available for staff to use. The compliance rate is monitored closely and remedial measures such as increased and bespoke training session have been offered to staff.

14.4 There has been an audit programme in place to ensure that care provided to vulnerable people is to agreed standards and any gaps in service are rectified in a timely manner and lessons learnt are shared widely across the organisation.

14.5 There is a robust governance process for reporting and reviewing of all safeguarding concerns through operational groups and leadership and scrutiny provided by the Vulnerable Persons Assurance Committee

15.0 Recommendations

15.1 The Board of Directors is asked to:

1) **Approve the work plans attached in Appendix 1.**
2) **Note the information contained within the report and the actions taken**

Appendix 1

Proposed Structure for Mental Heath