Board of Directors **Quality and Performance Committee**	
Vulnerable Adults Annual Report, March 2020 to March 2021	**Date of meeting: May 2021**

This paper is for:	
Decision	
Discussion	
Noting	X
Information	

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1. Summary

1.1 This thirteen month report (as now realigned with the Trust Quality and Performance Committee meeting dates) sets out the highlights of all activities related to safeguarding and vulnerable adults and how the Trust sets out to meet its statutory duties.

1.2 The report aims to give an overview of the performance of the different components of the vulnerable adults agenda including safeguarding adults, dementia and delirium, learning disability, mental health and end of life care specifically areas of key developments, risks within the service, learning from investigations and patient feedback.

2. Key Developments

2.1 Safeguarding

2.1.1 There were 1739 safeguarding adults referrals received over the last year. The safeguarding adults team has responded to its safeguarding duties throughout the pandemic in a timely manner despite some of the team being redeployed over the first phase of the pandemic. 5 members of the Safeguarding Adults team were redeployed during April and May 2020 leaving a smaller core team to support patients with safeguarding, dementia and delirium and learning disability needs. A risk mitigation plan (Appendix 7) was agreed to ensure vulnerable people were appropriately supported and referred during Quarter 1.

2.1.2 Service was extended to working over the bank holiday weekend to ensure that patients who lacked the relevant capacity were lawfully safeguarded. The team adapted the way it worked by case finding and

working flexibly to ensure that vulnerable patients received the safeguards and care appropriate to their needs. Additional support was offered to the community through redeployment which was well received

2.1.3 At a time of less patient and staff contact the team arranged and attended an increased number of professionals meetings optimising on the opportunities to communicate virtually. This allowed for complex situations to be discussed with a panel of experts and safeguarding plans put in place.

2.1.4 New interim national guidance was released with regards to COVID and DoLS, extending the Ferreira judgement to all hospital areas. Patients who lack capacity to consent to being in hospital and receiving life-sustaining treatment amounting to a deprivation of their liberty did not require a DoLS application, contributing to lower numbers of DoLS requests.

2.1.5 Despite the suspension of face to face training for safeguarding level 1 and level 2 training the training compliance figures remained above 85% for both levels of training. All non-compliant staff were reminded to complete their training online via email which has improved compliance

2.1.6 Prevent training has also maintained positive compliance with set targets. Prevent Level 3 (WRAP) which was previously provided face to face and was suspended over the pandemic and has been provided virtually, yielding good attendance and feedback. Training will also be provided face to face with appropriate social distancing measures for smaller numbers of staff focusing on community service where there are issues with connectivity. Safeguarding adults level 3 training has been successfully offered to the first cohort of staff involving the community learning disability team.

2.1.7 The safeguarding adults team has received safeguarding supervision training over the last year with four of the team having received the training. Safeguarding supervision is offered to staff when dealing with complex cases as and when required.

2.1.8 The last year has seen highest number of referrals for cases of self-neglect. These cases are often very complex with many agencies providing a service to the individuals. The team has contributed to the development of a complex care pathway which has been endorsed by both local safeguarding adults boards. The pathway has proven to be effective in getting agencies together to resolve complex cases and is being widely disseminated.

2.2 Learning Disability (LD)

2.2.1 The hospital LD clinical nurse specialist (CNS) saw an increase of 45% in referrals in the last compared to the previous year. Previously a significant number of the referrals were notifications only whereby the LD CNS could delegate information to ward staff/Clinicians and make a visit to the area if time allowed. Over the pandemic many the referrals were complex requiring time, information gathering and have needed specialist input. The LD CNS has had to risk assess and prioritise the work load making sure that those who needed the support had access.

2.2.1.2 Many of the complex cases involved the coordination of input from a variety of departments and professions. This would offer the vulnerable adult a one stop approach to their care co-ordination which would be a reasonable adjustment.

2.2.2 The pandemic and restrictions on visitors/support networks the LD CNS spent a lot more time on the wards and supported departments such as Intensive Care. The LD CNS was able to support staff and

patients during their admissions with (or without) COVID, although sadly this sometimes meant that the LD CNS was the last person to be with a patient who passed away whose relative was too elderly to be able to come into the Hospital. The LD CNS made sure that the family were able to face time with the patient (although the patient was sedated) but the family felt as if they were able to say goodbye.

2.2.3 The daily admission list via the LD register during the pandemic has allowed the LD CNS to work closely with the local Community Learning Disability team and together successfully supported several admissions and discharges with continued support many months after discharge. The register now has the facility to determine outpatients appointments 4 weeks in advance which allowed the LD CNS and community team to arrange suitable support and reasonable adjustments, where required. It is anticipated that the LD register will evolve to include LD patients within the Evelina services, GP services and eventually to support the KHP network so that all the local hospitals work together with confidence that a patient will be offered the same support when in any of the hospitals.

2.2.4 The LD CNS is working with the Evelina in developing a mandatory LD training programme which will address the needs of staff commensurate with their roles in supporting people with LD and their carers.

2.2.5 The LD bundle is being promoted by the LD CNS and available on the LD GTi page. The Bundle offers staff on the wards with information on reasonable adjustments they can offer patients with LD on admission and make the relevant notifications and connections with appropriate LD community teams. The Bundle is awaiting being uploaded onto EPR.

2.2.6 From the start of the COVID pandemic, the community learning disability team has been able to work flexibly to adapt to the changing needs of adults with learning disabilities. They have identified the people at highest risk and provided ongoing monitoring. Over time, as service users and carers have adapted to the restrictions to their routines and concerns have been addressed, risks have reduced but there continues to be a group of highest risk cases that continue to be actively supported.

2.2.7 The Learning Disability register has been fully utilised to improve the acute/community pathway. All GSTT admissions are identified each morning so that information can be shared and reasonable adjustments put in place. There continues to be weekly case discussion meetings with hospital liaison nurses from Kings College Hospital, University Hospital Lewisham and GSTT with the community learning disability team to ensure that the hospital pathway for adults with learning disabilities is meeting needs and information is appropriately shared across Southwark, Lambeth and Lewisham.

2.2.8 The community team have established a process with Trust Ole so that bespoke e-training packages are now available for carers and support workers in the community. The team then has live virtual training sessions to follow up the e-learning to ensure that the training can be applied to the specific adults with learning disabilities that the carers support. Use of virtual technology for training carers has meant that this can now be accessed much more quickly and easily than pre-pandemic and so some form of virtual learning will continue to be offered alongside face to face training when we are able to resume this.

2.2.9 There was an increase in staff awareness of the use of DNACPRs during the first wave of the pandemic. Learning disability team staff engaged in bespoke DNACPR training to gain an increased understanding of the decision-making process and to reflect on specific service user examples.

2.2.10 A current focus of the team is ensuring that adults with learning disabilities are able to access Covid vaccinations. The London Learning Disability COVID-19 Vaccine information pack published by NHS England and NHS Improvement was adapted from the "Supporting people with a learning disability around the COVID-19 vaccination programme toolkit" produced by our community learning disability nurses. Adults with learning disabilities are encouraged to attend the usual vaccination centres if they are able to do so. The toolkit provides accessible information and support for their carers to support this. Six community bespoke sessions for adults with learning disabilities have been set up with support from learning disability team members. The team have received 29 referrals for people with a history of poor engagement with health services who will need bespoke person centred individual pathways in order to enable them to access the vaccination. The team is continuing to work with these individuals.

2.2.11 The NHS Completed LD benchmarking NHSE & NHSI Learning Disabilities benchmarking for Year 2 was completed and published. This demonstrated the need for separate autism policy. The data for 2019-2020 has been submitted in April 2021. The deadline was extended due to the pandemic.

2.3 <u>Dementia and Delirium (DaD)</u>

2.3.1 Tier 1 training continues to be part of the trust induction with new members of staff watching Barbara's Story. Tier 2 dementia training was moved to the Microsoft (MS) teams' platform in July 2020 for both the full day training and the three yearly update training. All the Tier 2 training currently continues to be provided virtually.

2.3.2 Trust wide training compliance for Tier 2 is currently 73.59% this is the highest percentage achieved since the training commenced and an increase of 2% in comparison to 12 months ago. The training stopped for 12 weeks during the first wave of the Covid pandemic with the DaD trainer redeployed. This

dropped the compliance number significantly. Training has restarted virtually in July 2020 with a positive training compliance figure despite additional staff joining the Trust.

2.3.3 The DaD trainer in addition to the offered regular sessions has been providing specific training to teams to ensure compliance. This has included offering sessions to the community services and making this more relevant to this field of practice.

2.3.4 The DaD trainer has provided face to face dementia training to the Food Services Assistants (FSA) as part of their mandatory training as the training is bespoke. The FSA and Chef's training is currently being converted into an e-learning package with Education and Development Team and also other clinical teams including Speech and Language and Dietitians. This is hoped to improve compliance and also to improve auditing of training compliance.

2.3.5 To enhance staff knowledge of dementia and raise the dementia profile within the Trust the DaD Trainer has organised a webinar via the MS team's platform, with external speakers to run during Dementia Action week in May 2021. Carers and patients will also be invited to view this training. Other presentations during the Dementia week also include sessions by geriatricians and the DaD CNSs of dementia related subjects.

2.3.6 With the overall reduction in referrals to the DaD team as a result of the pandemic the DaD CNSs worked flexibly in proactively identifying patient with dementia who were admitted to hospital and review their care on the wards. The Dementia Care Reviews commenced during the first wave of the pandemic. This enabled the DaD team to continue to provide a seamless service which comprised of; the early recognition of dementia, offering specialist advice to staff and relatives, plus ensuring timely referral to the memory clinic where identified.

2.3.7 The DaD CNSs remind staff to add the dementia flag alert to e-noting as this serves to highlight to staff the patients' diagnosis and the level of support they may require. The DaD team continued promoting the use of the delirium bundle to assist clinical staff on how to effectively manage delirium on the wards.

2.3.8 During phase one of the Covid pandemic, the DaD team completed an audit based on the 'Dementia friendly hospital charter'. The survey consisted of 5 questions, information was collated via Survey monkey electronic questionnaire. Respondents stated that flexible visiting was offered to patients during the pre-pandemic periods and also during the pandemic but much less. The question about decision maker for medical treatment for patients who lacked capacity to make decisions about their treatment received a mixed response, some saying the consultant made the decision and others stating the MDT. No one had stated an LPA or court deputy. The third question was about which pain tool would be used with those with communication difficulties and the very positive response was received naming the appropriate tools. The results were disseminated to the relevant professionals and will inform work undertaken to promote the Mental Capacity Act 2005.

2.3.9 The DaD team have developed a new leaflet titled 'Managing patients with Dementia and Delirium during a pandemic'. The leaflet serves to remind and guide staff on how to support patients with the management of dementia and/or delirium, and how to appropriately educate and empower relatives.

2.3.10 During phase one of the pandemic, the DaD CNSs became aware of patients with dementia being isolated on wards as they did not have any visitors. They contacted local retailers and obtained donations of books, puzzles and other such items to occupy patients whilst on the ward. They proactively made up single use packs that were then delivered to the wards. They were very well received by patients and staff.

2.4 Mental Health

2.4.1 New Mental Health Lead successfully recruited to in June 2020.

2.4.2 The Mental Health Strategy was developed prior to the advent of Covid. It has therefore been necessary to revisit the Strategy in order to reflect the impact of Covid on the contents and the timescale for delivery of the Mental Health Strategy.

2.4.3 An addendum to the Strategy acknowledges the risk of increased rates of mental ill-health arising from Covid, as well as the potential detrimental impact on those with existing severe and enduring mental illness. The consequences arising from Covid will affect on how mental health care (in the broadest sense) is delivered within the Trust, both for staff and patients with no formal mental health diagnosis and those with longstanding diagnosed mental health conditions.

2.4.4 All initial mental health strategy local delivery plans have been completed, with the exception of RBHT, with whom work has just commenced to develop one. In light of Covid, these will need to be continually revisited and refined to ensure that they are remain relevant to the changing needs of the Trust, its staff and the communities it serves in relation to mental health.

2.4.5 A proposal has been completed and approved for the development of a Trust Suicide Prevention Strategy to be included as part of the Mental Health Strategy. The strategy will be structured in line with the Trust's Strategy "Together We Care - Patients, People and Partnerships", the details contained will be informed by current and emerging evidence relating to suicide.

2.4.6 As part of Suicide Prevention Strategy work, the Trust guidance for the care of patients who have been identified as being at increased risk of suicide has been redeveloped in conjunction with Kings College Hospital Trust. An initial draft is now being reviewed to ensure that it is also relevant to the RBHT site.

2.4.7 The replacement mental health service lead has now been appointed and commenced in May 2021 to deliver the four Lily Sterner Projects. Roll out of the four projects has continued in the interim, led by the Trust Lead for Mental Health. However, due to this, as well as delays to the roll out of the projects due to Covid, the lifespan of the project has been extended by 6 months until November 2022.

2.4.8 <u>Project 1 - Reducing mental health stigma</u>

2.4.8.1 Project 1 will take the form of a year-long campaign aimed at reducing stigma around mental health. This will be launched at a conference on 10th October 2021 (World Mental Health Day) with a film. The film is being made by Inner Eye Productions and will depict the experiences of a woman with a history of mental health difficulties and self-harming behaviour, with particular focus on her experiences on attending the Emergency Department. The film will have an emphasis on the power of compassion. Work is already underway to produce a main film, as well as a 90 second shorter film which will be used as both as a promotional trailer to the main film and a stand-alone film to be shared on social media platforms and beyond. Filming is scheduled to start week commencing 30th August 2021 with delivery by 8th October 2021. A promotional programme to support the film launch is also being planned.

2.4.9 <u>Project 2 - Reducing restraint and improving safe practice</u>

2.4.9.1 This project aims to improve the knowledge and skills of clinical staff across Acute and General Medicine, the Security Management Team, the Site Nurse Practitioner Service and the Mental Health Liaison Team

in relation to ensuring a safe and effective response to incidents of acute mental health and behavioural disturbance. Maudsley Learning have been commissioned to produce and deliver a 2-day simulation training programme focussed on de-escalation, risk management, mental health awareness, patient safety and reduction of stigma. The training commenced in March 2021 and initial feedback from attendees has been very positive in regard to its value. So far, 56 staff have completed the training including two staff from oncology. Further training will take place in May, with a further course planned for July (funded from outside the Lily Sterner Project). Following completion of the course in July, it is anticipated that around 120 staff will have completed the training and a training evaluation will follow.

2.4.10 Project 3 - Mind & Body Champions

2.4.10.1 The project aims to work with Mind and Body (King's Health Partners) to introduce mental health champions to key wards and departments within GSTT to promote positive mental health care within their areas through role modelling, training and quality initiatives. In preparation for this role, nominated mental health champions will undertake IMPARTS training run by Mind and Body which delivers training on common mental health presentations encountered in general hospital settings. Following completion of the course, Champions will be supported with the development of their areas to become "mental health friendly", promoting good mental health care through advocacy, role modelling, the development of mental health specific resources, mental health practice development and training. In total, 45 staff spanning all directorates will complete the IMPARTS training funded by the Lily Sterner Project with the aim of becoming Champions. Training is scheduled to commence in June 2021 and will be delivered in three cohorts with completion in February 2022.

2.4.11 Project 4 - Training of Staff in "Hot" Post-Incident Debriefs

2.4.11.1 The final project will focus on training a group of staff from the Acute and General Medicine directorate in a model of “hot debriefs”. “Hot debriefs” are supportive informal huddles that occur immediately following an incident, engaging with the staff who were involved. These may then be followed by more structured formal “cold” debrief meetings that occur sometime after the incident. The training is being developed and will be delivered by the Staff Psychology Team in Occupational Health, who will thereafter provide a supervision programme for trained debriefers. A start date for the delivery of this project has yet to be agreed.

2.4.12 Mental Health First Aid Training

2.4.12.1 Sixteen staff will have completed Mental Health First Aid (MHFA) training in April 2021. MHFA training is internationally recognised and provides individuals with an in-depth understanding of mental health and practical skills in how to recognise signs of a range of mental health issues and support individuals to obtain specialist help. It is anticipated that further MHFA training will be offered across the trust during 2021 and beyond.

2.4.13 SWAMPI training

2.4.13.1 In September 2020, sixty-six staff from Evelina London completed SWAMPI-CYP training commissioned from Maudsley Learning. SWAMPI-CYP is an acronym for “Simulation Workshop at the Mental Physical Interface for Children and Young People”. The training is a one-day inter-professional course that revolves around the management of young people with physical and mental health co-morbidities in the general hospital setting. It addresses a range of challenging issues encountered by staff in children and young person’s settings, including behavioural disturbance, suicidal ideation, abuse and anorexia. The course was very favorably received and Evelina has now commissioned Maudsley Learning to provide

"Train-the-Trainer" training to 12 staff who will then deliver in-house SWAMPI-CYP training to colleagues within Evelina.

2.4.13 Bespoke SWAMPI training has also been commissioned for adult services within GSTT. The training is scheduled to take place in September 2021 and will cover common mental health presentations encountered in the general hospital and legal frameworks underpinning mental health care. The training will be offered to 72 staff across the organisation.

2.4.14 A pathway has been developed to promote prompt and effective assessment of patients presenting to the ED with mental health problems with / without co-existing physical health needs. Where a screening at triage does not identify any physical health problems requiring further assessment and treatment, the patient is referred to the Mental Health Liaison Team for direct mental health assessment with no further medical interventions from ED. Where co-existing medical needs are identified, there are defined pathways to promote parallel mental and physical health assessment.

2.4.15 A mental health emergency response procedure for adults, known as "Code 10" has been developed. A pilot was successfully implemented on the St. Thomas site across the Emergency Floor in February 2021 and was rolled out across all adult inpatient wards on the St Thomas site from 6th April 2021. From implementation until 31st March there were 26 Code 10 calls, averaging just under 4 calls per week (range: 0 – 7). 46% of calls originated from ED, 34% from AAW, with the remaining 20% originating from outlying areas.

2.4.15.1 Code 10 also applies for all patients who are brought to the ED by the police in apparent mental health crisis. By providing a consistent front door response to police referrals, effective communication is enhanced, including circumstances leading to the police to convey the individual to the ED and the legal

framework under which the patient has been conveyed, e.g. section 136 MHA; under arrest; voluntary presentation of an individual possessing mental capacity. This in turn informs the mental health care provided to the patient, promoting safety and effectiveness, as well as ensuring that the appropriate legal framework is being applied.

2.4.16 A pilot of the use of a tool (Dynamic Assessment of Situational Aggression [DASA]) used to help predict situations which may result in a patient becoming aggressive was commenced on AAW on 10th March. The pilot was initially restricted to 10 beds across the ward, and from 6th April, was extended to additionally include any other patient displaying early signs of agitated behaviour where use of DASA might be useful in ensuring closer monitoring and early actions to de-escalate. There will be a further review of the pilot at the beginning of May 2021 with a view to expanding the use of the tool more widely.

2.4.17 Arising from the action plans of two serious incidents which occurred during the summer, the Trust's Rapid Tranquillisation and Restraint policies are being reviewed and updated to ensure that they are fit for purpose and provide clear guidance in relation to lawful practice around the use of chemical and physical restraint. The revised rapid tranquillisation policy will provide more emphasis on non-pharmacological approaches to the de-escalation of agitation, in conjunction with early and proactive use of anxiolytic and sedative medication under the appropriate legal frameworks to reduce the risk of further escalation and use of more restrictive interventions and hypnotics. The use of rapid tranquillisation and chemical restraint in the management of drug and alcohol intoxication is being drafted in separate guidance completed by the toxicology team.

2.4.18 The Enhanced Care Team commenced operation in May 2020 providing specialist mental health nursing support primarily to patients on the Emergency Floor, with some support also offered to medical wards in the North Wing. The team establishment consists of a band 7 team leader, supported by six band 6

and eleven band 5 mental health nurses and thirty one band 3 health care assistants. The band 5 nurse posts were recently created using funds from 37 unfilled band 3 posts. Once fully recruited to, the team will be able to provide greater support to medical wards in the North Wing. The team lead role recently became vacant following the resignation of the post holder; this has now been recruited to and it is anticipated that the new post holder will start in the early summer.

2.4.18.1 Since its inception, the team has worked with an average of 151 patients each month. Around 95% of all referrals originate from the Majors area of the Emergency Department (75-80%) and AAW (15-20%). The remaining 5% are from MSAU, resus or the general medical wards. Around 90-95% of patients referred have a current mental health diagnosis with a referral to the Mental Health Liaison Team; the remainder do not have a mental health diagnosis. Around 15% of patients referred to the team present with alcohol intoxication.

2.4.19 A review is underway of the mental health provision on the Guy's site. It is recognised that there is a disparity of provision between Guy's and St. Thomas Hospitals, with the former having a much smaller, mainly outpatient based mental health liaison team operating 0900-1700 Monday to Friday and no provision of enhanced care by a substantive Enhanced Care Team. This, in turn leads to other disparities, such as the inability to introduce innovations such at the Code 10 procedure due to the lack of a 24/7 multi-disciplinary liaison team. Initial discussions have taken place with SLAM and GSTT staff based at Guy's and data has been collected in preparation for formulating a series of business cases to increase the mental health care provision on the Guy's site.

2.4.20 In spring 2020, SLAM opened a Mental Health Crisis Assessment Unit (CAU) on the Denmark Hill site. This was in response to the Covid pandemic and aimed to divert people in mental health crisis away from the ED. Although mental health presentations fell during the early months of the pandemic, there was a

steady increase in the numbers of patients presenting to the ED in mental health crisis from April 2020 until a levelling off in August 2020 at a higher than pre-Covid level. Whilst the CAU was open, only 20-30% of patients presenting to STH in mental health crisis were diverted to the CAU for full assessment, with 70-80% continuing to need full assessment on the STH site. The STH Liaison Team were operating on a reduced team size whilst the CAU remained opened due to the need to deploy staff to the CAU. This led to increased pressures on the team remaining on the STH site, accompanied by an increase in 4 and 12 hour breaches, leading to increased pressures on space in ED. A decision was taken to close the unit on 24th August 2020.

2.4.20.1 In December, it was agreed with SLAM that a Mental Health Crisis Assessment Unit (CAU) would be developed on the St. Thomas Site. The unit will be sited in MSAU and will consist of 6 beds. It is proposed that the unit will be operational 24/7 and staffed by SLAM. The unit will be registered to GSTT but staffed and operated by SLAM. It is intended that the unit will open on 1 June 2021 once the necessary estates work has been completed

2.4.20.2 The purpose of the CAU to provide a more therapeutic safe environment for those assessed as requiring mental health admission to wait for a bed where one is not immediately available. It also accepts direct referrals of patients from triage following initial assessment by a senior mental health liaison nurse to await further mental health assessment on the unit. It does not accept patients assessed as requiring admission under the Mental Health Act 1983 or who present at risk of aggression or with acute medical needs requiring ongoing monitoring and treatment. Patients in CAU remain on the ED clock and do not have an inpatient status.

2.4.20.3 Pending the opening of the 6 bedded CAU model in June, a pilot two-bedded CAU opened in MSAU on 9 February 2021. The unit is staffed by two health care assistants from the Enhanced Care Team

supported by a band 5 mental health nurse employed by SLAM and the Mental Health Liaison team. In the first month 9th February to 9th March, there were 38 individuals transferred to the two-bedded unit. Thirty one per cent of these were subsequently discharged home with GP follow-up, 18% were admitted to a mental health bed voluntarily and 13% were detained to a bed under the Mental Health Act.

2.4.21 In November 2019, a mental health nurse specialist (mhns) was appointed to a one year project aimed at enhancing the engagement of individuals with mental health issues into the diagnostic and treatment pathways for head and neck cancer. The project demonstrated very encouraging results and the mhns was appointed to the role substantively in November 2020. Despite the challenges of Covid, in the first 17 months of being in post, the mhns received 98 eligible referrals and was able to engage 88 (90%) of these individuals into the initial diagnostic pathway. The mhns was then able to engage 82% (58) of the 71 individuals (identified as requiring further treatment) into the treatment pathway. Ongoing evaluation will continue and mhns is working closely with the Medical Lead for Head and Neck Cancer to write a series of papers for publication about the role and its impact. There will also be exploration of the value of replicating the role in other oncology services, such as lung cancer.

2.4.21 Evelina London reported a significant increase in the number of young people presenting in mental health crisis during 20/21 with a steady increase in presentations to ED from April 20 spiking in November 2020 with an increase of 580% on numbers attending in April 20 (5 v 29). Numbers fell slightly during December / January but rose again in February 21 (appendix 1). Waits for CYP mental health beds remain lengthy. Unsurprisingly, numbers of mental health crisis presentations rose in line with age, with 60% aged between 15-17 years. The three most common presentations were drugs / alcohol intoxication, suicidal thoughts and unusual behaviours.

2.4.21.1 Consideration of the environments within the ED and wards of Evelina London has taken place. Assessments have been conducted both in Children's ED and the CSSU and changes are to be made to one room in ED to make it a safe bespoke environment for children and young people presenting in acute mental health crisis. Safety pod beanbags have been ordered to assist with therapeutic restraint. An environmental assessment has also taken place on Mountain ward with a view to creating a bespoke room for children and young people presenting in mental health crisis or with behavioural disturbances.

2.4.22 A new full time consultant started in May 2020 which increased the working aged adult consultant liaison psychiatrist establishment to 3.8 WTE. In May 2020, a new team manager commenced in post but the role is now vacant awaiting recruitment. A new team manager for the Older Person's Psychiatric Liaison Team was also appointed in the last year

2.4.23 A number of band 7 senior mental health liaison nurses were recruited during 20/21 to provide a front door mental health triage role. The aim of front door mental health triage was to conduct a rapid initial mental health assessment in order to determine the level of presenting risk and to reach a decision regarding the most appropriate care pathway for the patient, be it to remain in the ED for further in-depth mental health assessment, or to be signposted away from the ED to another service which could more appropriately meet the needs of the individual. It was also anticipated that front door mental health triage would assist with the early identification of patients requiring assessment under the Mental Health Act leading to early referral for MHA assessment and thus hastening the MHA assessment process.

2.4.24 Overall, the number of ED referrals received by the WAA MHLT during 20/21 was comparable to the number received during 19/20, however there was marked fluctuations during the course of the year. In April 20, there was a sharp drop in the number of referrals after which there was a gradual increase spiking in July 20 at a level 17% higher than in July 19. Levels of referral remained high until October

when they fell again until December 20, after which they steadily rose to a level in March 21 which was 26% higher than March 19 (a better comparison than March 20). Appendix 2) provides further details on levels of referrals from ED to the WAA MHLT from January 19 to March 21.

2.4.25 A locum consultant has been appointed to the mental health team at Guy's hospital team. There remains part-time consultant with the team also working in neuropsychiatry and psycho-oncology

2.4.25.1 Whilst outpatient work forms the main focus of activity within the Guy's Liaison Team, there was an increase in the number of ward referrals they received during 20/21 compared to previous years. Overall there was a 31% increase in referrals in 20/21 compared to 19/20 but in some months, the number of ward referrals received were between 2 & 4 times higher than in 19/20.

2.4.26 Under the Mental Health Compact understanding NHSE / NHSI launched a Clinical Prioritisation Framework in April 2020. The aim of the framework is to avoid repeated re-assessments of patient requiring mental health admission by different teams involved in the admission process ("Trusted Assessment Framework"), clarification around the "Who's Pays Guidance" for admitting patients where they are usually resident, with subsequent cross-charging to the responsible CCG where their GP is not local to their place of residence, and London-wide adoption of the Mental Health Compact and standards for timely admission to a bed within a maximum of 12 hours of the decision to admit (DTA).

2.4.27 In November 2020, the South London Partnership launched a "South London Listens" month campaign aimed at preventing a Covid related mental ill-health crisis across South London. The campaign consulted with the local community on six ambitions underpinned by a public health approach, which sought to consider the importance of addressing housing issues, risk of unemployment, social isolation, support for families and young people and social disadvantage in promoting good mental health in the

local population. GSTT have engaged with the campaign by considering how the Trust can seek to address each of these ambitions, ensuring that relevant key principles are embedded into the Local Delivery Plans for the Mental Health Strategy. The campaign is scheduled to feedback on its full action plan in April 2021.

2.4.28 IMPARTS (Integrating Mental and Physical Healthcare)

2.4.28.1 E-IMPARTS (mental health screening) is live and screening in 38 outpatient clinics and 8 clinics are screening face-to-face. In total 19 clinics at GSTT are using e-IMPARTS and 1 is screening face-to-face. A qualitative evaluation of IMPARTS was conducted and themes/feedback analysed. Based on the patient survey, 90% of patients felt that e-IMPARTS had some positive effect on how well their healthcare professional understood their needs.

2.4.28.2 Compass (on-line Cognitive Behaviour Therapy) is live and being tested in eight NHS services at GST, including Renal, Xeroderma Pigmentossum, Neurofibromatosis, Oral Medicine, Rheumatology and Gastroenterology. Early data collected as part of the testing shows positive patient experiences and improvements in health outcomes. Work has just started to explore the value of piloting the use of COMPASS with High Intensity Users (HIU) to explore if this might lead to a reduction in the use of unscheduled and emergency care. Consideration is being given to some of the challenges that this might present, including IT access in the HIU cohort and availability of CBT trained staff to promote remote support to those accessing the programme.

2.4.28.3 Work continues to engage with KHP partners on the development of the Mind & Body Accreditation scheme. The accreditation scheme will create a consistent framework for how mind and body care

should be delivered across multiple healthcare settings and provide an assurance to patients, carers, staff and members of the public that mind and body care is being successfully delivered.

2.5 End of Life

2.5.1 The year has been dominated by our response to the pandemic with development of guidance, altering our service model, training redeployed staff and responding to a hugely increased workload in both the hospital and community arms of our service. Although the Trust is rightly proud of its low mortality rate relating to COVID, we nevertheless cared for a large number of dying patients and their families. Ongoing rolling clinical audit identified continued skilled compassionate end of life care, albeit with problems in delivering written supporting information to families.

2.5.2 The critical care teams have agreed to introduce the ‘end of life care notification’ into their practice when they recognise that a patient is dying. This notification triggers support from the EoLC team and from the chaplaincy team. This change in practice will take time to bed in.

2.5.3 Virtual visiting (Life Lines) was widely implemented across the Trust to support patients and families who were unable to see each other face to face due to restrictions.

2.5.4 Trust EoLC strategy – extensive stakeholder consultation has been completed. We have now agreed to extend the scope of the strategy to include paediatric services and RBHT so further discussions are underway.

2.5.5 DNACPR has been the subject of a significant CQC report in March 2021 ‘Protect, respect, connect – decisions about living and dying well during COVID-19’. A gap analysis has been planned and will identify actions required as a result.

2.5.6 The Let’s Talk programme successfully produced the patient-facing materials (written and digital) to promote open conversations about care towards the end of life and planning ahead. The programme additionally embedded the Second Conversation model with F1 doctor training to improve skills in conducting EoLC conversations. Finally, the programme, under the unique leadership of Kimberley St John, facilitated multiple public events to raise awareness of death, dying and grief. This programme is now closed but work will continue to embed and sustain the progress made, much of which supports the actions required by the CQC. Specifically, the palliative care service aims to fund a time-limited project post to embed use of the Let’s Talk materials, lead advance care planning (ACP) developments and support the Trust response to CQC DNACPR report.

2.5.7 The QIPs team with the vulnerable adults medical leads have agreed to introduce a rolling cross-Trust clinical audit to monitor practice with respect to DNACPR discussions and documentation. Clinical directorates will be responsible locally with reporting through TRAC and the EoLC committee. The audit will commence after introduction of the anticipated new EPR DNACPR form (see in ‘areas for improvement’). DNACPR e-learning has been updated in response to user feedback and embedded in Trust OLE.

2.5.8 A substantive fast track discharge coordinator is in post, funded by the palliative care team – this role supports rapid coordinated discharge for patients approaching the end of their lives with complex support needs.

2.5.9 A new cross-Trust bereaved carer survey has been introduced on a rolling basis to enable us to learn from the experience of those important to the patients dying under our care. The Medical Examiner team has been embedded with positive feedback via the bereaved carer survey.

2.5.10 A staff memorial service was held in February 2021 to remember our colleagues who have died in the past year

3.0 Identified Service Risks

3.1 Safeguarding Adults

3.1.1 There were 29 safeguarding adults concerns related to Trust. This is a 34% reduction in concerns compared to 2019-2020. Concerns raised about inappropriate discharge planning totalled 34% of the referrals with 24% of referrals referring to care on the wards or other aspects such as medication administration. Each of the concerns was fully investigated by the clinical teams and where appropriate lessons learnt and shared.

3.1.2 There were 15 allegations against staff in the last 13 months. The allegations were all investigated in accordance with agreed policy. Thirteen of the allegations investigations are now closed and two remain open.

3.1.3 Whilst virtual contact with patients with virtually no face to face was safe and beneficial when supporting vulnerable patients during the pandemic, going forward it is important to recognise that the full picture of any risks at home cannot be safely or effectively assessed virtually. Patients may not be able to disclose any risks they may be facing especially domestic abuse. The safeguarding team is increasing its visits to patients in hospital and advising colleagues in the community to see patients fact to face wherever possible.

3.1.4 The safeguarding adults intercollegiate training document set a target 85% compliance for Safeguarding Adults Level 3 training to be reached by March 2021. The Trust will not achieve this target by March 2021as little progress was made during the pandemic. Firstly the finished HEE training resource pack became available on the HEE website in the spring of 2020. The team had to make some changes in the delivery of the sessions as the interactive part of the session could not be hosted on the Trust Internet. Face to face training was suspended most of last year and continues currently. The day's training is very participative and it was developed as a face to face session. This training has now been converted to a virtual session. The first pilot session was delivered in 27th January 2020. Further amendments have been made. It is aimed that the training will be run regularly from May 2021 and aiming to reach the target compliance by 31st March 2022.

3.1.5 Significant delay in the publication of the Code of Practice and other regulations may lead to insufficient time to prepare for the implementation of the Liberty Protection Safeguards scheme to replace DoLS. To commence training for staff has been made difficult without appropriate guidance of the roles and responsibilities of staff together with the agreed documentation to be used. Staff profiling for training is also dependent on knowing who should undertake what roles. Further guidance for DHSC is awaited.

3.1.6 Work in underway looking at aligning the safeguarding adults policies and procedures with that of the Royal Brompton and Harefield Hospitals Trust. This includes agreeing reporting compliances and training data externally.

3.2 Learning Disability

3.2.1 Over the pandemic the team has used virtual technology to complete assessments, intervention, consultations and training. Virtual technology is hugely accessible to people with learning disabilities but there are limitations. Going forward the team will look at both virtual and face to face contact with patients for training and assessments, interventions and consultations as appropriate

3.2.1.1 Virtual Platforms such as Attend Anywhere have enabled team members to keep in contact with people with Learning Disabilities and their carers, especially when the individual was shielding and face to face visiting was restricted. This contact could be for welfare calls, which were being made daily during the pandemic or for assessments and interventions. Whilst the video calls were a useful media, there were limitations in their use. The quality of the video was variable and the connections frequently dropped out. There are also some assessments and interventions which could not be undertaken via this medium. Many adults with learning disabilities were unable to use virtual platforms to understand communication and to express their needs. Access to digital technology is not always available for this client group living in the community.

3.2.1.2 Covid saw the movement of training from face to face to virtual platforms. Initially training was offered via Microsoft Teams which was not ideal. The team worked with the GSTT Training and Development to set up e learning training for family carers and paid support staff on TrustOle. The Community learning disability team are redesigning training programmes for this platform. Training can be provided by a combination of e-learning and live follow up sessions ensuring that the training can be applied to meet the needs of the individuals that the carers are working with. This is an ongoing area of development and is already enhancing the Team's training offer and improving efficiency.

3.2.2 Transition from childhood to adulthood is a period of great change for the person with Learning Disability and their family and carers. It is a time when their medical and health needs which were previously coordinated by a paediatrician are managed by a variety of different consultants. It is also a time when families are grappling with the Mental Capacity Act amongst many other changes in their family member's lives. Thus by working jointly with our paediatric colleagues, and attending final medical reviews, we will be able to meet families and the person and understand the health needs of the person and ensure that this information is not lost and that it is followed up by the GP or Special Needs Dentist or another appropriate health professional.

3.2.3 Currently the information about a person's learning disability is not always shared across agencies which can result in adults with learning disabilities needs being missed. The GSTT Learning Disability register has enabled the hospital liaison nurse and the community learning disabilities teams to be alerted to all adults with learning disabilities currently admitted each day within the hospital. This has meant that information is shared with the ward staff and reasonable adjustments can be made to support the admission and discharge pathway. The GP QAF prioritised that there needs to be improvements to the GP LD register so that adults with learning disabilities can access annual health checks. Improved sharing of diagnostic information between GSTT and GPs will benefit the health support that can be provided for this client group. Information from paediatric records does not always identify if a person has learning disabilities which can delay access to adult services and GP annual health checks. There needs to be some joint work with Evelina to expand the GSTT LD register to include people from the age of 14.

3.2.4 GSTT were part of the successful bid of South East London CCG to be an Annual Health Checks for Adults with Learning Disabilities Exemplar site. The project aims to improve the quantity and quality of annual health checks completed in primary care for adults with learning disabilities. It is a key NHSE objective to improve the uptake of annual health checks within primary care as this is an evidenced way of ensuring that unmet health needs within the population are identified and managed.

3.2.5 The CLDT service has been linking with PCNs in Lambeth, Southwark and Lewisham to establish a project to improve identifications of people with learning disabilities by building on the LD register work already established across GSTT. Social prescriber link workers who are focused on adults with learning disabilities have been appointed in Southwark and the CLDT has been establishing links to support their work.

3.2.6 To continue to improve the use of reasonable adjustments across the organisation. The Equalities Act outlines the need for all organisations to make reasonable adjustments to systems and processes to

ensure that those individuals with additional needs have equal access to services. People with learning disabilities in particular require reasonable adjustments to be made to all healthcare systems and procedures to ensure they receive the care they need.

3.2.7 To develop the GSTT Autism policy which will include services within the community and RBHT. GSTT has committed to improve support for adults with autism and a strategy group is established led by Ciara Mackay. The needs of adults of autism without learning disabilities vary widely and need a different approach than adults with learning disabilities. Autism awareness training needs to be provided for all trust staff.

3.2.8 To expand on learning disability awareness training for all staff across GSTT and to increase the service user involvement in facilitating training. New learning disability and autism awareness mandatory staff training is planned to be launched nationally in 2021. The existing e-learning training is available on Trust Ole. There is work to identify different tiers of staff training depending on role which will include some simulation training targeted in specific areas. All training needs to be co-created with experts by experience with learning disabilities.

`33.2.9 The CLDT continues to provide a service into care homes and is exploring the use of a deterioration tool to enable carers to more easily understand the health needs of the adults with learning disabilities who they support and to identify when urgent medical attention is required.

3.3 <u>Dementia and Delirium</u>

3.3.1 Completed training numbers across the elderly and ILS services are below the HEE recommended 85%. Due to Covid pandemic this has been difficult to improve although ad hoc individualised team training has been offered to all managers and staff in these services by the DaD trainer.

3.3.2 Work is underway looking at aligning the dementia and delirium pathways and processes with services within RBHT following the merger.

3.3.3 The DaD team have been in contact with the three community sites and individual audit of training needs and resources were undertaken. Following the audit review undertaken at the Pulross Rehabilitation Unit, a meeting was held with the ward manager. Training needs were identified and discussed. An action plan has been devised and agreed with the ward manager. The DaD CNSs continue to work with the Pulross team.

3.3.3.1 Following a review and meeting with the staff and the staff at ARU the DaD trainer has identified the need for training needs in Dementia and also Depression. The DaD trainer is currently working with ARU staff to achieve this.

3.3.4 A key goal of the DaD service is to develop the Dementia Champions within the Trust. Plans are in progress to provide bespoke training sessions to the Dementia Champions. The DaD CNSs have revised and updated the list of champions across both Guy's and St Thomas's site. The DaD CNSs are currently working to produce a structured programme for the Dementia Champions.

3.4 Mental Health

3.4.1 Referrals to mental health services fell during the height of the pandemic due to people not accessing their GP to seek help; referrals are now beginning to rise again. Whilst there is no evidence to date that Covid has increased rates of suicide locally, nationally or internationally, it is important to remain vigilant to this, particularly when considering the significant emotional, social and financial impact that Covid has and will continue to have on local communities.

3.4.2 Restrictive Practice and Use of Restraint (including Rapid Tranquillisation)

3.4.2.1 The Patient Safety Report for Quarter 2 (July – September 2020) submitted to TRAC in December 2020, highlighted a concerning increase in the number of restraints taking place within the Trust. On average, there are 14 restraints reported on the Datix system each month. It was noted that from June 2020, the number of reported incidents of restraint rose above the mean average with a spike of 40 incidents of

restraint reported in July 2020. The number of restraints remained above the average until October 2020 when the rate fell back to the baseline average.

3.4.2.2 A deep dive of the restraints occurring between March 2020 & February 2021 highlighted revealed that a large majority of the restraints were carried out in the Acute & General Medicine sub-directorate. Parallel to this finding, an external review was commissioned in February 21 by the Director of Integrated and Specialist Medicine into the use of restraint and restrictive practices in Acute & General Medicine. This review was conducted in April and feedback and recommendations are expected shortly.

3.4.2.3 In addition, policies and procedures relating to restraint, the management of acute behavioural disturbance (including use of rapid tranquillisation) and the management of violence and aggression relating to recreational drug use are currently being reviewed to ensure that they remain fit for purpose and promote practice that is legally compliant.

3.4.3 Following a drop in the MH activity in the emergency department (ED) during the first three months of 2020 coinciding with the onset of the Covid pandemic, levels of referrals to the St Thomas Mental Health Liaison Team steadily rose up until December when there was a second dip coinciding with the second Covid wave of infections and lockdown. By March 21, levels were rising again as the lockdown ended and exceeded pre-Covid levels.

3.4.3.1 Mental health breaches have also risen since April 2020, and whilst there has been some month on month fluctuation, there has been a general trend upwards. A comparison of the third quarter, October to December 2019 with the same period in 2020 reveals a 75% increase in the number of mental health breaches.

3.4.3.2 Mental health attendances across the whole of South East London far exceed those in South West London, with approximately three times as many people attending EDs in South East London compared

to South West London. Levels of 12 hour DTA breaches in South East London are approximately two – three times that of South West London.

3.4.4 As previously highlighted, Evelina London reported a significant increase in the number of young people presenting in mental health crisis during 20/21. The CAMHS Liaison Service at STH only operates Monday – Friday 0900-1700. The out of hours CAMHS response team covers all four boroughs within SLAM and there can be long delays before a child or young person receives a CAMHS assessment out of hours. Inpatient mental health provision for children and young people was outstripped by demand.

3.4.4.1 All of the above have led to many occasions where children and young people in mental health crisis have spent very long periods of time in the acute trust environment before receiving the care and treatment that they require.

3.4.4.2 There are a number of concerns being expressed about the impact of Covid and its aftermath on young people's mental health. A large study, undertaken by the NHS in July 2020, found that clinically significant mental health conditions amongst children had risen by 50% compared to three years earlier. A study very recently released has shown some improvement in children and young people's mental health since the end of lockdown, although children with Special Educational Needs or Neurodevelopmental Disorders and those from low-income households have continued to show elevated mental health symptoms.

3.5 <u>End of Life</u>

3.5.1 Restricted hospital visiting and variation in application of the supporting action card in different clinical areas have impacted negatively on patient/ carer wellbeing, on communication and relationships within clinical teams, on staff distress. It was recognised that this was necessary for public health and safety of patients, public and staff but has been kept under review as restrictions have altered. A Trust policy has been developed in light of new national guidance and supporting patient information produced.

3.5.2 Delivery of written information to support families of those patients in the last days of life has been challenging during the pandemic (due to visiting restrictions and workload). This leaflet is being reformatted to allow it to be printed on the ward, supporting ward staff to share it.

3.5.3 Delivery of EoLC education has been challenging due to pandemic restrictions and workload. Having delivered a very high volume of training in wave 1 (in response to identified staff need), this dropped off significantly in wave 2 and face to face teaching was ceased. EoLC education is now largely virtual, is being championed by the ILS Lead Nurse for Education and discussions are underway to ensure this is multi-professional and cross-Trust.

3.5.4 Federated access to' Co-ordinate my Care' (CMC) is still awaited. This was delayed by the pandemic and the strategic commissioner for CMC has now initiated market engagement with a view to potentially procuring an alternative urgent care planning system. This introduces uncertainty into our strategic planning to more effectively support advance care planning across the system.

3.5.5 Marie Curie companions – the pandemic necessitated a change from the original project purpose (volunteers acting as companions to those dying in hospital without loved ones) to a new model (with a focus on virtual support for families of patients dying at home). Referral numbers have been low and the scope has been broadened to include the community heart failure team and reintroduce referrals from hospital.

3.5.6 Audit has identified the need to improve documentation of capacity assessment relating to DNACPR conversations, improve documentation of treatment escalation conversations and promote the offer of supporting information to patients and families. The EPR DNACPR form has been enhanced to support these improvements. Its release is awaited (from the EPR team) and practice will be re-audited following its introduction in practice.

3.5.7 The hospital EoLC team is keen to introduce a visual symbol for use on wards when a patient is recognised as dying. The aim is to support 'respectful awareness' amongst staff to enhance a peaceful and compassionate environment. This has been delayed in response to patient feedback, with the working group reviewing options and ensuring ongoing engagement with patient groups as well as Trust communications team.

4.0 Learning from Serious Incidents / Safeguarding Adults Reviews/Domestic Homicide Reviews

4.1 Safeguarding

4.1.1 Many of the Safeguarding Adults Reviews (SARs) and Domestic Homicide Reviews (DHRs) were not progressed over the pandemic due to capacity of staff capacity as teams were already stretched. One DHR and one SAR enquiries were suspended due to active Police investigations and the requirement that the case should not be discussed whilst under a Police investigation. The suspended SAR is now underway.

4.1.2 Safeguarding concerns against Trust services identified inappropriate discharges of patients. These were discussed at the Safeguarding Adults Operational Meeting and learning disseminated via the group. A key piece of learning about rearranging packages of care before discharge was shared as a Safety Signal widely across the Trust.

4.2 Learning Disability

4.2.1 There was a complex case involving a woman with significant learning disabilities who became pregnant. The case was investigated by the Police. Several issues were raised with how the case was managed. Regular meetings were held to support the patient which were extremely helpful. However it was noted that there could have been better partnership working between adult and children's teams particularly

with information sharing, clear identification of the team around the patient, timely escalation and clarity of roles and responsibilities. The case has been discussed with Lambeth Adult Social Care safeguarding lead with the view of looking at raising staff awareness of the issues raised.

4.3 Dementia and Delirium

4.3.1 There is a current investigation under the Domestic Homicide Review (DHR) process looking at the death of a person with dementia who was seen by services at the Trust. The DHR was delayed due to the case going through the Court process. On completion of the DHR and learning will be widely shared.

4.4 Mental Health

4.4.1 There were four serious untoward incidents occurring during the year 20/21. Three of these incidents were in adults and one related to a 17 year old young person. The incidents and learning were as follows:

4.4.1.1 One incident related to a death of a community patient with severe and enduring mental illness and comorbid insulin dependent diabetes. The patient was under the care of the District Nursing Team and Lambeth Community Mental Health Services. He engaged poorly with health care services and it came to light during a multi-agency meeting convened in November 2020 that he had not been seen by any care team for a number of days. Access was gained to his property with the assistance of the police where he was found deceased. Separate investigations were completed by GSTT and SLAM. A number of actions were identified which included increasing staff understanding of assessing mental capacity and improving communication between different teams.

4.4.1.2 One incident related to the use of general anaesthesia to manage acute behavioural disturbance in an 18 year old young person with acute mental health difficulties admitted for emergency surgery. The root

cause was found to be a failure to effectively recognise and manage the patient's anxiety and agitation, allowing it to escalate to a situation of violence and aggression which resulted in the decision to anaesthetize and intubate the patient for their safety, and that of other patients and staff. There were many recommendations arising from the investigation relating to the recognition and management of escalating mental and behavioural disturbance, awareness and understanding of rapid tranquillisation guidance, communication within and between GSTT and SLAM teams, prescribing of psychotropic medication, mental health emergency response procedures, recognition and management of prescribed and recreational drug withdrawal, including nicotine, application of legal frameworks (Mental Health Act and Mental Capacity Act), visiting policies for vulnerable patients and perioperative fasting guidance.

4.4.1.3 The third incident related to a vulnerable patient with cognitive impairment and multiple medical co-morbidities who fell whilst an inpatient sustaining a fractured neck of femur. The patient's walking stick had been removed because he had earlier been using it as a weapon and the nursing assistant observing him had temporarily left the bay in order to complete some data entry onto a computer since none were available by the bedside. Recommendations arising from the investigation related to review of computer availability for staff carrying out one to one observations and review of the rapid tranquillisation and enhanced care policies.

4.4.1.4 The fourth incident related to a vulnerable young person in voluntary foster care with a history of mental health problems who was admitted to a ward within Evelina London after presenting with suicidal ideation and later absconded whilst under one to one nursing observation, subsequently travelling with a friend to a party where they ingested illicit drugs. The investigation is still in progress.

4.5 <u>End of Life</u>

4.5.1 The role of palliative and EoLC (direct clinical care, staff education and support, coordination and guidelines/ standard setting/ assurance, bereavement support) was highlighted during waves 1 and 2 of the pandemic. Learning from wave 1 led the palliative / EoLC team to introduce a proactive in reach service to critical care in wave 2 which resulted in significantly more referrals and therefore opportunities to support patients, families and staff.

4.5.2 Audit of clinical care of dying patients continued to show a high standard of care but certainly an increase in 'sudden' deaths and reduced proportion receiving spiritual support / written information. We are aware that limited face to face visiting for families was a key cause of distress for many.

4.5.3 Improved access in the community to EoLC injectable medications out of hours – the GSTT resident pharmacist can be accessed for support but additionally, SELDOC will have a Home Office licence to hold their own stock.

4.5.4 An e-learning module has been completed to support staff in setting up T34 subcutaneous syringe pumps. This was developed in response to incident surveillance.

4.5.5 Opioid patch monitoring charts are used in paper form in ward settings to improve patient safety. Use of these patches is currently being audited in advance of plans to transfer this monitoring chart to e-noting.

4.5.6 EoLC incident surveillance has highlighted an issue relating to complex discharges for patients at the end of life. This has now been incorporated into Trust quality project work around safer discharges.

4.5.7 Medication errors relating to alfentanil and other opioids continue to be monitored albeit they are infrequent.

5.0 Feedback from Patients/Carers

5.1 One of the patients who was involved in raising an allegation fed back about his confusion and fears during a period when he had delirium and also provided some insight into how he perceived what was happening to him when he was being dissuaded from leaving the ward. Patient experience of restraint and delirium will form part of the work undertaken in the promotion of positive behaviour from patients.

5.1.1 The Lambeth Safeguarding Adults Board work plan going forward involves service user feedback. The safeguarding team is working with the local board in looking at a uniform way of collating patient feedback following a safeguarding adults intervention.

5.2 Learning Disabilities

5.2.1 The team is currently piloting the use of video interviews to gain feedback from adults with learning disability and their carers.

5.2.2 Feedback surveys have been sent to 100 service users as part of the LD benchmarking. Feedback from the surveys included:

- The link worker role during the early months of the pandemic were appreciated. Examples of feedback from family carers to the team: *"These resources look really helpful, thanks so much. I also valued our recent conversation a lot and have been making some small changes as a result already, so thank you!"*

- A man with learning disabilities and his mother said that they appreciated and looked forward to the contact from the AWLD team member. His challenging behaviours reduced during this time. The mother regularly told her friends and family *"how well her son's speech therapist was looking after [them]".*

5.2.3 The Big Health Day for people with learning disabilities across Lewisham, Bexley and Greenwich became a virtual Big Health Week in November 2020. This again was supported by the Lewisham community team for Learning Disability (CTLD). The week of events were well attended and the feedback from all those who attended and facilitated the event was very positive.

5.3 Dementia and Delirium

5.3.1 Staff feedback has been extremely positive about the move onto the team's platform, with some staff reporting they prefer teaching on-line.

5.3.2 Two Covid specific carer surveys were conducted over the last year. The carers of people with dementia understood the reasons for the restrictions to visiting and felt kept informed about their relative in hospital. They praised the efforts of nurses in their attempts to keep in touch with virtually. They felt involved as much as possible with the care of their relative in hospital;

5.3.3 Carers were not given the opportunity to speak with a DaD CNS during the stay of the person with dementia nor asked to complete a 'This is Me' document.

5.3.4 Carers felt that their relative was discharged home too quickly and were not given appropriate information relating to the discharge such as the person with dementia coming home with a new catheter with no information on its management.

5.4 Mental Health

5.4.1 During the course of 20/21, there were 11 complaints logged where mental health featured as an element. This was a reduction on the number received during the previous year, and is considered by the Complaints Department to be a low number, particularly as numbers of mental health presentations increased from spring 2020 onwards. The Complaints department are now working with the Safeguarding Adults, Inclusion and Patient Experience Teams, as well as carers and vulnerable partnership networks, in order to ascertain how the experiences of vulnerable patient groups can be viewed from different perspectives. Themes arising in the complaints included clinical care, communication, discrimination, cultural needs / racism, information held in clinical records, Covid related delays and discharge arrangements.

5.4.1.1 Of the 11 cases, 7 were not upheld (no evidence of failings following investigation of issues raised) and 4 were partially upheld. The learning identified included the importance of introductions, the importance of clear and accurate documentation, the importance of convening complex case panels early on where the patient is identified to have complex needs and the proactive development of clear care management plans where it is considered that the patient is likely to re-attend.

5.5 End of Life Care

5.5.1 Wave one of the COVID-19 pandemic led us to discontinue our previous **bereaved carer surveys** (which had been distributed when family attended to collect the medical certificate of cause of death) and delayed our introduction of a local adaptation of the national bereaved carer survey tool used within the national audit of care at the end of life (NACEL). We have now made the following progress:

1. A bereaved carer survey was re-launched in September 2020, sent to the carers of patients who died in hospital from April 2020 onwards, at approximately four months post death. A bereaved carer survey for those who died at home / in a care home known to the community end of life care or palliative care team was launched in December 2020. These will be reported to the EoLC committee on a quarterly basis and the most recent results are available in the appendix.

2. A prospective condolence letter and updated 'What should I do now?' leaflet will be posted within days of an inpatient death including practical information and bereavement support. This has been delayed by the pandemic. This will cover all clinical services and some teams will continue their own practice of separate/ later contact with bereaved carers eg palliative care, cardiovascular and critical care.

5.5.2 **EoLC complaints** continue to be monitored and discussed at the quarterly EoLC committee. Numbers remain low and key themes relate to communication and patient care. During the pandemic, loss of patient property triggered a complaint (procedures now improved) as did inability to provide a video call as requested by the family of a dying patient (due to unprecedented clinical pressures; a team has been established to support this important work and this will remain under review.

Appendices

Appendix 1: Safeguarding Adults

Appendix 2: Dementia and Delirium

Appendix 3: Learning Disabilities

Appendix 4: Mental Health

Appendix 5: End of Life Care

Appendix 6: Safeguarding Adults Work Plans

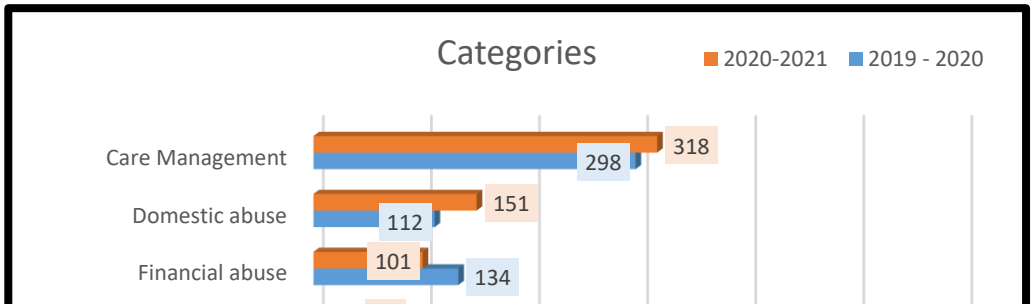
Appendix 7: Risk Mitigation plan

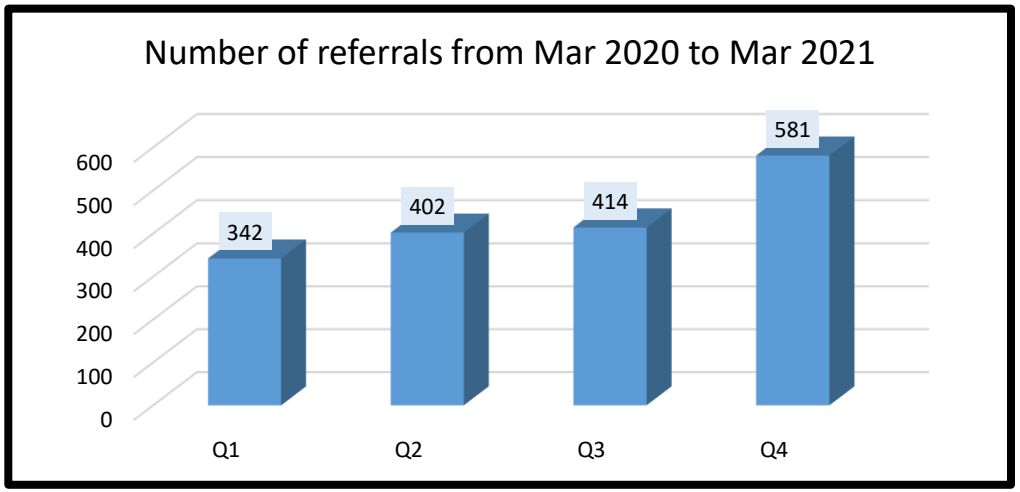
Appendix 1

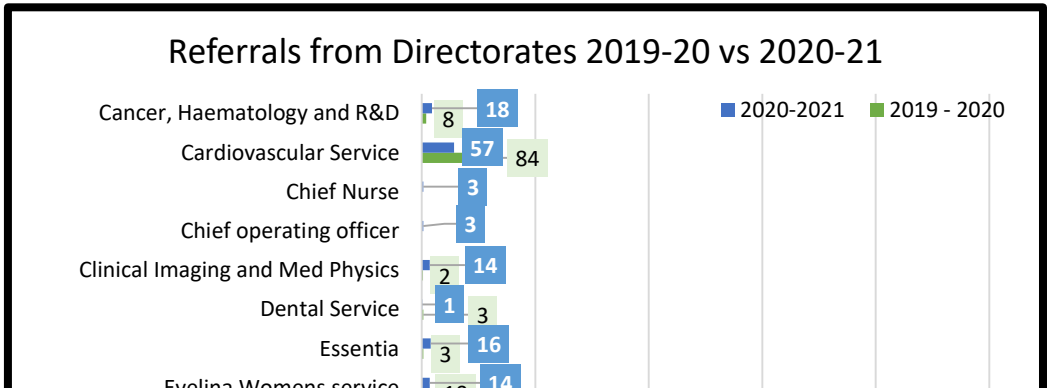
Safeguarding Dashboard

Safeguarding Adults Highlights:

- The year saw a steady number of referrals that were appropriate
- The referrals were received from across the Trust with the highest numbers from ITM and Integrated local services
- The highest number of referrals continue to be for self-neglect which are often complex and requires a multi-agency approach to resolution.
- There has been an increase in domestic abuse over the pandemic







Appendix 1.Cont.

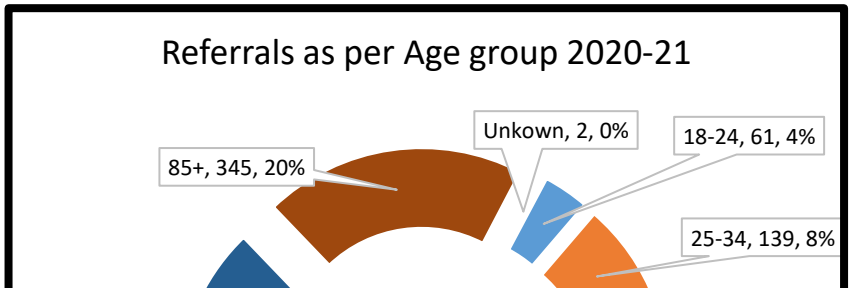
Safeguarding Dashboard

Safeguarding Adults Highlights:

- There was a 34% increase in domestic abuse referrals in the last year when compared to the previous year and
- Psychological /verbal abuse referrals increased by 23%, both of which may be a result of shielding and spending an increased amount of time in the home.
- Similarly sexual abuse and modern slavery concerns also increased over the pandemic

Age Range	Q1	Q2	Q3	Q4	Total	2019-20
17	0	0	0	0	**0**	**5**
18-24	15	13	24	9	**61**	**70**
25-34	39	22	43	35	**139**	**91**
35-44	30	18	41	35	**124**	**126**
45-54	37	29	60	34	**160**	**182**
55-64	48	37	70	60	**215**	**297**
65-74	68	73	103	72	**316**	**301**
75-84	84	82	125	86	**377**	**395**
85+	81	66	115	83	**345**	**337**
Unknown	0	2	0	0	**2**	**6**

2020-21	Q1	Q2	Q3	Q4	Total	2019-20



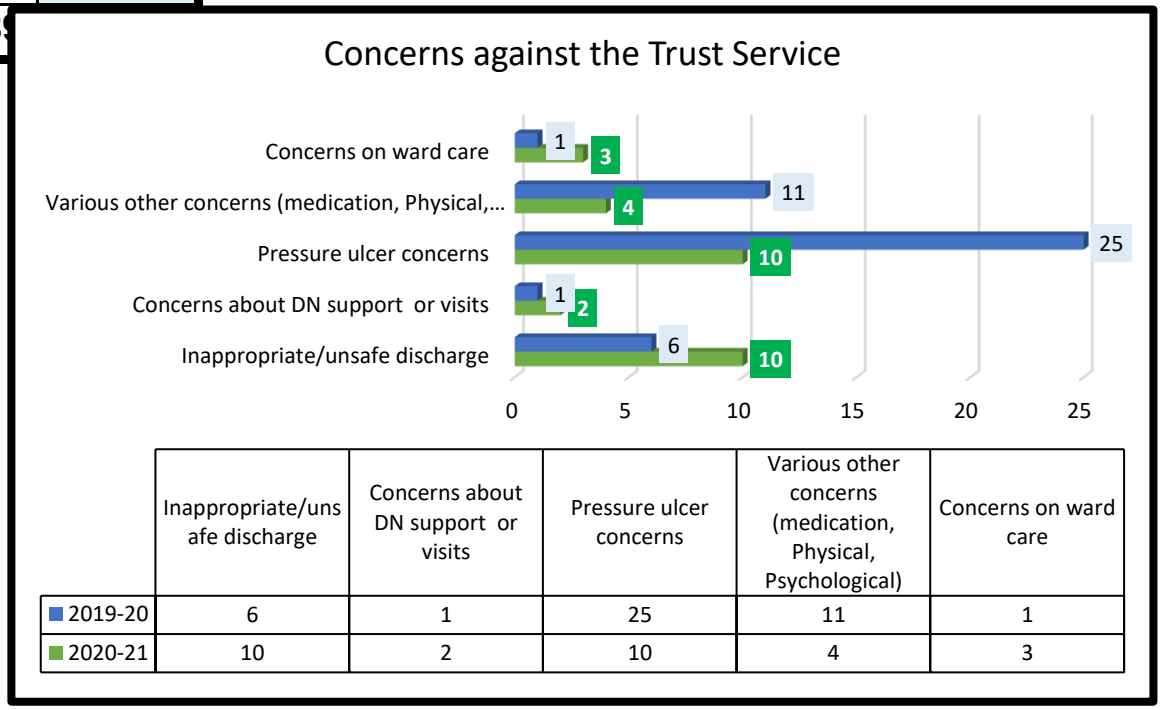
Domestic abuse and Force marriage	21	37	46	47	**151**	**112**
Financial abuse	20	20	31	30	**101**	**134**
Psychological and/or verbal	11	19	17	37	**84**	**68**
Physical abuse	19	23	12	29	**83**	**116**
Sexual abuse	9	7	9	10	**35**	**27**
Organisational abuse	2	1	1	2	**6**	**14**
Neglect by others	110	87	106	155	**458**	**526**
Care Management	49	79	53	137	**318**	**298**
Self-neglect	99	126	133	130	**488**	**504**
Modern Slavery	2	1	5	4	**12**	**7**
Prevent	0	2	1	0	**3**	**4**
Total	**342**	**402**	**414**	**581**	**173**	

Appendix 1 cont.

Concerns about the Trust service

Highlights:

- The concerns raised about Trust services involved ward based care and discharge planning. It was learnt from carers that they felt patients were sent home too early with not all support being in place post discharge.
- The lesson learnt about care not being restarted was disseminated widely as a safety signal message
- There was a significant reduction in concerns about pressure ulcers and partly attributable to ITU areas have put mitigation plans in place as a result of the increased pressure damage noticed in patients who had prolonged proning.



	Inappropriate/unsafe discharge	Concerns about DN support or visits	Pressure ulcer concerns	Various other concerns (medication, Physical, Psychological)	Concerns on ward care
2019-20	6	1	25	11	1
2020-21	10	2	10	4	3

Appendix 1 cont.

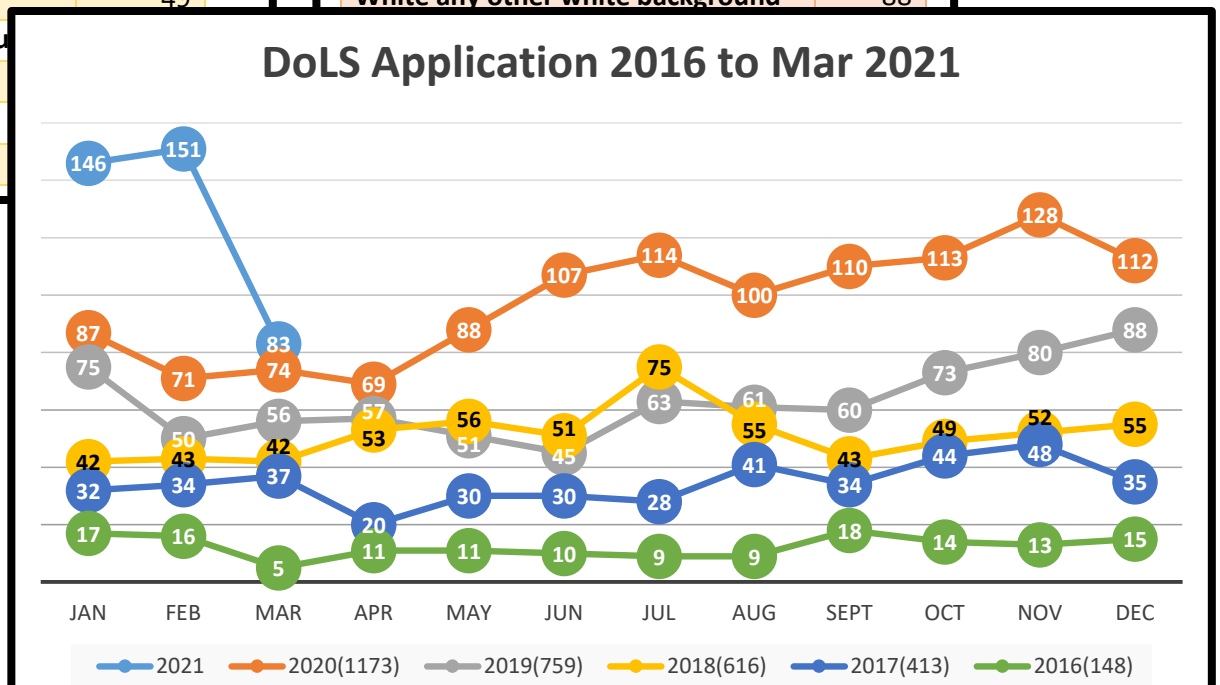
DoLS Dashboard

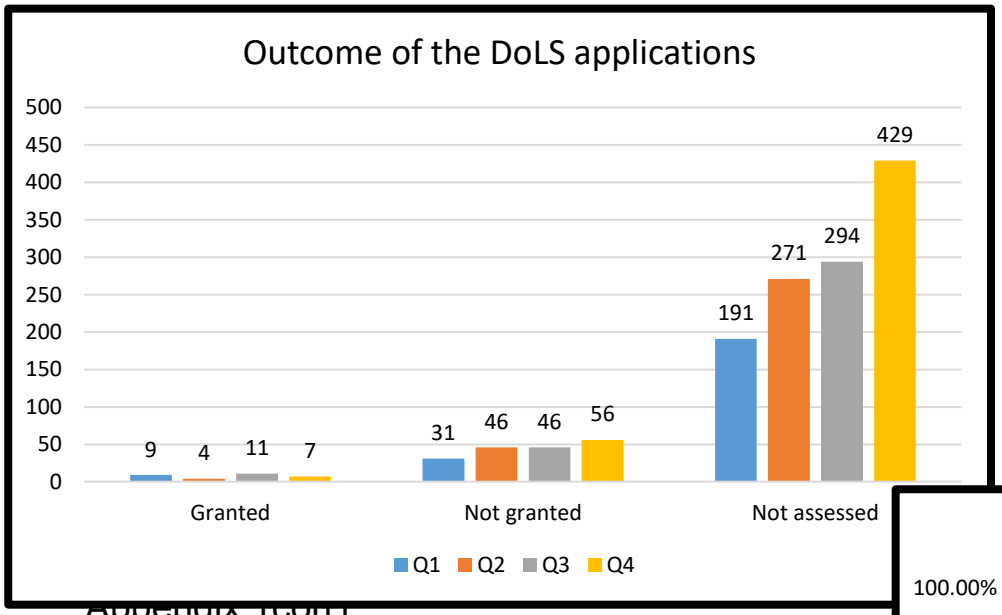
Highlights

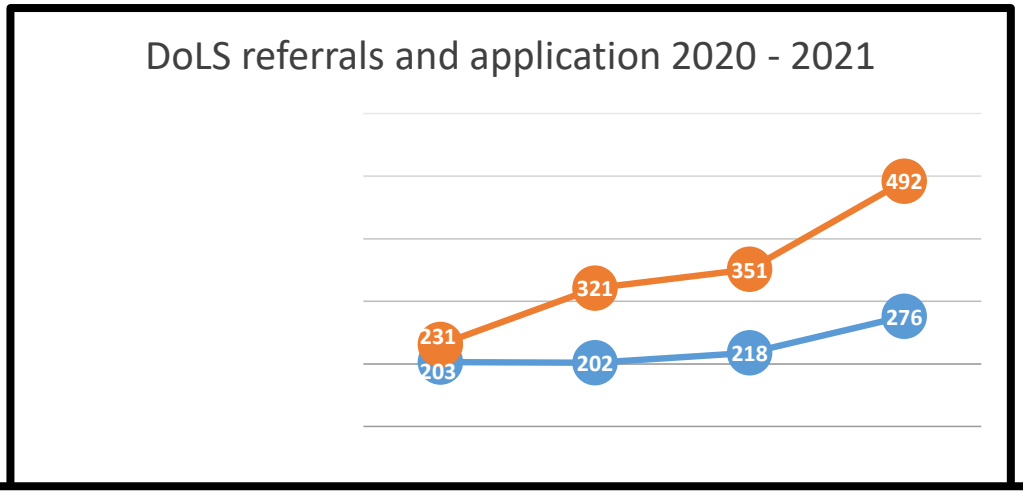
- DoLS referrals have increased year on year as the awareness of DoLS increases.
- Over the last year the team worked very proactively and undertook case finding of patients who may require a DoLS. This has been very successful and more patients were captured and applications made
- March of 2021 saw a significant dip in applications and this was partly due to reduced capacity with the team so less case finding was undertaken
- Ad hoc training on MCA and DoLS continues to be offered and provided

Ethnicity (Safeguarding Referrals)	Total
Asian or Asian British: Any Other	14
Asian or Asian British: Bangladeshi	14
Asian or Asian British: Indian	18
Asian or Asian British: Pakistani	4
Black or Black British: African	74
Black or Black British: Any Other	81
Black or Black British: Caribbean	133
Mixed: Any other mixed background	5
Mixed: White and Asian	8
Mixed: White and Black Caribbean	9
Not stated	318
Other Ethnic Group : Chinese	11
Other Ethnic Group: Any other	49
White any other white backgrou	
White British	
White Irish	
Grand Total	

Ethnicity (DoLS Applications)	Total
Any other ethnic group	2
Asian or Asian British: Any Other	3
Asian or Asian British: Bangladeshi	1
Asian or Asian British: Indian	66
Black or Black British: African	60
Black or Black British: Any Other	48
Black or Black British: Caribbean	115
Mixed: Any other mixed background	5
Mixed: White and Black Caribbean	2
Not stated	28
Other Ethnic Group : Chinese	1
Other Ethnic Group: Any other	28
White any other white background	88







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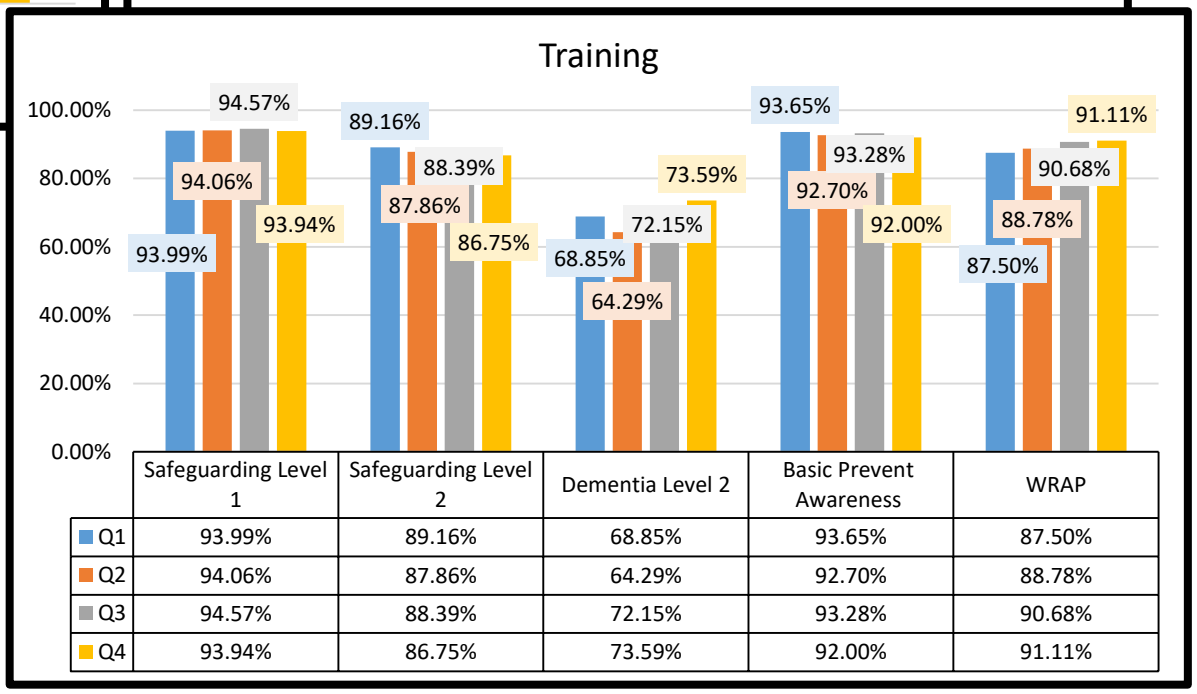
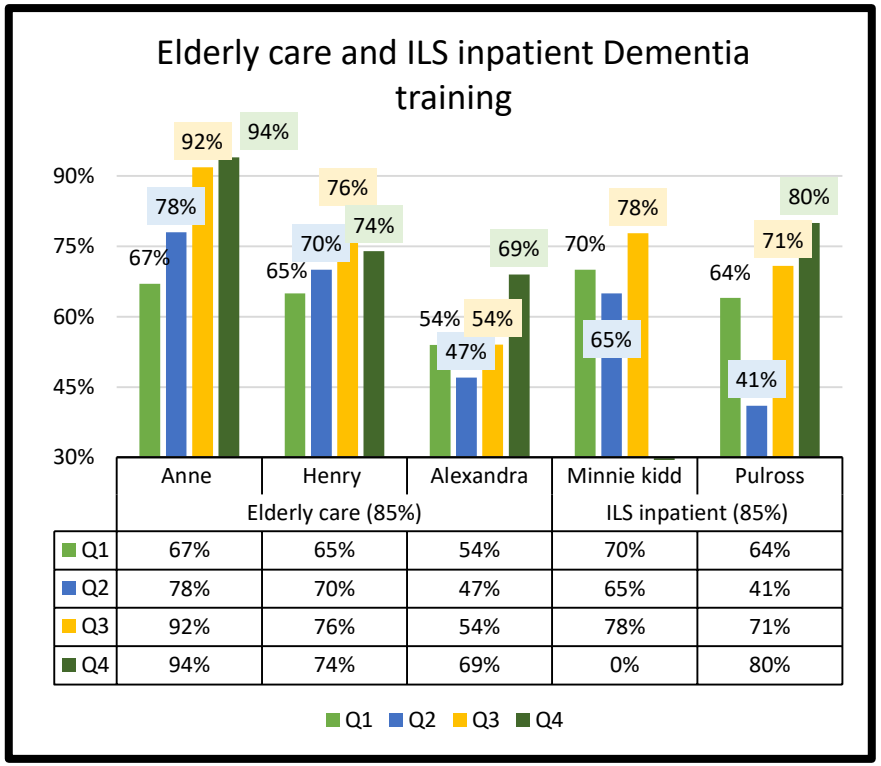
Training Dashboard

Highlights:

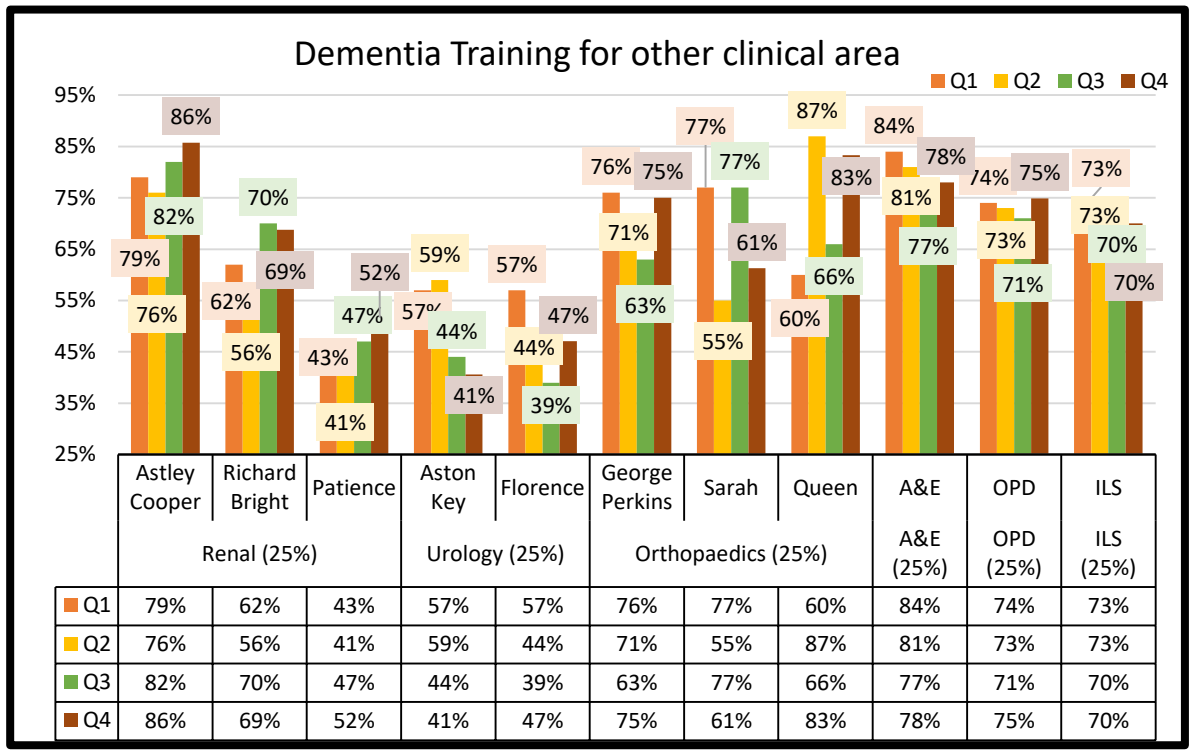
- Safeguarding and Prevent training have reached the target compliance.
- Dementia training figures look positive overall.
- The focus of the training will be on the Older persons Unit where the target compliance is 85% for all ward staff.
- Another area of focus will be community nursing where the target compliance is 85%
- Bespoke training is being provided at community sites.



	Safeguarding Level 1	Safeguarding Level 2	Dementia Level 2	Basic Prevent Awareness	WRAP
Q1	93.99%	89.16%	68.85%	93.65%	87.50%
Q2	94.06%	87.86%	64.29%	92.70%	88.78%
Q3	94.57%	88.39%	72.15%	93.28%	90.68%
Q4	93.94%	86.75%	73.59%	92.00%	91.11%



	Anne	Henry	Alexandra	Minnie kidd	Pulross
	Elderly care (85%)			ILS inpatient (85%)	
Q1	67%	65%	54%	70%	64%
Q2	78%	70%	47%	65%	41%
Q3	92%	76%	54%	78%	71%
Q4	94%	74%	69%	0%	80%



	Astley Cooper	Richard Bright	Patience	Aston Key	Florence	George Perkins	Sarah	Queen	A&E	OPD	ILS
	Renal (25%)			Urology (25%)		Orthopaedics (25%)			A&E (25%)	OPD (25%)	ILS (25%)
Q1	79%	62%	43%	57%	57%	76%	77%	60%	84%	74%	73%
Q2	76%	56%	41%	59%	44%	71%	55%	87%	81%	73%	73%
Q3	82%	70%	47%	44%	39%	63%	77%	66%	77%	71%	70%
Q4	86%	69%	52%	41%	47%	75%	61%	83%	78%	75%	70%

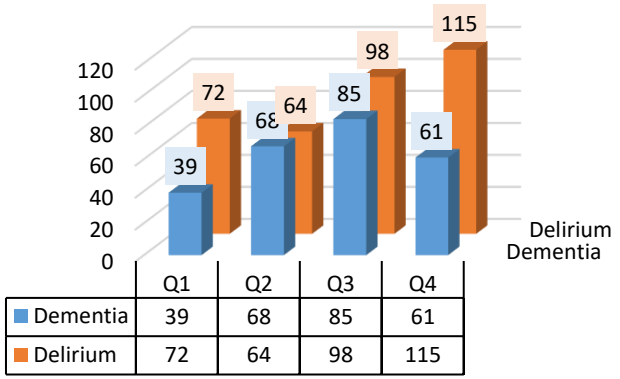
Appendix 2

Dementia and Delirium Dashboard

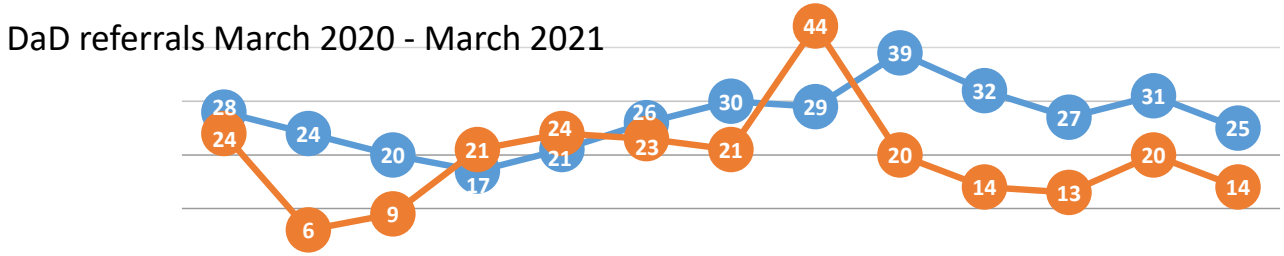
Highlights:

- The team has seen more referrals for Delirium management than dementia.
- The delirium bundle continues to be promoted and advice offered
- Research found that delirium was not diagnosed among patients with COVID. The DaD CNSs have supported the wards with identifying and reminding ward staff to look for Delirium and to undertake the CAM for appropriate patients

Dementia Care Review (DCR) October 2020 to March 2021	
Month	No. of patients DCR initiated
Oct' 20	28
Nov' 20	29
Dec' 20	10
Jan' 21	3
Feb' 21	21
Mar' 21	29
Total	120



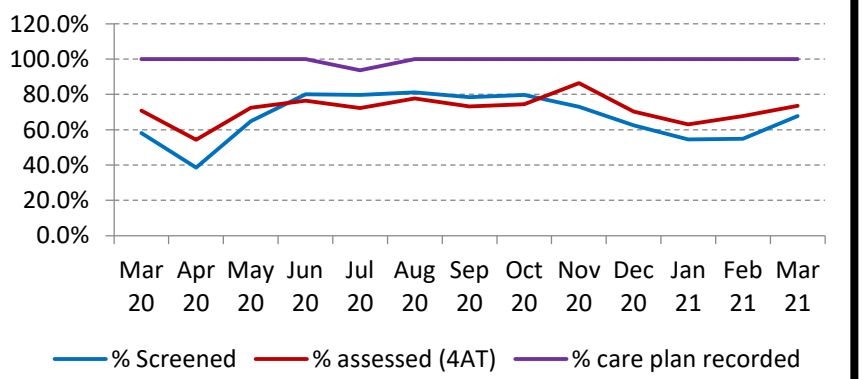
	Q1	Q2	Q3	Q4
Dementia	39	68	85	61
Delirium	72	64	98	115



	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar'21
Delirium	28	24	20	17	21	26	30	29	39	32	27	31	25
Dementia	24	6	9	21	24	23	21	44	20	14	13	20	14

Dementia Screening Highlights:

- Screening saw a significant fall during the start of the pandemic. It has increased but not meeting the 90% compliance each month as required. Wards continue to be supported and anomaly with EPR which is extracting data including those of age 70 yrs and over for the wards has been reported for resolution



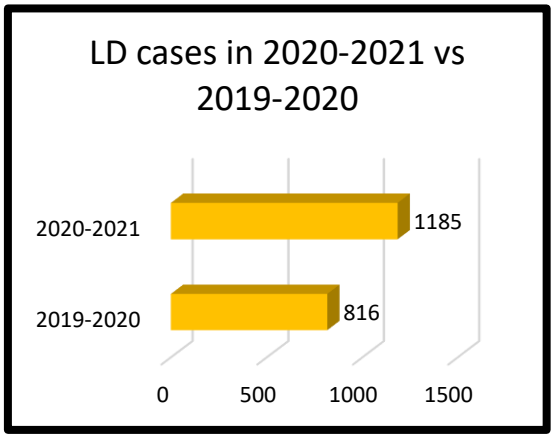
Dementia screening	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Emergency patients over 75	186	169	142	160	188	175	186	192	189	221	233	162	167
Screened	108	65	92	128	150	142	146	153	138	138	127	89	113
% Screened	58.1%	38.5%	64.8%	80.0%	79.8%	81.1%	78.5%	79.7%	73.0%	62.4%	54.5%	54.9%	67.7%
Patients needing 4AT assessment	24	35	29	34	47	45	41	47	37	37	46	34	34
Patients assessed	17	19	21	26	34	35	30	35	32	26	29	23	25
% assessed (4AT)	70.8%	54.3%	72.4%	76.5%	72.3%	77.8%	73.2%	74.5%	86.5%	70.3%	63.0%	67.6%	73.5%
Patients needing onward care plan	13	7	5	8	16	5	9	12	11	4	7	13	9
Patients with care plan recorded	13	7	5	8	15	5	9	12	11	4	7	13	9
% care plan recorded	100.0%	100.0%	100.0%	100.0%	93.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

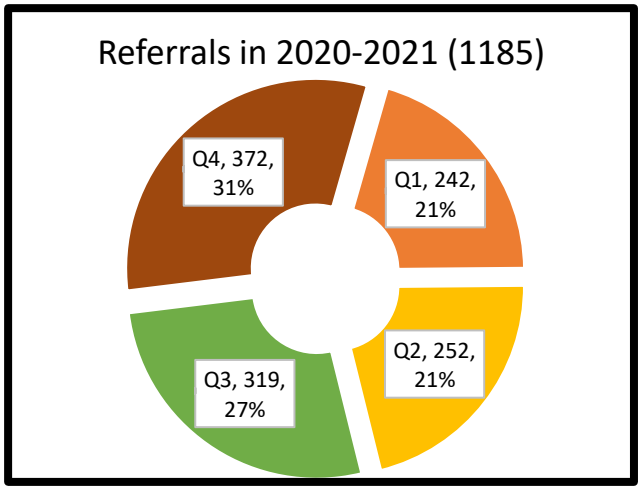
Appendix 3

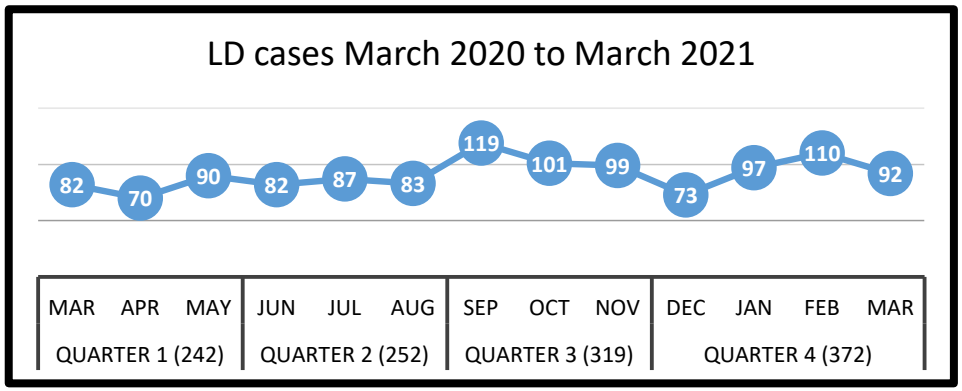
Learning Disability Dashboard

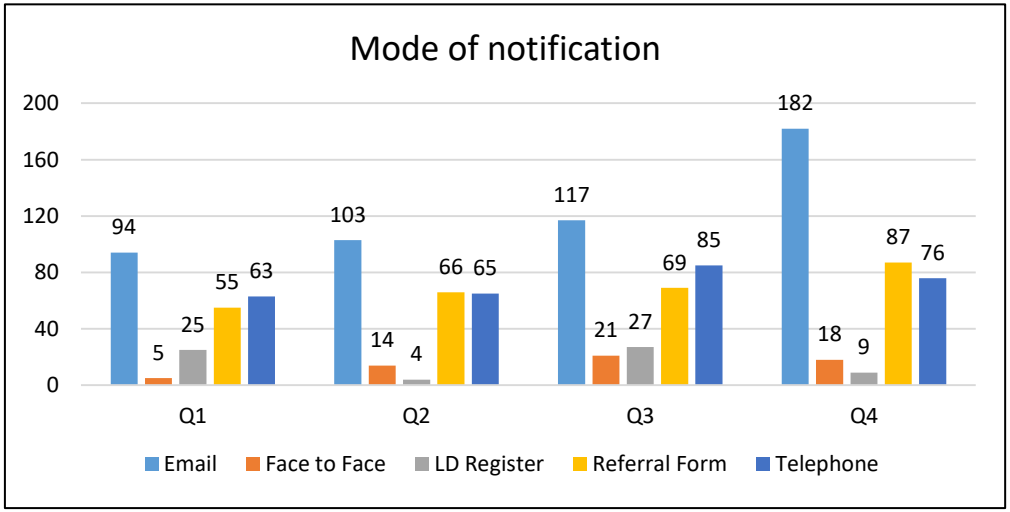
Highlights:

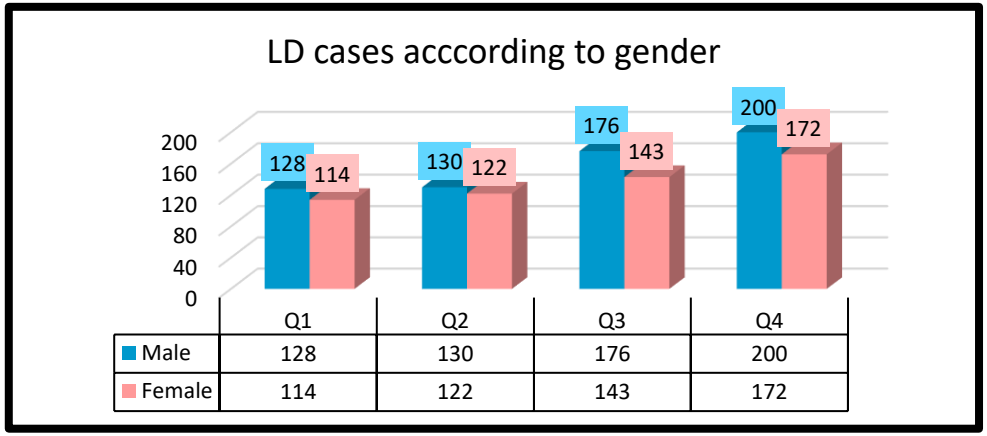
- Referrals remain high with most of the referrals coming from ITM Clinical Group
- A significant number of referrals were received from outpatient areas
- Referrals include requests for support with reasonable adjustments and attending and support at appointments











LD register:

- Data cleansing continues with the LD CNS verifying the LD diagnosis.
- With time this will be a very reliable system to identify patients in the hospital who have LD and support can be offered appropriately.
- High numbers of referrals for patients with LD continue as a pattern
- Activity for the hospital LD service continued to be high with support for those attending hospital was needed and mostly face to face support

Appendix 4 - End of Life Care

1. **Bereaved Carer Survey –** the GSTT bereaved carer survey has been adapted with permission from the the survey within the National Audit of Care at the End of Life (NACEL).

Part A – Hospital NACEL survey

This report (Part A) covers Hospital NACEL survey responses received between 1st December 2020 and 28th February 2021. Surveys were sent out in this period to NOK/carers who had been bereaved between July 2020 and October 2020 during the recovery phase of the first wave of the Covid-19 pandemic.
The response rate was lower this quarter (Q1= 14%; Q2, n=11%).

Scores about both patient care and care received by the NOK/carer themselves have improved compared to the previous quarter. Most surveys sent out in this period related to deaths during the recovery phase of the first wave of the pandemic, compared the previous quarter which was during the peak of the wave 1 of Covid.

The ‘Overall care’ score for patient care was 76% for ‘Outstanding’ or ‘Excellent’ compared to 58% in the previous quarter. The ‘Overall care’ score for NOK/bereaved carers’ care of themselves was 64% for ‘Outstanding’ or ‘Excellent’ compared to 55% in the previous quarter.

The largest positive themes from the free-text comments were ‘Staff kindness & Compassion’, ‘Staff – Professionalism’, ‘Amount of time/visits to say goodbye’, ‘Quality of Care’ and ‘Kept informed’.
The largest improvement/negative themes were ‘’Environment/ Location of death’, ‘Covid – no visits’, ‘Quality of care’, ‘Communication / Information’, ‘Explained likely to die’.

Scores for NOK/bereaved carers' care of themselves are lower than those about patient care. The visiting restrictions and clinical pressures may have limited the direct contact NOK/bereaved carers had with staff delivering care, and therefore opportunities for staff to recognise when support was needed. The feedback clearly suggests - as per the previous quarter - that visiting restrictions reduced opportunities for NOK/bereaved carers to spend as much time as they would have wanted with the person who died.

Visiting is currently being cautiously extended but we should remain mindful of the importance of communication and information sharing with NOK/carers of dying patients.

Part B – Community NACEL survey

This report (**Part B**) covers responses received from the **Community NACEL survey** between 1st December 2020 and 28th February 2021 and relating to patient deaths during the second half of the first wave of the Covid-19 pandemic (July – October 2020).
This is the first quarter of results of the Community NACEL survey so there is no historical comparison available. 30 responded from a total of 112 surveys sent, giving an overall response rate in this quarter of 27%.

The 'Overall care' score for patient care was 63.3% for 'Outstanding' or 'Excellent'. The 'Overall care' score for NOK/bereaved carers' care of themselves was 48% for 'Outstanding' or 'Excellent'.

The highest (best) scores in the survey relating to the care of the person who died related to 'Right place to die' (90% Yes definitely), 'Compassion' (83% Always), 'Care plan covering individual wishes' (Yes definitely 80%) and 'Peaceful environment' (76% Always).

The lowest (worst) scores in the survey relating to the care of the person who died were ‘Support overnight’ (Yes definitely = 50%), ‘Spiritual support’ (Always = 50%), ‘Symptom relief’ (Always = 50%),’ Emotional/psychological support’ (Always = 53%), Pain relief (Always = 50%).

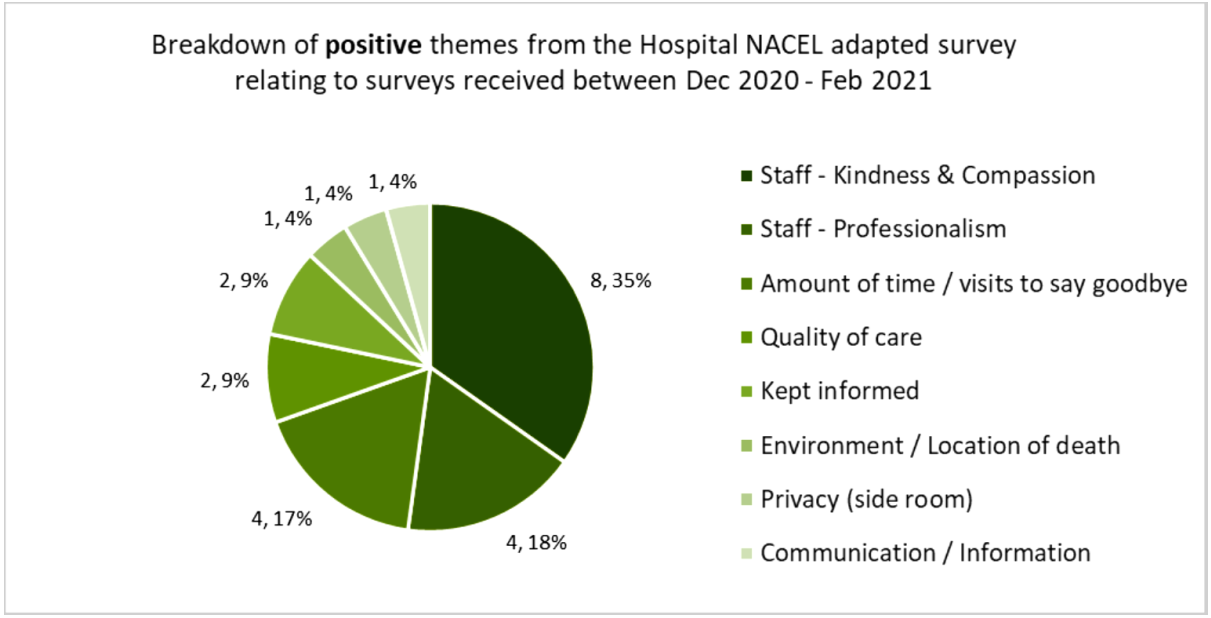
The highest (best) scores in the survey for NOK/Bereaved carer scores about care of themselves were ‘Delays to death certification (No = 77%), Involved in decisions (I was involved as much as I wanted to be= 77%), ‘Opportunity to ask questions’ (Always = 63%), Communicated sensitively (Always = 63%), and ‘Explained likely to die’ (Yes clearly = 63%).

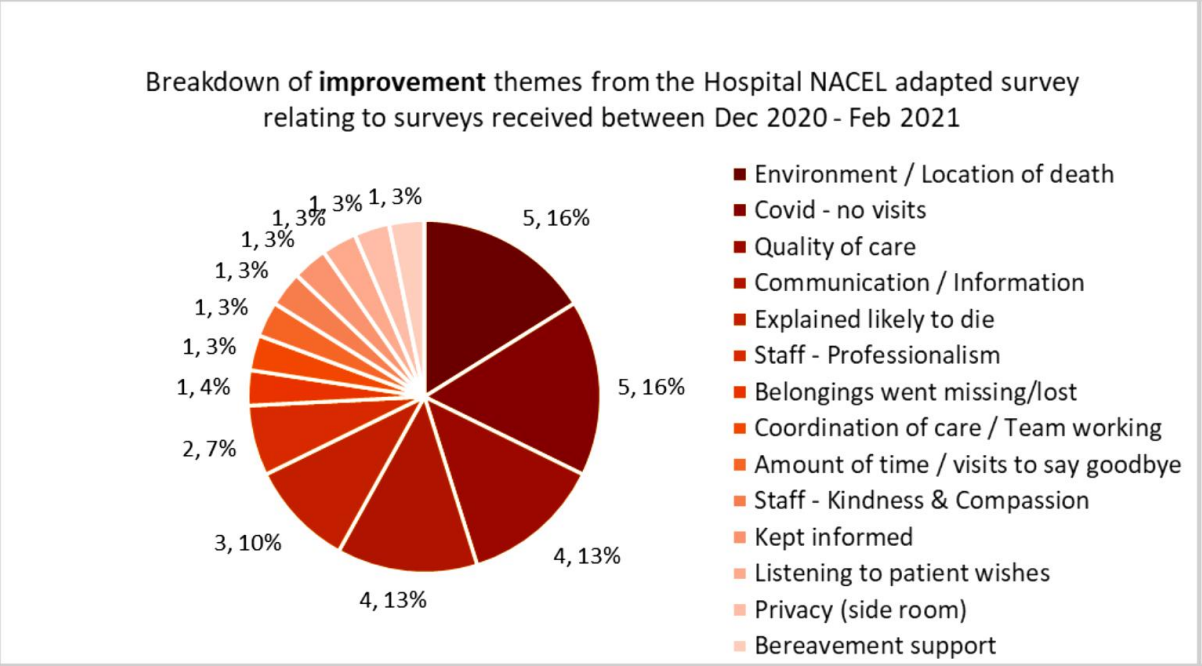
The lowest scores (worst) in the survey for NOK/Bereaved carer scores about care of themselves related to ‘Support after person died’ (Yes definitely = 33%), ‘Practical support (Always = 33%), ‘Emotional support’ (Always = 40%), and ‘Overall care to relatives/friends’ (Outstanding or Excellent = 48%).

The largest positive themes from the free-text comments were ‘Quality of care’, ‘Staff kindness and Compassion’ and ‘Listening to patient’s wishes’.
The largest negative/improvement themes from the free-text comments were ‘Level of support /contact from the CPC team’, ‘Covid – impact on care’, feedback relating to care delivered by ‘Other community teams / Carers’, and Coordination of care/Team working.

Relatives/friends/carers told us that although care from the Palliative Care team was overall of a very high standard across nearly all aspects of care, there were some gaps in care from other community / agency carers. Responses also suggest that demands on staff and the safety restrictions in place during the pandemic may have negatively impacted the level of support provided to NOK/bereaved carers themselves both before and after the person died.

Comments relating to coordination of care/team working, amount of contact with the NOK/carer before the patient died and communication with the NOK/carer after the person had died, suggest that these areas may influence NOK/carer scores of experiences patient care and how supported NOK/carers feel after the person has died.



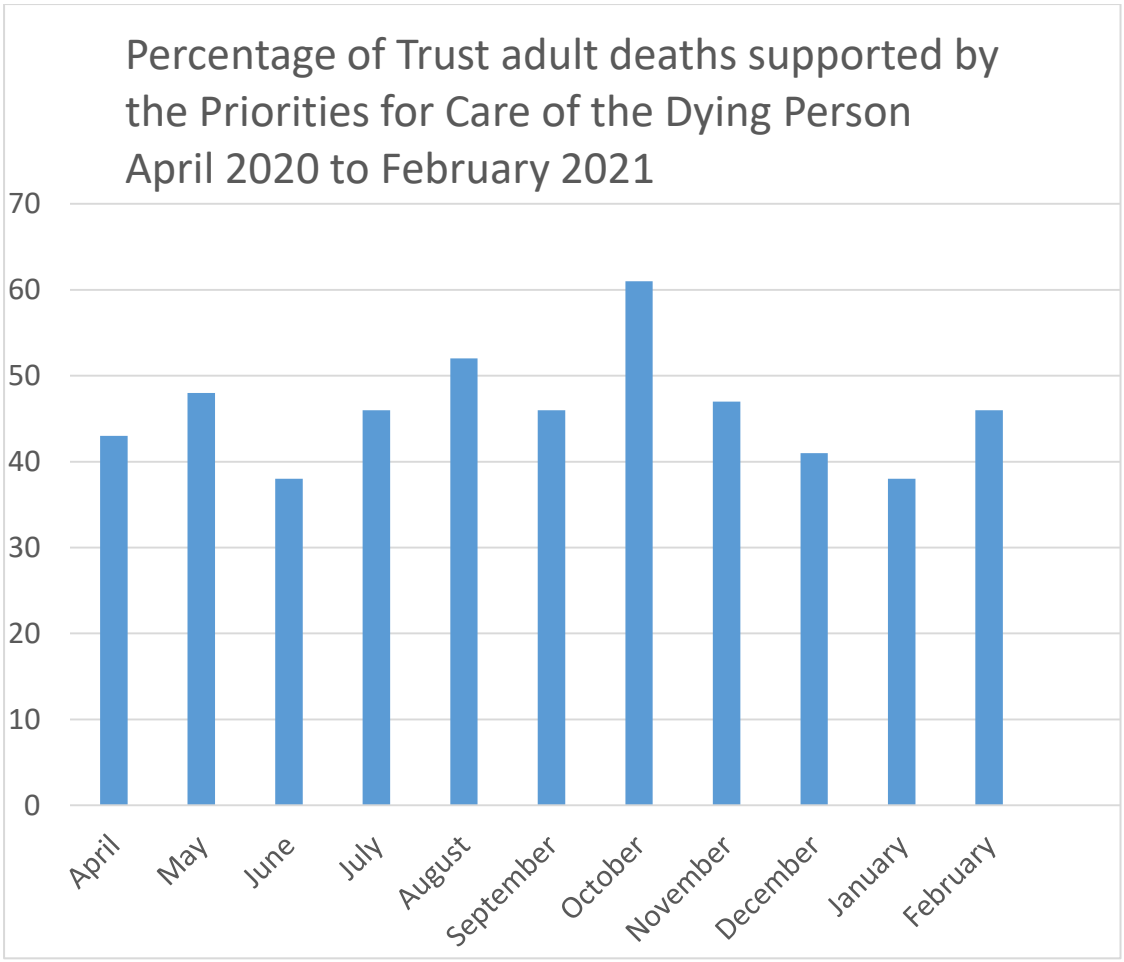


2. Proportion of Trust adult deaths supported by the Priorities for Care of the Dying Person.

The priorities for care of the dying person (Recognise; Communicate; Involve; Support; Plan & Do) provide a framework for high quality individualised care delivered to those thought to be in the last hours to days of life. We monitor the proportion of adult inpatient deaths supported by these priorities. This provides a proxy for quality of care as it indicates recognition of the fact the patient is dying and ensures focus on the nationally agreed key clinical parameters.

The numbers of those in the last days of life supported by the priorities for care of the dying person continues to exceed our minimum target of 25% and demonstrate natural variation. Given that it is widely accepted that

approximately 25% of hospital inpatient deaths are sudden, we would not seek to exceed approximately 75%. The priorities for care of the dying person have not been used routinely in critical care. Practice is evolving following the impact of the pandemic and greater recognition of the benefit of palliative care/ chaplaincy/ bereavement support for dying patients but it is likely that any change will be gradual. In the meantime, we recognise high quality one to one care in critical care supported by their pre-existing framework.



Guy's and St Thomas' NHS
NHS Foundation Trust

Adults at Risk Work Plan 2020 – 2021 (Completed actions)

(Following self-assessment on compliance with the Safeguarding Adults Assurance Framework for Health Care services)

Complete **Ongoing** **In Progress** **Needs Attention**

NO.	Standard to be achieved	Actions for compliance	Progress to date	Responsible Person	Evidence/Assurance	Strategic aims	Completion date	Rag Status
	Policy and Procedure Standards							
1.	Allegations policy in line with LSAB framework	• Review and amend current allegations guidance document • Guidance to change to policy • Presented to TME in March	• Existing allegation guidance in place • Guidance reviewed in line with the LSAB framework	• Safeguarding leads adults and children and HR	• A signed off policy document in place	Protection Prevention Accountability	April 2020	
	Governance and Leadership							
2.	The organisation has a policy that ensures that staff who are in contact with adults at risk receive regular supervision and an appraisal	• Staff supervision policy for safeguarding adults team to be completed • Team to have safeguarding supervision training injunction with LSAB providers	• Regular 121 are in place. • Supervision with cases mainly is provided to staff within the safeguarding team • Review of supervision protocol for safeguarding adults team • Development of safeguarding framework with LSAB • Train the trainer supervision course being sourced by LSAB	• Mala Karasu/ safeguarding leads	• Staff trained in providing safeguarding supervision • A record of any supervision provided to the staff in clinical areas	Protection Prevention Accountability	December 2020 Team supervision and 121s in place Framework complete Safeguarding Supervision training received by the team	
	Partnership and multiagency working							

3.	Complex case pathway	• Working with Lambeth and Bromley SABs on a complex case pathway to provide guidance on managing complex cases such as self neglect	• LSAB representative working with Bromley on this project • Regular updates on progress	• Safeguarding with LSAB	• An established complex case pathway that is being used in the management of patients with complex needs	Protection Prevention Partnership Accountability	July 2020 Complex pathway in place	
	Training and Development							
4.	Safeguarding Adults Level 3 training	• Established level 3 programme in the Trust • Appropriate staff profiled to receive this training • Training will meet intercollegiate competencies	• ET&D looking at SCROM compliance for HEE e-learning package to be used by Trust staff • Profiling for this level of training is being undertaken • Discussions being had with children safeguarding to look at joint training programme	• Safeguarding adults, children and ET&D	• Established level 3 package which is approved by stat-man training group	• Protection • Prevention	September 2020 Package agreed and piloted.	

** This work plan will be updated and added to depending on any changes in legislation and requirements of the organisation.*

Guy's and St Thomas' NHS
NHS Foundation Trust

Adults at Risk Work Plan 2021 - 2022

(Following self-assessment on compliance with the Safeguarding Adults Assurance Framework for Health Care services)

Complete **Ongoing** **In Progress** **Needs Attention**

NO.	Standard to be achieved	Actions for compliance	Progress to date	Responsible Person	Evidence/Assurance	Strategic aims	Completion date	Rag Status
	Policy and Procedure Standards							
5.	To ensure that all patient facing policies and guidance make clear reference to the Mental Capacity Act 2005	• Identify all polices and guidance that are patient facing. • Start with the safeguarding adults and related policies that safeguarding adults is responsible for and include a paragraph • Work through the other policies and guidance in a systematic manner	• Safeguarding adults and related policies have clear references to the Mental Capacity Act principles	• Safeguarding team and senior nursing and therapy staff	• All patient facing policies and guidance have clear reference to the MCA	Accountability Empowerment	March 2018 and ongoing	
6.	Policy and procedure for Liberty Protection Safeguards (LPS)	• Draft procedures in place identifying key changes and roles as a result of new legislation • Procedure to go out to wide consultation • Staff awareness raising workshops and training	• Scoping exercise • Awareness raising workshops • Monthly meetings organised	• Safeguarding team and senior nursing and therapy staff	• A signed off procedure document in place	Accountability Empowerment	June 2020 National delay	
7.	Digitalisation of MHA detention documentation	• Clear protocol to ensure that the new way of working is embedded with	• Protocol document in place • Out to consultation twice with final changes made	• Head of Safeguarding Adults and	• A signed off document in place	Protection Prevention	May 2021	

		minimal opportunity for errors • The protocol will be agreed with the AMHP service and SLaM liaison services and the SNP team		Mental Health Lead				
8.	Updated Protocol for the MHA administration for the safe and effective use of MHA 1983	• Protocol for the receiving and scrutiny of the section papers. • Clear identification of roles and responsibilities across the Trust with ensuring the patient understands they rights, completion of section 132 rights form, Completion of 136 forms Escalation of issues, organising IMHAs if required etc.	• Protocol document in place • Out to consultation twice and final changes made • Protocol aligned with RBHT	• Head of Safeguarding Adults/ Mental Health Act Office/ • Gemma Tunnel	• A signed off document in place	Protection Prevention Empowerment	May 2021	
9.	Updating MCA procedure document	• Updated and current procedures	• Protocol document in place • Out to consultation twice and final changes made • Protocol aligned with RBHT	• Head of Safeguarding Adults/ Mental Health Act Office/ • Frank Butau	• A signed off document in place	Protection Prevention Empowerment Accountability	May 2021	
	Partnership and multiagency working							
10.	The safeguarding strategy, planning and delivery, involves and takes account of patients, users and carers experience	• A patient and carer audit of safeguarding process • Audit template required to meet needs of vulnerable adults involved in a safeguarding investigation	• All Trust surveys are being reviewed with a focus on safeguarding • Feedback form to be agreed • Allegations cases to be used to seek feedback	• MK/ Safeguarding leads	• Monitoring through quarterly reports to Quality and performance committee, Vulnerable Persons Assurance committee	Partnership/ Empowerment	December 2020 Joint work with LSAB	

		• Joint feedback with local authority on section 42 cases						
	Training and Development							
11.	Staff to be offered Human trafficking and Modern Slavery training	• Staff groups to receive this training to be profiled • 4 sessions a year to be agreed for the Trust • 2 sessions to be arranged with the LSAB	• 2 multi-agency sessions provided in the community • Groups to be offered the training agreed but yet to be profiled • Standalone sessions being organised	• Safeguarding trainers	• Quarterly report on training uptake to the local SAB and to the Vulnerable Persons Assurance Committee	• Protection • Prevention	February 2018 and on-going	
12.	Safeguarding Adults Level 4 training for Safeguarding Team	• Established level 4 programme in the Trust • Appropriate staff profiled to receive this training • Training will meet intercollegiate competencies	• Identifying a range of experiential learning events together with formal training to meet the requirements of level 4 • Profiling for this level of training is being undertaken	• Safeguarding adults	• Established level 4 package which is approved by stat-man training group	• Protection • Prevention	September 2021	
13.	LPS training for clinical staff on assessments	• Assessments to be undertaken identified • Appropriate staff on wards and teams profiled for this training • Training strategy to be in place	• Awaiting guidance from central government • Nine assessments identified • Training currently being worked on	• Safeguarding adults	• Established LPS assessment training in place • Completed training strategy in place	• Protection • Prevention • Accountability	September 2021	
	Professional practice							
14.	Community staff to be able to identify a community deprivation of liberty (DoL.) when it occurs and report to	• Staff to have knowledge about a community DoL. • To recognise when this might be occurring	• As LPS occurs in any settings LPS workshops are being provided to raise staff awareness	• Mala Karasu, safeguarding team	• All community DoL. are identified early. • Staff have knowledge and	• Protection • Prevention • Accountability • Partnership	September 2020	

	the safeguarding adults team and other appropriate agencies	• Understand their responsibility in reporting a community DoL.	• Community staff will be provided with briefing on how to identify when someone is being deprived of their liberty in any settings • Plan on cue cards for staff to use as an aide memoire		understanding when a community DoL. occurring.			
15.	Successful transformation from DoLS to LPS	• On 1st October 2020 those on DoLS awaiting assessment will be assessed for an LPS authorisation • All patient deprived of their liberty from age of 16 who are inpatients will be assessed for LPS authorisation within the stipulated time period	• LPS workshops are being provided to raise staff awareness • Partnership working with SEL implementation group • Shared information via Safeguarding Operational Group and Vulnerable Persons Assurance committee and TME	• Safeguarding	• All appropriate patients on LPS and clear system for assessment and authorisation in place.	• Protection • Prevention • Accountability • Partnership • Proportionality • Empowerment	1st October 2020 National Delay	

** This work plan will be updated and added to depending on any changes in legislation and requirements of the organisation.*

Appendix 7

Service Risk and Mitigation Action Plan

1. Clinical staff shortages, patient acuity with COVID 19 and the lack of visitors can result in: • Less numbers of safeguarding concerns being identified and referrals being made to the Safeguarding team • Focus upon acute physical care with patients being very sick • Lack of visitors to gain information about self-neglect or abuse of vulnerable person • Possibility of neglect and abuse going unnoticed or unreported • High risk of packages of care not being in place when the patient is discharged • Lack of recreational and stimulating engagement of patients who are isolated or restless		
Practice Changes	**Risks to patient**	**Actions to Mitigate Risk**
Dementia and Delirium • Patients with dementia and delirium not being referred to the DaD CNSs for advice and support	• Patients with dementia and delirium who present with complex needs may not have appropriate interventions to manage their behaviour and agitation using a range of approaches such as trying using activities, engaging conversation, involving family and friends to offer reassurance to the patients to manage the symptoms in the first instance • Carers of those with dementia and delirium will not have easy access to talk to a DaD CNS for advice and reassurance on patient care and experience • Opportunity for onward referrals to the Memory Clinic for appropriate patients not optimised	• DaD CNS will review list of patients admitted with dementia and or delirium and contact wards outside of the Older Persons Unit daily to enquire if there are any issues and reinforce use of the Dementia and Delirium bundle • Referrals to Safeguarding are scrutinised for patients who are elderly with a diagnosis of dementia and or delirium • For patients with complex needs the CNS can be contacted via the phone for follow-up calls for reassurance and advice as directed in the dementia bundle. • Patients with delirium without a diagnosis of dementia will be referred to the Memory clinic by the CNS. • Screen saver message about the DaD team will be circulated in 3 weeks.
• Patients with dementia may not be screened for memory problems	• Loss of opportunity for early referral and diagnosis of dementia • New patients referred to the Guys Memory Clinic are assessed remotely and	• During this period of Covid19 the DaD CNS will review the screening register and support with screening patients who have not been screened.

	information gathered but no diagnosis is given until the clinic is restarted.	• Patients who were too ill to be screened will be reviewed by CNS at a later date and if appropriate referred to the memory clinic for further assessment
• Memory clinic suspension reduces the support for patients with dementia and their carers	• Patients and carers have delayed opportunity to speak to professionals about any issues they may have with mental or physical health issues • The diagnosis of dementia is also delayed leading to anxiety and worry • Potential for person with dementia being subject to poor support and possible abuse at home	• The CNS will continue to support patients and carers by calling them to rearrange their memory clinic appointment and to discuss any issue that they may have and sign-post them to the appropriate services if required • Patients are followed-up and all assessments and advice offered remotely • The Memory clinic patients now have a hotline number they can call to speak to a DaD CNS during the week
• Patients with dementia may not have access to their family or carers due reduction in visiting in hospital	• Patients with dementia will likely be disorientated and anxious in new environment • There may be increased incidents or falls, outbursts and patients may attempt to leave looking for familiarity. • Care may be more restrictive	• Where appropriate the CNS will discuss case with ward team and facilitate a video call or use Facetime for patient to speak with their carer or family • Where patient is very distressed the CNS will support ward staff escalate to Director of Vulnerable adults to facilitate family visit in line with pledge - John's Campaign • If the care provided is restrictive, the CNS will discuss with the safeguarding team for an assessment for DoLS
• Patients with dementia and or delirium on the wards may deteriorate due to being isolated and not stimulated meaningfully	• Patients may spend long periods without meaningful engagement such as reminiscence, conversation on favourite subjects of interest, colouring and other stimulating activity on the wards	• The DaD CNSs have organised some activity packs for patients in isolation to engage them in meaningful activity. This may be used by the carer if present or the Nursing Assistant providing enhanced care to occupy the patient and build a rapport with the patient
Learning Disabilities • Out-patient clinic cancellations for patients with LD and or autism	• Patients with LD or autism may be suffering anxiety and distress due to changes to planned activity. • There may be further delay in the person accessing the proposed procedure as they	• CNS assessing each case individually and works closely with treating team for continuity of care. CNS will continue to facilitate reasonable adjustments to care provided i.e. treatment provided outside of hospital, appointments kept and minimise delay in appointments.

	may need lengthy planning to achieve access to the procedure	• Daily meeting with community LD team to discuss creative ways of supporting each patient. • Escalated to the Director for Vulnerable Adults in weekly MDM with the LD CNS, Safeguarding and VA medical lead
• Patients with LD admitted may not receive the appropriate reasonable adjustments and support if the LD CNs is off and or during long bank holidays	• With one LD CNS, a seven day service is not possible with weekends and out of hours not being supported. • Care on the wards may be sub-optimal reasonable adjustments not being in place • Without carers and visitors being able to stay with the patient care may be more restrictive	• Safeguarding team staff who have LD and mental health training will see patients when LD CNS not on duty. • The Safeguarding team has daily huddle and discusses all cases referred to and being managed including LD patients. Plans agreed for support if LD CNS not available • All LD cases discussed daily with LD community team, LD team KCH and GSTT. Community team provides advice / support in managing patients across local community
Safeguarding Adults • Patients with safeguarding concerns not identified and referred appropriately	• Patients at risk of being abused may not be identified and referred to safeguarding with the patient continuing to be harmed	• Team will continue to case find patients with potential Safeguarding concerns from admissions list. Team will look at the lists for patients previously referred to team. • Ward contacts made to discuss patients and ward huddles attended to help identify safeguarding concerns
• Those deprived of their liberty not identified and referred to the safeguarding team for a DoLS	• Patients whose care amounts to a deprivation of liberty may not have access to the Article 5 rights through not being identified and referred for DoLS • The above risk can lead to a legal challenge by authorities or family and be referred to the Court of Protection	• The team will continue to case find patients who may be deprived of their liberty and contact wards to discuss if a DoLS would be appropriate using the admissions list • The team will attend ward huddles to identify patients and discuss with staff • The team will ensure good clear documentation in relation to why a DoLS was not applied for, restricted or no visiting at the time of admission and efforts made to ensure that the care delivered was the least restrictive.
• MCA principles not followed with regards to advocacy and consultation	• Patient decisions may not always be made following the MCA principles especially with respect to advocacy and consultation	• The MCA principles will be iterated during ward huddles and when supporting patients who may have dementia, LD or have safeguarding concerns raised. • Screen saver massaging will be used to remind staff that the MCA requirements have not changed during this period.

	• Assessments and documentation may be simplified and not meet the requirements of the MCA	• The team will follow-up complex cases and advice on advocacy and need to consult others with each case that they support
• Limits to visitation may result in delays in patients being assessed for DoLS by external assessors	• Staff may not be able to facilitate remote assessments for patients thus delaying assessments and DoLS authorisations , meaning patients' rights will not be met leaving it open to legal challenge • Lack of ward equipment may make it more difficult for staff to support remote assessments. Personal devices can be used with clear control guidelines	• External assessors will contact wards to request support with facilitating assessments of patients remotely. It is important these requests are facilitated. Safeguarding team will support wards with facilitating remote assessments of patients who they are already supporting • Staff can use the patient's phone, the ward lap top or their own mobile devices to facilitate remote assessment by other professionals or family and or carers • Staff in ITUs have access to 'Lifeline' for patients to speak with their family/cares as needed.
• Staffing reductions may increase staff stress levels and may increase staff allegations of misconduct against vulnerable patients	• Staff may be stressed especially supporting patients who present with challenging behaviour increasing the potential staff allegations for misconduct.	• Extra vigilance is required when supporting staff during this difficult time • The allegation guidance remains in force with no changes to its requirements
2. Reduction of safeguarding team through redeployment has the potential to: • Leave the safeguarding adults team not able to meet the needs of vulnerable patients		
Dementia and Delirium • Staff reduction may result in there being no service if the remaining staff member has to self-isolate	• Potential for there being no DaD CNS to respond to referrals or provide advice and support to the wards and carers	• Safeguarding team will pick up referrals and support the patient and staff accordingly using the skills of the team members who have necessary skills and knowledge • Where the problem is complex, the team will discuss with the medical leads for vulnerable adults and or the Clinical Lead for Dementia and Delirium care for advice. • Advice can also be sought from the POPS team and the Older Adults psychiatric team.

		• If the period of absence of DaD CNS is lengthy, one of the DaD CNS who is redeployed will be recalled following discussion with the Director of Vulnerable Adults
Learning Disability • There is a possibility of there being no service if the CNS has to self-isolate	• Self-isolation by LD CNS will mean no service to in-patients and those attending outpatients	• In preparation the team is learning to undertake mandated duties of LD CNS i.e. review admissions list daily, validating presence of LD with community team or and support wards with relevant information. • Team will attend daily meeting with LD Community team and will work closely with LD community team to support staff in caring for people with LD. • Wards will be given copy of the LD bundle to support care. • Team member LD trained assigned to support LD case load • All LD referrals discussed at Safeguarding daily huddle
Safeguarding Adults • Potential for a reduced service being provided if there are any further reductions to the team	• Potential reduction may result in a delay in responding to safeguarding referrals and DoLS applications	• Safeguarding adults team adequately staffed currently to provide a service that meets Safeguarding activity currently with appropriate back-up within team should anyone of the remaining team needs to self-isolate
3. Social Isolation and working from home potential for increase in: • Increase in incidences of domestic abuse • Exploitation/abuse or neglect of vulnerable adults • No having adequate support at home and increase in self- neglect • Increase in alcohol and substance misuse leading to declining of services and self-neglect		
• Social isolation may increase potential of domestic abuse and abuse of vulnerable adults	• Caring role without breaks may increase carer stress and potential abuse or neglect • Working from home may remove time away from abusive situation / increase risk • Hospital IDVA service working remotely	• Patients referred will be scrutinised for domestic abuse. Referrals also screened for other dependent vulnerable adults / children and discussed with appropriate teams. • Hospital Independent Domestic Violence Advisors (IDVA) working remotely and not able to have detailed discussions /assessments. Patients given contact details of community IDVAs and other safety precautions

		• Discussion with HR for awareness raising among staff who do not feel safe working at home that they can to come to work if needed.
• Social isolation may increase drug and alcohol dependence and other risks	• Drug and or alcohol increase can result in self-neglect and a decline in well-being. Being followed up by substance misuse service is currently a limited service.	• Patients referred to Safeguarding or admitted for substance abuse will continue to be scrutinised to ensure they are referred to substance misuse team for follow-up • Those who are deemed as being self-neglecting will continue to be offered a referral to social services if they have care and support needs
4. Reduction in regular mechanisms for Internal and External Scrutiny and Safeguarding Adults activity to meet statutory requirements with regards to : • Clinical incidents, complaints and serious incidents • Scrutiny of mental health detentions ensuring that the patients' rights are upheld • Allegations against staff • Safeguarding concerns raised against Trust services • High risk and complex cases • Suspension of internal and external boards • Staff training • Relaxation of DoLS requirements for those with COVID-19		
• Integration of safeguarding and clinical integrated practice as per local agreement requires the agreed scrutiny of appropriate clinical incidents and be reported vis the safeguarding route as needed • Scrutiny of complaints requires to be undertaken outside of the agreed process of reporting to the Safeguarding adults Operational Group	• Delayed reporting clinical incidents, possibility of some incidents not reported • Clinical incidents that may be allegation or safeguarding concern may not be recognised / responded to appropriately • Resolution and learning may not take place	• Daily scrutiny of incidents referred to team and safeguarding concerns will referred to social care for investigation and or scrutiny • Where a SI is declared team will work with social care to ensure they also have insight into issues involving people with care and support needs • Monthly conversations with the complaints manager to look for safeguarding concerns and where identified will be referred to social care • Learning will be shared via the directorate management teams for dissemination and action as appropriate

		• Data on numbers of SIs involving people with care and support needs will be reported to the local SAB
• Review of mental health detentions, incidents relating to mental health patients and ensuring that patient advocacy and rights under the Act are adhered to outside of the agreed process of reporting to the bimonthly MH Administration Group	• Potential for some detained patients not to have their rights explained to them • Some of these patients may not have an advocate to support them through their detention • Clinical incidents may not be investigated in timely manner / lessons learned shared	• Weekly discussions with MHA Manager looking at compliance rate of rights being explained to patients and actions to be taken where the compliance rate is low. • Discussion on any incidents involving detained patients and ensuring that the appropriate staff have been involved in the investigation • Devise a plan to ensure how the learning is disseminated
• Management of allegations in accordance with the Trust guidance to continue without any reduction in service	• Delay in allegations being reported • Allegations reported within a complaint or as an incident • Delay in the allegations being investigated and the right actions being taken	• This process will continue as per guidance • All complaints and incidents will be scrutinised for potential allegations and escalated as appropriate • Allegation process will continue to be started within 48 working hours of the allegation being reported
• Safeguarding concerns raised by external partners against Trust services to be responded to within the agreed 2 week for initial information and update and followed by a full investigation and report to be continues with little delay as possible	• Delays in Section 42 investigations being delayed due to staff capacity resulting in delays in lessons learnt and practice changes if needed	• Any sec42 notifications will be escalated to the directorate team and investigator identified. • The safeguarding team will then complete a report from the completed investigation and submit to social care following sign-off by directorate team • Lessons learnt shared via Directorate Management Team • Data of all sec42 will be collated / presented as required
• Continuation of high risk panel meetings now remotely to discuss and update on progress and issues and formulation of safety plan	• Remote meetings about high risk patients do not allow for detailed discussions, challenges and clarifications to take place. May also be attended by less professionals and risk plans may not be as robust	• These will continue to be attended remotely bearing in mind the challenges of having non-face to face meetings • Meeting minutes will be checked and agreed post meetings • Panels will be encouraged to make contact if between meetings if there are concerns or further clarification is needed
• Suspension of Safeguarding Adults Boards reduces the external scrutiny of safeguarding • Postponement of VPAC	• Reduction in overall scrutiny of safeguarding governance and performance	• Weekly 6 borough meeting convened and attended by safeguarding designated leads from 6 CCGs and provider safeguarding leads from KHP to discuss all activity, issues and sharing learning

	• Reduction of internal scrutiny of performance against the Care Act Safeguarding requirements	• The Lambeth Performance and Quality sub-group meets remotely fortnightly and discusses safeguarding issues that are being experienced by all partner organisations. • The group has worked out a template to complete when undertaking assessments remotely to achieve consistency • Regular remote discussions regarding MCA and the impact of the new DoLS guidance with the London MCA network with Alex Ruck-Keen, solicitor
• All staff training is suspended not allowing for our statutory requirements to be met	• Face to face training suspended, staff may not have the required training to ensure that vulnerable adults are safeguarded • Prevent training is only face to face, therefore staff who undertook training over three years ago / new to Trust may not be able to identify cases of potential radicalisation of a vulnerable adult	• Most of safeguarding adults training is available as e-learning packages for staff to access when required, • Staff have an extension of 3 months currently to complete their mandatory training • Prevent training not available on line and so risk many staff will not update until can resume face to face training • Trainer working with IT and ETD to provide Prevent training via a webinar
• Relaxation of the DoLS application for those patients with COVID 19 will require additional scrutiny as DoLS may apply once life-sustaining treatment is ceased	• Patients who may no longer be receiving life sustaining treatment may be deprived of their liberty and may not have their rights safeguarded without a DoLS in place	• Patients who are positive for COVID-19 and receiving life sustaining treatment are not considered as being deprived of their liberty. Good follow-up of these cases is required to determine if they will need a DoLS once they are no longer receiving life sustaining treatment • Not all patients who are COVID positive are receiving life sustaining treatment. The team will continue to scrutinise all patients who may be eligible for a DoLS